RONE2015 THE ART OF PERIOPERATIVE CARE: ETERNALLY EVOLVING

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ABSTRACT BOOK



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ABSTRACT BOOK

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MODERATORS BIOGRAPHIES

MODERATOR BIOGRAPHIES



Marie Afzelius

Sweden SEORNA

RN OR Nurse 1982. Account Manager 2001-2006, Materials Consultant 2006-2007, Board Member Swedish Operating Room Nurses Association (SEORNA) 1996-2001, 2012-Editor SEORNA Perioperative Magazine "Uppdukat" 1997-2001, 2012-Board Member EORNA 1999-2001, 2012-SC Member for 7th EORNA Congress Rome 2015.



Emese Bérczi

Hungary EORNA Board member

Education: B.Sc. degree in nursing at the Medical University of Debrecen, Dept. of Nursing, 1998; Health Care Manager at the Medical University of Debrecen, 2005. I have been working as OR nurse since 1989, as OR head nurse since 1996. I'm organising the activity of the Central Operating Department at Jósa András Teaching County Hospital, Nyíregyháza since 2005. I'm involved in basic and postbasic education in our hospital, and quality management at local and national level. Board member, Association of Hungarian Theatre Nurses (MMT).

Member of the board of directors of EORNA since 2005.



Charmaine Betzema

Netherland LVO

I am Charmaine Betzema and I graduated as an OR assistant in 1984. I have enjoyed working as an OR assistant in different hospitals and for the last 15 years I have been actively involved as Project Manager at the Medical Centre Leeuwarden, one of the projects I am involved with is the control of instruments for the OR.

I was the president of LVO till 6 March this year, which is the Dutch association for OR assistants, the LVO has been in existence for over 35 years and has organized many conferences and symposia for the profession we profiled a guideline "Nothing left behind in the patient". As an association we represent the interests of our profession and the safety and wellbeing of patients has always been our highest priority. In 2007 I became a board member of EORNA and in 2012 I was elected as treasurer.



Margaret Brett

Portugal

AESOP as Consultant and EORNA as Non Executive Board member Occupation: RETIRED - now CONSULTANT AESOP

Upon completion of general training in London Margaret proceeded to her Operating Room Specialist course. Taking time out of nursing to produce three children she undertook part time work in consumer research, marketing and business management.

She then worked for many years in posts in Theatres on the south coast before becoming a clinical teacher for theatres. Her later work saw her as ENB Course Leader for Brighton University covering many hospitals in the South followed by Course Developer and Leader for Theatres and Anaesthetics at South Bank University in London.

She became a Registered ENB specialist nurse. Throughout all her years in teaching Margaret held strong to the principal of retaining her clinical knowledge and always spent one day a week in the clinical area with her students, even though it was sometimes a fight to retain this time. In 1999 she was appointed Chairman of the Hastings and Rother NHS Trust and served three and a half years in post before retiring and moving to Portugal, where she became involved with their national organization AESOP and was on the organising committee for EORNA Congress 2012. Outside of formal work Margaret was a member of the National Congress committee for NATN and a UK representative on EORNA becoming the first secretary as one of the co-ordinators. She later became the 2nd President of EORNA during which time she led the Development of the Common Core Curriculum for EORNA, and hosted with VVOV the first EORNA Congress.

Margaret has presented papers at many congresses and events around the world, and has also published papers and written chapters in books on OR Nursing. She voluntarily taught Third World children and House mothers at the Pestalozzi Village in Sussex. MARGARET BRETT SRN, FETC, ENB 176-182, BSc, Dip. N. (Lond), Dip N.Ed (Lond) Msc, Ph.

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Tracy Coates



United Kingdom National health service Litigation authority Occupation: Patient safety lead Tracy Coates RGN ENB Safety and Learning Lead - National health service litigation authority (NHSLA) Past President AfPP

Tracy is currently working at the National Health Service Litigation Authority (NHS LA) as Safety and Learning Lead (Surgery) since March 2014. The NHS LA is a not for profit organisation that provides indemnity cover for legal claims against the NHS and supports learning from these claims within the UK patient safety national agenda. Previous to that she was working as Independent Consultant following the closure and restructure of the National

Patient Safety Agency under NHS England where, from July 2008 to June 2011, her role was Patient Safety lead for Anaesthesia. Tracy is a Past President of Association of Perioperative Practice (AfPP) ending her term of office in Jan 2013. Tracy has worked in the perioperative environment, in Anaesthetics and Post Anaesthetic care, in excess of 23 years, undertaking a variety of roles in management, education, clinical outreach and finally as a Matron in perioperative care before her appointment as Patient Safety Lead for Anaesthesia at the NPSA. Independent commissions have included perioperative never event reviews, communication interrelations between supporting departments, perioperative service reviews and patient safety reviews. She has also undertaken organisational education in improving practices in relation to use of the five steps to safer surgery and never event reduction and is an associate of a human factors training company delivering education to multidisciplinary clinical staff. Tracy is also a specialist advisor for the Care Quality Commission (the UK healthcare regulator) and has undertaken hospital inspections under the new inspection methodology. She received the Langton Hewer award for her services to Anaesthesia and patient safety from the Association of Anaesthetist Great Britain and Ireland (AAGBI) in Sept 2011.

Tracy sits on key safety committees at a national level including the Safer Anaesthesia Liaison Group (SALG) and the Clinical Board for Surgical Safety (CBSS) and the Perioperative Never Event Task force who's original report findings have led to the development of national preventative standards currently in progress.



Petra Ebbeke-Funke

Germany Community Hospital Braunschweig Occupation: Manager of the school for post-basic education for operating and endoscopic nurses Basic education in nursing 1978 - 1981 Post-basic education in operating room nursing 1984 - 1986 Post-basic education in nurse teaching 1989 - 1991



Edry Yael

Israel RN, OR, MPA OR department Head nurse, IPNA chair person, EORNA secretary My name is Edry Yael. Married + 3 children. Living in Regba a village in the north of Israel. Working in Rambam health Care Campus, in Haifa. Rambam is the biggest medical center and the only trauma center for the north of Israel, serving more than 2,000,000 citizens, soldier and USA Navy.

Education:

1979 - 1982 Nursing school - Register Nurse diploma
1983 - OR continuing education course
1994 -1997 - BA degree in General studies related to nursing
2000 -2001 - MPA Master degree in Public Health Administration

Professional:

1996 - OR department head nurse- 12 OR's rooms, 85 employees.
2005 - IPNA - Israel Perioperative Nurses Association, chairperson
2006 - EORNA Board member
2009 - 2015 EORNA secretary
Teaching in OR nurses course - Clinical practice and Managing.
Member in managing committees at the Hospital.
Consulting for the national health service - on OR issues.
Member of national health committees - related to quality of care in OR's.
Speaker in national and international conferences- Clinical Practice and Managing issues.
Speaker and moderator in last two EORNA congresses - Copenhagen and Lisbon.
Scientific committee member in 2009, 2012 EORNA congress.



Mona Guckian Fisher

United Kingdom President Director AfPP

Having trained as a nurse in London back in the 70s she recalls her 3 months theatre experience as the least enjoyable of all her placements. It is extraordinary therefore that she has been involved in the delivery of perioperative services for several decades.

Mona has worked in theatres at hospitals in the west of Ireland and in Dublin, where she undertook the post graduate theatre course at Beaumont Hospital and returned to the UK some years ago immediately joining NATN as it was then. And as she says herself the rest is history.

Mona is the current President of the Association taking up this role in January 2015. She represented the membership on the Governance Committee from 2006 and was the chair of this committee from 2012-2014. Elected as a Trustee in August 2010 and Vice President in 2013.

She has worked in a variety of settings from major teaching hospitals in the NHS to multi-specialty theatres in the independent healthcare sector and currently is an independent consultant.

With direct experience of many surgical disciplines she has held leadership roles in a variety of perioperative clinical areas and process improvement projects. She is one of a small number of registered safety practitioners working in the healthcare sector, is a qualified occupational health nurse and a chartered member of the Institute of Occupational Safety and Health (CMIOSH).

Her special interests largely centre on the study of medical law and ethics particularly in relation to patient safety, staffing, competence and human behaviour. She has a Masters degree (with commendation) in health law from Nottingham Trent University and her dissertation focused on the professional, legal and ethical issues of the 'dual role' in perioperative practice.

Mona is a board member on the European Operating Room Nurses Association (EORNA) and the International Federation of Perioperative Nurses (IFPN), and provides support and expertise to help influence the direction of perioperative services across Europe and the international healthcare community. Originally from Ireland, she lives in Derbyshire and is married to Philip, a wonderful Yorkshire man. Between them they have 6 children and 10 awesome grandchildren. Mona suggests that these young people are perhaps the perioperative practitioners of the future, thereby compounding the responsibility to be the example of everything that contributes to kindness, compassion, competence and leadership as the very basis of what we stand for.



Merja Fordell

Finland

Oulu University Hospital, Intensive and Surgical Care Accountable Unit, Northern Ostrobothnia Hospital District, Finland Chief Nursing Officer (RN, MSc), Vice President EORNA

Merja is a Registered Nurse and has post-basic education for perioperative nursing, including both operating room nursing and anesthetic nursing. She got her master's degree in health care administration at the Oulu University, 2002. She has gained her operating theatre experience for me than twenty years in a number of major operating departments being exposed to many different theatre management styles and organizations.

Merja is currently working at the Oulu University Hospital, Intensive and Surgical Care Accountable Unit as a Chief Nursing Officer. Although Merja left the perioperative arena many years ago, she has a great interest for OR nursing and prience including a lot of meetings and OR visits around the world showed her how important the purses' inh is for each

OR management. Her OR experience including a lot of meetings and OR visits around the world showed her how important the nurses' job is for each patient and for each colleague.

Merja has been Member of the board of directors of EORNA since 2000. She has been appointed a Member of the Scientific Committee for 4th EORNA Congress Dublin 2006 and a Chair of the Scientific Committee and a Member of the Organizing Committee for the 5th EORNA Congress in Copenhagen 2009 and 6th Congress Lisbon 2012. She has served as EORNA Vice President since 2012 and is a past President of the Finnish Operating Room Nurses Association (FORNA).



Ahuva Friedman

Vice president of INPA (Israeli Periperative Nurse Association) OR Nurse MA, Edith Wolfson Medical Center, Holon Israel, Secretary of Eorna Head of clinical instructors in OR nursing organizations in Israel Nursing diploma: 1974 OR nurse diploma: 1977 Course clinical instruction - 1997 BA - 1999, Bar Ilan University Bridging course - 2000, Bar Ilan university Director's course for senior executives - 2004 Medical administration MA, Tel - Aviv Univ. - 2005 Chairperson of 7 national conferences 3 international congress (2005) Course director of perioperative nurse course - 2002 Participated in international congresses: AORN 1998, 2007



Aina Hauge Norway Stavanger University Hospital OR-Manager



Kostas Karakostas

Greece Rn Nurse

1993 Bachelor in Nurse, Technological Educational Institute of Athens.

2005 Msc Public Health University of Athens/NSPH.

24 years as RN, Nurse of anaesthesia in operation room for 10 years, 9 years nurse in sterilization department, link of quality office.



May Karam

France French representative at EORNA. Occupation: Operating room Nurse in a public hospital in Paris.



Tiiu Koemets

Estonia

Member of EORNA Board; member of Estonian Nurses Union, president of Estonian Operating Room Nurses Association. Occupation: Tartu University Hospital; chief nurse of Operating Department.



Sue Lord

United Kingdom Chair Education Committee, EORNA Board, 2012 - present. EORNA Board member 2010 - present. Occupation: Head of Department, Allied and Public Health, Anglia Ruskin University, UK. Immediate Past President, Association for Perioperative Practice, (President 2012-2014). Former Board Member International Federation of Perioperative Nurses (IFPN 2013-2014). Currently undertaking my Doctorate in Health Sciences at De Montfort University.



Maria Loureiro Belgium



Graça Miguel Portugal AESOP Head Nurse



Sandra Monsalve Gomasriz

Spain Eorna board member. Aeeq vicepresident. Head nurse or. Hu infanta leonor. Madrid. Spain 25 years working in the OR in diferents levels. Represent to the spanish association in the EORNA board. Assistant to national and international course and congress. Speaker in national and international course and congress. OR nurses is one of the things in my life that i most like it.



Sandra Morton

Ireland

Irish Nurses and Midwives Organisation

Clinical facilitator (educator) Theatres

Sandra qualified as a Registered General Nurse in the Adelaide Hospital Dublin in 1995. She has 19 years of diverse Peri-operative experience in public and private hospitals in Ireland, Australia and the United Arab Emirates. She has been a theatre manager, nurse manager in anaesthetics and a Clinical Nurse Educator. She was the President of the INMO Operating Department Nurses Section for 7 years and Board member of the European Operating Room Nurses Association. She is currently Eorna Perioperative Nursing care committee chair, and represents EORNA and all patients and users on the CEN committee on surgical drapes and gowns known as Working group 14 for re-

development of the EN13795 standard.

In 2011, she was awarded an MSc in Health Service Management in Trinity college Dublin, and her thesis was entitled "Implementing savings in the Operating room supply chain using Action research". This project attained cost savings in the region of 1 million euro in one year and 20% of these savings were attributed to custom pack introduction.



Panayiota Mylona

Cyprus Eorna Board Member Occupation: nursing director



Britta Nielsen Denmark

Occupation: Plastic Surgery, Odense University Hospital Education: Nurse 1985 Svendborg Nursing school. Diploma in Public Management 2003 University of Southern Denmark. Master of Hospital Ward Management 2011 University of Southern Denmark. Candidate nursing in progress since 2014 University of Southern Denmark. I have been a nurse since 1985. I have worked in different OR and emergency wards. I have been a manager since 2000 in general surgery, emergency and from 2008 in Plastic Surgery. I have been in the national association of OR nurses in Denmark in 10 years and I am one of two how represent Denmark in EORNA.



Anne O'Brien

Ireland Irish Nurses Midwives Organisation (INMO) Clinical Nurse Manager, Operating Department, Children's University Hospital, Dublin.



Anette Pedersen

Denmark Member of the EORNA board since 1999. Occupation: Headnurse in the neuro - and ortopaedic surgery departments. President of the Danish Association of operating room nurses. Chair of the Organising Committee for the EORNA congress in Copenahgen 2009. Chair of the EORNA Org.C. Member of the Board of the National Association FS SASMO since 1999. President of the FS SASMO 2007. Worked in the ortopaedic OR for more than 30 years.



Jaana Perttunen

Finland JAMK University of Applied Sciences Senior lecturer

Graduated as a nurse in 1986. Worked as a theatre nurse and infection control nurse 1986-2003. Graduated Masters of Health Sciences from Jyväskylä University 2000 and as a teacher 2002. Worked as a lecturer in JAMK University of Applied Sciences since 2003. Member in the board of FORNA, NORNA and EORNA 2000-2006 and 2013-. President of FORNA since 2013. Member of the Scientific Committee of EORNA Congress in Dublin 2006 and Rome 2014.



Dimitris Poulis

Greece Onassis Cardiac Surgical Center. Occupation: RN Nurse, Nurse of Anaesthesia. Psychologist. 1997 Bachelor in Nurse, Technological Educational Institute of Athens. 2005 Bachelor in Psychology, Panteion University of Athens. 18 years as RN, Nurse of Anaesthesia, link of quality office, Onassis Cardiac Surgical Center. Member of research teams for medical research since 2000. Board Member of GORNA since 2009. Board Member of EORNA since 2010. Psychologist since 2005.

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Luciano Trozzi

Italy

Member of the Scientific Committee AICO - Scientific Society Italy - Association of Operating Room Nurses - Years 2011-2015

Works at the Polytechnic University of Marche, expert in clinical research Degree in Sociology with specialization in Communication and Mass Media - University of Urbino - Certified teacher for Class 36/A (Psychology, Pedagogy, Sociology, Philosophy). Master Degree in Nursing and Midwives - University Polytechnic of Marche.

Master's Degree in Management of Innovative Health Care Organizations - University of Urbino.

Course University in "Management of Innovative Health Care Organizations" - University of Urbino.

Master University II level in "Remote applied to health sciences and lct in medicine" - University Polytechnic of Marche. Degree in Midwifery - University of Ancona.

Training and Psychosomatic in Obstetric Psychoprophylaxis - Gynaecological - University Cattolica Sacro Cuore.



Manuel Valente

Portugal Bachelor in Nursing. Clinical Specialization on Med - Surgical Nursing - critically ill patients. Post - graduation on Infection Control Nursing. Consultant of the Portuguese Directorate General of Health. Coordinator of National Patient Safety programs. Vice President form AESOP (Portuguese Perioperative Nurse Association). Nurse Supervisor, Operating Room Department, Oporto Hospital Centre.



Liz Waters Ireland

Irish Nurses and Midwives Organisation Clinical Nurse Manager Three

Specialty: Nursing Management

Clinical Nurse manager Three Theatre/Endoscopy/CSSD & Day Services

Liz Waters is a Clinical Nurse Manager 3 responsible for Theatre Endoscopy, Central Sterile Supplies Department and Day services in Naas General Hospital in county Kildare Ireland. Liz over her career has worked in various hospitals in Ireland, Switzerland and Iraq over the last 28 years including 20 years' experience in nursing management.

In her current hospital she was a member of the Project teams involved in the planning and building of a new CSSD and Theatre Department. She is the Current chairperson of the Naas General Hospital decontamination committee and on the project team for a new endoscopy day services development. Liz was Vice chairperson and Chairperson of the Operating Department Nurses section of the Irish Nurses and Midwives organization in Ireland for seven years. She was a member of the local organizing committee for EORNA congress 2006 Dublin. Since 2009 Liz represents Irish theatre nurses at European level as a board member of the European operating room nurses association (EORNA). She was a member of the Scientific Committee for EORNA Congress Lisbon 2012 and is currently Chairperson of the Scientific Committee for the EORNA congress Rome 2015.

Affiliations: Irish Nurses and Midwives Organization Dublin Ireland.European Operating Room Nurses Organization (EORNA) Board member since 2009Irish association of Theatre Managers and Superintendents member. Irish Decontamination Institute/World forum sterile supplies WFSS member. Outside of work Liz's interests include horse racing, fashion, Skiing, fitness and archery.



Christine Willems

Belgium AFISO – Belgium, EORNA board member LECTURER – Haute Ecole Léonard de VINCI - Brussels Member of educational committee of EORNA

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Olivier Willième

Belgium

OR & CSSD Project Coodinator - CH EpiCURA, AFISO Vicepresident

Olivier Willième began his professional career in 1993 as a nurse at Cliniques Universitaires Saint-Luc, Brussels -Belgium. He worked at the bedside for 3 years while pursuing a university education. He then engaged in the cardiac intensive care nurse and became head of the recovery room in 1990. In contact with the perioperative environment, it has invested in AFISO, the professional association of French theater nurses in Belgium which he is vice-president and webmaster. He became a member of the EORNA in 1990 (European Operating Room Nurse Association) and has served two terms as vice-president. From 1993 to last year, he has been responsible for major operating theaters (up to 23 operating rooms). He currently manages a CSSD and works as project coordinator between OR

and CSSD at EpiCURA (group of 5 hospital) - Belgium. His experience in operating theaters enables it to address patient safety and nursing practice in terms of compliance and technological innovations.



Meryem Yavuz van Giersbergen

Turkey Ege University Nursing Faculty Head of Surgical Nursing Department Olivier Willième

ABSTRACT PRIORITY SESSION

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CAN WE CHANGE THE PERIOPERATIVE WORLD?

De Boeck, Jan Business unit leader: OR, recovery, one day clinic Hospital Network Antwerp ZNA, Antwerpen, BEL

Abstract

Even in the perioperative world the current and future trends are to push us to be more flexible in work and to work more efficiently.

In general change doesn't make us happy. When you walk into a hospital you will not be overwhelmed by an atmosphere of joy and happiness. Instead you are more likely to meet more people with a sad face rather than people full of enthusiasm and positivity.

Maybe you're lucky and you will retire soon. But for those of you that must stay, it maybe more interesting to change your daily mindset.

A lot of people make their partner, surgeon, boss, colleague and children responsible for their happiness. A lot of negativity is created by gossip, complaining to others who have no influence. What's for sure is that, if you want to change a world, you don't start by pushing others to change.

In this 'interactive' session we will look at how OR-workers can change the perioperative world. It may be difficult to know how to change the perioperative world in your daily struggle of the OR jungle.

How would the world look without OR-workers? How to deal with the challenge of change? How to focus on positivism? How can we create a wonderful energetic workspace? How to benefit from others happiness? How to communicate easily with co-workers? How to start with your own change?

Will it be possible for you to change the world as OR-worker? Yes you can \ldots

Let's leave Rome full of energy to create a new art of perioperative care.

ORAL COMMUNICATIONS

ORAL COMMUNICATIONS

0C 01

WHAT DO NURSES THINK ABOUT THE INTRODUCTION OF THE TECHNICIAN/NON-NURSE ROLE IN THE OPERATING ROOM ACROSS EUROPE?

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Faculty Of Medical Sciences, Anglia Ruskin University, Chelmsford, United Kingdom (1)

Keywords: Nurses, Technicians, Non-Nurses, Operating Theatres

In England technicians have been used to assist staffing of the Operating rooms since the early 70's ¹. This was initially due to the shortage of sufficient numbers of qualified nurses to maintain a safe environment for patients. However, in later years it has continued due to various reasons such as the European Working Time Directive ², political influences ^{3,4,} ^{5,6,7}, demographic changes ⁸, and economical influences ⁹. However, there are very few countries in Europe who have introduced the technician (non-nursing) role into theatres over the last 30 years. This research therefore sets out to explore the barriers and facilitators to the introduction of the non-nurse role in the operating room across Europe in order inform the perioperative workforce to allow them to make informed choices in the development of the theatre workforce across Europe.

The methodology utilised for this research is a constructivist approach as it is difficult for the researcher to bracket their bias and utilise a true phenomenological approach due to her professional background and involvement in the research topic and pre-formed opinions ¹⁰. The research has been undertaken in two stages. Stage one involved data collection from the Board members of the European Operating Room Nurses Association (EORNA) through a questionnaire as a scoping exercise to see who utilised non-nurses in the operating room. Stage two involved undertaking semi-structured interviews with four candidates from each of six countries. Three countries were selected who had introduced the role which included England, Netherlands and Turkey and three countries were recorded and transcribed and then member checked by participants for accuracy ¹¹. The rich data collected has been analysed using a thematic approach and the initial findings will be shared during this presentation.

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Faculty disclosure: No conflict reported

0C 02

THE IMPORTANCE OF THE ROLE OF THE NURSE IN OPERATING ROOM (OR) AND THE POSSIBILITY OF REPLACING HIM WITH OTHER PROFESSIONALS: AN OVERVIEW OF THE INTERNATIONAL AND ITALIAN REALITY

Elisa Stiavetti (1) - Mariarosa Oddo (2)

Azienda Ospedaliero Universitaria Pisana, Hospital, Pisa, Italy (1) - Student, University, Pisa, Italy (2)

Keywords: Staff integrationin Operating Room, nursing care process assessment, Social Health Care Operators

Background

In a time of spending review, nursing are being targeted for containment of the costs by the managers. In some foreign countries it was decided to replace the OR nurse with other technical figures. In Switzerland job schools have been born for OR technicians, who have replaced the instrumentalist². In the U.S. it has emerged the Scrub Tech, a paraprofessional who works under the supervision of the nurse. In Italy, some Regions have thought of solving the problem through a specialized training of the Social Health Care Operators (OSS) for the instrumentation inOR: a hypothesis that has had poor credit.

Materials and Methods

On march 2014 a survey has been carried out, addressed to nurses workingin differentOR of the Hospital of Pisa, aimed at analyzing the real need of nurses to better integrate OSS in the OR (with the assumptionthat the nursekeepsfull competence toassess care process). The instrument of the study was a semi-structured questionnaire, who 57 nurses responded (females 61% and male 39%).

Results

68% ofnursesbelieved that a greater collaborationis neededby the OSS. The nurses retain that the OSS in autonomy can reorder and controldeadlinesdevices, decontaminate and package surgical instruments. Instead, about cooperating activities the sample said: material preparation for surgery and assistance during surgery.

Conclusions

The research showed that nurses in OR need greater support from OSS about those activities which are easily controlled and not in contact directly with the patient. In a situation of staff under-sizing, the risk for the nurse is not to be able to ensure the golden standard. Plans of improvement are therefore linked to the outcomes of severe economic and social crisis that Italy is experiencing. It is essential to invest on health services and human resources.

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Faculty disclosure: No conflict reported

0C 03

PERIOPERATIVE NURSES A REQUIREMENT FOR SAFE SURGERY – SOMETHING EVERY-ONE IN OUR SOCIETY OUGHT TO KNOW?

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Keywords: Perioperative nursing care activities in collaboration, crucial perioperative nursing care activities by operating room nurses, crucial perioperative nursing care activities by anesthesia nurses.

A discussion between the Swedish Operating Room Nurses Association and the National Society of Anesthesia and Intensive Care about the need for specialist nurses/ perioperative nurses for safe surgery was performed in 2013. Perioperative nurses as operating room nurses (ORN) and anesthesia nurses (AN)have together as members of the surgical team been responsible for the patients' health, wellbeing and safety during surgery for more than 50 years in our country. There is a need of additional OR and AN Specialist nurses, i.e. perioperative nurses in coming years. Other nurses still let us know "you do not perform nursing care". The questionshigh-lighted therefore were How do we make our professions as operating room nurses (ORN) and anesthesia nurses (AN) known and how do we express the meaning of perioperative nursing care for safe surgery to fellow humans in our society.

The aim of the project was to create a statement based on scientific and experienced based knowledge about the meaning of perioperative nursing care by ORN and AN specialists for safe surgery in an easily read language.

Target groups for the statement are fellow humans in our society, media, and politiciansas well as other professionals in health care. The statement is free to use by our colleague ORNs and ANsfor example in discussions about working conditions with managers in health care, and in contact with media representatives, and with politicians about patient safety in health. The statement comprises perioperative nursing care actions for patients performed together by ORN and AN Nurses. Three crucial nursing care activities respectively for the OR and the AN Specialist nurses for patients maintained health, wellbeing and safe surgery are declared in an easily read short text.

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Faculty disclosure: No conflict reported

OC 04

THE SCRUB ROLE IN THE EUROPEAN SCENARIO: SHOULD IT STILL PERFORMED BY A NURSE?

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Keywords: scrub role, nursing philosophy, nursing evolution, care

Background

Nurses' roles have changed significantly over the years ⁽¹⁾; the scrub nurse is no exception. While some countries have provided the role an extension, in some others a technician performs these functions. In several European countries, including Italy, the situation is still unchanged.

Focus of interest

The focus of interest of this abstract is the nurse's scrub role. We examine the necessity of having a nurse hold the position.

Theoretical framework

Florence Nightingale stated in 1868 the operating room nurse "is instructed how to wait at operations, and as to the kind of aid the surgeon requires at her hands" ⁽²⁾. Manual tasks to support surgical procedures performed by physicians are still predominant for them ⁽³⁾. Scrubbing involves assisting the surgeon directly ⁽⁴⁾, maintaining sterility, controlling infections and conveying specimens, technical skills that only serve to assist another professional who maintains control of patient outcomes.

Conclusions

A scrub nurse is denied the caring role, the essence of being a nurse, and is only an assistant in the medical curing role ⁽⁵⁾. The assignment of this role to nurses undermines the worth of nursing. Limiting the realm of nursing to mere technology renders the nurse replaceable by other professionals and unnecessary in an operating room environment.

Implications for perioperative nursing

The future should be anticipated rather than waiting for it to happen; this is a vital strategy to survive and thrive in an ever-changing world ⁽⁶⁾, nursing included. Nurses should move to areas of care that require a greater professional culture linked to care outcome responsibility rather than performing only technical actions ⁽⁷⁾.

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Faculty Disclosure: No Conflict Reported

OC 05

EVALUATION OF "BLENDED LEARNING" IN A POSTGRADUATE MASTER COURSE OF "PERIOPERATIVE REGISTERED NURSES"

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First level postgraduate Master Course in "Perioperative Registered Nurses", organized from Catholic University School of Medicine in Rome, Italy, has been providing few lessons out of classroom, by a a self-paced "asynchronous" e-learning, since 2008. In 2012 a session of blended learning was inserted in its program. It consists in a interactive computer-based simulation session, that was used in conjunction with a face-to-face teaching.

Aim of this study was to compare blended learning to traditional teaching session, so to investigate if itmay be useful in a Perioperative Register Nurse educational program. Methods

A retrospective analysis was performed on data obtained from 2008 to 2012. The following variables were investigated: number of hits to each lesson, results of learning test for topic and for student, results of students learning satisfaction questionnaire. Furthermore, e-learning sessions before and after the insertion of blended learning (2010 and 2011) were compared. Learning Management System (LMS) was used as learning platform.

Results

The number of hits to each lesson was similar by all students with a mean+SD of 39,7+4,6 per year.

A significant higher number of hits was recorded in a case by a student with no informatic background.

Correct answers average rate were 78% per question and 82 % per student.

Students satisfaction for each course was graded from 1 (bad) to 5 (good), and resulted in a range from 3.8+1.0 to 4.4+0.8.

After the introduction of blended learning, we recorded a significant increase in the number of hits for that lesson from 23+8 to 35 +11; p<0.05ln addition we observed an increase of correct answer rate (from 82% to 84%; p>0.05).

Discussion

Blended learning was effectively used in a postgraduated nurse master course with no major problems. Further studies based on a larger population are necessary to confirm these results.

Faculty disclosure: No conflict reported

0C 06

PNDS: TRANSLATION AND CULTURAL ADAPTATION AND CLINICAL RELEVANCE

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Keywords: Perioperative Nursing, terminology, classification, translation, cultural adaptation

Background

The need for development of standardized nursing classifications systems to describe nursing practice and to incorporate computerized records has been widely acknowledged. Despite of this critical need, in Portugal little work on developing perioperative nursing information systems has been performed. In effect, in order to optimize nurses documentation in the perioperative information systems, it is pertinent to use the work of an existing terminology — the Perioperative Nursing Data Set — specifically developed for perioperative nursing. Purpose: To assess the relevance, clinical usefulness and cultural appropriateness of the PNDS for Perioperative Nursing in Portugal.

Goals

To translate PNDS 3rd edition into Portuguese; assess the cultural appropriateness of PNDS to Portuguese context; assess the clinical relevance of the Portuguese version of PNDS; evaluate the validity and reliability of the Portuguese version of PNDS.

Research problems

What is the cultural appropriateness of PNDS for Portuguese context? What is the clinical usefulness of PNDS after translation into Portuguese?

Methodology

This methodological design study is structured in two phases: a first phase for translation and cultural adaptation of PNDS to Portuguese through expert committee; and a second assessment of the clinical relevance and usefulness of the PNDS, performed by a sample of perioperative nurses of central hospitals in the district of Porto.

Theorethical Framework

The PNDS is a terminology designed for Perioperative Nursing, clinically validated and approved by the American Nurses Association, which was developed by the Association of periOperative Registered Nurses in the USA. As we live in the technology era, standardized terminologies are essential for the development of perioperative information systems and for representing nursing in the computer-based record. Information technology in perioperative area has the potential to improve communication among health care providers, enhance quality of care, reduce adverse events, increase management efficiency and patient data production, and subsequently, help to enhance the scientific body of knowledge. Note

This master degree study is still being finished, so the results will be displayed in the oral presentation.

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Faculty disclosure: No conflict reported

OC 07

EVIDENCE BASED DISCHARGE CRITERIA FOR PATIENT'S HOME READINESS FOR SAFE RETURN AFTER AMBULATORY SURGERY

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Keywords: Ambulatory surgery, Discharge Criteria, MPADSS

Background

With the acuity of outpatient surgery increasing, the aging population, and expansion of inclusion criteria for day surgery, it becomes even more significant to have clear, evidence-based discharge criteria in clinical use. Patient readiness for safe discharge needs to be addressed in a simple, clear, reproducible manner that meets national standards. There may be medicolegal implications involved in discharge after ambulatory surgery and anesthesia. At the moment there is lack of any standard practice and uniform policy.

Purpose

This study was conducted to compare three discharge criteria;1) discharge readiness determined by nurses based on clinical status, 2) discharge readiness by patients, 3)the Modified Post-Anesthetic Discharge Scoring system (MPADSS).

Methodology

A total of 370 day surgery cases were investigated. The MPADSS was employed in every 30 min. in parallel with discharge readiness assessment by nurses and patients. The percentage of the patients who were categorized as being ready to discharge were compared according to three discharge criteria.

Results

The percentage of patients scored to be as MPADSS > 9 in 30 min, 60 min, 90 min were 96.5%, 99.5%, 100% respectively. Whereas 11.1%, 44.3%, 71.1% of patients rated themselves as being ready to discharge and 2.7%, 23.5%, 54.3% of patients actually discharged by nurses according to discharge criteria of S Hospital.

Conclusions

Nurses tend to keep patients longer in the hospital when compared to the patient's own assessment about their readiness to home and to that of MPADSS. The findings suggest that patient's discharge can be influenced by nursing factors.bThis brings out the importance of scoring system to determine the safe discharge. The MPADSS could be a useful tool in evaluating patients for safe discharge.

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0C 08

PERIOPERATIVE NURSING EDUCATION: MEETING TODAY'S CHALLENGES

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Keywords: Perioperative, nurses, education, challenges, preceptorship, preceptor

Developed in response to challenges faced by an aging and retiring perioperative work force, the MacEwan University Post Basic Certificate in Perioperative Nursing Education program provides the registered nurse with a comprehensive and innovative specialty education opportunity that incorporates distance learning with an onsite skills lab and a preceptor led clinical practicum. This preparation is critically needed as there are too few nurses prepared to fill the anticipated workplace void, as nurses from the baby boomer generation begin to retire. The demographics of operating room nurses in Canada indicate that the average age is older than the Canadian average of 47.4 years of all nurses (Canadian Institute of Health Information, 2011). The teaching and learning strategies address trends and realities in perioperative nursing practice and the curriculum fosters a philosophy of care based on the standards from the Operating Room Nurses Association of Canada. The role of the preceptor is highlighted as the integral component to student retention. A preceptor orientation specific to the operating room has been immensely effective in providing a positive and successful student experience. Research findings reveal that preceptor support and training is crucial to student success and that a specialized perioperative preceptor toolkit is needed. The program is available across Canada as an alternative to traditional hospital based programs. It is approved by Alberta's Ministry of Advanced Education and Technology and accredited by the Operating Room Nurses Association of Canada. This paper describes the scope of MacEwan's Perioperative Program, an analyses of learner progress and employability, identification of current challenges, and implications for perioperative nursing education and practice specifically preceptor coaching. Overall, the program has been immensely successful; demonstrating improved partnerships and collaboration between academia, hospital staff, provincial health authorities, and has ultimately strengthened our health care system by improved participant competency

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Faculty disclosure: No conflict reported

0C 09

NURSE LED PRE-OPERATIVE ASSESSMENT.

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Background

The Pre-Admission Clinic (PAC) is an outpatient, multidisciplinary service which prepares, investigates and optimises patients before surgery. Heretofore patients were seen and assessed by the Medical Officer (MO). The Surgical Care Programme identified the need for a Nurse Led Pre-Assessment Clinic in order to foster the expertise whist expanding the role of the nurse.

Methodology

The Nurse Led Clinic was piloted as part of a quality improvement initiative in partial fulfilment for the Leading in Uncertain Times Programme. Theme 2: Effective Care and Support was selected from the HIQA National Standards for Safer Better Healthcare as a guiding framework for the PAC nurses in the delivery of pre-operative assessment care. Five standards of care were developed for the purpose in accordance with standards identified under the theme.

Inclusion/exclusion criteria in determining the cohort of patients suitable for Nurse Led Assessment were identified according to the NICE Pre-operative testing Guidelines-Grade of Surgery criteria.

Implementation

A 4 week pilot clinic was conducted in May 2014. An algorithm specific to each presenting condition was developed to support the Nurse in the assessment and provide clear instruction on when to access Medical/Anaesthetic advice. An agreed set off outcomes for patients were identified.

Findinas

35 patients attended according to the selected criteria. 5 patients declined their appointment and surgery.7 patients required MO review. A further 2 patients were referred to the Anaesthetist. 21 patients were deemed suitable for surgery by the PAC Nurse following discussion with the MO regarding pre-operative medication advice, elevated body mass index and ECG interpretation.

Recommendations.

The appointment of an Advanced Nurse Practitioner would enable patients to be assessed in a more timely fashion resulting in an increased throughput in the clinic. This in turn would reduce the length of time the patients is waiting for surgery.

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OC 10

FROM SBAR TO SHAR - A PORTUGUESE ADAPTATION

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Keywords: Perioeprative Nursing; Handover, Transition, Patient Safety, SBAR

This paper isbased on our experience of adapting SBAR (Situation, Background, Assessment, Recommendation), in a Portuguese hospital. We did an Integrative Literature Review aiming which assisted us in understanding and building a structured handover. The handover process is a time of transition in providing patient care, where the transmission of information and the transference of responsibility is from a health professional or team to others. Surgical patients are subject to a significant number of transitions in the perioperative period, which are considered high risk.

Failures, omissions and errors committed in this process may be adverse events that compromise the continuity of perioperative nursing care and lead to an effective damage to the patient. A frequent recommendation is the existence of a structured handover instrument. The SBAR, provides a standardized framework for communication between members of the healthcare team about the condition of the client.

Adapting SBAR to the Portuguese clinical settings, changed to SHAR (Situation, History, Assessment, Recommendation), which is a guiding tool to use at the surgical patient admission before his/her entrance at the operating theater. Each item summarizes a minimum data set, necessary for the transmission of information: SITUATION - Patient identification and confirmation of the preoperative procedures; HISTORY - Provided information on the status and medical history of the client; ASSESSMENT - customer needs, identifying potential risk factors, and; RECOMMENDATIONS - Transmission of relevant information and issue clarification.

In conclusion, this Perioperative Nursing tool leads to: promotes the surgical patientsafety; Prevention of adverse events; Effective communication among peers; Involvement of the surgical client; Minimum set of data to be transmitted; Efficacy of daily nursing routines and respective activities; Procedures standardization.

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Faculty disclosure: No conflict reported

0C 11

DUTCH QUALITY REGISTER

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On the 1st of January 2013 the LVO (the Dutch National Association of Theatre Nurses) introduced a quality register. Quality registration is a method to guarantee that patients, carers, employers and health insurers are dealing with theatre nurses with suitable professional qualifications. All TNs can be registered on the quality register, provided theyare in possession of the required professional qualification. The LVO considers it important that lay people know the profession guarantees guality.

Having achieved the diploma in the past does not necessarily show quality that is currently considered appropriate. Working in the profession as well as maintaining a personal development portfolio showing the operating assistant's active and conscious maintenance of knowledge and skill ensures he or she can deliver a certain degree of professional competence.

After a period of 5 years it is necessary to reregister. This will be necessary for all professionals who joined the register initially. At that moment all theatre nurses will need to demonstrate the ability to adhere to the agreed criteria which guarantee quality. To be allowed to reregister the theatre nurse has toshow the points he or she achieved in a personal portfolio.

Criteria for reregistration A. Work related experience Definition: All patient related work tasks that are described in the professional job description. 1600 hours of patient related tasks every five years, achieved in a minimum of 36 months

B. Education

Undergoing accredited training which contributes to the increase in quality of the professional worker

C. Activities

For the categories Education and Activities the following minimum achievements are necessary:

- 100 points in a total of five years.

The Accreditation Board

The accreditation board judges the requests on the basis of the submitted programme and indicates the number of points awarded to the programme in question.

Faculty disclosure: No conflict reported

0C 12

EVOLVING AND EXPANDING AN AUSTRALIAN PERIOPERATIVE ENVIRONMENT

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Keywords: Service development, stakeholder satisfaction, maintaining efficiency

Back ground

The extension of existing surgical services to provide the largest single site Operating Theatre complex in Australia and a discussion about the implications of this service development on the perioperative nurses in the workplace.

Hippocrates suggested, many moons ago that "the surgeon could stand or sit, in a comfortable posture dependent on the operative site and the light", never would he have imagined the complexity of surgery the innovation of equipment, and a light source brighter than the sun. Technology has driven operating room design since the earliest times and this is continuing to be the force behind the development of designs conducive to patient centred care. Today's operating theatres are costly and complex, however the impact of the environment can affect the morale of the skilled professionals and possibly improve patient outcomes.

Nine years ago three managers walked into a new environment, within twelve months two shelled theatres were opened to meet the demands of the community and the needs of local surgeons who required increased access to surgical time. Within three years we were again pushing the boundaries of our new environment and discussing expansion for service development yet again. Eventually it became clear that a decision for the future of our well respected hospital needed to be made – yesterday!

A design was submitted, in keeping with our demands for additional operating theatres and overnight beds to meet the demands of both surgical and medical patients. Healthcare facility guidelines were assessed, architects and designers were employed and a fabulous design was presented. Meetings with all the relevant user groups, including work health and safety, infection prevention and control staff and managers from the relevant departments were encouraged to assist in ensuring a workable design.

Plans for managing departments and maintaining efficiency were developed by individual managers in consultation with the relevant directors and Human resources. Prior to opening day staff are being employed, doctors sessions are being scheduled, power and water outages are being managed, troubleshooting areas of concern and final inspections are being undertaken. Detailed change management strategies will have the ability to provide stakeholder satisfaction and affect the morale of the entire team working within the perioperative environment of the largest private operating suite in the southern hemisphere. Imagining that the operating room can remain unchanged and meet the future demands of yet to be realized surgical innovation is not an option if we want to future proof surgical services for the members of our community.

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Faculty disclosure: No conflict reported

0C 13

B. PERIOPERATIVE/CLINICAL PRACTICE JUST IN TIME BETTER THAN JUST IN CASE? HOW TO CARE FOR THE PATIENT AFTER NEXT

 $\label{eq:prue-lambda} \begin{array}{l} \mbox{Prue-Hames}^{(1)} \mbox{-} \mbox{Leigh Anderson}^{(1)} \\ \mbox{Auckland District Health Board, Auckland City Hospital, Auckland, New Zealand}^{(1)} \end{array}$

Keywords: Engagement; patient after next;

Background/purpose/goal

We don't have to look far to hear and see that healthcare resources are very limited. The stretched healthcare dollar is something that frontlines in all of our conversations and actions wherever we may work. The purpose of this project was to learn if we could reduce waste by decreasing the number of sterile items that were opened to the field and then not used and therefore discarded. The goal was to reduce waste by 70%.

This project has been acknowledged nationally in New Zealand for its potential and won an innovation award in Australia.

Methodology

At Auckland District Health Board Cardiac Operating Theatre Suite, when setting up sterile trolleys in the operating room we are guided by the surgeon's preference list for what they may need. To be efficient and save time we may choose to open each item on this preference list to the sterile field "just in case". We measured the waste for these cases and learned that in doing this we were wasting resources that could be saved.

The multidisciplinary team worked together to reduce this waste and by changing the pattern from opening items "Just in Case" to "Just in Time" We managed to save \$170 000 per annum across only 4 operating rooms without any change to patient care.

This presentation will include the lessons learnt and also show how this project can be simply replicated by building a process & visual tool to suit their needs in any operating room department from very small to multiple sites. We can each save our valuable resource so that we can care for those patients who are yet to be admitted for care to our organisations.

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0C 14

THE PRESENCE OF A SURGICAL CARE PRACTITIONER IN THE PERIOPERATIVE TEAM FACILITATES SAME DAY DISCHARGE AFTER LAPAROSCOPIC CHOLECYSTECTOMY

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Keywords: Safety, Surgical Care Practitioner, Day Surgery, Patient Satisfaction

Background

The Šurgical Care Practitioner (SCP) is acknowledged as making a positive contribution to the care of patients undergoing Laparoscopic Cholecystectomy (LC) $^{(1)}(2)$. The perioperative nature of the role enables support for patients and interprofessional colleagues.

Focus of interest

Day case LC is well established as a safe procedure in the United Kingdom ⁽³⁾. It attracts a higher tariff than in-patient LC. In some units it has become routine to admit patients following surgery. This often generates pressure on beds.

Methodology

An initiative aimed to increase safely the number of patients undergoing same day LC. Following ethical approval, a protocol was devised to ensure suitability of patients and appropriate anaesthetic pathways with avoidance of opiate analgesia.

The SCP occupied a key role, forming a link between surgeons, theatre and ward nursing staff and patients; by pre-operative education ensuring that patients had realistic expectations ⁽⁴⁾; providing surgical assistance as necessary; completing personalised electronic discharge summaries, participating in post-operative care and conducting telephone review 48 hours post discharge. An adaptation of National Patient Safety Agency criteria for the assessment of patients post LC was used prospectively in phone calls (⁵⁾ ⁽⁶⁾, with an algorithm designed to ensure the SCP was adequately supported should surgical assessment of a patient be required. Patients were encouraged to rate their satisfaction with the pre-operative information.

Results

110 patients underwent LC over a six month period. Retrospective audit of the unit's performance before the initiative revealed a same day discharge rate of 46%; post intervention this rose to 75.5 % (P<0.001). Of the 84 patients who went home it was possible to contact 56. Patient satisfaction with pre-operative information was high at 75%.

Conclusion

The inclusion of a SCP in the team throughout the perioperative period significantly increased the same day discharge rate – at least in part through better patient education and support.

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OC 15

USE A "PASSPORT" IN RELATION TO THE PATIENT HANDOVERS IN THE OPERATING ROOM (OR) AND INCREASE THE PATIENT SAFETY.

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Keywords: Handover Observational study Patient safety

Background

According to the litterateur the patient handovers are among the most potentially risky procedures in the healthcare system (1-4). Scientific results shows that there are often a lack of structure in the handovers and that efforts should be made to improve this (1.5). In the OR one of the challenges is that the handover takes place during practice (2,3,5-11).

Purpose

To investigate whether the use of a structured tool will increase the patient safety.

Goals

To investigate the perioperative nurses practice for handovers. To develop a handover tool and test it for usability in the perioperative nurses everyday practice in the OR.

Research problems

How does the perioperative nurse at the OR handle the handovers? Will the use of a handover tool increase the patient safety and the perioperative nurses awareness of the importance of a systematic handover?

Methodology

The study was divided into three parts. Part one, was an observational study were 21 handover situations were observed in the OR. Part two was a development of the tool made from the analysis of a systematic review. Part three was a six month testing of the tool.

Theoretical framework

For development of the tool the content analysis was inspired by Polit and Beck (12). The observational study was inspired by Spradleys theories on Participant observation (13-17).

Results

The observational study showed that the handovers were characterized by subjectivity and randomness. A tool named "PAS" (Patient, Activity and Surroundings) was developed and tested. A guestionnaire survey (N=83) after six month showed that the perioperative nurses found an increased patient safety and that the use of "PAS" was meaningful and suitable for their practice.

Implication

The use of a structured handover tool will increase the patient safety in relation to handovers in the OR.

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OC 16

COMFORT SCALE: PERIOPERATIVE VALIDATION

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Keywords: comfort scale; perioperative comfort

Thermal comfort is a human response to ambient temperature, which results from the combination of biophysiological and experiential components. Being discomfort from cold the strongest memory of many people that undergo surgeries, makes thermal comfort in the peri-operative context a highly expressed aspect of overall comfort. However, the factors that, in this scenario, influence the perception of comfort, especially thermal comfort, are multiple, complex and hard to measure.

The need for a valid and reliable tool for assessment of perioperative comfort, led us to adapt and evaluate the psychometric properties of a thermal comfort scale, based on Wagner, Byrne and Kolcaba (2006). The trial version of this instrument included 10 items, assessed through a Likert type measure. The scale was tested on 3 different areas of the hospital context, covering a total of 301 individuals.

For the evaluation of the psychometric characteristics two visual scales have been applied, one for thermal comfort (bidirectional) and other for anxiety (analog), also used previously by Wagner, Byrne and Kolcaba (2006). The study received a favourable opinion from the Ethics Committee of the Institutions where it was conducted, and the participants signed an informed consent.

The final version of thermal comfort scale includes 9 items, grouped in two dimensions: physical (comfort with body temperature, with room temperature, with bed temperature, cold perception, shivering, self-control) and emotional (self-confidence, privacy, anxiety). Thermal comfort presented significant correlation with the visual analogue scale for thermal comfort and with the anxiety scale. The instrument showed good internal consistency, with a value of Crobach's alpha coefficient of 0.82.

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OC 17

OPERATING ROOM NURSES' ANXIETY AND BURNOUT LEVELS ACCORDING TO SAFETY PRECAUTIONS

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Background

Operating room nurses are generally considered as a high risk group regarding job stress and burnout and this syndrome has been a major concern in this field. Experiencing

stress can affect people's mental and physical health. A major source of stress can be the workplace environment. Unsafe and unhealthy work environment effects employees' motivation and reduces the performance. To reduce the anxiety and burnout, safety conditions of workers should be created and organized. Aim: This study was planned to determine the relationship between employee safety and nurses' anxiety and level of burnout. Methods: This descriptive study was carried out between 01.01.2014-30.04.2014. Totally 106 operating room nurses were working in three university and two state hospitals and 60% (n=64) of them accepted to participate in this study. Beck Anxiety Scale and Maslach Burnout Inventory were used in data collection and they were sent to nurses by post. Descriptive analysis, t-test and Pearson Correlation were used for evaluation of data. Results: In this study, the mean age of nurses was 31.9 $\pm6.7,$ mean year of working was 7.32±6.6 and 38% of them were working in the tables with application of mixed surgical procedures. Forty-eight percent of them were married and 73% of them had bachelor's degree. Positive correlation (r=,626, p=0,000) was detected between the levels of anxiety (16,28 \pm 10,52) and emotional burnout (17,89 \pm 7,039) of operating room nurses. Lack of the health care screening, failure in taking precaution for stab woundsand being unvaccinated for infection control increased both anxiety and burnout levels of nurses; lack of protection from diseases with high level of infectiousness and code white application increased nurses' anxiety levels and lack of support received from the administration increased the nurses' burnout levels statistically at a significant level (p<0.05). Conclusion: We recommend that safety precautions to be taken in line with suggestions and that burnout andanxiety should be reduced.

Keywords: anxiety, burnout, operating room nurse, safety precautions.

Introduction

Anxiety is an elusive feeling of fear and worry. It can be defined as nausea, boredom or an unpleasant emotive anxiety state (Türkçapar, 2004). Nursing is characterized as a stressful occupation with an intense work burden resulting from several negative factors due to the working environment. Operating room nurses are responsible for keeping the intervention area sterilized during the surgical intervention (Circenis et al, 2011). Lately, due to the fact that hospitals contain occupational hazard, operating room nursing has recognized as having a high level of job stress and burnout and the employee of this field have been recognized as being tend to have a burnout syndrome (Circenis et al, 2011, Niasar et al, 2013). When nurses continue to work in a stressful environment, they experience exhaustion as a stress response. This is the first stage of burnout (Kitaoka and Masuda, 2013). The notion of burnout was defined by Feudenberger (1974) as "a status of exhaustion in an individual's internal resources as a result of unmet demands". Burnout is a syndrome, including emotional exhaustion, depersonalization and reduced personal competence (Maslach, 2003). It is characterized with physical, emotional and intellectual exhaustion accompanied by such symptoms as loss of self-confidence, negative selfconcept, and negative attitude towards the work, towards the employees in the workplace and towards the life (Sinat ve Kutlu, 2009). It is accepted that in general nurses' workplace environment is stressful and for nurses working in a stressful environment for a long term results in burnout (Wright, 2014). Sharp object injuries, physically hard works, excessive working hours and with less staff, non-ergonomic working environment, insufficient physical conditions, toxic agents, infection agents, radiation, noise, allergens (latex), anesthetic gases, disinfectants, etc. are important stress and burnout reasons for operating room nurses. Working in unsafe and unhealthy environment decreases the motivation and the performance of the operating room nurses (Kitaoka and Masuda, 2013). In her study in which she researched the job stress management among nurses Laal (2013) stated that stress and burnout are not only about personal characteristics but also about working environment. Other researchers, Watts et al. (2013) stated that nurses' general well-being is affected by the perception of working environment. It is suggested for the operating room nurses to work in a healthy workplace environment that regular health care screening for the nurses and the other healthcare personnel should be provided, in risky situations safety precautions should be taken (i.e. protection from radiation, use of secure materials etc.), sharp object injuries should be decreased/ prevented, workplace conditions should be improved and support from the management should be provided (AORN, 2014; Radiation Protection Guidance For Hospital Staff, 2010; Lundstrom et al, 2002). However, there is no information about the effect of employee safety applications on operating room nurses' stress and burnout levels.

This study was planned to determine the relationship between employee safety in operating room and level of nurses' anxiety and burnout.

Methods

Study setting and design

This descriptive study was carried out between the dates of 01.01.2014 - 30.04.2014 with the operating room nurses working in three universities and two public hospitals located in Trakya region of Turkey.

Ethical considerations

The institutions in which the study was carried out, nurse managers and nurses were informed in written about the aim and the scope of the study.

Participants

The operating room nurses who were working in the operating room and volunteered to participate in the study and completely filled the data collection form sent by post were included in the study. Totally 106 operating room nurses were working in three university and two state hospitals and 60% (n=64) of them were accepted to include this study.

Data collection and instruments

"Personal Information Form" and "Employee Safety Precautions Form" and "Maslach Burnout Inventory" were used in data collection.

Personal Information Form

The questions included in this form are participants' age, education, working year in the operating room, number of daily cases, position in the operating room, type of working and satisfaction about their working environment.

Employee Safety Precautions Form

It was a form of the measures should be taken to providee the safety of employees in the operating room. It was created by using suggestions of the Turkish Ministry of Health and the relevant literature (Turkey Ministry of Health, Table 1).

Maslak Burnout Inventory (MBI)

Maslach Burnout Inventory was developed by Maslach and Jackson (1981). Inventory's validity and reliability study in Turkey was carried out by Ergin (1992). It consists of three subscale and 22 articles. The subscales are the chapters of "emotional burnout", "desensitization" and "personal success". Emotional burnout varies between 0-32 points (<16 = low; 17-26= medium; >27= high), desensitization varies between 0-24 points, and personal success varies between 0-32 points. For people experiencing burnout it is expected that the points of emotional burnout and desensitization are high, and the personal success point is low.

Beck Anxiety Inventory (BAI)

It was developed by Beck et al. in 1998 because of the need for a scale to distinguish the anxiety from depression. It measures the level of the symptoms of anxiety. It is a scale which questions the subjective anxiety and physical symptoms. It consists of 21 articles; it is graded in likert type between 0-3 and filled by patients personally. Score interval is 0-63. The level of the total score shows the volume of the experienced anxiety. Validity and reliability studies for Turkey were carried out by Ulusoy et al (1998).

Data analysis

Descriptive analysis, t-test and Pearson Correlation were used for evaluation of data. The level of statistical significance was set at P < 0.05.

Results

In this study, the mean age of nurses was 31.9 ± 6.7 , mean year of working was 7.32 ± 6.6 and 38% of them were working in the tables with application of mixed surgical procedures. Forty-eight percent of them were married and 73% of them had bachelor's degree.

A positive correlation (r=,626, p=0,000) was detected between operating room nurses' levels of anxiety (16,28 \pm 10,52) and emotional burnout (17,89 \pm 7,039). Of the employee safety precautions, lack of medical screening, precaution for stab woundsand vaccination for infection control increased both anxiety and burnout levels of nurses; lack of protection from diseases with high level of infectiousness andcode white application increased nurses' anxiety levels and lack of support received from the administration increased the nurses' burnout levels statistically at a significant level (p<0.05).

Discussion

In this study it was determined that operating room nurses' anxiety level was low, emotional burnout level was medium and that they affect each other positively.

In studies which have been conducted there are findings supporting the result of this study. Azizpour et al (2013), showed that the majority of the participants were experiencing a low level of stress, Azizpour et al (2013) and Vessey et al (2009) detected a stress level which changes from medium to severe among nurses. Kayalha et al (2)013 detected a medium level anxiety among operating room nurses.

Circenis et al (2011) stated nurses' state anxiety (48, 39 (±10, 61) and emotional burnout (23,49 (±10,82) levels as being above the average. Khalatbaria et al (2013) detected a positive correlation between job stress and burnout. Operating room nurses' encountering stressful situations and burnout is widespread phenomenon in this profession (Niasar et al, 2013). Of the employee safety precautions, lack of medical screening, precaution for stab woundsand vaccination for infection control increased both anxiety and burnout levels of nurses; lack of protection from diseases with high level of infectiousness and white code application increased nurses' anxiety levels and lack of support received from the administration increased the nurses' burnout levels statistically at a significant level (p<0.05). Kayalha et al (2013) stated that the most common anxiety reason among the operating room nurses is the fear of interaction with infected biological agents. Azizpour et al (2013) stated in their research in which thereasons of operating room nurses' stress was examined, that the fear of getting a HIV and Hepatitis infection were very important reasons of the stress. Aholaakko (2011) detected in the study in which nurses' stress related to aseptic applications was examined, that it changed from motivation to burnout. The employees who do not have a Hepatitis B vaccine should be scanned yearly in case of a possible infection and it is suggested that a scan test and a vaccination should be applied to the people who have recently started working or training (Lundstrom et al, 2002). People who are known or suspected to be HIV and Hepatitis B virus carriers should be restrained to participate in risky practices (http:// www.newcastle-). Lack of codewhite application increased nurses' anxiety levels and lack of support received from the administration increased the nurses' burnout levels statistically at a significant level. In case of any physical attack, sexual harassment or violence to the patients and employees "CodeWhite" is applied and required procedures are followed. Vahey et al. (2004) found that the burnout level of nurses who have enough personnel and receive administrative support in patient care is low. Wright (2014) stated that it was essential to meet the nurses' demands and to support employees in order to reduces job stress and Lundstrom et al (2002) indicated that creating a positive environment in workplace has an impact on adaptation to safety applications. Epp (2012) stated that administrative nurses play an important role in reducing burnout among operating room nurses by creating a supportive workplace environment. Stewart (2009) found out that training of the administrative nurses' results in reducing burnout among nurses. Results of the studies are essential for reducing job stress and consequently burnout by creating a supportive workplace in operating rooms and ensuring job satisfaction(Chen et al, 2009; Epp, 2012).

Conclusion

In this study it was stated that operating room nurses were experiencing medium-level burnout and low-level anxiety, and there was a positive correlation between burnout and anxiety. It was found out that lack of precaution for preventing infection agents to transmit and lack of support from the management increase anxiety and burnout. In order to reduce operating room nurses' anxiety and burnout we recommend that precautions should be taken in order to prevent the transmission of biological agents in operating rooms and support of the operating room nurses' management should be provided

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Table 1. Employee Safety Applications Anxiety and Emotional Burnout

		1		l
Employee safety precautons in the operating room		n (%)	Emotional Burnout	Beck Anxiety
There is an employee safety program that strives to protect nurses from hazards.	Yes	31 (48.4)	18.61(7.21)	16.25±12.03
	No	33 (51.6)	17.21(6.90)	16.30±9.06
Regular health screenings are provided.	Yes	35 (54.7)	14.62±5.82	11.60±6.92
	No	29 (45.3)	21.82±6.39*	21.93±11.41*
Necessary precautions to prevent stab wounds are taken.	Yes	51 (79.7)	16.66±6.56	14.43±9.74
	No	13(20.3)	22.69±7.01*	23.53±10.68*
Application with antineoplastic medication and chemicals is carried out in compliance with the "Safe Working Guide."	Yes	18(28.1)	16.61±5.59	15.00±7.84
	No	46(71.9)	18.39±2.52	16.78±11,43
Personal protective equipment (e.g., aprons, nonallergic gloves, and goggles) is provided.	Yes	61(95.3)	17.68±7.00	15.85±10.29
	No	3(4.7)	22.00±7.93	25.00±13.74
The institution takes necessary precautions to protect employees from patients whose contagion feature is high.	Yes	53(82.8)	17.35±6.84	15,03±9,19
	No	11(17.2)	20.45±7.75	22,27±14,42*
Precautions are taken	Yes	57(89.8)	17.40±6.81	16.26±10.67
infections in the operating room.	No	7 (10.9)	21.85±8.11	16.42±9.91
Cleaning, disinfection,	Yes	55(85.9)	18.01±7.14	16.01±10.87
applications are adequate.	No	9(14.1)	17.11±6.67	17.88±8.40
Necessary precautions	Yes	29(45.3)	16.10±6.77	14.86±9.32
where radioactive substances are used.	No	35(54.7)	19.37±7.00	17.45±11.41
Vaccinations are administered by the infection control committee.	Yes	40(62.5)	16.20±6.57	13.67±8.68
	No	24(37.5)	20.70±7.01*	20.12±12.27*
Safety measures (color- coding application) against physical assault, sexual abuse, and violence are applied.	Yes	47((73.4)	17.02±6.95	13.54±8.40
	No	17(26.6)	20.35±7.08	23.76±12.49*
There is an arrangement that makes operating room nurses feel the support of the senior management.	Yes	30(46.9)	15.06±5.84	14.40±9.29
	No	34(53.1)	20.38±7.13*	17.94±11.36
Accommodations	Yes	14(21.9)	16.42±5.76	16.85±12.56
employees are made.	No	50(78.1)	18.30±7.35	16.12±10.01
Employee safety	Yes	40(62.5)	17.70±6.75	16.32±11.24
operating room nurses.	No	24(37.5)	18.20±7.63	16.20±9.42

*p<0.05;t: t-test

Faculty disclosure: No conflict reported

NURSE'S WORK ENVIRONMENT AND JOB SATISFACTION ON CARE NURSE PERIOPERATIVE IN A TERTIARY HOSPITAL OF BARCELONA(SPAIN)

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Keywords: Work environment, nursing care, surgical area, burnout, magnet hospital

Background

The philosophy of the magnet hospital remains highly relevant in today's hospital environment for healthy workplaces for nurses. International evidence suggests that attention to work environments might improve retention and the nurse satisfaction job. However, little attention has been given to perioperative nurse.

Aim

To determine the perioperative nurses' perceptions about the work environment characteristics and their job satisfaction.

Methods

Cross-sectional study was developed in 2013-2014 .Data was collected on: sociodemographic and academic background, job satisfaction, perception of work environment and burnout ; nursing practice environment, using two questionnaires Practice Environment Scale of the Nursing Work Index (PES-NWI) and job satisfaction and burnout MBI) was distributed to all nurses in surgical area(N= 136)on a tertiary hospital of Barcelona (Spain). Univariate analyses were performed to describe the PES_NWI and MBI scores.

Results

130 nurses (95.6%) completed questionnaires. The nurses' average age was 43.4 (SD = 11.9) years old, 91.5% were female and they had a mean of 21.6 years of experience. Twenty five (19.2%) respondents reported burnout in the dimension of emotional exhaustion (EE), 10(7.7%) in the dimension of depersonalization (D), and 21 (16.2%) in the dimension of reduced personal accomplishment (RPA). The results of the PES_NWI scale showed that the work environment was unfavorable.

Conclusions

This study gives us information on the assessment of the perioperative nurse work environment about of the current situation of nurses of a tertiary hospital in Spain. Although the results show a high nurses' participation, nurses perceived an unfavourable work environment, and explain one moderate job satisfaction. The environment work assessment of perioperative nursing practice in our area is important to determine the characteristics of the nurse practice environments perioperative and to improve them.

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Faculty disclosure: No conflict reported

OC 19

BULLYING IN OPERATING ROOM (OR) AND INTENSIVE CARE UNIT (ICU) NURSES: DIFFERENCES AND CONSEQUENCES.

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Keywords: Bullying, OR, ICU.

Background

The primary purpose of this study is to validate the perceptions of frequency and patterns of bullying behaviours experienced by registered nurses in OR and ICU.

The phenomenon of bullying or peer incivility in Nursing is not new issue address to the occupational field of Nurses but last years managers of human recourses have recognized the consequences to work efficiently.

Horizontal hostility can lead to profound a long-lasting effects, including diminished productivity and increased absenteeism.

Objectives

This study was conducted as a cross-sectional and descriptive study for the purpose of assessing the bullying of nurses in operating room and intensive care unit. Our hypothesis is that closed space in OR encourages bullying.

Method

The sample was composed of 160 nurses. The research instrument was The Negative Acts Questionnaire (NAQ; © Einarsen, Raknes, Matthiesen & Hellesøy, 1994; Hoel, 1999). The sample comprised (40%) OR Nurses and (60%) ICU Nurses. Analyses of covariance were used to evaluate the data.

Results

A total of 112 Nurses completed the questionnaire (70% response rate). Respondents reported that the most frequent source of bullying was doctors, and most usual victim was circulating nurse.

Conclusion

Workplace bullying is a measurable problem that negatively affects the psychology and performance of the nurses in this study. Especially the Nurses who work at the OR are most exposed in Bullying.

Faculty disclosure: No conflict reported

0C 20

F. HEALTHY WORKPLACES

THE EMOTIONAL DIMENSION OF THE NURSING TEAM IN THE ORGAN REMOVAL PROCESS

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Keywords: organ removal, focus groups, emotions, emotion regulation

Background

The topic of the removal of organs and tissues is characterized by an high level of distress and emotion that are experienced by those who those who works in the operating room ^(1,5,6). For this reason it is striking to note that the studies about perspective of the medical and nursing team in the operating room, particularly in relation to emotions and feelings that the act of organ removal entails, are really limited in literature and the removal seem to be considered a simply technical procedure in which there are no emotions to cope with ^(2,3). However, it is evident that the organ removal is a process heavily characterized by thoughts and emotions, sometimes very critical and traumatic, that need to be regulated and managed in different ways to prevent the risk of burnout ⁽⁴⁾.

These include expectations regarding the outcome (will be it an unsuccessful transplant?) Resonances with personal experiences (a recent loss), mirroring the patient or family (organ removal with children), relational aspects of the operating team (fatigue, difficulty of working with new colleagues), suggestions relating to surgical procedures (anger or blame for the way in which the organs are removed, the care of the dead body) ⁽²⁻⁴⁾.

Materials and Methods

The work has been developed through a qualitative approach with the conduction of two focus groups with 15 nurses working in the perioperative context of organ harvesting in two Italian centers (Monza and Bergamo).

The interviews were transcribed and analyzed according to a qualitative approach, highlighting the most relevant core themes.

Conclusions

The results highlight some key topics within the emotional dimension of the medical and nursing team and the subjective dimension of the nurses; it emerges the need to define an adequate training to the emotion regulation specifically devoted to the operating nurses and to provide de-briefing interventions for the operators, mainly in case of novice perioperative nurses and with interventions of organ removal particularly traumatic and complex (such as with children or young people).

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Faculty disclosure: No conflict reported

OC 21

THE EFFECTS OF OPERATING ROOM NURSE'S VISIT ON PATIENTS' PREOPERATIVE STRESS

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Keywords: Nurse visit, operating room, scrup nurse, stress, surgical intervention

Background

Despite the significant advances in surgery and anesthesia and no matter what the size of surgery is, being operated causes stress and anxiety among individuals.

Purpose

The aim of this study was to determine the effect of the visit made by the operating room nurse on patients' operation stress

Methodology

The sample of the study was composed of 179 patients who were hospitalized to have an operation at the general surgery department of a state hospital. Patients in the experimental group were visited by the operating room nurse one day before the surgery. The visit included meeting and providing information needed by the patient about the process in the operating room. The patients in the control group received the routine preoperative care services. The data of the study were collected using questionnaire form and Burford stress thermometer.

Results

It was found out that 91.1% of the patients felt stressed because of the surgery. While the difference between the stress levels of the experimental group and control group was not significant (p=0.95) before the operation, it was significant (p=0.01) between the groups after the operation. It was discovered that 98.8% of the patients in the experimental group were of the opinion that the visit made by the operating room nurse was effective in decreasing their stress. These patients listed the effects of the visit made by the operating room nurse as "the visit made me feel better" (49.7%), "the visit made me not to feel alone in operating room" (30.2%) and "the visit filled my information gap" (25.6%).

Implications for perioperative nursing

It is seen that operation room nurse's visit made for the patients in preoperative period contributes to decrease the stress undergone by the patients due to surgery.

Faculty disclosure: No conflict reported

OC 22

THE 10 MOST IMPORTANT SECONDS TO WELCOME THE PATIENT IN THE OPERATING ROOM

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For a patient, the arrival in the operating room is often felt as a painful moment, source of discomfort. This is also very real for the OR team, everyone making a representation of the other, based on his experience.

What is the quality of care in the OR? What is the feeling of the patient and the team face to the home of one? Everyone is faced with various feelings. How do they react to them?

The OR nursing should not be a simple reflection of the technology, anesthesia or equipment. It also reflects a relationship that is reduced over time, but that needs to be the most effective, the most accurate, the most comforting to the patient. It is just as important as technical knowledge and actions. It is away of being first.

The presentation analyzes the rights and the Charter of the patient, reviewing concepts such as the reception, care, caring, support, different types of communication and especially therapeutic communication.

Based on the work of G.Benson, welcome to the OR in 10 seconds integrates therapeutic

communication as a corollary of the relationship. How to establish the nurse-patient relationship, the privileged moment of the reception, the power of suggestion and the choice of words who can not be improvised. The OR nurse, like any human being, is haunted by its own representations of the disease. His verbal and non-verbal attitudes reflect these distortions that pollute, despite training and simulation exercises during his training.

To learn and to develop to accommodate each patient as we would be in its place, is a challenge that will bring real value to our business and for each patient in surgery.

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Faculty disclosure: No conflict reported

0C 23

LOOKING BEYOND THE DOUBLE DOORS TO THEATRE- THE POWER OF CONNECTIVITY

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Working on improving theatre efficiencies the perioperative team examined theatre processes, identifying where improvements and change could to be undertaken. The use of data, measurements and lean techniques was paramount in driving our change process. Analysing delays in theatre highlighted that manywere due to patient preparation issues whichoccurred outside of the theatre department. We needed, therefore to look outwards and connect with other departments identifying where improvements could be made.

Mapping the patient's actual journey from arrival at the hospitalto the theatre suite, gave us an in-depth understanding of the patient's experience on the day of their surgery. Identifying our stakeholders, we connected with departments along the patient pathway and formed multifunctional teams. This enabled an understanding and co-operation between each department along the patient pathwayallowing us to work towards a common goal.

Connecting together, we delivered benefits for the patients, staff and hospital including opening of Pre-Admission Assessment and Day of Surgery Admission Units, standardised documentation, improved theatre start times, an improved patient pathway, better communication between departments and changes in department start times; resulting in staff on the ground taking ownership of further projects.

Staff outside of theatre in areas such as Day of Surgery Admission (DOSA) followed patients through theatre to understand the patient flow.Medical secretaries and bed booking staff have walked the process in theatre, increasing their understanding of the importance of correct information on each theatre list.

Theatre is central to the surgical patient pathway however we cannot work in isolation. We need to ensure there is connectivity; beyond the double doors of theatre; between the departments feeding into the surgical patient pathway

Connectivity is key to safe patient flow. No individual is as good as all of us working together.

Faculty disclosure: No conflict reported

0C 24

THE IMPACT OF DR. CLOWN'S PRESENCE IN PEDIATRIC PERIOPERATIVE CARE

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Keywords: OR pediatric reception, Dr. Clown, Perioperative Nursing

This project aims to divulge the Operation Red Nose's benefits in Paediatric surgery. The used methodology was:

- Literature review
- Projects' Description
- Comparative study with quantitative and qualitative analysis

Combined with a donation, the Association of Perioperative Portuguese Nurses (AESOP) and the Operation Red Nose made an unprecedented partnership in Portugal, an innovative project, which aims to improve the delivery of nursing care in Dona Estefânia's Hospital pediatric operating room (OR).

In this OR, the first contact between the child/ parents and perioperative nurses is accomplished in a short period of time and separation is always very emotional.

"Therapeutic playing is usually used to reduce the trauma of illness and hospitalization and to prepare children for therapeutic procedures" [(1), p. 114, 2006].

Thus, a Dr. Clown with specific training accompanies the pre and postoperative children one morning per week, suiting his action to each age. At the same time, a comparative study with gualitative and guantitative analysis of the differences between the receptions with and without the presence of the Dr. Clown was conducted.

The reception time became a moment of banter for the child, with less negative emotions, making the separation less painful act.

The Dr. Clown's presence approaches and facilitates communication between parents, child and nurses, reducing stress and fear, making it easier to establish a close relationship, based on empathy and trust, removing the negative charge to the perioperative period. The atmosphere becomes happier and professionals work with greater satisfaction. The role and image of both the perioperative nurse and the institution are recognized and valued among the population.

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Faculty disclosure: No conflict reported

OC 25

DEVELOPMENT, VALIDATION AND RELIABILITY OF A SAFETY PROTOCOL FOR THIRST MANAGEMENT IN THE IMMEDIATE POSTOPERATIVE PERIOD

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Thirst, highly incident and very distressing in the perioperative period, poses specific challenges: finding safe ways to mitigate it without jeopardizing patient safety. The lack of protocols to assess clinical safety criteria, contributes to the fact that thirst is not assessed, recorded and treated1,2.

Objective

To develop, validate and test the reliability of a safety protocol for thirst management postoperatively

Method

Methodological and applied research, with a quantitative approach, conducted from 2012 to 2013. All ethical aspects were respected. An extensive literature search as well as expert consultations, face validity, semantic analysis and content validation procedures were conducted. For content validation, the Delphi technique was employed with nine experts. Reliability was tested in a Post Anesthesia Care Unit of a public teaching hospital in Brazil. Two nurses and two nursing technicians applied the Safety Protocol for Thirst Management (SPTM) in 118 patients independently and simultaneously.

Results

Safety criteria chosen were: level of consciousness, protective airway reflexes (coughing and swallowing) and absence of nausea and vomiting, where approval in all criteria are mandatory3. A 93-97% consensus of the criteria was reached amongst experts (Content Validity Index -1).

Reliability

A duo o BSN nurses applied the TSMP 118 times in 78 patients. Concordance rates were nearly perfect, reaching a kappa of 0.853 to 1, with an overall kappa of 0.968. Nursing technicians applied the TSMP 48 times in 40 patients with moderate agreement (0.791) in the level of consciousness criterion and almost perfect in the other criteria (0.878 to 1), with an overall kappa of 0.867.

Conclusion

The Thirst Safe Management Protocol (TSMP) was validated and tested for its reliability reaching satisfactory results. The TSMP allows for the screening and assessment of patients during recovery from anesthesia, who would, otherwise, likely have remained in distress caused by intense thirst.

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Faculty disclosure: No conflict reported

OC 26

EVIDENCE BASED PRACTICE FOR MANAGING PERIOPERATIVE PATIENTS IN THE PREVENTION OF DEEP VEIN THROMBOSIS AND PULMONARY EMBOLISM

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Keywords: Deep Vein Thrombosis, Pulmonary Embolism, Prevention, Risk Assessment

As a personal survivor of a Deep Vein Thrombosis (DVT) and massive Pulmonary Emboli (PE) my chance of dying according to statistics was 1 in 4. Fortunate for me, luck and excellent medical treatment saved my life. PE is one of the leading killers of patients in the United States and around the world annually. DVT and PE have been called the "silent killer" since 80% of the patients with DVT are unaware that they have any signs or symptoms in the first place. According to The Joint Commission, deaths in our hospitals due to Pulmonary Embolisms are considered to be the number one preventable hospital acquired condition. Statistics further show that between 10% - 25% of all deaths in our hospitals are related to a pulmonary embolism and if managed appropriately could have been prevented. Perioperative Nurses are the front line for assessing and identifying patient risk levels in order to implement prophylactic measures to reduce the patient risks and save lives.

Objectives

- 1 Describe the physiology and risk factors associated with blood clot formation that can lead to Deep Vein Thrombosis (DVT) and Pulmonary Emboli (PE)
- 2 Understand the evidence based risk factors that put an individual at risk for developing DVT
- 3 Discuss the signs and symptoms to assess patients for possible DVT and/or PE
- 4 Discuss evidenced based protocols for the prevention and treatment of DVT or PE

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Faculty disclosure: No conflict reported

OC 27

MANAGEMENT OF INSTRUMENTATION IN AORTIC VALVE RECONSTRUCTION SURGERY USING BOVINE/EQUINE PERICARDIAL PATCH

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Introduction

Heart valve disease is defined as a condition in which the heart valves have undergone a change in the dimensions or the building, which leads to their irregular function. Changes leading to valve stenosis and / or insufficiency(leaky valve). Stenotic changes comes to accumulating fibro- kacifikates the valves gradually shortening the dimensions, and this leads to the inability to complete closure and reduced flow of blood into the circulation, later it causes hypertrophic changes of heart muscle.

Division according to origin

Congenital: Changes occurred in fetal development, and can be in the form of distortion of size or malformed valves (like bicuspid aortic valve);

Acquired: Changes occur in valves that once had normal morphology and function. Thay can occur in isolation(separated) or as part of other diseases(diffuse atherosclerotic disease), one or more valves(aortic valve, mitral valve, ..), may be involved one or two leaflets, lead to stenosis or insufficiency.

Etiology

In Part of atherosclerotic changes (Fibro-calcific degeneration);-Reumatic disease;-Endokarditis (Surgery, surgical procedures on teeth, haemodialysis, patients with specific infections that lead to endocarditis, eg .syphilis).

Our experience: There have been 315 patients with reconstruction of the aortic valve of which 123 with arterial hypertension, 89 with atherosclerosis, 4 with Marfan syndrome, 46 with bicuspid aortic valve, 98 of them with calcified leaflets changed.

Symptoms of aortic stenosis

Easy fatigue, shortness of breath, palpitations, weakness and dizziness, hypertension, decompensation with slowdown in the lungs, leading to liver and kidney insufficiency. Simptoms gradually grew frequent reinforce and to lead to the occurrence of edema ankles, feet and abdomen.

Diagnosis

Klinical review (specific noise-marmur, because blood have tubular movement), echocardiogram, electrocardiogram, MRI, RTG,CT-scan.

Treatment of aortic stenosis

Conservative, invasive procedures (TAVI) or surgery, depending on the extent of damage the valves, age of the patients and other comorbidities.

Surgical treatment

The choice of surgical procedure depends on the assessment of the functionality of the aortic valve and aortic dimensions .We can do the replacement or reconstruction of the heart valve. Replacement we are doing with mechanical prosthesis(in patients younger than 63 years) or biological prosthesis (in postoperative treatment is not required anticoagulant therapy). The choice depends on the clinical findings (medium or severe aortic stenosis), the patient's age (biological in patients older then 62 years), psychological condition, social condition (degree of health culture).

Surgical technique

Depending on the assessment reconstruction can be done in one, two or all three of the aortic leaflets .For leaflet can we use Human homograft (Ross procedure) or Bovin / Equin pericardial patch.In our hospitalwe are doing reconstruction - replacement aortic valves with surgical technique that has been accepted as a patent in the USA (09.12.2008). This surgical technique is performed in three steps. Firs is extraction of the cusps and cleaning calcium deposits. A second is measuring and cutting of the cusps of bovine / equine pericardium (complying to be nearly as natural). Third is positioning and sewing of the cusps.

Materials

To perform this surgical technique, except general surgical instruments and kit for sternotomy, we are useing a specific kit for extraction of the aortic valves. This consists of special chest retractor with specific inserts(allowing attachment of surgical sutures used during the sewing of the valves), specially designed retractors for aortic valve, deranzhe (several types and dimensions), forceps for extraction the calcificates (Russian forceps), special jankauer, nonthraumatic forceps for holding the pericardial valves, nonthraumatic clamp for aorta.

Nursing role and importance

Timely information on the surgical technique, preparation of the overall material required for operation, check the terms of sterility and active participation in the operation, looking for the proper implementation of asepsis, antisepsis, care for sterility during the operation. Special emphasis is devoted to the preparation and washing of biological material (pericardium), which should be applied to the patiens. We are use the protocol recommended by the manufacturer of the pericardium. (Flushing a piece of pericardium with sol.NaCl 0,9%, in three bowls with min.200 ml, 2 min = total time of 6 minutes minimum, because the pericardium is preserved with Glutaraldehid).

Statistics and Results

Before using this set in 2012 in our hospital operated a total of 194 patients with aortic valve replacement, of which 118 with reconstruct of the valves.

Average time of terminal aorta clamping is 45-60 minutes, and the total time of operation was 110-150 min.

2013., The application of this set instruments operated 186 patients with aortic valve replacement, of which 126 with reconstruction of the aortic valves. Average time of terminal aorta clamping is 35-50 minutes, and the total time of operation was 95 -135 minutes.

Postoperative complications

Early (bleeding, time prolonged ventilation, brain stroke, length of hospital stay) and late (insufficiency, restenosis- reoperation).

Conclusion

Reconstructive surgery of the aortic valve belongs to complex surgical procedures.

The patient does not need anticoagulation therapy postoperatively, which reduces the percentage of postoperative complications.

With good preoperative preparation, adequate set of instruments and good trained team, the operation runs smoothly and without a hitch, the duration of operation is less, at the end the work becomes a pleasure.

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Faculty disclosure: No conflict reported

OC 28

IMPROVING GYNEONCOLOGIC SURGICAL PATIENT CARE

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Keywords: CUSP Team, GyneOncology, surgical patient

The Ottawa Hospital formed its GyneOncology Comprehensive Unit-Based Safety Program (CUSP) team in February 2013. The CUSP team was formed as a response to the National Surgical Quality Improvement Program (NSQIP) data that showed that while our patients did not have a high mortality rate at our hospital, they did have an above average and deemed unacceptable degree of morbidity. Comprised of representatives from the full range of health care professionals who interact with the surgical patient, the team first conducted surveys to inform understanding of the factors leading to increased morbidity and the hospital's increased surgical site infection rate. Based on this understanding the CUSP team identified common themes and identified three key initiatives to improve the surgical patient's care. These initiatives included improving dressing protocols, sterilization processes for surgical instruments, and identifying and managing glucose levels in hyperglycemic but non-diabetic or previously non diagnosed patients. First, dressing protocols, the perioperative and unit nurses identified problems with current materials and practices. In collaboration with a wound care nurse, a review of literature and comparison with other Canadian hospitals, materials and protocols were improved. Second, sterilization processes for surgical instruments, two issues of primary importance were identified including incorrect instrumentation delivered in trays and bioburden remaining on sterilized instruments. Third, identification of high blood glucose levels in preoperative patients enabled management of care to ensure glucose levels remained stable postoperatively.

At the time of the European Operating Room Nurses Association 2015 Congress NSQIP data will be available to evaluate the effectiveness of these interventions.

Faculty disclosure: No conflict reported

0C 29

OPERATING ROOM NURSES EXPERIENCES OF TEAMWORK FOR SAFE SURGERY

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Keywords: operating room nurse, perioperative nursing, teamwork, communication, collaboration, surgery, content analysis

Background

Safe surgery for patients is based on teamwork involving communication and collaboration in a safe manner between the professional members in the surgical team. This includes the professionals' competence of both technical and non-technical skills ⁽¹⁻³⁾. The ORN's responsibility is to provide professional perioperative nursing care for the patient ^(4, 5). This comprises caring for the patients' wellbeing and health ⁽⁶⁾ as well as conducting safety controls of the aseptic environment and the instruments, material and equipment used during surgery ⁽⁷⁾. Flaws in communication and lack of collaboration can occur at all organizational levels of care ⁽⁸⁾ and this may be fatal for the patient and his/her outcome of the surgery ⁽⁹⁾. Surgical team members seem to value collaboration differently. Surgeons report high scores for satisfactory collaboration compared to other members of the surgical team ⁽¹⁰⁾. Previously there have been only a few studies regarding aspects of teamwork in surgical teams from the ORNs' point of view.

The purpose with the study was to illuminate operating room nurses experiences of communication and collaboration in the surgical team in regard to achieving safe surgery.

Method

A qualitative design was chosen for increased understanding of ORN's experiences of teamwork. Data collection was conducted with narrative interviews with 16 ORN ⁽¹¹⁾ and data analysis used content analysis ⁽¹²⁾.

The result shows that safe surgery from the ORNs perspective was achieved when teamwork in the surgical team was performed with synergy and goal-orientation. That was realized when the ORN had made a care-plan in a preoperative dialogue with the patient. Furthermore, having confidence in one's own competence and in co-workers competences was described. Ineffective teamwork led to hazardous surgery when no synergy could be reached between the members and the ORNs developed strategies to endure situations in order to maintain patient safety.

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Faculty disclosure: No conflict reported

00.30

GENERATION Y, THE FUTURE OF THE PROFESSION. HOW TO INTEGRATE THEM IN THE MANAGEMENT OF AN OPERATING THEATER?

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Keywords: OR Management, generation y, multigenerational management, nursing teamwork

Background

Each generation has particular characteristics. Managers have to adapt themselves to mentality changes and workers' exigencies. They have to deal with generation conflicts as well. Today, the lengthening of working life requires the coexistence of at least three generations. The operating theater, complex scenery, is not stranger by this phenomenon.

Focus of interest

Generations Baby boomers (1946-1964), X (1965-1980) and Y (1981-1995) have a different perception towards work, as well as different constraints and management. For instance, the first will perform supplementary hours by conviction, the second if constrained and the latter does not want to do it. Generation Y is confident, ambitious, connected to latest digital technologies, and does not dissociate work from pleasure... How to motivate, integrate then generation Y to the constraints of an operating theater? How to conduct interaction in between the three generations with the purpose of ameliorating the efficiency and the quality of healthcare towards our patients?

Method

The author has performed a literature review for the characteristics of each generation, of the principal type of conflicts between generations, as well of the management constraints in the operating theater and their functioning. Theoretical and biographical data were correlated with the results of an investigation performed among chief nurses of operating theaters in the French and German speaking part of Belgium. This investigation was meant to highlight the constraints and the difficulties of management in operating theaters.

Conclusions

The author presents different ways for managing each generation depending of their characteristics and constraints linked the operating theaters. She proposes different approaches on order to reduce conflict of interests.

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Faculty disclosure: No conflict reported

OC 31

KAISER PERMANENTE MEDICAL CENTERS' HIGHLY RELIABLE TEAM: IMPROVING QUALITY HEALTH CARE THROUGH PATIENT SAFETY

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Keywords: HRST, Periopoperative Nursing Care, Trends in Surgical Safety

Institute of Medicine (IOM) defined quality care as safe, effective, patient-centered, timely, efficient and equitable. Patient safety is the cornerstone of all other aspects of quality care, and the ultimate goal of high-quality healthcare.

A literature review from Administrative Sciences (AS), stated that effective teamwork and communication in healthcare teams is essential to patient care. Researches on healthcare teams indicated that communication and collaboration have important effect on patient morbidity and mortality. Citing IOM's report "To Err is Human", AS emphasized that healthcare system is unsafe and errors can be prevented through improved teamwork and system design.

Several years ago, Aviation industry introduced training for flight crews to eliminate or minimize errors and fatalities in air travel. Later, healthcare industry recognized the relevance of principles behind such training to patient care.

Contributing factors to adverse events are poor communication, chaos, stress, and fatigue to name a few. These factors cannot be completely prevented especially in emergency situations. However, risks can be minimized by strategies to manage chaos, improve active communication, and cope successfully with fatigue and stress. The result is Highly Reliable Surgical in Team (HRST). Operating rooms (OR) in Kaiser Permanente Medical Centers (KPMC) have applied said surgical safety team approach for many years now.

Studies conducted by Mazzocco et al showed direct correlation between team behaviors and patient outcomes. Study of team dynamics demonstrated that affirmative behaviors are learnable, and implementation of improved behaviors increases reliable results, improves patient safety, and increases professional satisfaction of every OR team member. As art of PeriOperative Nursing Care constantly evolves, every OR nurse should be aware of trends in surgical safety and discuss the possibility of implementing team training with other OR leaders in their respective institutions in order to build a HRST.

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Faculty disclosure: No conflict reported

OC 32

RELATIONAL COORDINATION IN AN ORTHOPEDIC SURGICAL TEAM: A STUDY OF THE RELATIONSHIP BETWEEN INTERDISCIPLINARY TEAMWORK AND PATIENT SAFETY CULTURE.

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Keywords: relational coordination, inter professional communication, inter professional relations, teamwork, patient safety, health care professionals, operating room staff, operating room

Background

In surgical teams, where health professionals are highly interdependent and work under time pressure with often unpredictable tasks, it is of particular importance that the teamwork is strong and well-functioning to secure treatment quality and patient safety (1, 2). Relational coordination (RC) is an expression of the quality of the interdisciplinary cooperation (3). It is well known that coordination and communication has implications for the psychological safety in the team (4,5). There is a need for further knowledge about the effects of interventions that intend to improve teamwork and patient safety culture in the operating room (OR)

Purnose

To examine how RC in multidisciplinary teams in OR can be strengthened, and examine how an improved teamwork may have an impact on patient safety culture in OR.

The research questions are: 1) How is the interdisciplinary collaboration in OR characterized? 2) Which interventions can be used in order to strengthen the communication, coordination and relations in OR? 3) How do the use of RC as a theoretical framework strengthen the interdisciplinary teamwork and the patient safety culture in OR?

Methods

A three-phased sequential mixed methods study involving; 1) an ethnographic field study; 2) an intervention study in which an intervention program is developed and implemented; 3) an outcome study in which indicators related to patient safety culture will be measured in a pre-and post-interventional period. Organizational development theories referring to RC $^{\rm (3,\,6)}$ will be used together with theories concerning patient safety culture $^{\rm (4)}$. The study will be carried out between 2014 and 2017 and the first results are expected to be available in 2015.

Perspectives

The project is expected to gain knowledge about how the interdisciplinary collaboration in the OR can be strengthened through the use of RC. An improvement which will result in increased treatment quality and efficiency, greater job satisfaction and reduce the risk of adverse events.

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Faculty disclosure: No conflict reported

OC 33

SUSTAINABLE PERIOPERATIVE PRACTICES! REDUCING, REUSING OR RECYCLING – WHAT IS THE EVIDENCE?

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Keywords: recycling; hazardous and non-hazardous waste; waste reduction strategies.

Background

Significant resources are consumed in the healthcare sector, with inevitable waste created that has the potential to pollute the environment unless correctly managed ^(1; 2). With the potential fiscal profit due to efficient reduction of clinical waste ⁽³⁾ it is important for all HCF to reduce resource costs and consider waste reduction strategies to address environmental issues ⁽²⁾.

Focus of Interest

Recycling can be difficult in the perioperative setting due to concerns and regulations regarding regulated medical waste and biohazardous materials. However, many supplies that do not come into contact with body fluids or blood are able to be recycled, such as cardboard, paper, glass and plastic ⁽⁴⁾ decreasing the amount and cost of waste disposal and reducing potential human and environmental health threat ^(4; 5).

Conclusion

Healthcare professionals working in the perioperative suite have an ethical responsibility to actively promote and take actions to minimise waste, thereby reducing the impact of waste on the environment.

Implications for perioperative nurses

All healthcare workers also have a responsibility to promote environmentally friendly, sustainable practices that may influence local and global ecosystems as inappropriate disposal of clinical waste has a considerable environmental and financial impact for HCFs ^(4, 6).

The development of guidelines for appropriate recycling in the perioperative environment was identified as a priority by the ACORN Standards committee for inclusion in the 2014 – 2016 ACORN Standards for Perioperative Nursing. A team of perioperative nurses from around Australia were invited to review the current literature and develop a guidance statement that would document best practice in the operating suite. Outcomes from the literature review will be presented as well as practical strategies that could be considered in perioperative departments 'going green'.

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Faculty disclosure: No conflict reported

0C 34

REPROCESSING OF "SINGLE-USE" MEDICAL DEVICES: REGULATIONS COMING TO EUROPE

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Keywords: Reprocessing, single-use devices, European Union regulations, safety, environmentalism, cost-savings

Objective

This session will provide an overview of the reprocessing of "single-use" devices (SUDs). The session will include an update on current European Union efforts to regulate SUD reprocessing as part of the forthcoming EU-wide Medical Device Regulation. The session will also provide a summary of the safety, cost-savings, and environmental benefits of regulated reprocessing, including a discussion of regulations and experience for SUD reprocessing from the U.S. and Germany.

Methods

Worldwide, healthcare providers are struggling to find safe, reliable, and affordable solutions to reduce the financial and environmental burden of providing excellent care. One solution hospitals utilize is to reuse devices labeled for "single-use." Though regulated by FDA in the U.S., the European Union does not currently regulate SUD reprocessing, leaving the matter to individual Member States.

As the U.S. and Germany have long had regulations in place that allow for SUD reprocessing, this session will evaluate the U.S. and German experience. With the EU Commission, Parliament, and Council now considering legislation to harmonize medical reprocessing requirements across the EU, evaluation of the existing evidence on SUD reprocessing safety and effectiveness is critical.

Results

Regulated SUD reprocessing stopped inappropriate SUD reuse, held SUD reprocessors equivalent to manufacturers, and resulted in hospitals having access to safe, regulated, lower-cost, and environmentally responsible reprocessed SUDs.

Conclusions

Europe should adopt high standards for SUD reuse to stop inappropriate hospital reuse and regulate entities that do reprocess.

Key Message

When regulated, SUD reprocessing can be safe, lower-cost, and environmentally responsible.

Faculty disclosure: The author is the President & CEO of the Association of Medical Device Reprocessors, the trade group representing commercial reprocessors of "single-use" devices.

OC 35

IS THE INCREASED USE OF PRIVATE CELLPHONES IN THE OPERATING ROOM A RISK FOR THE HANDHYGIENE?

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Keywords: handhygiene, private cellphones, disinfection, contamination

Annual observation of handhygiene shows that the use of private cellphones is more and more common. The cellphone is, as many studies shows us, not clean. They contain several microorganisms- both pathogenic and non pathogenic. In spite of this do we still keep a high standard of handhygiene? Where do we keep these cellphones? And do we wash our hands and disinfect with alcohol after using private cellphones for texting, checking time, reading news, reading relevant documents for different procedures? Do we disinfect the cellphones? The handhygiene observations show, that we don't see the cellphone as an infection risk.

By using a method to show the Surface ATP(adenosintriphosphat) on the cellphones, showing interviews about routines with private cellphones, and offering a higher level of information from relevant randomized litterature about the risk – can we then change the behavior in the use of cellphones at the OR and therefore increase the currently lower standard in handhygiene and minimize the risk for the nosokomielle infections for the patients?

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OC 36

THE BENEFITS, DANGERS AND DILEMMA'S OF THE SOCIAL MEDIA

Ruth Shumaker (1)

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Keywords:

1 Discuss the benefits of social networking

- 2 Explain the dangers of social networking personally and in the workplace
- 3 Discuss what to do when a situation arises an employee does something inappropriate
- on a social network and the impact
- 4 Describe suggested employee guidelines

Bibliography

Over the course of the last 5-10 years, as we have all interacted with social media to some degree, we have learned the power of the people. User generated feedback is very powerful. Blogs, Twitter, YouTube or Facebook can virtually "go viral" in short order. Social sites are a big hit nowadays, not with just the younger generation but with people of all ages. The social media has become a significant part of our modern civilization. People cities or continents apart can keep in touch effortlessly, creating an opportunity to experience different cultures. There are many ways social media has changed the world. Its and amazing platform for people and organizations to connect but it certainly isn't without its danger's.

OC 37

CELL PHONES AS POTENTIAL SOURCES OF BACTERIAL SPREAD

Victoria Eremchenko $^{\rm (2)}$ - Ahuva Friedman $^{\rm (1)}$ - Iris Laniado $^{\rm (1)}$ - Sveta Levitan $^{\rm (1)}$ - Mona Boaz $^{\rm (1)}$ - Orna Shvartz $^{\rm (1)}$

Wolfson Medical Center, Wolfson Medical Center, Holon, Israel (1) - Wolfson Medical Center (2)

Background

Hospital acquired bacterial infections can cause morbidity and mortality and represent a serious challenge to health care systems. Cellular telephones (cell phones) have become essential to health care workers, critical to clinical communication. The 2001 Israel Ministry of Health Guidelines for Preventing Infection in Operating Rooms did not refer to cell phones. Prior studies have shown micro-organism growth on the surfaces of cell phones used by medical teams.

Objectives

The present study was undertaken to determine the prevalence of pathogenic bacteria on the surface of personal cell phones used by operating room staff on a typical work day and to compare prevalence by worker sector.

Hypothesis

Pathogenic bacteria will grow on the surface of cell phones used by operating room. Further, cell phone bacterial growth will differ by sector among operation room workers.

Methods

Permission was obtained from operating room management, hospital management and the institutional ethics committee prior to conducting this study. On a predetermined day, the personal cell phones of operating room staff were collected and sampled for pathogen growth.

Results

Pathogenic bacteria were identified on only 4% of cell phones collected. No difference in bacterial growth was detected by sector.

Recommendations

A multi-center study should be conducted to increase sample size to facilitate by-sector comparisons. Further, cell phone manufacturers should be consulted regarding methods for cleaning and sterilizing cell phones used in the operating room. Cell phones used in the operating room should be routinely sampled for bacterial growth. The Israel Ministry of Health should write guidelines for cell phone hygiene.

Faculty disclosure: No conflict reported

OC 38

THE EFFECT OF TEMPERATURE OF FLUID FOR IRRIGATION ON BODY TEMPERATURE DURING ENDOSCOPIC SURGERIES

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Keywords: Body temperature, Shivering, Endoscopy

Background

Hypothermia in the perioperative setting can have serious consequences, including increased risk of infection or adverse cardiac events ^(1, 2). Forced-air warming system and warmed intravenous fluid commonly are used to prevent hypothermia ⁽³⁾. Irrigation fluid, which is used in large quantities during endoscopic surgeries at room temperature, is considered to be associated with hypothermia and shivering. It remains controversial

whether using warmed irrigation fluid will decrease the drop of body temperature and the occurrence of hypothermia ⁽⁴⁻⁶⁾. This study aimed to determine the effect of irrigation fluid temperature on body temperature change and the occurrence of shivering in patients undergoing endoscopicsurgeries using blanket and forced-air warming system.

Materials and Methods

Seventy-nine patients scheduled for endoscopy surgeries including arthroscopic shoulder surgery, laparoscopic gastrectomy, laparoscopic assisted vaginal hysterectomy, and transurethral resection of bladder tumor were randomized to one of two groups. The experimental group was consisted of 39 patients performed with warmed irrigation fluid ($37\pm1^\circ$ C), and control group was consisted of 40 patients with room temperature irrigation fluid ($20-24^\circ$ C) throughout the operation. The Blanket and forced-air warming system were used for both groups. The baseline tympanic temperature was measured in pre-operative waiting room. The esophageal temperature was measured every fifteen minutes after induction of general anesthesia. The outcome measures included post operative body temperature and chilling score.

Results

The patients' general characteristics including demographic and operative variables were similar in both groups. There were no statistically significant differences in mean lowest body temperature($35.86\pm0.41^{\circ}$ C compared with $35.71\pm0.40^{\circ}$ C, P=0.100), temperature drop($0.29\pm0.27^{\circ}$ C compared with $0.39\pm0.27^{\circ}$ C, P=0.115), or the occurrence of shivering [1 (3%) compared with 2 (5%), P>0.05] between the experimental group and the control group.

Conclusion

In endoscopic surgeries, the temperature of irrigation fluid does not significantly affect the body temperature, if the blanket and forced-air warming system are used.

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Faculty disclosure: No conflict reported

OC 39

THE INFLUENCE OF AN ENVIRONMENT AT THE CENTRAL OPERATING THEATERS IN THE UNIVERSITY HOSPITAL BRNO ON A BODY TEMPERATURE OF THE SURGICAL PATIENT.

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Keywords: perioperative care, thermoregulation, safety, quality

The lecture summarizes the results of an exploratory monitoring of body temperature in patients during their stay at the central operating theaters at the University Hospital Brno, in the Czech Republic.^[1]

The reason for the initiation of this study was a finding out that a large proportion of the patients already has a sensation of cold before surgery. Patients' hypothermia and with it associated discomfort during surgery is not conducive to a good course of treatment. ^[2, 3] This led the authors to prepare and perform an exploratory investigation.

The aim was to record the feelings of patients in an objective way. [4, 5]

A method of quantification was chosen for this exploratory investigation. It means that the detected body temperature of the patient at different stages of perioperative care was recorded.

Measurements were performed in three types of surgical procedures. It was a total arthroplasty of the knee or hip, an operation of intervertebral discs and a digestive tract operation.

Seven measurements were always performed: in the patient lying on the bed before his transportation to the operation theatre, at the beginning of preparation for patient's surgery, during surgery and after the end of surgery.

Values were followed both in patients who had no aids to maintain body temperature and in patients with thermal foil or with a heating pad.

A frontal bone (forehead) was an area of body temperature measuring. Non-contact thermometer was used.

Exploratory investigation began in February 2014 and will be completed in October 2014. The results will be used to develop recommendations for the care of the physical well being in patients at operating theaters of University Hospital Brno.

Implementation of these recommendations will contribute to the quality and safety of perioperative care, and thus also to the better postoperative treatment of patients.

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Faculty disclosure: No conflict reported

0C 40

AN EXPLORATION OF PERIOPERATIVE NURSES KNOWLEDGE, ATTITUDES AND CURRENT PRACTICES IN THE PREVENTION OF INADVERTENT PERIOPERATIVE HYPOTHERMIA

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Keywords: Inadvertent Perioperative Hypothermia (IPH), Forced Air Warming (FAW), Normothermia, Perioperative Nurses, Prevention,

Inadvertent Perioperative Hypothermia (IPH) is a common, recurrent and highly avoidable complication of surgery affecting as many as 50% to 90% of surgical patients (1-4). The National Institute for Health and Clinical Excellence (5) guidelines on the management of IPH require that the necessary steps are taken to prevent surgical patients from developing IPH. Maintaining perioperative normothermia is fundamental to patient safety, beneficial to surgical outcomes, reduces service costs and ensures quality patient care (6,3,4) Perioperative nurses must encompass a comprehensive knowledge and understanding of the development of IPH as well as the risks, complications and preventative measures to successfully fulfil their roles and protect patients 77. Knowledge of IPH is central to its successful prevention, recognition and management, nurses' knowledge of the concept however remains critically under-investigated. The researcher believed that by interviewing perioperative nurses about their individual thoughts and perceptions of this subject, a true account if their subjective experiences would emerge. The primary goal of this research is to explore perioperative nurses' knowledge attitudes and current practices in the prevention of IPH. A qualitative descriptive study was utilised which permitted the study to reach its aims and objectives by facilitating an accurate portrayal of perioperative nurses perceptions regarding IPH. A constant comparative method of data analysis was utilised to evaluate 11 semi-structured interviews with perioperative nurses revealing 4 prevalent themes through which the findings are discussed. 11 subthemes were subsequently identified and there was evidence of large-scale interrelation between the themes and subthemes which emerged from the study.

The nurses highlighted knowledge as a concept which encompassed both theoretical knowledge of the condition in addition to awareness of the prevention of IPH. The nurses identified a profound lack of education about IPH prevention in the perioperative environment. Deficits in education were directly linked to nurses' knowledge and awareness of this condition. All of the perioperative nurses agreed that education including strategies to prevent IPH is essential to increase awareness and prepare nurses with the knowledge to direct nursing practice. The nurses outlined an apparent lack of standardised guidelines which instruct and assist nurses in practice. This directly impacts on their ability to protect patients due to disparities with reference to theduration of a surgical procedure necessary to warrant active FAW. This also had implications on decisions about which patients warranted FAW, lead to confusion and disagreement between staff. This was collectively impacting negatively on nurses' knowledge base and awareness of the topic resulting in conflicting perceptions about patient assessment and management throughout the perioperative environment.

Barriers to the prevention of IPH were outlined as lack of education and standardised policy, autonomy, doctor's preference, necessity, tradition, resources and workload. The perioperative nurses outlined the presence of hierarchical issues in the perioperative environment and this was impacting negatively on the provision of optimal patient care. The findings indicate that a broad inclusive and comprehensive approach to multidisciplinary team education in IPH prevention is necessary to highlight significance and ensure an increased level of awareness to allow the perioperative team to successfully protect patients.

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Faculty disclosure: No conflict reported

0C 41

THE SURGICAL COUNT: ETERNALLY EVOLVING OR A PROCESS THAT NEEDS REVIEW?

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Keywords: Surgical Count, Patient Safety, Human Factors, Environmental factors, prescribed, retained foreign adjuncts

Background

Patient safety is the ultimate goal for every health care professional ^(1,2). One way that perioperative nurses can ensure patient safety occurs in the perioperative environment is by following a prescribed surgical count prior to undertaking a surgical procedure ⁽³⁾.

Research demonstrates that even though prescribed surgical counting is undertaken retained foreign adjuncts continue to occur, resulting in severe harm and sometimes death within surgical patients $^{\rm (4.6)}$.

Focus of interest

Current literature describes many of the human and environmental factors that may prevent perioperative nurses from following a prescribed surgical count process. However, little is written on their thought processes when this occurs and what considerations they may give to patient safety ^(6,7).

Theoretical framework

The author is proposing to undertake a sequential mixed methods research study utilising observation, focus groups and interviews with relevant stakeholders to examine the behaviour and rituals that occur within the perioperative environment, in relation to the surgical count process.

Implications for practice

Outcomes of this study will provide opportunities to review current standards of practice and health care facility policy and procedure to assist perioperative personnel to undertake a prescribed surgical count.

Conclusion

Surgical counting is not new and has not really evolved in the last few years. This presentation aims to put a different context to the issues surrounding the success of following prescribed counting techniques

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Faculty disclosure: No conflict reported

0C 42

TWO, FOUR, SIX, EIGHT.... STOP AND COUNT BEFORE IT IS TOO LATE! AN AUDIT ON SWAB, NEEDLE AND INSTRUMENT COUNTS IN THEATRE AT SLIGO REGIONAL HOSPITAL

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Keywords: Abdominal surgery, Four counts, Time of counts, Communication, Documentation

Patient safety is one of the most pressing challenges in health care. Incidents compromising

patient safety, such as unintended retention of swabs or instruments, are regarded as 'never events'. Jackson and Brady (2008) suggest that retention of swabs and instruments following surgery may occur as often as 1 in 100 procedures. There were 111 never events in the UK last year (DOH 2013). The WHO (2009) issued a surgical safety checklist and its aim is to reduce the incidences of error in the Operating Room (OR). Although law does not dictate what method of swab, needle and instrument count should be carried out, local policy has been adapted using recommended standards from professional organisations such as the Association of Operating Room Nurses (AORN 2011) and Association for Perioperative Practice (AFPP 2011). Theatre nurses are the core care providers in the perioperative environment. The use of audit can ensure our care is continually improving and has the potential to make huge improvements in patient safety (Thomas 2011).

The aim of the audit was to determine if current practice is adhering to the recommended guidelines regarding swab, needle and instrument counts on patients admitted to the operating room for abdominal surgery. The local policy for abdominal surgery states that each count must be performed by two registered practitioners. Four counts should take place. The initial count immediately prior to surgery commencing, the second before closure of a cavity within a cavity, the third count before wound closure begins and finally at skin closure. The surgeon should allow adequate time for counts. All counts should be complete, verbalised as correct or incorrect by the scrub practitioner and acknowledged by the surgeon before the patient leaves the OR. The counts should be documented accurately and signed by both registered practitioners. Theatre personnel are the core care providers in the perioperative environment. The audit also wanted to ascertain length of time each count takes.

This concurrent audit was undertaken by the Clinical Nurse Manager 2 in the General Operating Theatre over a 4 week period. Data was collected on 30 surgical procedures. Information was gathered on:

- (a) Type of surgery
- (b) Qualifications of scrub and circulating nurse
- (c) Length of time of each count
- (d) Counting technique
- (e) Verbal confirmation of counts
- (f) Documentation and signing of counts

The number of procedures audited: 29 Type of surgery: Major 21(72%). Minor 8(28%)

Staff skill: Scrub nurse: Senior 15(52%) Junior 14 (48%)

Circulating nurse: Senior 19 (65%) Junior 10 (35%)

Findings from this audit provided information on how long each count took. It highlighted failings in the count process. It identified poor communication within the Multidisciplinary Team (MDT) as a cause for local count policy not being adhered to. Significant findings regarding the length of time for counts and poor MDT communication.

This audit provided valuable information regarding counting procedures in the OR. In addition to highlighting that poor communication is a common cause for non-adherence to local policy it also measured the length of time it took to carry out counts. This new information is beneficial to have an estimated guide to advice colleague's especially junior and new staff. It is crucial that policy and procedures are observed to reduce the incidences of counting errors in the OR.

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0C 43

"WHAT YOU USE YOU CAN LOSE"

Charmaine Betzema (1) Mcl, Hospital, Leeuwarden, Netherlands (1)

Keywords: lost instruments, weight system

This presentation is about the problems hospitals have with losing instruments after operations. It show research from the Netherlands, how many time it happens and also the developing from guidelines. Different organizations have described about this problem and this presentations show how to deal with it. It shows how you can use different systems to control everything. Special a weight system.

Bibliography

I'm Charmaine Betzema, past OR assistant worked 30 year on the OR in different hospitals in the Netherlands. On the moment project manager OR complex. President of the Dutch organization LVO and treasurer EORNA. Patient safety is a goal for me.

Faculty disclosure: No conflict reported

OC 44

G. INNOVATION IN PERIOPERATIVE CARE WEARABLE TECHNOLOGY: THE PERIOPERATIVE PERSPECTIVE

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Deloitte Consulting Llp, Multiple Clients In Us And Uk, Mclean, Virginia, United States (1)

Keywords: Wearable technology, Google Glass, telemedicine, virtual presence, electronic distraction, patient data privacy, Internet.

Google's Executive Chairman, Eric Schmidt, described the Internet as "...the first thing that humanity has built that humanity doesn't understand, the largest experiment in anarchy that we have ever had." While no rational clinician would intentionally introduce anarchy in the surgical environment, wearable technology, such as Google Glass, brings both risk and reward, for the surgical team and patient alike.

The Association of PeriOperative Registered Nurses (AORN)'s Position Statement on Managing Distractions and Noise During Perioperative Patient Care Management addresses, in part, the use of technology and electronic activities. Google Glass introduces a new level of electronic transactions, with hands-free, voice-activated Internet access at the operative field. Surgeons can now "float" medical images in their field of vision, without diverting attention from the operative field. Proponents extol additional rewards from a head-worn computer, such as:

Pinpoint accuracy for tumor location World-wide teaching and training through live-feed streams In-the-field diagnosis and treatment for patients who are in transit to hospitals Immediate access to data and images Potential risks include:

Perceptual blindness (tunnel vision)

Distraction, including processing emails during the surgical procedure Patient security and privacy violation through online streaming of confidential information Uncertainty about images being automatically uploaded to the cloud

Personal wearable technology, now in its infancy, will impact every member of the Perioperative team. This oral presentation will examine this exciting evolution, as well as discuss specific implications for perioperative nursing.

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Faculty disclosure: No conflict reported

0C 45

PRESENTING THE ACUTE SURGICAL UNIT AT A REGIONAL HOSPITAL IN NSW AUSTRALIA

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Keywords: Acute Surgical Unit (ASU), emergency surgery, laparoscopic cholecystectomy, National Elective Surgery Targets (NEST)

Background

The Acute Surgical Unit (ASU) is a model of care introduced in Australia in 2005 for managing emergency general surgery

In January 2012 the ASU was introduced at Gosford hospital to manage the large volume of emergency surgery cases to ensure the best outcome for emergency surgery patients and to reduce the disruption to elective surgery (2).

Focus of interest & theoretical framework

Emergency surgery is a major component of every surgical specialty and is highly disruptive to elective surgery requiring surgeons to balance elective lists with emergency surgery requirements ⁽³⁾. The vision is to significantly improve the timing of patient assessment, timing of operative management, theatre utilisation and reduction in the proportion of cases performed after hours. The ASU model has undergone 3 variations since implementation and currently includes an 'on-site' consultant roster that supports continuity of care with less frequent handover between teams and has consultants free from external commitments. The ASU theatre has executed an additional 246 emergency cases in 2012 increasing to 307 in 2013 (2) The main diagnostic related group (DRG) remain patients with gallstone related disease

(2014-38%), recent evidence has indicated that early laparoscopic cholecystectomy during acute cholecystitis is safer and may shorten hospital stay (4). Prior to the ASU in 2011 there was 10 cholecystectomies performed acutely compared with 116 in 2013, highlighting the capability of the ASU to assist with National Elective Surgery Targets (NEST) (5).

Conclusions and implications for perioperative nursing

In presenting this ASU model, development, background, key features and achievements it is hoped it will assist other hospitals to implement a suitable model of emergency surgery management and improve perioperative nurses scope of practice in managing predictable emergency surgery.

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Faculty disclosure: No conflict reported

OC 46

THE IMPACT OF THE NON-MEDICAL SURGICAL ASSISTANT: A BRITISH PERSPECTIVE.

Julie Quick (1)

Manor Hospital, Walsall Healthcare Nhs Trust, Walsall, United Kingdom (1)

Keywords: Surgical Care Practitioner, Patient Care, European Working Time directive

Background

The European Working Time Directive combined with changes to medical training has reduced the attendance of junior doctors in the operating room (1). In response, some health departments in Europe have developed initiatives to maintain surgical service provision. Within Britain, a Surgical Care Practitioner (SCP) performs surgical intervention along with other elements of care under the supervision of a consultant surgeon (2).

Focus of Interest

With limited literature evaluating the role of the SCP within a surgical team, the impact of their inclusion remains largely anecdotal.

Methodology

An autoethnographical approach allowed the researcher to examine the experiences of surgical team members alongside her own experiences of working as an SCP in general surgery (3).

Findings

The permanent addition of an SCP to the surgical team was identified toenhance the patient experience and help maintain surgical services. The SCP not only provided skilled surgical assistance but had become a competent operator.

Conclusion

The SCP is a valuable addition to the surgical team; enhancing patient care and maintaining the provision of surgical services. The SCP also contributes to the training of perioperative nurses and junior doctors.

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Faculty disclosure: No conflict reported

OC 47

THE IMPACT OF A STANDARDIZED INCIDENT REPORTING SYSTEM IN THE PERIOPERATIVE SETTING: A SINGLE CENTER EXPERIENCE ON 2,563 'NEAR-MISSES' AND ADVERSE EVENTS

Anita J. Heideveld-chevalking (1) - Hiske Calsbeek (2) - Johan Damen (3) - Hein Gooszen (1) - André Wolff (3)

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Keywords: hospital incident reporting, guideline adherence, patient safety, perioperative care, quality improvement

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Background

Patient safety is a major priority in health care and the systematic reporting of incidents and their causes is an important source of information to improve perioperative patient safety.

Purpose of the study

We explored the number, nature and causes of voluntarily reported perioperative incidents. Goals

Highlighting the areas where further efforts are required to improve patient safety.

Research problems

Because of the likelihood of under-reporting, our dataset cannot be considered a reproduction of all actually occurred incidents.

Methodology

Data from the Hospital Incident Management System, relating to the voluntary perioperatieve incident reports in the period July 2009-July 2012, were analysed. Employees in the perioperative field filled out a semi-structured digital form of the reporting system. At least the following had to be reported: date, time and location of the incident, a brief description of the incident and the circumstances, the type of incident and the possible causes, the potential patient impact and th estimated risk of recurrence of that incident, and the measures that may prevent the incident from repeating. The risk classification of the reported adverse events and 'near misses' were based on the estimated patient consequences and risk of recurrence, according to national guidelines . According to the Dutch consensus definitions, reported incident causes were categorized as human, organizational, technical and patient related

Theoretical framework

A systematic review reveals that 14% of perioperative patients experience adverse events, that 38% of these events are preventable and that 4% of patients experiencing adverse events have fatal outcomes . There is increasing information that better guideline compliance, better communication and better team work are associated with improved perioperative outcomes

Results

In the study period, 2,563 incidents (1,300 adverse events and 1,263 'near-misses') were reported during 67,360 operations. Reporters were anaesthesia, operating room and recovery nurses (37%), ward nurses (31%), physicians (17%), administrative personnel (5%) and others (9%). A total of 414 (16%) adverse events had patient consequences, estimated as catastrophic in 2, major in 34, moderate in 105, and minor in 273 cases. Non-compliance with standard operating procedures (SOPs; instructions, regulations, protocols and guidelines) was associated with 877(34%) of the reported incidents. In total, 1,194 (27%) causes were SOP-related, mainly human-based (79%) and partially organization-based (21%). Furthermore 'mistake or forgotten' (15%) and 'communication problems' (11%) were frequently reported.

Implications for perioperative nursing

Voluntary incident reports provide important information on how to improve perioperative patient safety. For this reason, we discussed the study results with our OR team members and developed and introduced safety barrier tools, such as the 'Golden Patient Safety Operating Room Rules', the 'Perioperative Track and Trace Checklist', and multidisciplinary team training.

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0C 48

E. PATIENT SAFETY

LEARNING FROM LITIGATION AND CLAIMS TO IMPROVE PATIENT SAFETY IN THE PERIOPERATIVE ENVIRONMENT

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Keywords: Patient safety, Culture, learning, accountability, blame, improvement, sharing, litigation

Within the United Kingdom, there is an increasing financial burden to the National Health Service and healthcare organizations in medical litigation. The impact on patients, clinicians and the wider family and carers is more difficult to measure.

The processes, investigations and outcomes surrounding incidents that progress to litigation is a scary situation for all involved and are commonly poorly understood by clinicians unless they are implicated or supporting the process.

The NHS LA, through its Safety and Learning function have been unpacking and examining the data held within its unique database of case histories and outcomes that have been lodged against healthcare institutions in England, historically over a period of approximately 20 years. This work has sought to uncover the themes and common causes of high volume high value cases that its data identifies. This information is then creatively shared within organizations and networks to support organizational improvements to reduce the harm to patients and associated litigation if this occurs.

This session will give an overview of the methodology and examination of the unique claims data and discuss the learning shared with healthcare organizations to effect improvements in patient safety.

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Faculty disclosure: No conflict reported

OC 49

TAKING THE RISK OUT OF RISK MANAGEMENT THROUGH LASER SAFETY AUDIT: KEY TO QUALITY AND COMPLIANCE

Penny Smalley ⁽¹⁾ Technology Concepts International, N/a, Chicago, United States ⁽¹⁾

Keywords: audit, safety, compliance, interview, inspection, observation Laser Safety Audit is the foundation for quality assurance, yet it is very seldom understood in the perioperative environment. This session will present a clinically relevant, and simple to follow model for performance of safety audit which is the key to safe practice.

Quality assurance depends on assessing safety management, deficits in both knowledge and practice, and implementing remedies for those identified areas needing improvement. Occupational health and safety acts, refer to this as worksite analysis, and require clinical facilities to perform this task on a routine and on-going basis. Knowing what to look for and how to report and then remedy the deficits, is the basis for compliance.

An appropriate and usable audit plan includes interview, observation, and inspection, by a person who knows and understands the clinical environment, and is responsible for assessing levels of compliance with a variety of national and international standards and regulations. Interview results in the assessment of knowledge and identification of learning needs. Observation identifies whether or not staff and providers are aware of policy and procedure, and how their actual practices reflect facility policies. Inspection identifies equipment, physical plant, and supplies, that don't meet safety standards, as well as practice issues that result in damage to or mishandling of equipment, leading to potential hazards to personnel and patients.

Compliance is the key to safe practice: safety for patients, staff, and providers alike. Delegates attending this presentation will receive a detailed audit form and notes on how to use it, to assist them in conducting a safety audit in the clinical practice setting, regardless of whether it is based in hospital, clinic, or private practice.

At the conclusion of this presentation the participant will be able to:

- 1 Discuss the rationale for performing routine safety audits in a clinical facility.
- 2 Identify standards and regulations that mandate worksite analysis.
- 3 Discuss the procedure for conducting a clinically relevant safety audit

Faculty disclosure: No conflict reported

OC 50

VIOLATIONS AND MIGRATIONS IN PERIOPERATIVE PRACTICE: HOW ORGANISATIONAL DRIFT PUTS PATIENTS AT RISK

Jane Reid ⁽¹⁾ Bournemouth, University, Bournemouth, United Kingdom ⁽¹⁾

Keywords: error, patient safety, migrations, safety culture, violations

Overview

Short cuts are a feature of professional life, yet they are insidious and can quickly evolve to unacceptable ways of working. This session will explore the concepts of violation and migrations in perioperative practice, highlightingcommon deviations that undermine quality patient care and increase the potential to avoidable harm. In particular the role of Perioperative Leaders will be examined, together with strategies for addressing and affecting safer care.

Background

Short cuts and work-arounds, are a feature of daily life domestically and professionally, such as failing to separate household waste for recycling or wearing scrubs to the hospital canteen. Amalberti et al (2006) describe such acts, as violationsbecause theyoccur as deliberate digressions from standard practices and in the case of our professional lives, deviations from established organisational procedures, processes and protocols. Our collective challenge is that depending upon the context violations can also be justified, as creative ways of managing difficult situations; while this can prove true, in the majority of cases, violations are unconscious acts of deviance, that are extremely seductive, because they 'appear' easier to execute and offer a range of perceived immediatebenefits, including time savings.

Unless the circumstances, surrounding any and all deviations from desired practice, are properly examined through a safety science lens (Emanuel et al 2008) the situation canrarely be rectified, or improved upon, because the underlying reasons/justifications are rarely properly surfaced.

Objectives

This session will:

- 1) Discuss the concept of violation and migration in clinical practice
- 2) Identify common violations and migrations in the operating room
- Consider the importance of identifying and owning routine violations to determine tolerances and thresholds of service quality
- Explore and debate the challenges faced by Perioperative Leaders in upholding clinical and professional standards
- 5) Propose a range of strategies for Perioperative leaders to adopt
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CREATIVE CARING IN THE OPERATING ROOM

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Keywords: Caring, creative, nurse, healing, operating room

The Theory of Human Caring developed by Jean Watson is centered on the concept of care and existential phenomenological assumptions, which means to look beyond the physical body.

Jean Watsonintroduced the paradigm of transpersonal human care in care science as the process that transforms, generates and enhances the healing process.

From a humanist perspective this new way of caring provides growth and autonomy to perioperative nurses, as well as reaches a more ethical care, moral and human, in the Operating Room. It also brings innovation in nursing practice, humanizes relations, and promotes an approachingbetween caregiver and the patient.

The Creative Caring promoted in the Hospital of Braga, according to the theory of Jean Watson, allows nurses to better understandeach other, and enables theirabilityto restructure their concept of caring. A new vision of care thatembodiesand enhances the triad body-mind-spirit, in which is provided a new focus fortreatment, a focus towardsa cure for re-establishment and love.

The implementation of this project by adopting Jean Watson's philosophy as a theoretical reference model for the practice of care at the Hospital of Braga was taken over by the Nursing Director within this organization and over all departments. This process was based in an institutional training plan that includes, education on Jean Watson's theoretical model and reflections about Caring in multiple units, training in therapeutic touch for holistic practice, involvement of the nurses attending the training, and examination in perception of Caring about ourselves. Each unit participates with elements from their department contribute for the dynamics of these practices.

The Operative Room and their nurses are also trained to implement the Creative Caring. This investigation aims to reveal the results of the participants' experiences and to promote holistic practices in Perioperative Care, allowing the Hospital of Braga to act as a national center of reference in Holistic Care in Portugal.

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PERIOPERATIVE NURSING CARE OF OLDER ADULTS EXPERIENCING COGNITIVE IMPAIRMENT - RESEARCH PROPOSAL

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Keywords: perioperative, cognitive impairment, elderly

Whilst many of the physical concerns of the older perioperative patient are being increasingly met and the recognition that complexity of disease as a more meaningful predictor of risk factors connected with surgery than purely age, there remains a chaotic pathway in the nursing assessment of the cognitively impaired older adult. Many papers focusing on the topic of perioperative care of the older person overlooked the complexity and relevance of a diagnosis of dementia, as well as well as the psycho-social issues specific to the patients and those who care or support them. One major concern is the scope of a dementia, particularly in the area of decision making, as well as the receiving and interpreting of advice given; the disease course is on a continuum but the time length and profundity of the process is an unknown within a given time. In Australia the debate rages concerning the privacy and dignity issues of mandatory cognitive assessment testing for pre-operative clients within a certain age group. A further concern was highlighted as to what constitutes a data subset of the older patient, in Australia it is increasingly open to debate as this population group progressively become fitter and healthier. Data sets commonly report on an open ended parameter; 65+ which does not allow for variances in decades or median. Older people, are not a homogeneous group and those with cognitive impairment are frequently assessed using diagnostic instruments which do not allow for individual assessment of manifestations of altered personality or attitude.

Although the perioperative area responds to research from all areas of the surgical milieu because of the uniqueness of the environment there is a requirement for greater investigation into the perioperative experience of the cognitively impaired patient and all the stakeholders.

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D. LEADERSHIP/MANAGEMENT

PERIOPERATIVE NURSING CARE – DEFINING NURSING-SENSITIVE QUALITY INDICATORS IN OPORTO HOSPITAL CENTER

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Keyword: Perioperative nursing care; quality indicators

Background

Clinical data, aggregated and reused for different levels of clinical governance, is today an important variable in the management of Healthcare Organizations. Reality description through health indicators, inform managers, enabling effective and efficient oriented decision problems, supported by objective and comparable data ⁽¹⁾. Nurses are one of the largest professional health groups, present in almost all environments. However, the invisibility of the profession is still a current issue, demonstrated by the lack of quantifiable data about the impact of nursing care on populations health ⁽²⁾.

Goal

Define nurse-sensitive indicators related to perioperative context, in Oporto Hospital Center (CHP).

Methodology

A systematic literature review was performed, in order to list nurse quality indicators related to perioperative period. Subsequently, based on the International Classification for Nursing Practice subset in use, and the proposed indicators by Portugal Nurses Council, we proceeded toidentify new indicators relevant to CHP context.

Results

Regardless the Indicator organization type (process or outcome), there are a great concern in measuring the absence of adverse events, or monitoring the existence of interventions to prevent these events. Infection, falls, burns, wrong procedure/patient/ site/side, are the most common events measuredfound. (3-9)

Ten indicators were constructed, distributed in the follow focus: Knowledge; Ability To Manage Regime; Adherence To Medication Regime and Self Management of Symptom.

Conclusion

Perioperative nurses have an important challenge - give visibility to perioperative nursing care, developed in a restricted environment, which result in a lack of interconnecting channels with outside environments and consequently in the invisibility of the work done by these professionals. Nurse-sensitive indicators defined, are not only based on adverse events prevention, but enhance the patient ability to manage regime, sensitive nursing care territory. This work highlight the need in defining an internationalnursing perioperative minimum data set, essential for data comparability between different organizations.

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OC 54

OPTIMIZING THE INTRAOPERATIVE CARE FOR PATIENTS WITH ADVANCED OVARIAN CANCER

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Keywords: Intraoperative care, ovarian cancer, surgery

Background

Ovarian cancer affects over 204.000 women/year worldwide. Due to vague and late symptomsmore than 70% of the women are diagnosed with advanced cancer ⁽¹⁾. Surgery for ovarian cancer has during the last five years changed character to a more accessing worked where the accessing and environmentation are reducting and the reduction.

aggressive method where the prognosis and survival rate are depending on the reduction of tumor tissue at the primary procedure ⁽²⁾. The method, called "Extended radicality" includes diaphragm peritonectomy, splenectomy, liver resection, omentectomy, bowel surgery, appencectomy, pelvic and paraaortal lymphadenectomy, hysterectomy and bilateral salpingo-oophorectomy.

The procedure places great demands on the perioperative staff. Due to the long operation time (8-10 hours), the risk of infection, thrombosis, hypothermia and pressure ulcer is high. The primary goal is to prevent this and to create a safe care and environment for the patient.

Focus of interest

Based on experience from the Department of Obstetrics and Gynecology, Skane University Hospital, Lund, Sweden which is the center for gynecological oncology in the southern region of Sweden, this presentation will focus on things needed to create an optimal and safe intraoperative care for patients undergoing surgery for advanced ovarian cancer. Subjects discussed will be correct positioning, draping, surgical instruments, technical equipmentand prevention of hypothermia, infections and thrombosis. A brief introduction to ovarian cancer will be given.

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OC 55

CREATING A PICTURE: THE ART OF BRIEF/DEBRIEF IN THE OR.

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Keywords: ORL surgery, multidisciplinary teams, briefing and debriefing

Background

The scope and complexity of otorhinolaryngology (ORL) surgery is continuously evolving. This necessitates simultaneous, ongoing developments in the care required to ensure patient safety and operating room efficiency. These developments can be enhanced by harnessing and integrating knowledge and expertise from the multidisciplinary team ⁽¹⁾. Although the WHO surgical safety checklist ⁽²⁾ ensures generic pre-surgery checks, specific matters such as establishing a plan for shared airway procedures are not always addressed. Pre-list briefing and post-list debriefing ^(3,4) were identified by perioperative nurses as potential strategies to improve multidisciplinary collaboration and reduce complications during ORL surgery. Research problems

Recurring issues such as list overruns, last-minute changes and problems with resource availability in two New Zealand ORL operating suites led to the need for identifying and addressing problems in list management.

Purpose

To develop documents to guidemultidisciplinary teambriefing and debriefing for ORL lists.

Goals

To expedite the multidisciplinary management of operating sessions in order to improve patient safety and OR efficiency.

Methodology

Briefing and debriefing documents were developed for use during selected operating sessions in two ORL suites. Data was gathered from online staff surveys, written staff feedback and computer records reporting empirical data that included session times and intra-operative incidents.

Theoretical framework

Action Research $^{\rm (5,6)}$ was used to test and refine the documents. Data was analysed using a general qualitative approach $^{(7)}.$

Results

The project will conclude in November, 2014. Results will be reported at the Congress in 2015.

Implications for perioperative nursing

Briefing can contribute to a multidisciplinary perioperative environment where information is shared, specific concerns are highlighted and a plan is established to address identified issues ⁽⁸⁾. The art of perioperative nursing is in the ongoing assessment and management of dynamic multidisciplinary scenarios. Nurses are therefore in a pivotal position to enhance improved OR efficiency, quality of care and safe patient outcomes by promoting the use of brief/debriefs to create a clear picture for the multidisciplinary team.

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OC 56

THE SAFE SURGERY APPROACHES OF SURGICAL NURSES

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Introduction

Today, surgical treatment is one of the first options, and %4 of the population in developing countries have an operation in a year, whereas this ratio may go up to %8 in developed countries (Panesar et al., 2011). In Turkey, according to the statistics of Ministry of Health, 4.410.218 surgeries were done in 2012 (Republic of Turkey Ministry of Health Annual Health Statistics, 2012). Surgical interventions are invasive, and environments, in which surgical interventions are done, are hazardous areas for patients because of the higher risks of getting infection and physical injury, and encountering to dangerous materials. For the conditions, in which necessary preventions and precautions are not taken, medical errors are inevitable. Although the first principle of patient care is "first do no harm" (primum non nocere) is widely known, %3-16 of the inpatients in hospitals are affected by erroneous interventions, and it is also known that more than half of these interventions are preventable. Again, despite the increase in knowledge related to safe surgery, almost half of these incidents (%48) occur during surgical care (Yavuz, 2011). It is seen that in %3-22 of the inpatients, who accept surgical treatment in order to be healed, complications developed and %0.4-0.8 of these patients lost their lives (Haynes et al., 2009; World Health Organization, 2009). According to the Institute of Medicine's (IOM) report in 2000, 44.000-98.000 people in a year die due to the medical errors. In the U.S., it was seen that %3.7 of the hospitalizations are erroneous. Moreover, %2.62 of the medical errors result in permanent disability, and %13.6 of the medical errors result in death (Brennan, 2004).

Patient safety refers to all precautions taken by hospitals and hospital staff in order to prevent potential damages, which might be derived from healthcare services given to patients. National Patient Safety Foundation-NPSF (2003) defined patient safety as "The avoidance, prevention, and amelioration of adverse outcomes or injuries stemming from the processes of health care." Campaign of "Safe Surgery Saves Life" developed by World Wealth Organization aims to increase the quality of surgical care through developing world-wide safety standards. Project of "Quality Standards in Healthcare", developed by Department of Performance Management and Quality Development of Ministry of Health in 2009, is the first step in Turkey in terms of establishing this safety concerns. In order to endorse and maintain safety culture among healthcare personnel, "Safe Surgery Checklist", developed by WHO, was advanced unique to Turkey, and published as "Safe Surgery Checklist". By doing this, a standard form that will be used by hospitals in Turkey was generated.

Patient safety is significant in surgical process, it is important to define the stages of this process, and it is vital for medical workers to follow these steps. These steps are Safe Surgery Checklist use, validation of patient identity, correct treatment, correct patient surgery, and final control.

Safe Surgery ChecklistTR developed by Ministry of Health is composed of four parts. The first part is the form that must be filled by the patient before leaving hospital. This part involves patient credentials, surgery, surgery area, and patient consent. The second part is the area that must be checked before giving anesthesia to patient. In this part, marking of surgery area, information that is required to be verified by patient, anesthesia safety checklist, pulse oximetre, allergies of patient, necessary visualization devices, and evaluation of risk of blood loss are done. The third part involves the activities that would be done by surgery team. Finally, the fourth part involves the name of procedure, sponge, compress, and needle counts, specimen labeling, critical requirements after surgery, and the department where patient will go after surgery. Because surgical interventions are one of the most complex healthcare operations, patient safety in surgery and safe surgical interventions have gained more importance in the last years. This study was done in order to determine safe surgery applications, and surgery nurses' attitudes and opinions about safe surgery applications.

Methodology

This is a descriptive study, which was done in an institute of medical sciences of a foundation university in March 2014. 70 students, registered in 2012-2013 academic year, in Surgical Diseases Nursing Graduate Program, form the sample of this study. Survey form was developed by drawing on the theoretical knowledge in the literature, and it includes demographic information, medical errors, safe surgery, identity validation
process, and 26 other questions. The aim of the study was explained to the participants, and their verbal and written permissions were obtained. Survey forms were filled through face-to-face interview method, and SPSS for Windows 20 statistical software package was used to analyze the data.

Findings

%52.9 (n=37) of the participants are in 23-32 age group, %37.1 (n=26) of them are in 33-42 age group, and %10 (n=7) of them are above 43 years old. Only one of the participants is male, and the other 69 of them are female. Vast majority of the participants (%52.9, n=37) work in private healthcare organizations, and %31.4 (n=22) of them have 1-5 years of surgical nursing experience, %42.9 (n=30) of them are surgical service nurse, %25.7 (n=18) of them are surgical intensive care unit nurse, and %31.4 (n=22) of them are operating room nurses. In Table 1, distributions related to medical errors are given. Accordingly, 26 (%37.1) of 70 nurses have witnessed medical errors.

Table 1. Distributions of Medical Errors

Medical Error		n	%
Witnessing Medical Error	Witnessed	26	37.1
	Not Witnessed	44	62.9
	Total	70	100.0
Witnessed Medical Error Type (n=26)	Wrong Patient Delivery to Surgery Room	6	23.1
	Incorrect Blood Transfusion	4	15.4
	Conducting wrong site surgery	4	15.4
	Incorrect Surgery	2	7.7
	Incorrect Medication	4	15.4
	Forgetting sponge in patient	2	7.7
	Wrong record of surgery area in patient records	2	7.7
	Mix of patients of doctors with the same name	1	3.8
	Giving wrong biopsy report	1	3.8
	Total	26	100.0

 $\frac{1}{2}$ $\frac{1}$

When the participants' education status related to safe surgery is examined, it is seen that %92.9 of them (n=65) have safe surgery education, and %57.1 (n=40) of them have not received safe surgery applications training during their nursing occupational education. However, %74.3 (n=52) of the participants have received training within the hospital, in which they are working for. Moreover, it was found that safe surgery and quality improvement practices are carried out almost in every organization. Accordingly, %94.3 (n=66) of the participants stated that procedures and instructions related to safe surgery exist in their organization; %94.3 (n=66) of them stated that safe surgery checklist is used in their organization, %97.1 (n=68) of them stated that they evaluate safe surgery checklist as necessary for patients, %92.9 (n=65) of them noted that they participated in these quality improvement work.

Related to wristband and identity validation applications, \$94.3 (n=66) of the participants said that wristband was put on every patient in their hospital, \$98.6 (n=69) of them noted that identity validation was done, and \$37.1 (n=26) of the identity validation activity were done by nurses. On the contrary, it was determined that \$64.3 (n=45) of the participants could not correctly define identity validation method. \$97.1 (n=68) of the participants stated that they see wristband application as necessary, and \$91.2 (n=62) of them noted that this application ensures applying correct intervention to correct patient.

When site-marking application was evaluated, it was seen that %82.9 (n=58) of the participants said "yes" to the question of "Does your hospital apply site marking?" However, %55.2 (n=32) of the site-marking applications were done wrongly or erroneously, and it was seen that site-marking applications were done by physician of the patient mostly (%77.6, n=45).

Moreover, it is seen that all the participants think that site-marking is necessary. The reason behind this necessity is based on the policy of "correct intervention to correct patient." Patients' physicians did site-marking application most of the time (%74.3, n=52). What is more, if patient has plaster or roller bandage, %52.9 (n=37) of the participants noted that site-marking was done on plaster or roller bandage, whereas %31.4 (n=42) of the participants noted that they did not know this kind of an application.

%88.6 (n=62) of the participants stated that "final control application" was done in their hospitals, whereas %11.4 (n=8) of them stated that it was not done in their hospitals. %91.3 (n=63) of the participants noted that final control application is necessary for safe surgery. Moreover, %54.3 (n=38) of the participants noted that final control application must be done by the entire surgery team.

Table 2. Participants' opinions about safe surgery applications

	Participants' Opinions	n	%
Safe Surgery	"Quality of surgical care increases, and surgical risks decrease."	31	44.3
	"Wrong patient and site interventions might be prevented"	9	12.9
	Complications might be avoided	18	25.7
	"Medical staff's training must be increased"	7	10
	"Safety precautions must be developed, and frequency of regular controls must be increased"	5	7.1
	Total	70	100.0

%44.3 (n=31) of the participants noted that safe surgery applications "increase quality of surgical care, and decrease surgical risks", %25.7 (n=18) of them noted that complications might be avoided, and %12.9 (n=9) of them said "wrong patient, and wrong site interventions might be prevented."

Discussion

Generally, nurses start to work at the ages of 20-22, and until quite recently nursing has been seen as women's job. In Turkey, men's involvement in nursing occupation is quite new. The results of this study also support these general tendencies, specifically only one of the participants in the study, out of 70, is male. In a prior study, which was done to determine the effects of workload on patient safety, it was found that %67.1 of the nurses are between the ages of 26-33, %78.1 of them are women, and %95.9 of them have 0-5 years of experience (Eroglu, 2011). Furthermore, in a similar study done by Isik (2012), it was found that %50.9 of the nurses are between the ages of 26-33, and %40.7 of them have 0-4 years of experience. In this study, age distribution and occupational experience were found to be consistent with the literature. Patient safety, since Hippocrates, has been an issue that has not lost its significance. Therefore, in a report published by IOM, two of the most important problems related to healthcare services were revealed. These problems are medical errors or patient safety and quality problems in healthcare services. In this study, which focused on the current conditions related to these problems, it was found that 26 of 70 nurses (%37.1) have witnessed a medical error. Moreover, this ratio was found to be as %35 for physicians, and %42 for people who are not physician (Institute of Medicine, 2001). This situation is consistent with the results of this study. Findings in this study, together with IOM findings, imply that safe surgery recommendations of WHO are not applied properly. In studies related to patient safety, generally, statistical results are given, and it is aimed to find solutions toward medical errors. According to a study, the ratio of people believing that a medical error has occurred is %34 in the U.S., %30 in Canada, %27 in Australia, %23 in Germany, and %22 in the U.K. (Schoen et al., 2005; Çakır & Tütüncü, 2009). In this study, cases of wrong patient delivery to operating room and writing patient's surgery site in a wrong way are the medical errors that have been witnessed by nurses. These medical errors are defined as errors that have potential to cause harm when they occur. Medical errors that reach to patients are wrong blood transfusion, doing wrong site surgery, doing wrong surgery, applying wrong medication, and forgetting sponge in patient. In the U.K., %62.7 (2716) of 4334 mis-implementations between 1996-2007 were reported as wrong blood transfusion (The Serious Hazards of Transfusion Steering Group, 2008). Minimizing medical errors that threaten patient safety might be achieved through determining the sources of errors and taking precautions (Farguhar et al., 2007; Mitchell, 2008). It was found that %92.9 of the participants have taken training related to safe surgery. According to Eroglu (2011), nurses, who take safe surgery training, report more error notification, compared to the control group. Therefore, hospitals should give these trainings to their medical staff, particularly to surgical nurses. According to the findings, nurses mostly get their safe surgery training within their healthcare organizations. It is argued that this situation might be based on the differences exist in nursing education, and the fact that nurses in this study might have graduated from different schools. Moreover, it is also thought that practices about patient safety and safe surgery done by Ministry of Health in recent years might be effective.

What is more, it is found that safe surgery and quality improvement practices are done in almost every organization in this study. %94.3 of the nurses participated in the study noted that procedures and instructions exist in their organization, %94.3 of them stated safe surgery checklist is used in their organization, and %92.9 of them noted that quality improvement activities are done in their organization. According to a study focused on use of safe surgery checklist, %93 of 147 surgical personnel are aware of safe surgery checklist, %88.8 of them know the aims of this checklist and how to apply it, and, respectively, %73.7 and %100 of nurses working in state hospitals and private hospitals noted that they use this checklist in every surgical operation (Hurtado et al., 2012). Another study focused on effective use of safe surgery checklist shows that %92.4 of the nurses use checklist in every surgical operation (Abbasoglu et al., 2013). However, even though there are quality improvement practices, and procedures and instructions related to safe surgery in the participant's hospitals, it is thought-provoking that %37.1 of the participants have witnessed medical error. Thus, it is argued that there might be certain problems and shortcomings related to internalizing safe surgery applications in organizations, and it is also thought that safe surgery applications have not become a part of organizational culture. Therefore, it is offered that further work related to these issues must be persisted.

One of the first and most important steps of safe surgery is identity validation. Hospitals should develop a proper method to improve patients' identity validation process. In this study, it was seen that surgical nurses put wristband on every patient (%94.3), and identity validation was done (%98.6). In addition, %37.1 of identity validation practices were done by nurses. In the literature, it is possible to see medical errors caused by not doing or improper identity validation. In a prior study, absence of identity validation or wristband is

found to be %15.3, diet or nutrition errors were %11, not following current protocols and procedures is %11, isolation errors are %10.4, erroneous catheter/tube/drain put on/ take off is %4.3, and allergy development is found to be %3.1 (Eroglu, 2011). Göktas (2007) found that the ratio of transaction errors was %23.6. The findings in this study are consistent with the findings in the literature, and it is argued that not doing identity validation and improper identity validation may lead to other important medical errors, which were indicated both in this study and in other studies in the literature. In this study, rates of putting wristband on every patient and doing identity validation were high, and this results support the findings of higher rate of having safe surgery applications and procedures in nurses' hospitals. In addition to this, %64.3 of the participants could not define identity validation, and this result is evaluated as nurses need more information related to this issue.

Another step in safe surgery application is site making. Correct site surgery is based on correct area, correct operation, correct patient surgery, and implementing correct surgical intervention to correct level of correct anatomic area of correct organ through correct approach. It was seen that site-marking was mostly done in study hospitals, however, %55.2 of them were done inappropriately, which is evaluated as site-marking procedure might not be well-defined in organizations or nurses do not know the correct method. Inappropriate site-marking is an important issue that may lead to inappropriate surgical interventions. Although $\sqrt[6]{94.3}$ of the participants noted that they have safe surgery checklist in their organizations, the ratio of inappropriate site-marking was found to be %55.2, which is evaluated as people doing site-marking might need training. Furthermore, it is thought that recent studies on site-marking and activities of Ministry of Health on sitemarking might be influential on high rate of site-marking application. However, it could be said that there are still shortcomings about the current stage of safe surgery applications. In this study, it is found that participants see site-marking as necessary, which is evaluated as surgical nurses' awareness about this issue is high, and they pay attention to this subject. Moreover, having safe surgery training might be also influential on these results. Comparison could not be done due to the lack of relevant study about this issue.

Immediately before the surgical intervention, all team members, who will participate in the surgery (surgeon, anesthesiologist, and nurses) make the final control practice (time-out) until the last moment for the right side, the right process and the right patient with the other members in the room, who also stand there without doing nothing at that moment. It is found that a high rate of the surgical nurses, who participated in the study, know how to make the final control practices. In a study, interviewed with 12,390 neurosurgery patients, which is purposed testing the final control and operation safety, it is determined that a survical incision was made in the wrong place in an emergency case once and a lumbar incision was made in the wrong place at another time (once in 8795 cases). Again in the same study, it is concluded that in 3595 operations, in which the final control practices were made and in which the team and the checklist were effectively used, these kind of errors were not occured (Oszvald et al., 2012).

In a surgical process, it is expected that nurses, who undertake the role of being the patients' defender, should support the practices that are for the benefit of the patients and lead these practices. The data obtained in the study may be interpreted as a contribution to the awareness of safe surgery trainings and specialization trainings, which have been taken by the surgical nurses.

In the study, it is determined that %44.3 of the surgical nurses state that the safe surgical practices "improve the surgical nursing quality and reduce surgical risks", %25.7 of them state "the safe surgical practices may prevent complications" and the %12.9 of them state "the safe surgical practices may prevent the attempts in wrong patients, wrong area and wrong parties". In a study conducted by physicians and nurses (n = 180), it is found that the importance of the final control practice in improving the patient safety was not adopted with a rate of %50.1. In the same study, it is determined that the participants have a common decision about education issues but the physicians do not agree that the final controls prevent communication errors and they were reluctant to participate in trainings comparing to the nurses (Prabhakar et al., 2012). In a study, conducted in Guatemala, it is found that % 88.8 of the 147 surgical staff know about the safe surgery checklist, implementation aims and benefits of use (Hurtado et al., 2012).

In another study, it has been shown that the mortality rate of %1.5 decreased to 0.8%, the %11 complication rate in inpatients decreased to 7% and the results are statistically significant and reliable with the use of the safe surgery shecklist (Haynes et al., 2009). In a study, in which different studies were systematically examined, trainings on the support of the safety culture in the operating room, structured training programs and sample practices were provided (Fudickar, 2012). In the literature, it is considered that the surgical nurses support the safe surgical approaches and the results of this research are parallel with the other research results.

Conclusions and Recommendations

In direction with these results, it is considered that the campaigns on safe surgery practices, carried out by WHO and the Ministry of Health are effective. It is obvious that the books, guidelines and regulations edited by official institutions, make a positive contribution and there is an awareness in this case. It is also considered that the surgical nurses have a positive perspective on safe surgery practices and the surgical nurses will play a key role in health services related to the patient safety and the safe surgery practices. It is recommended to plan and follow-up multidisciplinary trainings on patient safety and safe surgery practices, to do extensive researches and to share their results.

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OC 57

EXPERIENCES AND MEANINGS AMONG OPERATING ROOM NURSES AND OPERATING ROOM NURSING STUDENTS REGARDING PRACTICING OF THE SAFE SURGERY CHECKLIST.

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Keywords: Safe Surgery checklist, patient safety, operating room nursing, communication, responsibility.

Background

Patients undergoing surgery are exposed to risks. To improve security in connection with surgical procedures, World Health Organization prepared a checklist for safe surgery, a standardized method of communication insurgical teams.

OR nurses and students shared their experiences and opinions on practicing the checklist.

Purpose

The purpose was to obtain knowledge about OR nurses and students experiences and meanings related to practicing the checklist.

Goal

Assesswhether theobtained knowledge can contribute to develop communication upon practicing of the checklist. Assesswhether theobtained knowledge can be valuable in developing training for staff and students.

Research problems

Which experiences and opinions do OR nurses and students have upon practices of thechecklist?

How can communication upon practicing the checklist be developed, according to OR nurses and students?

Methodology

17 operating room nurses and 2 students participated in focus group discussions. Data were analyzed using systematic text condensation and summarized to new knowledge.

Theoretical framework

The study is anchored in the WHO SafeSurgery program $^{(1,2)},$ research on patient outcome $^{(3)}$ and the importance of teamwork $^{(4)}$ and shared responsibility in the patient's perioperative pathway.

Preliminary results

The study revealed that OR nurses and students experienced largevariations on practicing the checklist. Under some surgical procedures, the checklist worked correctly, during others there were major challenges associated with not taking responsibility, not sharing critical information and improper and disrespectful communication between the professions. Furthermore, there were different levels of knowledge about the checklist and there were nosanctions if the checklist was completed incorrectly or not implemented at all.

Implications for perioperative nursing

Help develop strategies to build a culture insurgical departments, where the focus is patient safety and healthy communication.

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Faculty disclosure: No conflict reported

OC 58

SURGICAL CHECKLIST: CONTRIBUTION TO AN INTERVENTION IN PATIENT SAFETY AREA

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The Clinical Risk Management and Patient Safety (PS) are highlighted in the Operating Room (OR) due to its complex dynamics. Surgery is an integral part of health care worldwide, with an estimated 234 million operations performed annually. Surgical complications are common and often preventable^{1.4}. It's essential that organizations develop a culture of safety, in which work system's design should be aware that health professionals are an integral part⁵. During 2007, under the Safe Surgery Saves Lives, took place the introduction of WHO Surgical Checklist (WSC) to reduce adverse events during surgical procedures, contributing to the improvement of PS³.

This is an exploratory-descriptive cross-sectional study with a quantitative approach, whose goal is to analyse the opinions of professionals in the ORs (nurses, anaesthesiologists and surgeons), within the EPE Hospitals in Alentejo (Portugal), about the WSC, in particular, and issues of PS in general.

After analysing the data, the unanimity of professionals involved in the study expressed a very positive opinion addressing the issues of PS in the OR and 98% agreed/agreed completely that PS takes on paramount importance. Regarding WSC, 100% believes that PS is particularly important in the OR environment; 97.3% considered that the WCS is paramount to improve PS; 95.3% believe that the use of WCS helps to improve teamwork. To achieve a successful implementation of quality policies, it's essential to involve the entire organization, since it's necessary that the base of the pyramid, concerning the achievement of excellence, don't feel left out of the process, objectives and intentions of middle and senior managers⁶.

Professionals training on PS policies, implementation of WSC, the establishment of an office for clinical risk management and the creation of a system to report adverse events are proposals for socio-organizational interventions that lead the continuous improvement of quality of care provided.

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0C 59 LEADERSHIP IN THE OR

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Keywords: Leadership, stress handling, organization.

The operating theatre is an exceptional place, where different professionals are working together for the same case: a better patient.

The way to obtain an ideal result, is not always without accidents and misunderstandings. Each professional is convinced that his way is the best way.

How can a head nurse survive the daily stress and discussions, not only for one year but for several years? How can she or he, protect herself or himself from the burnout and the despair?

Objective

A way of surviving with the team of nurses in the daily struggle in the OR, a way of working together.

Method

Explaining the different methods the head nurse can use, to obtain a good result.

Setting The OR in the daily practice.

Bу

Monique Van Hiel President WOV Flemish organization for OR nurses in Belgium Experience OR leadership from 1974 in an evolution from 1 OR room with emergency room to 12 OR rooms, from 1 colleague to 83, building twice a new OR theatre, starting an organization WOV and still working full time.

Bibliography

Maslow theory Stephen Covey = controlling the situation Peter Drucker = management by objectives Michael George = Six sigma -> lean -> lean six sigma

Faculty disclosure: No conflict reported

0C 60

LEAN LEADERSHIP INITIATIVES FUELING INNOVATION IN CLINICAL PRACTIC

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Keywords: Lean, Leadership, Innovation, Quality

Quality is today's healthcare mandate. Yet there is a dark cloud blurring the vision of many nurse executives today because Lean has had some false starts and stops in days gone by. Lean is one very useful tool for achieving quality that is easy, but confusing to many. Ask ten different nurses what Lean is and you will receive ten different definitions. However, with the right education, long-term focus for lasting change, and short-term ideas for easy wins, nurse executives can use Lean principles to change culture and the bottom line, making quality improvement a win-win for patients, the hospital, and the employees. Today, we work in broken processes that require excellent people to achieve average results. Lean running hospitals think differently, focusing on building excellent processes, the key is applying Lean in the right way. This presentation will focus on: describing how Lean processes increase quality and create measurable financial savings; describe and demonstrate a mobile leadership rounding application for patients, staff and physicians; and discuss how Lean innovation created a staffing skills matrix for the Operating Room.

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The study concerns the organization of work protocols of nurses assigned to the Surgical Unit of the Hepato-Biliopancreatic specialized centre and the emergency surgery unit at the Treviso Hospital which are alternately on duty day and night. The staff linked to these facilities include: a head nurse who works as an instrumentalist, a scrub nurse, a nurse anesthetist, and a nurse responsible for post-operative care. The entire team is composed of: 16 surgeons, a team manager, 25 nurses, and a social worker specialized in health care; all of these work on rotating schedules. The centre is responsible for a geographic area in Northern Italy where 450,000 persons are living; 2232 operations were performed over 2013

The project's aim was to improve the management and care of patients facing elective surgery by assigning a nurse to meet with each patient before his/her admission. Our intent was to gain further data on the patient's health status and, at the same time, to provide the patient with a clearer picture about the surgery being planned and what to expect with regard to post-operative care and follow-up. An epidemiological study was thus carried out on a sample of 138 patients during the pre-surgical hospital stay who were questioned about the two variables described in the table.

A comparison between the data collected from the patients who were interviewed and information found in hospital records confirmed that the patients were not informed about all aspects of surgery.

Swot analysis and fishbone diagrams were used to analyze work organization, feasibilities, and to identify the causes of problems. Direct observation, brain storming techniques, focus group meetings over a six-month period were utilized to develop a Gantt chart. An information pamphlet that was to be given to all patients at the time of their first examination was prepared. Scheduling of pre-surgical examinations was reorganized for 3 specific times a week so that patients would be able to meet both the nurse anesthetist and the surgical nurse at the same time (this service was also provided in cases of emergency operations). A questionnaire concerning the pamphlet's clearness and the utility of the meeting with the two specialized nurses was formulated and the responses of 1533 forms were collected anal analyzed.

Analysis of the results as well as the patients' behaviour in the operating room confirmed the positive outcome of the project. The patients were considered more communicative, participatory and aware of what was going on. It is known that communication is the essence of nursing and the channel through which a nurse provides patient care. Giving the patient information is an important aspect of the nurse's role, and it is one of the ways by which the patient/nurse relationship is developed. The content, the instruments, and the methods used to give a specific message are, nevertheless, less important than the way it is communicated. Self-awareness and recognition of the nurse's role and professional aims together with recognition of the patient's distinctiveness were found to be of fundamental importance in favoring communication and collaboration not only between the nurse and the patient but also between the ward and the ambulatory and between the staff surgeons and the anesthetists.

Faculty disclosure: No conflict reported

0C 62

INNOVATIVE TECHNOLOGY AND PERIOPERATIVE NURSING MANAGEMENT

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Keywords: Perioperative nursing management, innovations, manager roles

Abstract

The introduction of advanced medial surgical innovation driven by medical surgical industry, scientific progress, medical interest and public expectation. It is revolutionizing the medical care both outside and inside operating rooms. This increases demand for patients safety measures, thus challenges for perioperative nursing management.

To meet current and future technology challenges, perioperative nurses need to be routinely and appropriately involved to provide safe patient care during surgical procedures. As new technology usually adds to the hospital cost, the managerial aspect of providing health services to patients in hospitals is becoming increasingly important. Hospitals want to reduce costs and improve their financial assets, One unit that is of particular interest is the operating room suites OR. Management of OR requires the coordination of human and material resources in such a way that surgical procedures can be performed efficiently, cost effectively, and safely

It is important to recognize the impact of new technology and how it can affect intraoperative nursing functions. Perioperative nurse manager responsibility is to ensure and maintain staff members' skills and competency, and to promote evidence based research to ensure that staff members have the knowledge to perform their jobs safely and properly.

Faculty disclosure: No conflict reported

OC 63

TRACEABILITY AND EFFICIENCY IN SURGICAL AND STERILISATION PROCESSES.

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Keywords: Traceability, Sterilisation, Biological indicator, Surgical Site Infection, Patient Safety

Background

11,000 surgical interventions were carried out at the Hospital of Galdakao-Usansolo in 2013. Sterilised material is used in all the surgical procedures. This material is always processed at the Sterilisation Unit and, occasionally, in small autoclaves (or tabletop autoclaves) located in the Surgical Area. All of them are controlled by Quality Standards, under current regulations.

Both the Surgical and Sterilisation Processes are key elements for the prevention of Surgical Site Infection which is an indicator of Care Quality. These Processes are guaranteed by a strict monitoring of the physical, chemical and bacteriological indicators. A Traceability System is essential to retrieve the information as soon as possible.

Focus of interest Patient Safety Clinical Safety

Objectives

The common objective is to guarantee the efficiency of both the Sterilisation and Surgical

Processes

To obtain a traceability record that provides us with the identity of Surgical Patients, allowing us to keep track of the sterilised material and to quickly identify those patients who have undergone surgery with the results of the quality standards within the process.

Methods

Implementing a protocol of working for the sterilisation procedures where a parametric control of the process is set. Also, the implementation of a guideline to follow in the event of a positive biological indicator.

Outcome/Results

To have the information of the process which registers all the physical, chemical and biological quality indicators that are processed under current regulations.

Guidelines for action in case of a positive biological indicator

Implications for perioperative nursing

Due to the traceability record implemented within the Intervention Registration Documents, it takes us less than 10 minutes to locate a patient whose material has been sterilised in the autoclaves at the Sterilisation Unit, and we find them immediately when the material has been sterilised in the miniclaves that are situated in the Surgical Area.

Conclusions

This system guarantees Patient Safety since all the Surgical Patients have their own traceability record which is registered in the Intervention Registration Documents that exist in both the Sterilisation Unit and the Surgical Area.

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Faculty disclosure: No conflict reported

0C 64

WILL I BE WORKING WITH SURGICAL INSTRUMENTS DAMAGED?

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Keywords: surgical instrument

Good practices in surgery and our professional capacity for discernment invite us to use, handle, take care of surgical instruments in our OR nurse's daily practice in the operating theater. Indeed, their design and their composition have a specific purpose: to allow the surge on to work in the best possible conditions with the best tools in the patient's interest. We've all been faced with evil sharp surgical instruments, stained, soiled, damage property. Once in the surgical field, a pair of scissors badly sharpened, may damage the fragile tissues, damaging the bone surface, hinder the surge on in his manipulations

The paper address esa series of problematic situations and tries to explain the origin of the degradation of surgical instruments. The role of the OR nurse in the operating room is review edin light of the precautions and proper handling of instruments before, during and after surgery. The WHO checklist focus eson specific points in the Timeout "There are equipment issues or any concerns?" and in Signout "whether there are problems to be any equipment addressed?".

The OR nurse must ensure the integrity of the patient material used for its well-being per and postoperatively. It's his/her responsibility.

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Faculty disclosure: No conflict reported

0C 65

THE JOURNEY TOWARDS PROFESSIONALIZATION, AN EMERGING PROFESSION: EXPLORING THE PERCEPTIONS OF STERILE SERVICES STAFF

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Keywords: Nurses, Infection Control and Prevention, Sterile Servies, Operating Theatres

In England alone there are approximately 168 National Health Service (NHS) hospitals managed by acute trusts and over 4.2 million surgical procedures are performed annually ^{7,10}. The majority of these procedures involve patient and staff contact with surgical instruments. Thus, opening up the opportunity for a major risk of cross contamination from patient, staff or surgical instrumentation. One previous study reported failure to remove surface contamination effectively from surgical instruments may result in microorganisms becoming trapped and surviving within organic material ¹¹.

Over the last fifteen years, there have been significant changes in legislation relating to decontamination processes, mainly resulting from the focus on variant Creutzfeldt-Jakob disease (vCJD) outbreaks and the need to tackle Healthcare Associated Infections (HCAI) ^{9.12}. This raises the potential for a major risk of cross contamination for patient and staff ³. Over the past several decades, surgical instruments are reprocessed and prepared for reuse by dedicated sterile service staff predominantly employed in technical roles, and yet are often on the lowest NHS pay bands ³.

Government reforms across a range of allied health professions are seeking to empower staff to maximise the use of their skills and abilities and to devolve productive leadership. The commitment to reform such professions is strongly evident in the NHS Operating Framework for 2008/09^{4,5} setting out priorities to assist NHS organisations to plan and shape services around their community's needs. Continuing to be at the forefront of the Health and Social Care Bill ⁶, and the government's agenda to modernise the NHS ^{4,5}.

This research study aims to explore individual expectations of sterile service staff as an emerging profession by exploring the impact on practice and identifying any perceived barriers. Therefore, providing insight into whether a transsition will empower staff, improve staff retention and job satisfaction¹. It is hoped that through exploration of these specialized technician roles that it will highlight the contribution decontamination technicians attribute to the control and prevention of hospital acquired infection. Inadequate decontamination potentially exposes staff and patients to pathogenic bacteria and blood borne-viruses.

The methodology utilised for this research is a constructivist approach as it would be percieved difficult for the researcher to bracket any bias and utilise a phenomenological or grounded theory approach due to the researchers professional background and involvement in the research topic and pre-formed opinions ¹. The rich data collected has been analysed using a thematic approach and the initial findings will be shared during this presentation.

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TRANSPARENT BASIC EDUCATION FOR CENTRAL STERIL TECHNICIANS THE RESULT OF COLLABORATION BETWEEN COUNTRIES

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Keywords: Steril techincian, education, validation of knowledge, implementation of new project, teamwork

Ten institutions in seven countries formed a working group with the aim of writing together a curriculum for staff in sterilization departments. The interest of the group was based on the need for increased education of employees in this profession to prevent infection and to increase the safety of staff and patients.

There are different programs for sterile technicians in many countries, the problem is that they are not recognized between organizations and not between countries.

Theoretical framework

The curriculum was designed according to European and International Standards and Laws, ensuring the basic training for sterile technicians ⁽¹⁾. It was emphasis that the syllabus was designed to deliver a high standard of care, enabling safe and effective patient outcomes.

Pilot Study was made in Iceland, which focused on the needs, age structure and formal education in this field. The result was; no formal education, age of employees are high, this is a low-paid job, many workers are of foreign origin and only women.

Result

A complete curriculum in English was published, which includes relevant modules $^{(1)}$ which enables institutions in other countries to use $^{(2)}$. And a Icelandic curriculum for sterile technicians was made together with a booklet for education demands at working place $^{(3)}$.

Conclusion

Increasing Healthcare Associated Infections makes it manifest that a more advanced education in this field is needed. Perioperative nurses understand the importance of clean, sterile and save instruments in the operations and are in the position to create an understanding from the world of work about the necessity of this training and education. Therefore their support and understanding is needed.

Important is also to enable mobility for those trained within this field in order to increase employability and the overall level of competence in the sector

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Faculty disclosure: No conflict reported

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THE USE OF A SURVEILLANCE SYSTEM AS A RELIABLE TOOL IN THE REDUCTION OF SURGICAL SITE INFECTIONS: A SYSTEMATIC LITERATURE REVIEW

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Keywords: surgical site infection (SSI), wound infection, surveillance system, surveillance programme, risk index

Background

According to the literature any patientundergoing a surgical procedure is susceptible to Surgical Site Infection (SSI). SSI is a major public health issue as it has a significant impact on the cost of health care, is a cause of increased mortality and morbidity, it prolongs hospitalization and last but not least affects the quality of life of the individual. Therefore, an effective infection control program must be implemented to compact this major public health problem. Epidemiological surveillance is considered to be the cornerstone of an effective infection control program. This must focus on the guidelines, protocols and subsequent actions applied in such a way as to allow the assessment of its effectiveness and its ongoing evolution. In Cyprus no such surveillance program is in place in our hospitals.

Purpose of the study

The aimis to establish whether the use of a surveillance system will reduce SSI. Consequently, it is hoped and anticipated that an effective surveillance system will be put in place in the Cyprus Hospitals.

Method

An extensive literature review was carried out in the "Pubmed database" which referred in the incidence of SSI's through a surveillance system.

Results

In all studies, comparison of the results of the first year of surveillance with the next yearsshowed that a reduction of the SSI's can be achieved through a surveillance system. The enquiry and analysis of the characteristicsof each system showed that using a standardized registration protocol and software; regular training of data collectors; inter-hospital comparison of infection rates and feedback of results; dissemination of results to health care professionals; regular discussion of both successful and failing prevention strategies that had been instituted based on the surveillance results, can reduce the risk of SSI's.

Conclusions

Surveillance, supported by prevention and control perioperative interventions, reduced the risk of SSI in surgical patients.

Faculty disclosure: No conflict reported

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C. EDUCATION

WAIT! DOES YOUR PATIENT REALLY NEED A FOLEY? AN INTERPROFESSIONAL TEAM APPROACH IN THE PREVENTION OF CATHETER-ASSOCIATED URINARY TRACT INFECTION

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Urinary tract infections (UTI) are the most common type of healthcare-associated infection, accounting for more than 30% of infections reported by acute hospitals (Edward et al., 2006). Up to 80% of UTI are associated with the presence of an indwelling urinary catheter (Apisarnthanarak et al., 2007). In addition, a catheter-associated urinary tract infection (CAUTI) has been associated with increased morbidity, mortality, hospital cost, and length of stay. The Ministry of Health has mandated Canadian hospitals to reduce and report incidences of hospital-acquired infections in healthcare settings. Likewise, the Healthcare Management Organization (HMO) in US has taken a proactive approach in making healthcare providers more accountable by cutting payments for hospital-acquired infections and complications deemed avoidable and preventable.

This presentation will identify the major risk factors for CAUTI. It will highlight the collaborative efforts made by a large group of interdisciplinary team members at UHN in developing strategies for prevention of CAUTI. Empowering nurses through education and training and implementing changes in each of the inpatient care units will be discussed.

Faculty disclosure: No conflict reported

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WHEN AN INFECTION IS TOO

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Keywords: prevention, safety, quality.

The surgical site infections are one of the most common complications following surgery. 90% of surgical site infections occur in the operating room. Infections impact in terms of increased costs, and outcomes of inpatient days. The surgical site infections are those that can most easily be prevented. The World Health Organization, in its second global campaign on patient safety, "The Safe Surgery Saves Lives" dedicates an entire chapter to the prevention of infections. Antisepsis of the operative field plays an important role in preventing infections. The inactivation of bacterial growth, the destruction of pathogenic microorganisms and their inactivation are closely related to the choice of antiseptic. The main features of an antiseptic are: bactericidal action, persistence, speed of action, convenience, broad-spectrum of action. Another important aspect in the choice of antiseptic is given by the presence of alcohol. Today there are two molecules in surgery most commonly used: the clorexidine and povidone iodine. This work, through a literature search on the internet, compare the indications that the various guidelines suggest sull'antisepsi perioperative surgical.

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0C 70

THE CHALLENGES AND SUCCESSES OF IMPLEMENTING COMPREHENSIVE UNIT-BASED SAFETY PROGRAM (CUSP) IN A CANADIAN OPERATING ROOM.

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Keywords: Patient safety, evidence based care, clinical outcomes, teamwork, surgical site infections, safety culture.

Surgical site infections (SSI) are the leading nosocomial cause of complications for post operative patients. The potential harm to patients caused by SSI's can not only delay recovery but could lead to prolonged hospital stay and in some cases death ^(1,2). A high SSI rate within the Ottawa hospital prompted a proactive and unique way of addressing the potential harm to patients by starting a CUSP initiative within the operating room. This implementation of a CUSP initiative was the first in Canada. This presentation will show how the CUSP initiative was implemented and discuss the difficulties and successes arising from the program. This presentation will educate perioperative nurses on how they can be a proactive member of a team and help initiate changes within their units^(3,4,5,6,7,8).

Focus

This presentation will describe

- The following five steps of CUSP designed to incorporate an ongoing evidence based safety infrastructure into your existing unit. the steps are;
- 1 Educate Staff on the Science of Safety Training
- 2 Staff Identify Defects
- 3 Executive Partnership
- 4 Begin Learning from Defects
- 5 Implement Teamwork Tools
- Knowledge translation Strategy
- Challenges faced attempting to form the colorectal focus group for CUSP
- How staff were surveyed on their perceptions of potential harm to patients within the operating room
- How the results from the survey were correlated into a tangible set of values that could be utilised by the CUSP process
- The implementation of change within the unit, starts with culture
- The results of the CUSP focus group
- Difficulties of measuring results of CUSP
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0C 71

WHY IS ERGONOMICS SO IMPORTANT IN THE OPERATING ROOM?

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Aim of Study: The aim of this review is that to highlight the importance of ergonomics in the operating room, to determine the ergonomic risk factors and to offer possible solutions for nurses.

Affiliation(s): There is no affiliations.

Introduction

There is a mutual interaction between health and workplace. Health affects work life and working condition affects worker's health. Hazardsarising from the work environment like occupational accidents and many health problemscaused by work and work processes could impair the health of workers. This highlights the importance of a healthy working

environment. It is important immunization and intermittent check-up of health workers and to assess their working environment. To be protected health of employees, identification factors that impair the health of the workers, taking protective measures, making the necessary changes in working environment, improvement ofinappropriate conditions and training workers is required. Factors that may affect health and safety in the working environment is expressed as chemical, physical, infectious, psychosocial and ergonomic risk factors. In these factors, ergonomic factors directly influence the relationship between work and workers (Babayigit 2013; Parlar 2008; Schlossmacher and Amaral 2012).

Hospitals are complex systems including an extremely diverse group of occupations. Health workers working separate profession, occupation, job, department in hospital may encounter different occupational risks from each other. Operating rooms (ORs) are stressful and complex working settings which contain various medical materials, equipment and newly technologic device and require special knowledge, skill, caution and endeavor. The growing number of complex machines has led to increased interactions among humans and technology. In recent years ORs conditions have not been reorganized in terms of ergonomic factors in compatible with novel technologic equipment and proceed to be employed without proper design changes. At the consequence of this, this situation enhances physical ergonomic risk factors that negatively affect the health of employees. Open surgical procedures are required long time to prepare and to end. In these procedures, complications and delays lead to more stress and time pressure on surgical staff. Both open surgery and laparoscopic surgery necessitate utilizing of different and large equipment from each other (Parlar 2008; Matern and Koneczny 2007; Choobineh et al 2010; Sheikhzadeh et al 2009). For this reason, operating rooms contain many ergonomic risk factors and OR nurses can be exposed to these risk factors in the OR, including physical, cognitive and organizational ergonomic risk factors.

International Ergonomic Association (IEA)define ergonomics as "Ergonomics (or human factors) is the scientific discipline concerned with the understanding of interacting among humans and other elements of a system, and the profession that applies theory, principles, data and methods to design in order to optimize human well-being and overall system performance". Ergonomics harmonizes things that interact with people in terms of people's needs, abilities and limitations. Ergonomics has a holistic approach in which consider physical, psychosocial, organizational, environmental and other relevant factors. Ergonomics which is multidisciplinary scope has 3 specialized domain(IEA 2014).

Physical Ergonomics: Physical ergonomics is concerned with human anatomical, anthropometric, physiological and biomechanical characteristics as they relate to physical activity(IEA 2014).

Cognitive Ergonomics: Cognitive ergonomics is concerned with mental processes, such as perception, memory, reasoning, and motor response, as they affect interactions among humans and other elements of a system (IEA 2014).

Organizational Ergonomics: Organizational ergonomics is concerned with the optimization of sociotechnical systems, including their organizational structures, policies, and processes (IEA 2014).

- . 1 Physical ergonomic risk factors; like multiple lifts per shift, lifting alone, lifting bariatric patients or un-cooperative patients, lateral or side lifting, back hyperextension or flexion, holding heavy instruments such as a saw or drill with a rechargeable battery at reach distance for long time, wrong body biomechanics and posture; twisting while lifting, lifting heavy instrument trays and at times above the shoulder level and beyond reach, working in awkward postures (awkward postures need to be last more than 1 hour continuously or several hours in the work shift), slippery or wet floors, uneven floor surfaces, poorly maintained walkway or broken equipment, inadequate lighting, especially during evening shifts computer work; wearing of lead aprons during surgical operations that usedoften x-rays, moving monitors; keeping equipment away from the body for prolonged time, bumping against OR equipment, carts, monitors, too much walking; standing on cold and wet floor for a period of time twisting at the waist and bending; standing long hours (up to 10 hours for some surgical operations) and fixed postures, pushing, pulling heavy objects such as stretcher, moving, lifting and lowering heavy loads such as trays, patients; repetitive movements with hand/wriststhe transfer of the patient from bed to stretcher, manual handling of patients. workplace layout, safety and health(IEA 2014; OSHA 2014; Sheikhzadeh et al 2009; Choobineh et al 2010; Schlossmacher and Amaral 2012)
- 2 Cognitive/ psychosocial ergonomic risk factors;job demands, job control, support from colleagues and supervisors (Long et al 2012), the lack of effective communication in the OR (with OR staff and surgeons), exposure to violence, pain, fatigue, delays and surgical complications psychological load of work, job dissatisfaction. decision-making, skilled performance, human-computer interaction, human reliability, work stress and training conflicting between nurses, waiting on work from other nurses and limited time to finish job (IEA 2014; Etienne 2014; Choobineh et al 2010; Sheikhzadeh et al 2009; Schlossmacher and Amaral 2012).
- 3 Organizational ergonomic risk factors; like shift scheduling (unceasing days or rotations), long working hours, less time between shifts, work while ill or on day off, forced overtime, most days worked without a day off, working at the weekend, pauseover workday human resource management, organization of work and working times, teamwork, collaboration, virtual organizations, telework, and quality managementare associated with work-related musculoskeletal disorders in nursing (Long et al 2012; IEA 2014).

Musculoskeletal disorders (MSDs) affect the muscles, nerves and tendons. Work related MSDs are one of the leading causes of lost workday injury and illness.Exposure to these ergonomic risk factors boosts a nurses's risk of injury (OSHA 2014). Work related musculoskeletal disorders (WMSD) is seen, with the most common complaint is low back pain (Sheikzadeh et al 2009; Choobineh et al 2010), as a consequences of unhealthy ergonomics conditions. Musculoskeletal disorders include the neck, shoulders, wrist, hand, elbow, waist, back, hip, knee,ankle and foot disorders.

Sheikzadeh et al (2009) in his study found that a high prevalence of WMSDs among perioperative nurse(n=50), with lower back pain the most prevalent (84%) complaint, followed by ankle/foot (74%) and shoulder (74%) and neck (71%) pain complaints.

Working when in pain occured as the most arduouswork-related activity for nurses; carrying, lifting or moving heavy materials were the second.

Simosen et al (2012) found in their study that assistant nurses (n=93) and OR nurses (n=99) were diagnosed neck/shoulder discomfort prevalence of 25 % and of 17 %, respectively. In particular, Long et al (2012) highlighted that working while sick increases about 2 times the risk of neck MSD. OR nurses working in shift system had roughly 2 to 3 times increased risk of MSDs in neck, upper back and knee as compared to those who were day workers. Wrists/hands symptoms had higher prevalence among younger OR nurses than their older counterparts (Choobineh et al 2010). In addition, prevalence of elbow/hand disorders was found higher in the assistant nurses, and awkward postures and repetitive movements in the OR nurse compared to the assistant nurse (Simonsen et al 2012). Choobineh et al (2010) found that the prevalence of knee problems in orthopedics and neurosurgery nurses was substantially higher than cardiac surgery and other surgery nurses.

Psychological factors such as conflicting between nurses and waiting on others nurses gave rise to significantly MSDs of shoulders and wrists/hands (Choobineh et al 2010). Szeto et al (2009) found that psychosocial factors significantly associated with the symptoms severity of the lower back.

At the consequences of WMSDs that nurses receive medical or therapeutic measures, sleep disturbance and retire from work. Also nurses had absenteeism, changed jobs, had work accidents, reduced of daily activity and of % 70 abandoned of the profession (Long et al 2012; Sheikzadeh et al 2009; Choobineh et al 2010; Schlossmacher and Amaral 2012). Choobineh et al (2010) found in their study (n=375) that 38.5 % of nurses had physician visits, 25.1 % of themtook medical rest and 18.8 % of them required physiotherapy treatment within one year due to WMSDs.

As a result of related studies, as a solution to diminish ergonomic risk factors and to combat WMSD; repairing of broken appliances and carts, well identifying the trays for each surgical operation, properlyalignment of the trays, effective communication between team members, positive organizational structure and climate, preventing violence, never transferring patients when off balance, lifting loads closer to the body, never lifting alone, using mechanical assistance device or transporting with the team, training in when and how to use mechanical assistance, limiting the number of allowed lifts per person per day, avoiding heavy lifting especially with spine rotated, eliminating uneven floor surfaces, immediately cleaning up of fluids spilled on the ground, eliminating cluttered or obstructed work areas, ensuring adequate staffing, educating and training workers about safer lifting techniques remodeling of OR environment large enough, creating of sufficient space by removing excess unnecessary equipment, using chair supporting your body, providing optimal humidity, heat and effective ventilation, enough lighting the area of operations, changing posture and small pauses supporting ORworkers in coping with stressphysical activity and exercise programs, rotation of scrub and circular nurse and lumbar stabilization exercises are recommended(Sheikhzadeh et al 2009; OSHA 2014; Wauben et al 2009; Long et al 2012; Choobineh et al 2010; Ellapen and Narsigan 2014).

This review has identified that nurses are vulnerable to WMSD, in particular low back pain. There is limited number experimental intervention studies that have been conducted to cope with the WMSD among operating nurses. Further research should be conducted to identify other intervention strategies to alleviate WMSD among operating room nurses.

As a conclusion, in order to create ergonomic working conditions, firstly collaboration between administrator and workers is needed. Then, ergonomic risk factors in the operating room should be identified clearly, possible solutions to implement should be researched and consequences should be evaluated. Then it should be done that planning of measures for risk factors, developing of prevention policies and strategy, making necessary control and keeping health records of related injuries caused by risks.

Ergonomics is crucial for operating room nurses. Work environment should be organized to augment nurses' health. Enhancing quality of working condition in the operating room increases nurses' occupational health and safety, productivity and performance, which contribute to nurses health and nursing care outcomes in a positive way. Moreever ergonomic working conditions will increase motivation, job satisfaction, and contribute to reduce nurses' stress, absenteeism, occupantional diseases and work accidents. Thus nurses' commitment the organization will increase and intent to leave the profession will reduce.

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A SCIENTIFIC RESEARCH

SURGICAL SMOKES: A KNOWN RISK BY OPERATING ROOM NURSES?

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Key words: surgical smokes, risk, information, prevention

Surgical smokes contain potentially contaminant biological components, particles and chemicals. They can induce acute or chronic respiratory irritation or even cancer.

Suck up surgical smokes at source is the most effective way to prevent those complications. Without specific filter for laparoscopy, it is recommended to put a compress on the trocar opening. A survey was conducted in two French university hospitals.

172 questionnaires were distributed to nurses working in operating room. The response rate was 43% (38 non specialized nurses and 36 specialized OR nurses*). The study showed that 68,5% of non specialized nurses, and almost 28% of specialized OR nurses do not know this risk. The surgical mask is seen as a preventative measure against surgical smokes but it does no protect against smokes components. The specific devices to suck smokes were not available.

At the same time, two occupational physicians were interviewed: they know this risk but they do not inform nurses for several reasons:

- non-priority risk

- absence of complaints and adverse reporting

- cost of specific equipment
- lack of French regulation

Occupational risk is a reality, but professionals are not well informed.

Communication among team members is essential to transmit information. It is also important to promote the training in Operating Room Nurses schools. Reading professional journals and conference attendance are also reliable sources of information. Time should be accorded for practice analysis in operating room to allow sharing knowledge, ideas and practices.

Without a prevention strategy, this public health issue would probably be more costly than the purchase of specific equipment.

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Faculty disclosure: No conflict reported

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NOISE IN THE OPERATION ROOM

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Keywords: Noise, operating rooms, noise pollution, perioperative nurses.

Introduction

In the past few years the rapid growth of science and technology have offered medicine and nursing countless new tools, machines and equipment. Unfortunately their beneficial advances are associated with the corresponding noises that result from their use. In conjunction with human speech, voices and behaviors during an operation, noise in OR is increased in maximum levels. Increased anxiety is the effect of the exposure of perioperative patients and staff to noise. Researchers incriminate noise for surgical infection appearance. Noise is a distraction that interrupts patient care and potentially increases the risk of error.

Maingoal/purpose

Studying the noise effects in OR on both patients and healthcare staff.

Method

It's been used a literature review, Surveys and articles from databases such as Pub Med, Medline and the internet via search engines.

Results

Searching literature was found that excessive noise in the OR environment is a stressful agent with adverse effect on both patients and healthcare staff in the OR and therefore must be conceder as a major area of concern. Communication among staff is affected and stress management becomes extremely difficult, so the noise must be limited or avoided whenever possible. Furthermore noise in OR constitutes a risk factor for patient safety during the operative procedure and its limitation is imperative.

Conclusion

Knowledge of the effects of continuous exposure to increased level of noise on perioperative patient and nursing staff is needed. Not only communication is affected but patient safetyis at risk. An important piece for prevention is provided with the knowledge of the negative effects of noise. This could be achieved by modifying the attitudes and behavior of the perioperative team members, with respect to their colleagues and the patients too.

Faculty disclosure: No conflict reported

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INVESTIGATION OF SURGICAL SMOKE RISKS AND PREVENTIVE MEASURES IN TURKISH OPERATING ROOMS

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Introduction

Surgical smoke is produced by electrosurgical, laser, and ultrasonic devices as a result of disruption and vaporisation of tissue protein and fat. The content and the hazardous effect of the surgical smoke vary widely, depending on the nature and pathology of the treated tissue and the exposure time. Numerous studies have established the presence of hazardous components in surgical smoke and these components could cause a range of adverse health symptoms and effects on surgical team members and patients. (Alp et al 2006, Bigony 2007, Krones et al 2007, Edwards and Reiman 2008, Ulmer 2008, Fan et al 2009, Watson 2009).

Operating Room (OR) nurses are routinely exposed to the surgical smoke during daily surgical life. The inhalation of aerosols during electrosurgery can cause a range of adverse health symptoms and effects. For several decades, health care workers have been aware of the surgical smoke hazards (Edwards and Reiman 2008, Fan et al 2009). However, there isn't any study investigating preventive measures of surgical smoke, perceived hazards and any adverse events OR nurses have experienced in Turkey.

Aim of Study

The aim of this study was to investigate surgical smoke risks and preventive measures in Turkish operating rooms.

Material and Method

The sample of this descriptive study comprised 672 operating room nurses who attended Turkish Surgical and Operating Room Nurses Association's scientific meetings. A sampling method was not used; all the OR nurses who agreed to participate, were included within the scope of the research. Data were collected during the scientific meetings of Turkish Surgical and Operating Room Nurses Association. Turkish Surgical and Operating Room Nurses Association is scientific meetings of Turkish Surgical and Operating Room Nurses Association. Turkish Surgical and Operating Room Nurses Association is scientific educations related with "Surgical Smoke" regularly. The data collection was done prior to association's meetings about Surgical Smoke which were conducted in Istanbul, Ankara, Izmir, Bolu and Adana.

For data collection, a questionnaire form developed by the researches in accordance with the related literature was used. The form included a total of 41 questions to determine socio-demographic data as well as the symptom experiences related with surgical smoke and surgical smoke control measure practices sections.

Written permission to conduct the research was obtained from the Ege University Faculty of Nursing Ethics Committee, as well as board of Turkish Surgical and Operating Room Nurses Association. The purpose and details of the study were explained to the nurses and oral consent was provided by all participants.

Data obtained from this research were analyzed using Statistical Package for the Social Sciences (SPSS) for Windows 16.0 software. Descriptive statistics of nurses were presented as number, percentage and mean. Compliance of quantitative variables with the normal distribution was assessed by Kolmogorov Smirnov test. As for the variables that were not normally distributed, Mann Whitney U test was used. The resulting p value at <0.05 was considered statistically significant.

Results

The average age of the 672 operating room nurses included in the study was 34.50 ± 7.39 years (range, 19-58 years), their average length of service in the profession was $14.13\pm$ years (range, 1-37 years), and their average length of service in operating room was 10.00 ± 7.76 years (range, 1-35 years). 92.9% (n:624) were female and 7.17% (n:48) were male, and 15.0% (n:101) had a health vocational high school degree, 30.2% (n:203) had associated degree, 48.7% (n:327) had a bachelor's degree and 6.1% (n:41) had graduate degree. 54.8% (n:247) of the respondents were working in public hospitals. 36.8% (n:247) were working in university hospitals and 8.5% (n:57) were working in private hospitals. The practice areas in which they work were shown in Table 1.

Table 1: Practice Areas Presented by Operating Room Nurses

Practice Area	Number	Percentage
Central Operating Room	241	35.9
General Surgery	166	24.7
Thoracic and Cardiovascular Surgery	66	9.8
Orthopedics and Traumatology	42	6.3
Urology	38	5.7
Obstetrics and Gynecology	32	4.8
Neurosurgery	29	4.3
Ophthalmology	21	3.1
Otorhinolaryngology	20	3.0
Plastic and Reconstructive Surgery	14	2.1
Outpatient surgery	3	0.4

This study showed that 73.2% (n:492) of the nurses lived at least one symptom because of surgical smoke. Acute and chronic inflammatory respiratory changes (57.3%), headache (51.2%), nausea or vomiting (39.1%) and hypoxia or dizziness (34.1%) are the symptoms and potential risks which are indicated mostly by the OR nurses. The other symptoms and potential risks of surgical smoke indicated by OR nurses participated in this study are shown in Graphic 1.



Graphic 1: The symptoms and potential risks of surgical smoke indicated by OR nurses

According to this study it is found that length of service in OR doesn't effect the status of living surgical smoke symptom (U:42446.5 p:0.410 p>0.05). Besides statistically significant differences were found between length of service in OR and nausea or vomiting (U:46906.0 p:0.005 p<0.05), conjunctivitis (U:29858.0 p:0.012 p<0.05), hair smell (U:36019.0 p:0.021 p<0.05), hepatitis (U:4760.5 p:0.039 p<0.05), throat irritation (U:41243.0 p:0.033 p<0.05), anemia (U:24548.0 p:0.014 p<0.05), lacrimation (U:41570.5 p:0.010 p<0.05). OR nurses who suffered from these symptoms have longer length of service in OR than others.

As shown in Graphic 2, only 24.3% (n:163) respondents indicated that there are smoke evacuators in the OR which they are working in. 81.0% (n:132) of the nurses who indicated that they have smoke evacuators in their working place mentioned that the devices are used actively. Refusal to allow smoke evacuation is usually a reflection of lack of knowledge (52.3%), high cost of device (20.3%), believing standard surgical masks provide adequate protection (9.8%), surgeons' concers about device decreases their eye-hand coordination, lack of staff (6.3%) an excessive noise (5.9%).



In this study; only 15.0% (n:101) of the nurses stated that filters are existed on the instruments produce surgical smoke (Graphis 3).



Graphic 3: Status of Filter Existing on the Instruments Produce Surgical Smoke

OR nurses stated that central smoke evacuation (15.9%), portable smoke evacuation (3.3%) and wall suction tubing (3.3%) systems are used for prevention of surgical smoke. Also nurses indicated that they use personal protection equipments such as surgical masks (65.0%), gloves (40.3%), glasses,(38.7%) gowns (37.5%) and filtration masks (11.5%) to protect themselves from surgical smoke.

As shown in Graphic 4, only 8.2% (n:55) respondents indicated that their institution have protocols against surgical smoke.



Graphic 4: Status of Having Protocol Against Surgical Smoke

Discussion

The purpose of this descriptive study was to investigate surgical smoke risks and preventive measures in Turkish operating rooms.

There are few research studies that showed surgical smoke to harm health care professionals or patients. Because it is very difficult to verify a direct connection between surgical smoke and identifiable cases of health problems. But it is generally accepted that surgical smoke has hazardous effects to both patients and surgical team. Because surgical smoke contains chemical products which is occured by burning of proteins and lipids during electrosurgery. Studies have shown that these chemical products cause various symptoms and potential long term adverse effects (Alp et al 2006, Krones et al 2007, Fan et al 2009). In the current study, surgical smoke symptoms were prevalent for OR nurses, as they reported acute and chronic inflammatory respiratory changes, headache, nausea or vomiting, hypoxia or dizziness, lacrimation, throat irritation, sneezing, temper, hair smell, myalgia, weakness, rhinitis, conjunctivitis, anemia, colic, dermatitis, cardiovascular dysfunction, nasopharyngeal lesions, carcinoma and hepatitis. These results concur with other findings in the literature which investigated potential hazards of surgical smoke. In the literature the potential surgical smoke risks to OR personel are determined as pulmonary irritation and inflammation, transmission of infection, headache, fatique, eve irritation and genotoxicity (Barret et al 2003, Alp et al 2006, Fan et al 2009).

This study identified some deficiencies in the usage of preventive measures against surgical smoke. This condition may also lead to the development of surgical smoke symptoms. Respondents indicated a lower frequency of smoke evacuator use during the procedures producing surgical smoke. Several studies have indicated that health care workers are inconsistent with and have suboptimal adherence to recommended surgical smoke precautions (Ball 2006). Edwards and Reiman stated that many facilities have not implemented best practices for protecting patients and health care workers from surgical smoke hazards, especially smoke created during electrosurgical, electrocautery, and diathermy procedures (Edwards and Reiman 2008).

In the literature reasons of refusing usage of smoke evacuation are pointed out as: concern that an altered protocol could negatively affect the surgical result, anxiety associated with any change to routines, a lack of knowledge about sources that recommend the removal of smoke, lack of management support, distraction caused by the noise generated by the smoke evacuator, unavailability of devices that achieve high efficiency capture, or devices that require the surgeon's involvement, bulkiness, getting in the way, cost, not recognizing surgical smoke as a hazard, not having enough staff to hold suction inlets (Edwards and Reiman 2008, Schultz 2014). The obstacles to use smoke evacuators are reported as lack of knowledge, high cost of device, believing standard surgical masks provide adequate protection, surgeons' concers about device decreases their eye-hand coordination, lack of staff and an excessive noise by participants. In this respect our results are resumble with literature.

Standard surgical masks are designed to protect patients and healthcare professionals

from microorganisms and aerosolised body fluids in the operating room. However only large droplets or particles (>5 microns) are blocked. Therefore they do not provide adequate protection in filtering surgical smoke (Barret et al 2003, Carbajo-Rodríguez et al 2009, Watson 2009). Nevertheless most of the OR nurses participated in this study erroneously feel that standart surgical masks protect themselves from surgical smoke exposure. It is recommended using high performance filtration masks to provide greater protection against surgical smoke. But majority of OR nurses indicated they they do not use filtration masks. This results are similar with Edwards and Reiman's results showing that very few nurses routinely use effective respiratory protection for surgical smoke (Edwards and Reiman 2008).

The other important finding of this study is that too few healthcare institutions have got protocols against surgical smoke. There are no mandatory regulations in Turkey against surgical smoke but there are voluntary standards from professional organizations protocols.

Conclusion

These results suggest that Turkish OR nurses are not adequately protected from exposure to surgical smoke and they have adverse symptoms because of surgical smoke. Although these results provide an interesting snapshot of surgical smoke management in Turkey, they also indicate that much work remains to be done.

As a result it was found that effective engineering controls for surgical smoke in the operating rooms are inadequate and Turkish operating room nurses have adverse symptoms because of surgical smoke.

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Faculty disclosure: No conflict reported

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TAYLORING EDUCATION FOR OPERATING ROOMS IN AUSTRALIA

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Keywords: communication,teamwork,patient safety

Lilliana Levada Nurse Manager Perioperative Services Fairfield Hospital Sydney Australia

Aim

Evaluate nursing knowledge, level of clinical skills, introduce professional development initiatives and improve the overall structure of educational systems in an operating suite which caters for novice to expert nurses and aims to create an environment that promotes evidence-based practice.

Background

Research of literature related to perioperative nursing indicates that unless instrument and circulatory nurses take a dynamic approach to education, quality of care in the operating suite negatively effects patient care outcomes. This project evaluated the attitudes of nursing professionals towards expected and prescribed standards of patient care in a large operating suite in Sydney, Australia.

Method

A quantitative descriptive study, which used a self-administered metrics. Participants (perioperative nurses) were involved from December 2012 until June 2014 and took part in this project throughout the entire duration of the project. Assessment and evaluation tools were self-developed and used to analyse the data.

Findings

Even though encouragement, communication and collaboration were found to be employed in the operating suite, there was evidence that education was not optimal.

Conclusion

This project resulted in a structured approach to education. Clearer understanding of leadership is needed to increase efficiency of educational programs in operating suites and promote patient safety. In this presentation EORNA congress participants will learn how their approach can help create an environment enriched with education. The combination of visual and storytelling will allow the audience to see the key elements that influence perioperative nursing staff's perceptions of requirements for professional nursing development in operating rooms.

Faculty disclosure: No conflict reported

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USING PICOT QUESTIONS TO TEACH EVIDENCE BASED PRACTICE TO PERIOPERATIVE INTERNS

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Keywords: PICOT, Perioperative, Evidence-based Practice, Nursing, Education, Interns

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Background

The Northwest Perioperative Consortium (NWPC) is a collaboration of nine Greater Seattle area hospitals. The main goal of the NWPC is to recruit and train perioperative nurses in an internship program. NWPC faculty introduced evidence-based practice (EBP) to the curriculum using a PICOT (Problem, Intervention, Comparison Outcome, Time) project to reflect current clinical practice and provide the interns with an opportunity to construct and research practice questions to advance perioperative nursing knowledge.

Objectives of the PICOT Project

- Identify elements of EBP
- Identify PICOT question from practice environment
- Utilize literature search and review
- Present PICOT projects to share knowledge and develop presentation skills

 $\mbox{Goal}-\mbox{To evaluate the effectiveness of the PICOT Project on interns' comfort with and future use of EBP.$

Problem

As identified by the Institute of Medicine in their report, Crossing the Quality Chasm1, to meet the challenges of the future, nursing is required to acquire new skills, one approach of which is to teach evidence based practice (EBP). EBP is an effective method to use critically appraised and scientifically proven evidence for delivering quality health care to a specific population2. "The first step in achieving EBP is to develop a system for embracing inquiry and supporting it at the point of patient care".3

Methodology

Test- retest

Perioperative interns in the Spring and Fall 2014 will be given a questionnaire before and after their class on EBP, PICOT question project and final presentation. The questionnaire asks about years of nursing practice, knowledge of EBP, PICOT questions and both experience and confidence /comfort with nursing practice research.

Results

Preliminary findings will be presented at the EORNA Congress 2015. The results are expected to demonstrate an increase of interns' comfort with and future use of EBP.

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FACTORS INFLUENCING GREEK PERIOPERATIVE NURSES' READINESS TOWARDS EBP-IMPLEMENTATION: A CROSS-SECTIONAL STUDY

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Keywords: attitude, barrier, evidence-based practice, implementation, perioperative nursing Introduction

The notion of evidence-based practice (EBP) has had globally influenced the field of healthcare practice by providing high quality services (Barker, 2013, Melnyk & Fineout-Overholt, 2005). There is sound evidence highlighting nurses' positive attitude towards EBP-implementation, but only few data are available regarding EBP-implementation among Greek nurses (Patelarou, Dafermos, Brokalaki, Melas, Koukia, 2014). Specifically, literature provides limited evidence regarding EBP-dissemination by perioperative nurses.

Aim

To investigate Greek perioperative nurses' readiness towards EBP implementation.

Methods

A cross-sectional study was conducted in a representative sample of five national healthcare settings in Greece. 154 perioperative nurses were asked to complete a self-administered questionnaire, the Greek version of the Evidence-Based Practice Readiness Survey (EBPRS). Statistical analysis was carried out using SPSS 20. Results: According to our findings, 64.9% (n=100) of Greek perioperative nurses stated familiarity with the term of "EBP" and more than half of participants (54.9%, n=86) believed that EBP must be implemented to achieve desired patient outcomes. Only 25.3% (n=39) of the sample reported successful or highly successful ability in MEDLINE search, while 70.2% (n=108) indicated internet search as the most preferred method of information seeking. The majority (80.5%, n=124) reported no utilization of research in daily practice and indicated that the limited organisational budget for acquisition. Interestingly, difficulty in accessing research materials (27.3%, n=42) and the lack of skills to critique the literature (20.1%, n=31) were listed as the two primary barriers for personal use of research findings.

Conclusion - Implication for perioperative nurses

Although Greek perioperative nurses seem to adapt a positive EBP-attitude, they lack the EBP-skills and knowledge required. Future strategies aimed at changing the organisational context need to be developed and EBP-educational programs may help nurses overcome the aforementioned barriers and secure quality in perioperative care.

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AN EVOLVING EXPERIENCE WITH USING SIMULATION IN PERIOPERATIVE EDUCATION

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Keywords: simulation; perioperative; anaesthetics; recovery; human factors.

Over the last decade we have experienced simulation being used increasingly in health care within Australia to teach clinical skills and non-technical skills. First experiences with simulation can be a stressful experience for both participants and facilitators, however, as experience with simulation increase both participants and facilitators evolve to see more clearly the value of and how best to get the most from simulation ⁽¹⁾.

A course titled "Crisis Management for Anaesthetic Nurses' was developed at St Vincent's Hospital in Sydney to assist anaesthetic nurses develop skills and knowledge in crisis that could occur in the perioperative environment. Clinical skills such as basic life support and airway management are included in the program as well as non-clinical skills such as communication, situational awareness and the importance of planning. Interestingly when asked what is the big lesson they will take from the day it is the later, the non-technical skills that are identified most frequently.

This was a first experience as a facilitator of simulation learning in a high tech environment and the experience has taught a lot which is worth sharing. Key points to be highlighted and discussed incorporating a personal experience with what the literature has to say such as: the importance of objectives; keeping it real; going with the flow; time management; getting the most from the debrief and possibly the most important to make it a non-stressful and learning experience for everyone participating in the simulation $^{\scriptscriptstyle (2)}$ $^{\scriptscriptstyle (3)}$.

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A QUALITATIVE STUDY OF SURGICAL NURSES POSSIBILITIES FOR DEVELOPING COMPETENCES IN PRACTICE-HIGHLIGHTS FROM A MASTER THESIS.

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Introduction

The leadership at Aarhus University Hospital has made a model to ensure development of equal competences within professional -, learning -, organisational- and social competences: "Model for systematic competencedevelopment".

In parallel, New Public Management is a part of the hospitals strategy. Concepts toincrease production, efficiency alongside tight financial management are the working-frame in the hospital. Due to that following questions can be raised:

- How can surgical nurses develop their competences in practice?

Materials, methods

The study is investigated empirical and theoretical. The main theory deals with learning, reflection, profession and profession terms (Illeris; Schön; Moos; Hansen, Schierup; Hansbøl, Krejsler). Data was collected by an observational study and semi-structured research interview in a surgical ward.

The empirical data where analysed according to Kvale and Brinkmann, and organized in meaningful units (Flick; Kvale, Brinkmann).

These units were used as mayor headers for the further analyses, based on the chosen theory.

Discussion, conclusion

Based on the empirical data and the applied theory I conclude that the nurses perform and use their competences as knowing-in-action, based on the apprenticeship. The observed nurses showedimpetus to learn, which in daily activities was positively meet by the leadership of the department.

When unexpected and unfamiliar situations occurred the observed nursesmade reflectionin-action, and by that new knowledge and awareness emerged. The observed nurses extend their knowledge by assimilative learning.

The collected data made indications for an operating department where keywords were production, efficiency rather than learning. Due to that learning opportunities, beside the normal daily work, as reflection-on-action were limited.

So in conclusion the model is challenged by the agenda of NPM, however it is suitable but might need extra resources to become a success.

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INNOVATION IN CLINICAL COMPETENCE ASSESSMENT FOR OR NURSES

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Keywords: education, competence development, OR nursing skills, clinical competence assessment

The Nurse Education Council in the Capital Region of Denmark decided to develope an evidence-based structured educational programme for new and novice employees training as OR nurses to ensure a consistent high level of OR nusing skills.

The primary aim of this programme was to develope a mangament tool, which could ensure the optimal plan for education of every participant. This management tool should include theoretical and practical skills, general as well as related to a specific specialty. Therefore, the OR nurse education in the Capital Region would become systematic, consistent and measurable. Also, the levels of training in the individual hospitals could be comparable.

The checklist of skill assessment was implemented from September 2012 in all surgical theatres in the region and turned out to be a success. All OR novice nurses recieved an evidence-based reference list for their tasks. Both novices and well-experienced nurses conducted professional theoretical discussions. These initiatives gave them the feeling of evolving competences.

This programme for novices has also discovered the need for development a similar objective clinical competence tool for the well-experienced OR nurses. Therefore the Nurse Education Council in the Capital Region of Denmark has allready initiated a group of clinical OR specialists, who together with a review group will ensure this process. The process is due end of 2014.

Clinical competence assessment has made it possible for the OR nurses to work focused with nurserelated topics allready determined in a innovative yet strategic way, which expands the knowledge and understanding of existing practice and perioperitive nursing care.

Faculty disclosure: No conflict reported

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DEVELOPING STANDARDS AND RECOMMENDED PRACTICES FOR EORNA

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Keywords: Standards, Recommended practices, Development , Review Learning objectives

- To summarise the processes used by different perioperative organisations around the world to develop standards and recommended practices documents
- To know how the EORNA Standards and Recommended Practices document has been compiled
- To have a detailed knowledge by comparison of two standards from different parts of the world.
- To identify how 'Recommended Practices' are used in practice to guide local policy and best practice.

Standards of practice across a diverse population of countries with different and practices and healthcare systems in Europe is a challenge to achieve consensus. We have learned from the history of the EU, that this is a challenge. EORNA has taken up this quest to write perioperative standards and recommended practices for the organisation.

Some EORNA Member Associations already use a set of recommended practices in perioperative care, but many surgical teams do not have access to them. A short review of the countries around the world that do have standards will be undertaken and their creation and development process explored. We will explore two standards and compare and contrast the recommendations.

We will highlight differences in local practice and also the Directives which as member states we harmonise into national legislation. These laws do not directly change perioperative practice but they do influence aspects of it significantly.

We will highlight the process of creation, development and review process which EORNA has put in place to devise their standards and how this may work into the future. The process of development is a dynamic one and lessons may be learned from other associations around the world. Once the process has begun, there will be continuing work for EORNA into the future.

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PILOTSTUDY ON BEDSORES RELATED TO OR??

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Britta Nielsen The Department of Plastic Surgery Odense University Hospital, Denmark

Background

2014 is the year where focus has been directed towards bedsores on Odense Universitetshospital and has the goal not to impose patients with bedsores. It is unclear if the methods and materials used today "as is" on OR are sufficient in relation to preventing bedsores to occur. Today "as is" all patients undersurgery are "fixated" by using different types of relief pillows to avoid bedsores. There are guidelines for the different types of fixation of the patient during surgery but in reality no evidence that this is correct or best practice being performed.

Purpose

- 1 At afklare om patienter udvikler decubitus i forbindelse med operation
- To determine if patients develops "decubitus" in relation to OR
- 2 At afklare om et sensor lagen kan bruges som parameter for bevægeregime under operation. To determine if a "sensor sheet"can be used as parameter for "move regime" during surgery

Method

- Prevalence: Audit in 10 OR theatre on a given day.
- 1 Patients is being evaluated towards risk
- controlled at ward
- in OR theatre when moved to the bed
- 2 hours after surgery for pressure marks
- EPUAP international scale is being used for evaluation
- 2 An investigation is performed with Sensor sheet to determine if a patient during long surgery is more liable to get bedsores.

Results

66 patients were evaluated: There were pressure marks on 50 patients (75%) after surgery, 2 hours later 10 patients still had pressure marks and 2 patients witd bedsores. 2 Measurement shows when there is need for relief on critical areas.

Conclusion

- 1 We have observed many pressure marks after surgery which might indicate that post surgery positioning should be different than the one during surgery. One patient was evaluated to be "high risk" group prior to surgery and developed 2 bedsores. The project group has to consider what the next step is.
- 2 The use of "Sensor sheet" can be used for "move regime" or for developing guideline for movement of "high risk" patients during surgery.

Faculty disclosure: No conflict reported

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POSTOPERATIVELY ACQUIRED PRESSURE ULCER IN CARDIOVASCULAR SURGERY

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Introduction

Pressure ulcers (PUs) are defined by the National Pressure Ulcer Advisory Panel (NPUAP 2009) as "localised injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear.¹They occur in people who do not have the ability to reposition themselves in order to relieve pressure on bony prominences.^{2,3,4}Patients undergoing surgical procedures who are immobile for long periods and are unable to change positions are at greater risk than are patients who are mobile for the development of PU. Because of sedation and anesthesia, surgical patients cannot fell the discomfort that prolonged pressure causes and subsequently are unable to change position to relieve the pressure.^{4,5}

Patients who undergoing cardiovascular surgery are highly vulnerable to PUs3because of the long time on the operating room table, the special perfusion and temperature situation, during surgery and the immobility in the first phase after surgery.⁶The intraoperative period may be the time of highest risk for thesepatients.^{7,8} Ulcers may appear within a few hours postoperatively, but most usually occur 1 to 3 days after surgery. For patients undergoing cardiovascular surgery, pressure ulcer incidence is reported to be up to 38%.3In a study carried out in 1988 with 387 cardiovascular surgery had a higher risk of developing a pressure ulcer.9Another study carried out in 1998 by Scott confirmed that higher incidence of PUs in vascular patients in comparison with abdominal, urologic, and orthopedic surgery patients.10Papantonio et al. (1994) examined the development of PU in 136 cardiac surgery patients and reported that fourteen percent of the stage I ulcers appeared in the first 18 hours after surgery, and 63% of the ulcers that progressed to stage II or III first appeared within this time.¹¹

Patients who undergoing cardiovascular surgery have multible risk factors, many of which become exacerbated with surgery. Risk factors identified can be divided into two groups: those which are in existence before surgery such as preoperative diabetes and other comorbidities, ^{8,11,12} older age, ^{3,11,13,14} low serum albumin ^{8,11-13} and total protein levels, ^{8,14} reduced homoglobin concentration, ^{12,13,15}reduced hematocrit levels; ^{11,12,13} and those which occur as a direct result of surgery such as the operating room time, ^{11,13,14} immobility time, ^{12,13} use of extracorporal circulation (ECC), ¹⁴ additional medical interventions such as intraaortic balloon pump, ¹² hypothermia, ^{8,10}the number of hypotensive period and vazoactive drugs, ¹³steroid medication, ¹⁵and more rapid returns to preoperative body temperatures.¹²The risk assessment scores are also significantly associated with pressure ulcer development in this population. ^{12,13,15}

PUs is a significant health care problem that decreases patients' quality of life, extends length of hospital stay, increases the risk of illness and death, and increases healthcare expenses.^{2,16-18}PUs also increase the workload of healthcare professionals because of the extra need for care required.^{16,18}International programs have been initiated to manage this problem and to stimulate preventive actions.^{1,19}The most significant intervention to decrease the incidence of PUs is determination of risk factors.^{5,16} Knowledge of the risk factors in a particular population is helpful in the development of a prevention program.¹³It has also become increasingly clear that the bedside nurse needs to evaluate patients for PU risk to plan preventive interventions and use a team approach to decrease the incidence of PU. Prevention of PUs benefits both the patients, who may be spared a common, painful and debilitating condition and healthcare professionals, because of the reduction in work load and bed occupancy, as well as potential cost savings.²⁰On the other hand, monitoring and maintaining skin integrity is an essential component of defining a patient's health status and evaluating the quality of nursing care. It is incumbent upon all health care providers to work not only to decrease the incidence of PUs, but also to effectively treat them when they occur.21

There are only few incidence studies concerning pressure ulcers in Turkey, although it is a common problem in various countries. Kurtulus and Pinar (2003) found a PU incidence of 18.3% in a neurology intensive care unit (ICU).²² Karadag and Gümüskaya (2005) reported an incidence rate of 54.8% in postoperative surgical patients.²³ Sayar et al (2008) found a rate of 14.3% in ICU (reanimation, medical and surgical) patients.¹⁶ No studies were found to determine the PU incidence or prevalence in cardiovascular surgery in Turkey.

Aim of Study

The aims of this study were to (a) verify the relationship between risk factors and the development of pressure ulcer (b) assess the number of patients who are 'at risk' for the development of pressure ulcer according to the Norton Scale (NS) in the ICU after cardiovascular surgery.

Methodology

Design and sample

The study was conducted as a descriptive and prospective study in the cardiovascular surgery ICU. Prior to beginning the study, approval for the study was granted by the Dr. Siyami Ersek Thoracic and Cardiovascular Surgery Training and Research Hospital Ethics Committee and hospital's chief executive (13.04.2014-4909). Informed consent was obtained from all the patients.

The cardiovascular surgery ICU is an 26-bed unit in which 7 nurses work in each shift as two shift in a day. All of the beds used in this unit are 'decubitus beds', which are designed to prevent PUs. The decubitus beds are made of a visco-elastic, temperature sensitive open-cell material, which has unique pressure-relieving qualities. In this unit, the patients are evaluated with the NS within 1 - 2 hours after patients' admission to the ICU, once every shift and when there was a change in their general condition. Standard precautions are taken to prevent the development of PUs such as frequent position changes, skin assessment. The evaluation of newly developed ulcers and changes, and treatment of current PUs are done by nurses worked in this unit.

Subjects were selected according to the following criteria; over 18 years, had coronary artery bypass graft and/or valve surgery, absence pressure ulcers preoperatively, and were admitted to the ICU. Patients were excluded received mini bypass grafts or had mitral valve surgery because of the shortened length of stay.Between 1 May and 16 June 2014, 139 patients were admitted to this unit. After patients' admission to the ICU, the NS was administered to determine PU risk and 103 patients were taken into the study, who were given scores that were within the 'high risk' limits.

Instruments

Data were collected using a data collection form, prepared by the researchers based on information in the literature, the skin assessment instrument and the NS.

The data collection form, which was prepared by us to determine risk factors for the development of PUs, was used for documenting sociodemographic characteristics and medical conditions that could be PU risk factors, including age, gender, smoking, chronic disease, total operation time, diastolic hypotensive episodes during surgery (diastolic blood pressure < 60 mm Hg), and ECC. The usage of some specific medications (steroids and vasopressors) was assessed. The patients' activity status (independent, partially dependent, and dependent), use of devices reduced the mobilization, and body mass index (BMI) were also recorded. The patient's laboratory findings from the day of admission to the unit, including total protein, albumin, hemoglobin, and hematocrit values were also recorded.

The skin assessment instrument includes a list of the most common sites for PUs: back of the head, scapula, iliac crest, trochanter, sacrum, ischium, lateral malleolus, lateral edge ofthe foot and the heel. The instrument also includes a PU staging system. PUs have been classified according to the standard staging system developed by EPUAP.1The first postoperative skin assessment was carried out on the admission to the ICU by a nurse and a trained researcher.

In this study, risk assessment for pressure ulcers was carried out with the aid of the NS in which the following risk factors are taken into consideration: the general health status of the patient, level of consciousness, level of mobility, continence of urine and faeces, independence in the ability to change body position. Each of these factors is assessed on a scale of 1 to 4 points and the patient may score between 5 and 20 points overall. A final score of 13 points or less was considered a high risk for pressure ulcers.²⁴The Norton scale is used very often in Turkish hospitals because it is well known through articles and books in Turkish.^{25,26} Because it is short and therefore requires less nursing time for the risk assessment.²⁵The sensitivity and specificity of the Norton scoring system are reported as 63% and 70%, respectively.²⁷

Data collection

The data were collected by the a researcher nurse, which working at this hospital and included the research team. Patients with a score of 13 or lower were evaluated as being in the group at "high risk" for PU and were taken into the study. The 103 patients who were over the risk limit (high risk) were monitored daily during their stay for PUs. A member of the research team visited the ICU every day to recruit patients during the data collection. The patient's skin condition was observed over the entire body, especially over bony prominences. All skin assessments were completed every day until discharge from the cardiovascular surgery ICU. Then an evaluation was conducted on the risk factors from the data collection form. In addition, the patients' laboratory findings from the day of admission to the unit, including total protein, albumin, hemoglobin and hematocrit values were monitored daily for PUs and care was given.

Data analysis

Statistical analysis was performed using a nonparametric signal test because of the variables did not have a normal distribution. Descriptive statistical were calculated for all variables. Data were expressed as number, mean values \pm standard deviations (SD) and median. The Chi-square test was used for the analysis of categorical variables. The correlations between variables were calculated by Spearman's Correlation. P values of less than 0.05 were considered statistically significant.

Results

Of the 139 patients who were admitted to the cardiavascular surgery ICU during the study period, 74.1 % were at high risk for PU according to the NS. The mean age of the 103 patients, who were at high risk for PU according to the NS and were included in the study, was 60.13 \pm 11.83 (range 20–86) and 74.8% were male.

A pressure ulcer was diagnosed in 18.4 % of the study patients. The mean length of time for developed of PU in these patients was 2.78 ± 1.96 days (range, 1-6 day) and the median was two days. The mean length of stay was 3 days (SD 1-8 days). In the 19 patients with diagnosed PU, there were 21 PUs, of these 15 were grade I and four were

grade II. Eighteen patients' PUs were on the sacrum (18/21, i.e, 85.7% of all lesions) and they were in more than one place in one patients (Table 1). In the evaluation of NS scores of the patients who developed PUs, it was determined that nineteen patients were also in the 'very high risk' group.

No statistically significant difference was found for PU development according to patients' age, gender, chronic illness, smoking, BMI, ECC, vasoactive drugs and steroid use, activities, and use of devices reduced the mobilization. The mean risk scores in ICU were lower for patients in whom a pressure ulcer developed than for patients in whom no ulcer developed (p=.013). A significant correlation was found between laboratory findings such as albumine (p<.01), total protein (p<.01), hemoglobin (p<.01), hematorit (p<.01) levels, total surgery time (p=.036), diastolic hypotensive episodes during surgery (p=.022), postoperative risk score (p=.013), and the presence of pressure ulcer.

As a result, pressure ulcer incidence was low in this study compared to other studies. Factors such as the preoperative serum albumin, total protein, hemoglobin, and hematocrit values, total operation time, diastolic hypotensive episodes during surgery, and postoperative Norton scale score were associated with ulcer development. The study concluded that the patients in the ICU after cardiovascular surgerycan be identified as at risk during their stays.

Implications for perioperative nursing: Skin assessments and nursing interventions should be increased on the day of surgery and the first to six postoperative days, including multiple assessments and skin care focused on maintaining skin integrity. Individual risk assessment by a standardized risk assessment instrument is recommended to enable initiation of preventive measures based on patient-specific risk factors.

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Table 1. Patients characteristics

		Pressure ulcers		
Characteristic	n	Yes (n=19) n or mean ± SD	No (n=95) n or mean ± SD	p-value
Age-years (mean)		62.84 ±14.83	59.52 ± 11.06	0.272
Gender Female Male	26 77	6 13	20 64	0.481
Chronic illness Yes No	73 30	16 3	57 27	.157
Smoking Yes No	35 66	5 14	30 52	.551
Hypotensive period Yes No	19 85	7 12	12 72	0.022
Extra corporal circulation Yes No	86 16	17 1	69 15	0.193
Vazoactive drugs use Yes No	96 7	19 -	77 7	0.192
Steroid use Yes No	5 98	1 18	4 80	0.927
Activities Partially dependent Dependent	12 91	2 17	10 74	0.866
Use of divices reduced the mobilization Yes No	101 2	19 -	82 2	0.497
Total operation time (minute)		327.89 ± 53.80	292.14 ± 68.77	0.036
Body mass index (mean)		28.17 ± 4.19	27.77 ± 4.03	.701
Laboratory findings (mean) Albumin Total protein Hemoglobin Hematocrit		2.64 ± 0.48 6.29 ± 0.97 10.86 ± 2.03 31.95 ± 6.11	3.50 ± 0.45 6.87 ± 0.63 12.53 ± 2.37 36.99 ± 7.06	0.001 0.002 0.005 0.005
Norton scale score (mean)		5.47 ± 0.96	6.92 ±2.44	0.013

Table 2. Pressure ulcer location and staging

	Number	of	patients	Stage	
Location	(n=19)			Grade I	Grade II
Sacrum	18			14	4
Both heel + sacrum	1			1	-

*In the 19 patients with diagnosed PU there were 21 PUs.

Faculty disclosure: No conflict reported

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PRESSURE ULCERS PREVENTION IN THE PERIOPERATIVE ENVIRONMENT

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Keywords: Pressure ulcer, surgical patients, operating room, perioperative care, risk assessment, risk factors, operating table, patient positioning.

Pressure ulcer is defined as a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear. Pressure ulcers are a serious surgical complication and can be difficult to treat. Theycan cause patients pain, reduce quality of life and sometimes lead to death. There is a lack of research concerning prevention of pressure ulcersduring surgery.

The purpose of this thesis was to review the literature of pressure ulcer risk factors and prevention in the perioperative period, to update Clinical practice guidelines fromNPUAP and EPUAP (2009) regarding pressure ulcers prevention and treatment and to develop implementation of these guidelines according to Rogers's theory Diffusion of Innovations. The study was in the form of focus group study and integrative literature review concerning risk factors and prevention of pressure ulcers. The population in the focus group were seven operating room (nurses) and anaesthetic nurses. The purpose was to examine the attitudes of the nurses toward implementation of clinical guidelines about pressure ulcers. Literature review showed that risk factors in the perioperative period were the length of surgery, age, nutritional status, low pressure periods and ASA classification status. The conclusions of the focus group indicated that interest exists to implement the clinical guidelines and that the instructions are compatible with existing practices and can lead to more effective working methods.

It is important that operating room nurses have solid knowledge about the prevention and risk factors concerning pressure ulcers in order to decrease their prevalence in the perioperative period. Implementation of clinical guidelines facilitates perioperative nursing careand documentation regarding risk assessment and pressure ulcers prevention.

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OC 85

INCIDENCE OF PERIOPERATIVE INADVERTENT HYPOTHERMIA AND COMPLIANCE WITH EVIDENCE-BASED RECOMMENDATIONS AT FOUR AUSTRALIAN HOSPITALS

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Keywords: Perioperative inadvertent hypothermia; clinical audit; evidence-based practice

Background

Perioperative inadvertent hypothermia significantly increases a patient's risk of adverse complications such as surgical site infection; morbid cardiac events; and surgical bleeding . Perioperative inadvertent hypothermia is preventable and guidelines exist which synthesise research findings into evidence-based recommendations . Although the recommendations are relatively simple and inexpensive they are often not adhered to in clinical practice. Up to 70% of patients will experience hypothermia postoperatively when recommended prevention practices are not implemented .

Method

A retrospective audit of 400 patients was conducted to identify the incidence of perioperative inadvertent hypothermia and compliance with evidence-based recommendations at four Australian hospitals. Patients were excluded from the audit if they were pregnant, under 18yrs, had impaired thermoregulation, therapeutic hypothermia, or local anaesthesia only. Trained auditors extracted data on the incidence of perioperative inadvertent hypothermia, compliance with evidence-based recommendations, and patient characteristics.

Results

350 patients met the inclusion criteria. The mean age of patients was 56 (SD 19). The majority (74%, n= 260) had elective surgery with orthopaedic procedures the most common surgical type (28%, n=98). The incidence of perioperative inadvertent hypothermia in the population was 32% (n=101) and the lowest recorded temperature was 34.0°C. 80% (n=280) of patients did not have a temperature documented intraoperatively and only 8.8% (n=29) had at least one documented temperature for each perioperative phase (pre, intra, and postoperative). 45% (n=133) of intraoperative patients and 77% (n=97) of postoperative patients did not receive active warming when indicated. Contrary to recommended practice, 47% (n=137) of patients were hypothermic at discharge from the Post Anaesthetic Recovery Unit.

Conclusion

This audit revealed poor compliance with evidence-based recommendations which may have contributed to the significant number of patients who experienced perioperative inadvertent hypothermia. Further research should be undertaken to identify mitigating strategies to overcome barriers to evidence-based perioperative hypothermia prevention.

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Faculty disclosure: No conflict reported

00.86

PERIOPERATIVE HYPOTHERMIA: A CALL FOR ACTION

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Keywords: inadvertent hypothermia, orthopedic surgery, abdominal surgery, lumbar neurosurgery

Background

The ASPAN's guideline for the promotion of perioperative normothermia recommends the use of prewarming for a minimum of 30 minutes to reduce the risk of hypothermia (1). During the last years industry developed new devices for active prewarming. The use of it is limited because of insufficient evidence and high costs.

Purpose of the study

This study was conducted as part of preparatory work for a randomized controlled trial assessing the effect of active prewarming on patients core temperature.

Methods

Core temperature was measured preoperative and immediately postoperative on recovery with a tympanic thermometer in adult patients who underwent an abdominal, orthopedic or lumbar neurosurgical procedure between July 2012 and February 2014. Procedures longer than 150 minutes were excluded. Hypothermia was defined as a temperature <35°C.

Results

In this study 162 patients were included. 28% underwent an abdominal, 32% an orthopedic and 40% a lumbar neurosurgical procedure. Mean temperature in the preoperative period was 36,3°C. There were no patients with hypothermia in the preoperative period and there was no significant difference in temperature between abdominal, orthopedic and neurosurgical patients (p=0,247). Immediately after surgery the mean temperature was 34,9°C and 52% of the patients had hypothermia, 41% had a decreased temperature and only 7% had normothermia. After surgery 63% of the abdominal patients and 58% of the orthopedic patients had hypothermia. The percentage of patients with hypothermia after lumbar neurosurgery was 39% (p=0,009).

Implications for perioperative nursing

These results show us the ongoing necessity for improving the standard care for patients undergoing a surgical procedure. Nurses can have an important role in the prevention of inadvertent hypothermia by using active prewarming. Further studies assessing the effect of active prewarming are recommended.

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OC 87

THE PREVENTION OF PERIOPERATIVE HYPOTHERMIA SAFETY TOOLKIT

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Keywords: perioperative hypothermia, safety, evidence-based practice

Background

Mild hypothermia increases the risk of negative patient outcomes. To prevent hypothermia, active warming (e.g. forced air warming (FAW)) should be initiated prior to induction of anesthesia. Applying FAW preoperatively in addition to intraoperatively decreases the incidence of hypothermia compared to intraoperative FAW alone.⁽¹⁾

Problem

Evidence on prevention of perioperative hypothermia is often inadequately infused into clinical practice.

Purpose

The purpose of this project was to develop the Prevention of Perioperative Hypothermia Safety Toolkit.

Goal

The goal is to increase adherence to evidence-based practices and improve patient outcomes (ie. normothermia).

Methods

This toolkit was developed based upon a comprehensive review of published evidence, internal data, and a proactive risk analysis. The Promoting Action on Research Implementation in Health Systems (PARIHS) model was used as a theoretical framework.⁽²⁾

Results

Components of the toolkit include: a failure mode and effects analyis, education, staff engagement, audit and feedback tools, policy, checklist, triggers, and lessons learned. Implications

The toolkit will be available for use on the AORN website for perioperative nurses to use.

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0C 88

CREATING EFFICIENCIES IN SURGERY USING THE LEAN PROCESS AND SIX-SIGMA

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The hospital was experiencing cancelations of inpatient and outpatient surgery patients, on the day of surgery. These cancelations of surgery patients on the day of surgery caused turbulence on the unit, including increased costs and decreased patient satisfaction. A lean, six-sigma redesign was developed to decrease the number of patient cancelations. Prior to the lean, six-sigma redesign, an operating room labor cost of \$478,000 annually was directly associated to the cancelations. This cost did not include the loss of opened supplies, wasted prime operating room time, or clerical time. Through the use of the dmaic process in six sigma, random word association, and parallel thinking, a pilot project was developed for a trial to weigh the benefits of the projected results. The project was trialed in the outpatient surgery department. Responding to the results from the pareto chart, which identified patient medical records to be incomplete in four major categories and determined the cumulative sum of these categories. An algorithm was developed which was used to analyze the patient's individual health history. This health history focused on the patient's pre-operative, co-morbidities, which would determine the type of patient testing that would give the greatest benefit of information and deter the day-of-surgery cancelations. After the pilot project was completed, and by incorporating the redesign of the pre-operative assessment clinic from the pilot project, there was a 96% improvement from day-of-surgery cancelations. Once the pilot project in the outpatient surgery department was successfully completed, the process was incorporated into the inpatient surgery department. Prior to the improvement project, the baseline sigma was 1.05. After the pilot was implemented the sigma went to 2.27, showing a 116% improvement and decrease in the number of day-of-surgery cancelations. By incorporating the redesign of project, the patient cancelation rate for both inpatient and outpatient surgery was less than 0.13 per day showing improvement from the pre-pilot number of 1.7 cancelations per day over the inpatient hospital and outpatient center.

OC 89

AN EXAMPLE OF NURSING WORKFORCE PLANNING IN THE OPERATING ROOMS OF EGE UNIVERSITY MEDICAL FACULTY HOSPITAL

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In determining nursing workforce requirements, the methods which can be used include traditional methods which take into account numbers of beds and patients or systems of patient classification, methods of care criteria and those based on workload analysis. Whatever method is used in planning the nursing workforce, it is vital from the perspective of quality of patient care and hospital efficiency that in addition to number of beds, workload and degree of patient dependency are taken into account. Methods which only take into account bed and patient numbers do not generally produce realistic results and do not identify the needs of the department in a way which meets workload requirements^(1, 2, 3). There are serious problems with the planning of the nursing workforce in operating rooms in our country, as there are in many other fields.

Aim

This study aimed to determine the number of nurses required in the operating rooms of the clinics of a university hospital using workload measurement.

Materials and Methods

This was a descriptive study planning to determine the number of nurses required to work in the operating rooms of the clinics of a university hospital using methods based on workload measurement.

Methods

The research was carried out between 4-11 May 2012 at Ege University Medical Faculty Hospital. In this descriptive study, data were obtained using a questionnaire including number of nurses working in the operating rooms, number of operating rooms in the clinics, total numbers of operations by day, week and month, types of operations and estimated duration of operations.

Results and conclusion

It was observed that in the 48 operating rooms of the 13 clinics at the university hospital, 12001 operations were performed over the three month period, with an average of 4000 per month. Assessments indicated that in one month, 7626 hours of surgery were performed on the 48 operating tables, with 158 hours performed per table and that the rate of use of operating tables was 94%.

According to the results of the research, there were a total of 95 nurses including 11 charge nurses, 72 nurses and 12 technicians (who do the jobs of scrub nurses and circulating nurses) working in the 48 operating rooms of the 13 surgical clinics of the university hospital: however, it was determined that the requirement was 110 nurses.

Sources

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Faculty disclosure: No conflict reported

OC 90

WORKING EFFICIENTLY AND EFFECTIVELY FOR NIGHT SHIFT NURSES

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Keywords: workers health, patient security, night work

Some care givers choose to work nights and others are obliged to.

But is that ideal for our health and to be effective all time?

Several precautions must be followed for the safety of workers and therefore the patients. For the night shifts, we have what is required by the Law and many advices to stay healthy and provide safe patient care in Operating Rooms and in the wards.

Recently, the public hospital where I work has proposed recommendations for night shifts: how to eat, when to sleep, how to manage our different way of life.

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00.91

BEING AN OPERATING ROOM NURSE ON A HUMANITARIAN SURGICAL MISSION

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Keywords: operating room nurse, humanitarian work, surgical mission

Every day humanitarian medical organizations help millions of people around the world. They battle hunger, diseases and violence in some of the most inhospitable situations, locations and climates. All medical staff are professionals who choose to work as humanitarians because of a commitment and concern for people's health, survival and to mantain human dignity. For some it is a way of living, for others just occasional work. As an operating room nurse I work in Slovenia's largest hospital at the University medical centre Ljubljana. In 2011 I joined one of the humanitarian medical organizations (Médecins Sans Frontières) and until today I have been on 2 surgical missions; 2012 in Gaza Strip and 2013 in South Sudan. I stayed 6 weeks in the Gaza Strip where I was a supervisory operating room nurse for a mission of a plastic reconstructive surgery. We operated in a tent placed near a local hospital where local employees came to observe and learn our way of working. In South Sudan I stayed 3 months where I was an operating room manager for a surgical mission of paediatrics and gynaecology. We worked in a hospital built by a humanitarian organization, but later half of it belonged to a local authority. At the beginning we were operating in a tent and we moved into an area with two new operating rooms after a renovation of an old operating room.

Two different countries, two different cultural, religious and political backgrounds and two different (almost no-existing) health systems. Demanding working environment filled with violence and challenges - but somehow they made me a better person and a better operating room nurse as well.

Faculty disclosure: No conflict reported

OC 92

A CROSS-SECTIONAL SURVEY STUDY ON FACTORS INFLUENCING PERIOPERATIVE NURSES' PERCEIVED OCCUPATIONAL STRESS IN AN IRISH HEALTHCARE SETTING

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Keywords: occupational stress, theatre, perioperative environment, transactional model, survey

Background

Occupational stress is an existing concern and contemporary focus throughout Europe (1,2,3) and within Ireland ^(4,5). Occupational stress can have negative consequences on an individuals' wellbeing resulting in absenteeism and presenteeism (3,6). In a healthcare setting, impaired health in nurses' directly impacts on patients' (6). The perioperative department is a highly interdependent, technologically advanced setting necessitating nurses' to perform effectively at work. Improvements in technology and the current economic recession are resulting in continuing demands and constant changes in policy and practice in the Irish health sector (7.8). Consequently, perioperative nurses' are exposed to increasing demands in their complex work environment. Framed by the transactional model of stress ⁽⁹⁾, this study explores the dynamic relationship between the nurse and the perioperative environment.

Aim and objectives of the study

To identify environmental and personal factors influencing perioperative nurses' occupational stress. Thereby addressing issues requiring support, education or a change in practice with the intention of expanding resources to cope and reduce stress.

Method

A quantitative cross-sectional survey design was used to collect data on 13 personal characteristics and 20 Events in the environment. Data was obtained through a self-report questionnaire from a convenience sample of 111 perioperative nurses from two large teaching hospitals within one of the biggest cities in Ireland. Data was analysed with descriptive and inferential statistics. Ethical approval was obtained to conduct this study.

Findinas

Events originating in the social environment elicited the highest intensity of stress and occurred the most frequently amongst the nurses.

Conclusions and Implications

Key stressors arose from the nature of the highly technological, fast past and highly interdependent setting. Findings sit inline with prior knowledge on factors influencing stress in perioperative nurses and current pressures on the Irish health sector. Recommendations are focused on improved communication to assist with early preparation of the environment. Where stress impedes the nurses' ability to work, a reduction in stress can improve the individual nurses' quality of life, interdisciplinary clinical practice in the work environment, and society, through quality patient care and reduced costs on the health sector.

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Faculty disclosure: No conflict reported

0C 93

HOW GREEK ORS OVERCOME ECONOMIC CRISIS

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Keywords: operating room, economic crisis

Background

Greek economy is in the swirl of international crisis, the depth of which is difficult to determine. The continuous growth of hospital costs in combination with economic crisis has driven governments in Greece, to restructure the hospital sector (also known as "hospital mergers") 1.

Purpose of the study

The study, conducted under the auspices of Greek Operating Room Nurses Association (GORNA), was done to identify how Greek ORs overcome economic crisis.

Goals

The measures to tackle economic crisis was teamwork to cope with less staff, effective central renderings, cut waste by educating nurses about supply prices, shrink inventories to avoid product expiration, trim preference cards, watch costs and control supplies to reduce supply spending.

Research problems

The collection and compilation of relevant data in a short term of one month, the extent of study sample to which the findings cannot be generalized and last minute adjustments.

Brief description on methodology

250 questionnaires were administered (October - November 2013) to a convenience sample (227 respondents) of Greek OR Nurses (RR=90,8%). The Statistical Package for the Social Sciences (SPSS version 19.0 was used. P-value <.05 considered as statistical significant.

Theoretical framework

Economic crisis in the hospital sector in Greece, is taking the form, on one hand, of high costs for the services provided by hospitals and, on the other, of a pressing public demand for better treatment. Everything depends on good and effective management so Healthcare organizations need to innovate in management (financial, human resource development and education) in order to remain competitive².

Results and the implications for perioperative nursing

Economic crises can be addressed as an opportunity for health reform policies, for providing more cost-effective and efficient services and for identifying actions that can help to mitigate the negative impact of financial shortages.

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FREE PAPERS

REE PAPERS

FP 01

B. PERIOPERATIVE/CLINICAL PRACTICE

PERI-OPERATIVE NURSES' CURRENT PRACTICES AND KNOWLEDGE OF THE PNEUMAT-IC TOURNIQUET IN THE SURGICAL SETTING

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Background

The pneumatic tourniquet is a device which is used worldwide in the creation of a bloodless field in extremity surgery. They improve vision of anatomical structures and facilitate careful surgical dissection. Despite the well documented benefits of the pneumatic tourniquet, their use is not without risk. In order to deliver optimum care, peri-operative nurses are required to have an excellent understanding of the application, removal, contraindications and complications associated with the use of the pneumatic tourniquet.

Aims: The aim of the study was therefore to examine peri-operative nurses' knowledge and current practices of the pneumatic tourniquet in relation to three different aspects of tourniquet use.

Methods

This research design employed was a non-experimental descriptive design using a non probability convenience sampling method. A sample of peri-operative nurses was selected from two large urban university affiliated hospital sites. Participation was completely voluntary and entailed completion of an anonymous questionnaire. A pre-existing questionnaire was utilised. The response rate was 54% (n=107). Data analysis was achieved by use of the Statistical Package for Social Sciences (SPSS).

Findings

Over 57% of the nurses questioned had some specialist knowledge. The majority of peri-operative nurses agreed that they receive periodic education but nurses generally disagreed that are competent to exsanguinate limbs. It was discovered that often non-nursing personnel apply the tourniquet. Nurses disagreed that they decide the pressure to be applied for each case. Nursing staff agreed that a nursing assessment of each patient's physical appearance is conducted prior to the application of the tourniquet yet it was unclear if nurses examine pedal pulses and limb temperature post operatively. There appeared to be a distinct lack of knowledge in relation to the actual positioning of the pneumatic tourniquet. Knowledge levels appeared average in this study and coincided with previous research results.

Conclusion

It is obvious that it is necessary that an education programme is devised to include areas of poor knowledge identified in this study. This education should be delivered to all nurses working in the theatre environment. Peri-operative nurses need to be trained adequately in order to deliver optimum patient care.

Faculty disclosure: No conflict reported

FP 02

POSTOPERATIVE PAIN: ROLE OF THE NURSE IN THE SURGICAL PATIENT MANAGEMENT

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Keywords: postoperative, pain, nurse, management

Postoperative pain is one of the main consequences of surgery. It's a rapid onset and symptoms with a limited duration in time, whose intensity varies depending on the location and nature of injury, general condition of the patient, and psycho-physical preparation of person in preoperatively, and is evaluated in a subjective way and approximate. For this reason the patient is the primary source of info about the pain. The intensity of postoperative pain can be measured through Assessment scales, making it possible to identify the most appropriate analgesic therapy for symptoms.

To evaluate nursing knowledge relating to the management of postoperative pain, a questionnaire was administered to nurses of Operating Block of General Surgery and Thoracic Surgery Unit of the Gemelli Hospital (Rome).

From a thorough analysis of the data, it was found that 48% of operating theatre nurses, measuring postoperative pain through direct observation of the patient (vital signs, behaviour), while 46% of nurses of the department, makes use of numerical scale (NRS). The painful symptoms are more frequent in anxious people (82%), because of the surgical procedure (38%) and anesthesia (58%), and the first choice analgesic is Paracetamol (58%) at scheduled times, intravenously, often associated with adjuvant drugs. The main side effects are: nausea (45%), vomiting, constipation and drowsiness

According to these same nurses, in order to achieve a proper management of postoperative pain, it is important to inform the patient and, above all, be professionally trained. In this regard, however, only 32% of them claims to have participated in training courses on the management of postoperative pain. It is recommended, therefore, that all nurses should attend the same courses, along with the medical staff, in order to become multi skilled professionals and to put into practice the knowledge learned to improve the daily welfare practice.

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Faculty disclosure: No conflict reported

FP 03

G. INNOVATION IN PERIOPERATIVE CARE

THE USES OF SMARTPHONE TECHNOLOGIES AND THE SMARTPHONE APPS IN THE OPERATING ROOM DURING THE SURGERY AND THEIR IMPACT ON THE PERIOPERATIVE PROCESS

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Keywords: smartphone, technology, operating room, surgery, impact perioperative, process

Background

The population of study participants are nurses, surgeons and orthopedists, who worked in operating rooms and were exposed to the uses of smartphone technology in the operating room during perioperative process in Rambam - Health Care Campus 2014.

Research Target

Collecting data about the frequency uses smartphones in the operating room and types of smartphones applications used during perioperative process among nurses, surgeons and orthopedists in Rambam 2014. Determine and identify the needs of uses smartphones technology in the operating room during a surgery and highlight the advantages and disadvantages of using a smartphone in the operating room.

General purpose

Examine the level of necessity for using smartphones during the surgery in operating room among nurses, surgeons and orthopedists in Rambam 2014.

Specific objectives

- Identify major purposes for using a smartphone during the surgery in operating room among nurses, surgeons and orthopedists in Rambam 2014.
- Examine the level of accessibility for using smartphones and applications technology in operating room among nurses, surgeons and orthopedists during perioperative process.
- Examine the level of simplicity for using smartphones and applications technology in operating room among nurses, surgeons and orthopedists during perioperative process, compared with conventional ways of healthcare system.
- Identify the most useful smartphone apps in operating room among nurses, surgeons and orthopedists during perioperative process.
- Identify and highlight the advantages and disadvantages of using a smartphone technology in operating room during perioperative process

Method

Distributing and collecting a questionnaire and collecting data by observations about the uses of smartphone technologies and the smartphone apps in the operating room during the surgery among nurses, surgeons and orthopedists who were exposed to the uses smartphone technology and applications in Rambam - Health Care Campus 2014

Faculty disclosure: No conflict reported

FP 04

HOW DO EXPERIENCED OPERATING ROOM NURSES CONTRIBUTE TO PATIENT SAFETY?

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Unni Igesund, lecturer in operating room nursing, University of Tromsø in Norway

Introduction

We are challenged by an increasing complexity in the OR. Lack of situational awareness, communication failures, problems with collaboration and interactions are directly related to coordinating in team and has an impact on patient safety.

Aim of Study

The aim of study was to analyze how experienced theater nurses coordinate in team, and interpret how they put into practice and assess the work of coordinating.

Methodology

Data is collected by observation and semi-structured interviews conducted with 3 experienced theater nurses, representing all surgery specialities in a University Hospital in Norway. The study is qualitative with a hermeneutic approach.

Results

Coordinating in team can be structured in 3 phases where these concepts are expressed:

- to be prepared
- to harmonize
- to promote workflow

Future research should focus on how to develop competence concerning coordinating OR team that can improve patient outcomes.

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Faculty disclosure: No conflict reported

FP05

C. EDUCATION DESIGNATED CENTERS FOR SIMULATION LEARNING

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Designated Centers for Simulation Learning

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Background

Since 2008 the graduates of the basic operation room course take the federal registration examination in nursing specialties. The examination takes place as structured simulations/ scenarios which simulate the clinical perioperative reality in the operation and recovery rooms. The examination assesses all the components required for these qualifications including: theoretical knowledge, professional skills/ performance capabilities and decision making abilities. Gideon Aloni in his article "The simulated patient" stated that the use of simulations in medicine is expanding rapidly. Simulation is an imitation of a complex reality using an appropriate model. The objective of the simulation is to represent (resemble) specific characteristics in the behavior of the system for various aims as: teaching and explaining, examination of systems before they are operational, practice for future users, maintaining knowledge, improving capabilities and more.

Focus of interest

Preparing the students for the registration examination with structured simulations, exposure of the students to the division of operation and recovery rooms, for orientation and integration, empowerment of the professional staff serving as mentors/tutors.

Methods

The head nurse in the operation roomwho had coordinated a basic operation room course identified the need for a setting for training students towards their registration examination. A meeting took place with the operation management staff together with the coordinator of the operation room course and they decided there is a need to open a simulation center in the operation room setting in the Hasharon Hospital. A training program was designed simulating the perioperative process. The program was authorized by the hospital management and the nursing school management. Reality simulating scenarioswere devised and a designated staff was trained as mentors. The project took place in June this year with a group of 18 students from the operation room course. Four simulation stations were set up, in each station every student performed 2 scenarios, in total each student practiced and was exposed to 8 different scenario types of reality simulation in the operation and recovery rooms. Written and oral feedback was received from the students and from the mentors.

Results

Sixteen feedbacks were received at the end of each training day. The feedbacks were structured based on the "teaching feedback" questionnaire commonly used in the 'Dina' academic nursing school. The objective of the questionnaire was to assess the students' degree of satisfaction in a number of variables offering the possibility for learning and improving by the team that organizes the day of simulations.

Analysis of the feedback shows the following findings: General review -Very good, Contri-

bution of the training to their knowledge-Very high, The training day contributes towards the examination-Excellent, The learning atmosphere-very high degree

Conclusions

Training students using simulations is a powerful tool reflecting their degree of preparedness towards the registration examination while giving them the opportunity to practice communication skills, basic operation room skills and prepare them for dealing with professional activities in the operation room. The process of mentoring by the operation room nursing staff added an additional level of learning and professional experience and was perceived as challenging and empowering.

Implications for perioperative nursing: to increase the number of training days during the operation room course, to expand the training using simulations to additional units in which the basic course graduates are required to be examined using simulations as combined intensive care.

FP 06

G. INNOVATION IN PERIOPERATIVE CARE SMARTTRAY A COMPLETE OR COUNT WAY?

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Keywords: completeness surgical instruments, visible support

During acute surgery with a lot of surgical instruments, the check for the completeness of tools remains quite a challenge. The scrub nurse is responsible for the completeness of instruments, sponges, disposables and sharps. After trying various existing solutions, we came up with a new approach. We concluded that the question we should asked ourselves is not "how many instruments do you have?" but rather: "are the instruments complete?" Visual support helps realise this in a more efficient way. Compare it with a crate of beer. It's easier to check if the crate is complete full than count each single bottle. Put the surgical instruments in a crate and see at a glance that all the instruments are complete. The surgical team can safely close the wound.

The at-a-glance insight into the completeness of surgical instruments is called Smarttray and is approved by Dutch national organizations and they recommended Smarttray in several hospitals. This good practice might also be an good example for other countries. It is a workable concept (also in critical situations), which leads to increased patient safety. The Smarttray concept is more than just fixating surgical instruments. By standardizing instrument sets and eliminating pitfalls in the entire process of the completion control, patient safety can be guaranteed.

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Faculty disclosure: No conflict reported

FP 07

E. PATIENT SAFETY SAFETY CHECKLIST FOR POSITIONING IN ROBOTIC SURGERY

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Keyworks: Perioperative Nursing, Patient Safety, Positioning in robotic surgery

Descriptive study on the development of safety checklist for robotic surgery, after identification of adverse events related to positioning. This institution is classified as tertiary hospital with 393 beds and 13753 surgical patients and 20887 surgical procedures per year. These events were discussed with the staff of the operating room and the champion on patient safety, in order to identify improvements to be implemented. Nurses, surgeons and anesthesiologists participated in this action.

The accuracy of surgical positioning to perform the correct coupling robotic system is essential for patient safety, such as ensuring the technical success of surgery. The patient positioning for robotic surgery has been challengig for the staff during surgery, to avoid patient motion and related injuries, and the pressure before and after positioning of the robotic system¹. Despite the effort and involvement of teams on the safe positioning of the patient, the final decision still belongs to the surgical team, causing dissatisfaction among the teams and not aligned with literature².

After root cause analysis of events, it was identified the lack of standardization in patient positioning among the different teams, favoring the occurrence of related events. We developed standardization of theposition from a comsensus among teams and security checklist. In this document we list devices that are indicated for skin protection, helping the surgical procedure. Thus, we make sure all the care necessary to ensure patient safety will be done. This printwill be in the scope of nurse work, shared and signed by the

responsible staff for positioning and attached the medical record.

The protocols implemented in the institutions need to be used as working tool for professionals, through understanding importance and necessity by teams, adhering for process effectively³.

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Faculty disclosure: No conflict reported

FP 08

C. EDUCATION SCRUB NURSES NON-TECHNICAL SKILLS

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Key words: Perioperative nursing, Non-technical Skills, Scrub Nurse

We are increasingly witnessing a social request for confidence ^[1]. The health care area is no exception to this matter as surgical clients express a situation of vulnerability, manifested as an overriding need for security ^[2]. Studies show that improving the quality of communication in intra-operative environment favors the safety of the surgical client ^[3]. The scrub nurse constitutes one of the key elements in maintaining intraoperative security ^[4].

by mediating communication within the multidisciplinary team. It is found that experienced scrub nurses that can stay calm in stressful situations contribute greatly in solving problems effectively. These nurses show good non-technical skills, which are social and cognitive skills that complement technical skills, in an interdependent way, for safe and effective task performance ^[6] [7] ^[8]. However, these skills are not yet formally identified or trained ^[9]. A quasiexperimental, pretest/post-test study was conducted with the aim of measuring the scrub nurses non-technical skills, in two operating theatres in Lisbon region, using the Scrub Practitioners' List of Intraoperative Non-Technical Skills (SPLINTS) rating form ^[6]. Initial observations were conducted for a period of 4 weeks. Nursing staff then received educational sessions regarding general information about non-technical skills competency. One month after the education session, the same scrub nurses were observed for an additional 4 weeks to determine the impact of the educational intervention.

The SPLINTS system has shown potential promoting concepts of reflective practice as an individual and as a team, to identify positive outcomes and quality improvements, providing feedback to other team members in a constructive and prompt manner. The training sessions showed an improvement in the ability of managing conflict situations in a timely and effective manner utilizing good communication strategies. The results will be included in the presentation.

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Faculty disclosure: No conflict reported

FP 09

C. EDUCATION

OPERATING ROOM NURSES ON A HUMANITARIAN MISSION - "SAVE A CHILD'S HEART" PROJECT

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Background

The prevalence of congenital heart defects is high in developing countries. Appropriate medical and nursing interventions are necessary to save the lives of these patients.

Procedure

We review the activity of Save a Child's Hearth (SACH), an organization officially recognized by the United Nations, since its foundation in 1995. SACH provides complex logistic support involving a multi-disciplinary team from the Edith Wolfson Medical Center, Israel, including physicians, operating room and ICU nurses, technicians, as well as logistics specialists and volunteers. While operating abroad, the teams leave Israel with all the necessary equipment. It is mainly the responsibility of the operating room nurses to select and maintain the equipment.

Results

With the aid of SACH, more than 3,000 procedures were perfomed at Wolfson, on children from 44 countries, including Iran, Iraq, Jordan, the Palestinian Authority, Africa, Asia, Romania, and the former Soviet Union. Additionally, more than 250 physicians, nurses, and technicians from developing countries have been trained through the SACH program. Among many others, 36 children from Romania have been successfully operated on at Wolfson.

Conclusion

Operating room nurses from Wolfson have a crucial role in the SACH project of improving medical and nursing surgical capabilities in the developing world.

Faculty disclosure: No conflict reported

FP 10

"SAFE SURGERY SAVES LIVES": A DOCUMENTARY ANALYSIS OF THE W.H.O. (2009) GUIDELINES FOR SAFE SURGERY AND ITS IMPLICATIONS ON PERIOPERATIVE-PRACTICE.

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Keywords: Surgical, safety, checklist, theatre-safety, operating room safety, morbidity, mortality, compliance and W.H.O.

Abbreviations

- W.H.O: World Health Organisation
- S.S.C: Surgical Safety Checklist
- O.D.N: Operating Department Nurses
- H.S.E: Health Service Executive
- H.I.Q.A: Health Information and Quality Authority

Context

In near future the increasing incidence of both disorders and diseases and those who may require surgery is expected to increase around the world (W.H.O. 2009). By having a set of 'Gold' standards that can be applied across the perioperative setting like the W.H.O. (2009) global initiative of "Safe Surgery Saves Lives" hopes to create an environment of safety for the surgical team and minimise risk for the surgical patients.

Ireland has endorsed the use of the W.H.O. recommended Surgical Safety Checklists at the Health Information and Quality Authority (HIQA) and the World Health Organisation's Second Global Patient Safety Challenge; Safe Surgery Saves Lives on 25th June, 2008. This initiative introduces Surgical Safety Checklists to ensure that the entire operating theatre staffs have a common understanding of the procedure, risk and a thorough knowledge of the patient prior to the commencement of any surgery (HIQA 2008). Endorsing the complexity of operating theatres World Health Organisation recommends that the checklist be used in all operations (Nilsson et al. 2010) and integrated into surgical training (Helmio et al. 2011). The checklist can be individually adapted for the content, form, and mode of use to suit

Organisational needs as long as the purpose remains unchanged.

Methodolgy

The Methodology usedis"Documentary Analysis"and a conceptualmodel for nursing and health policy analysis by Fawcett & Russell (2001) is chosen to guide the data analysis and to frame 'themes'.

Conclusion

The author has reviewed the W.H.O. (2009) document on SSC, frames themes, and discusses findings for better compliance.

Implications for perioperative practice

In Ireland, the Clinical Nurse Manager is in-charge for leading the SSC and nurses were found to be particularly inclined (O.D.N. 2009). Though the implementation comes with varying degrees of adherence, compliance and ongoing criticism (Vats et al. 2010) the author acknowledges that the introduction of any evidence based change needs strong leadership qualities, rigour and willingness from all team members to participate in the application of any new health intervention.

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Please note: Harvard Referencing System used

FP 11

B. PERIOPERATIVE/CLINICAL PRACTICE AN EXPLORATION OF ADULT-TRAINED PERIOPERATIVE NURSES' PRACTICE OF FAMI-LY-CENTERED CARE IN AN ACUTE IRISH REGIONAL HOSPITAL

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Keywords: Adult nursing; Family-centered care; Perioperative nursing.

Background

Family-centered care (FCC) is defined as a way of caring for children and their families within the health service which ensures that care is planned around the whole family, not just the individual child ⁽¹⁾. It is a concept of care that is widely accepted in paediatric practice as the best method of caring for hospitalised children and their families ⁽²⁾. Regional hospitals in Ireland currently provide surgical care for children in operating theatres where adult patients are also present ⁽³⁾. Many of the perioperative nurses involved in the care process are likely to be adult-trained and therefore unaware of current philosophies for the care of hospitalised children and their families.

Aim

This study aimed to explore adult-trained perioperative nurses' practice FCC when caring for children undergoing surgery.

Method

A qualitative research design using a hermeneutic phenomenological approach guided by Heideggerian philosophy was employed. In-depth interviews were conducted with six adult-trained perioperative nurses. Data analysis was guided by Colaizzis' seven-step framework, resulting in a composite description of perioperative nurses' practice of FCC.

Findings

Findings indicated that while participants supported the principle of family participation in care they found its implementation in practice difficult and stressful. They reported that families often appeared inadequately prepared for the surgical experience and subsequent poor experiences for families caused feelings of upset and inadequacy for nurses. Lack of knowledge, inadequate staffing levels and inadequate physical environment were identified as impediments to the delivery of effective family-centered care.

Conclusion

While some of these findings are similar to previous studies of paediatric nurses' practice of FCC ^(4, 5), this is the first known study to examine adult-trained perioperative nurses' practice of FCC. Participants articulated an awareness of what constitutes effective FCC and demonstrated the motivation to accomplish the task of improving family-centered practice in their practice area.

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- 5 Hughes, M. Parents' and nurses' attitudes to family-centered care: an Irish perspective. Journal of Clinical Nursing, 2007; 16 (12): 2341-2348.

FP 12 A.SCIENTIFIC RESEARCH ATTITUDES OF OPERATING THEATER WORKERS TO PATIENT SAFETY

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Keywords: Patient Safety, Culture Of Patient Safety, Attitudes To Patient Safety

Introduction

One of the most important topics in quality programs in health service is patient safety. In the United States, the most influential organization guiding medical practice, the Institute of Medicine (IOM), defines patient safety as "the prevention of harm which could come to a patient". It states that this can be achieved by means of a care system founded on a culture of safety which includes health care workers, institutions and patients and in which mistakes are prevented and lessons are learned from mistakes which are made.

Aim

The aim of the study was to evaluate the attitudes of operating theater workers to patient safety.

Research questions

What are the attitudes of operating theater workers to patient safety?

What are the factors affecting the attitudes to patient safety of operating theater workers? Is there a difference between the attitudes of operating theater workers to patient safety?

Material and Method

The population of the study consisted of the 354 people working in the central operating theater of the Atatürk Education and Research Hospital of zmir Katip Çelebi University (surgeons and surgical assistants, anesthetists, assistant anesthetists, anesthesia technicians, anesthesia nurses, and operating theater nurses). In sampling, the criterion sampling method, which did not involve selection, was used. In this way, the study sample was formed from 200 people who had at least one year of experience working in the operating theater. Prior to the research, written permission was obtained from the Scientific Ethics Committee of Ege University Nursing Faculty and the Southern Secretariat of the Public Health Association, and oral permission was obtained from the operating Boom Version) was used to collect data. This has 21 questions covering such topics as the age, gender, marital status, education level, position at work, year of graduation, average working in the vorkers, whether they knew of in-service training in the hospital where they worked and whether they had participated in it, and whether they had had training in patient safety.

The Safety Attitudes Questionnaire (SAQ) was developed by Sexton et al. at the University of Texas to measure the attitudes of operating theater workers to patient safety, and validity and reliability studies were carried out in 2006. Data is collected in six areas relating to team cooperation, job satisfaction, thoughts on method, safety environment, working conditions and stress levels. Some items contain negative statements (1,12,16,24,25,27, 31,32,33,36,39,44,47,49,52,53,56,58). Since the negative statements are scored the other way round, a higher score denotes a more positive attitude. A five-point Likert-type scale is used for responses (1=I completely disagree, 2=I disagree, 3=I am undecided, 4=I agree, 5=I completely agree). Scores were converted to percentages thus: 1=0, 2=25, 3=50, 4=75, 5=100 (Shteynberg et al. 2005; Makary, Sexton, Freischlag, Millman et al. 2006).

The program SPSS 17.0 was used in the analysis of data. Frequencies, percentages, means and standard deviations were used to present data descriptively. One-way variance analysis (ANOVA), t test, Kruskall Wallis H test and Mann Whitney U test were used to determine correlations between the data.

Results

The study sample consisted of 200 individuals working in the central operating theater of Izmir Katip Çelebi University Atatürk Teaching and Research Hospital.

Table 1: Distribution of Workers by Age, Gender and Marital Status

Variables	Subcategory	No	%
Gender	Female	112	56.0
	Male	88	44.0
Age	18-29	32	16.0
	30-39	85	42.5
	40-49	60	30.0
	50 and over	23	11.5
Marital Status	Married	151	75.5
	Single	49	24.5

It was found that 16% of operating theater workers were between the ages of 18 and 29, 42.5% were between 30 and 39, 30% were between 40 and 49, and 11.5% were aged 50 or over; in addition, 56% were female. Also, it was seen that 75.5% of those who participated in the study were married (Table 1).

Table 2: Distributions of Workers by Positions and Work Status

Characteristic	No	%
Position		
Surgeon	67	33.5
Anesthetist	29	14.5
Anesthesia Nurse	11	5.5
Anesthesia Technician	11	5.5
Operating Theater Nurse	82	41

It was found that 33.5% of the work group were surgeons, 14.5% were anesthetists, 5.5% were anesthesia nurses, 5.55% were anesthesia technicians, and 41% were operating theater nurses (Table 2).

Table 3: Distributions of Workers by Years of Specialist Experience

Characteristic	No	%
Years of Specialist		
Experience		
1-5 years	73	36.5
6-10 years	53	26.5
11 years or more	74	37.0

It was seen that 36.5% of the work group had 1-5 years of experience in their field of specialization, 26.5% had 6-10 years of experience, and 37% had 11 or more years of experience (Table 3).

Table 4: Distribution by Participation in Orientation Program When Starting to Work

Characteristic	No	%
Participation in Or		
Yes	46.5	
No	107	53.5

It was found that 46.5% of the workers had participated in an orientation program when they first started to work (Table 4).

Tablo 5	5: Mean	Scores	for	Patient	Safety	and	Subdimensions
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	Minimum	Maximum	x±SD
Team Cooperation	19.64	89.29	62.60±13.82
Job Satisfaction	.00	100.00	63.13±20.27
Thoughts on Method	.00	100.00	52.79±19.09
Safety Environment	7.35	85.29	56.89±15.10
Working Conditions	-8.33	100.00	58.04±26.00
Stress Level	-2.08	91.67	28.55±14.67
Total Patient Safety Attitude	10.78	76.72	52.51±11.78

Examining the mean scores of the work group personnel on the SAQ, it was found that the mean score for team cooperation was 62.60 \pm 13.82, for job satisfaction it was 63.13 \pm 20.27, for thoughts on method 52.79 \pm 19.09, for safe environment 56.89 \pm 15.10, for working conditions 58.04 \pm 26.00, and for stress levels 28.55 \pm 14.67, while the total mean score for patient safety attitudes was 52.51 \pm 11.78 (Table 5).

Table 6. Comparison of Mean Scores on the Safety Attitudes Questionnaire with Operating Theater Workers' Positions

	No	Mean order	Н	p	Significant difference
Surgeon (1)	67	79.79			
Anesthetist (2)	29	63.88			1.3
Anesthesia Nurse (3)	12	139.80		0.000	1-4 1-5
Anesthesia Technician (4)	11	135.41	39.926	926 0.000 2-3 2-4 2-5	2-3 2-4 2-5
Operating Theater Nurse (5)	81	119.85			

When mean scores for patient safety were compared with the positions of operating theater workers by means of Kruskall Wallis analysis, it was found that there was a statistically significant difference between the position groups and the mean scores (p<0.05). it was established by Mann Whitney U test post hoc analysis that there was a significant difference between surgeons and anesthesia nurses, anesthesia technicians and operation theatre nurses, and between anesthetists and anesthesia nurses, anesthesia technician and operation theatre nurses (Table 6).

Table 7: Comparison of Mean SAQ Scores According to Specialist Experience of Operating Theater Workers

	No	x±SD	F	р	Significant Difference
1-5 years ¹	73	49.19±12.44			1-2
6-10 years ²	53	54.39±9.48	4.721	21 0.010	
11 years or more ³	74	54.43±12.02			1-3

When specialist experience of operating theater workers was compared with mean patient safety attitude scores by one way variance analysis (ANOVA), a statistically significant difference was found between specialist experience and average attitude scores (p<0.05). It was established by post hoc analysis that there was a significant difference between those with 1-5 years of experience and those with 6-10 years of experience on the one hand, and those with 11 or more years of experience on the other (Table 7).

Table 8: Comparison of Mean SAQ Scores of Operating Theater Workers and Their Participation in an Orientation Program When They Started Work at the Hospital

	No	x ±SD	t	Р	
Yes	93	55.75±10.69	0.740	0.000	
No	107	49.69±12.01	3.743		

When a comparison was made by t test in the independent groups between the mean patient safety attitude scores of operating theater workers and their participation in an orientation program when they started to work at the hospital, a significant difference was found between mean patient safety attitude scores (p<0.05, Table 8).

When mean scores on the SAQ for Operating Theater Workers were examined in this study, it was established that total mean scores for patient safety attitudes were 52.51 ± 11.78 . Mean scores on the subscale for job satisfaction were the highest at 63.13 ± 20.27 , and those on the subscale of stress levels were lowest at 28.55 ± 14.67 . In a study by Sexton et al. (2006), it was found that mean scores on the subdimension of stress levels of the SAQ were 54.7 ± 26.6 . Pressure of work in operating theaters and the high turnover of workers and patients, as also the delicate nature of the work, increase workers' stress levels.

When safety attitudes were compared with the work positions of doctors, nurses and anesthetists forming the sampling group in a study by Önler and Akyolcu (2010), it was found that there was no statistically significant difference between the mean scores of the groups. In a study by Prati and Pietrantoni (2013) of the safety attitudes of operating theater nurses and surgeons in Italy, a statistically significant difference was found between the professional groups. In the present study, it was found when safety attitudes were compared according to the work positions of the surgeons, anesthetists, anesthesia technicians and anesthesia nurses and operating theater nurses who formed the sample group that there was a statistically significant difference (p<0.05). It was found that the mean scores on the SAQ of anesthesia nurses, anesthesia technicians and operating theater nurses were significantly higher than those of surgeons and anesthetists. It is thought that this difference may be an effect of the fact that in the institution where the study took place anesthesia technicians, anesthesia nurses and operating theater nurses take part more regularly in in-service training programs on patient safety than do surgeons and anesthetists.

In the study by Önler and Akyolcu (2010), it was determined that the mean safety attitude scores of those who had been working in their field of specialization for 6-11 years was lower than those of individuals who had worked for more than 11 years. In the present study a statistically significant difference was found between specialist experience and mean attitude scores (p<0.05). It is an expected result that as professional experience increases, patient safety attitudes will change in a positive way.

A significant difference was found between mean patient safety attitude scores according to whether operating theater workers had taken part in an orientation program when they started to work at the hospital (p<0.05). The patient safety attitude scores of operating theater workers who had taken part in orientation programs were found to be significantly higher than those of individuals who had not taken part in such a program. These results are in accordance with the literature. According to the results of the study, a measure which must be taken in order to improve the patient safety climate is to remove or at least reduce to a minimum the level of work stress. It is recommended that the whole team should regularly attend training programs in order to form a culture of patient safety.

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FP 13

C. EDUCATION

STAFF ENHANCEMENT IN THE PERIOPERATIVE ENVIRONMENT

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Keywords: coaching, enhance, contribute

Coaching is now part of professional development and enables people to meet their goals for improved performance and career enhancement. Nursing Midwifery Council 2011.^[1] When I read Whitmore 2009^[2] stating "Coaching is not about teaching at all but is about creating the conditions for learning and growing", I felt a real connection and I think that this was the starting point for developing my interest in the Coaching process and how it could be utilised to support and enhance the development of individuals.The question in my mind was how can the individual be the best they can be?

Whilst Coaching is on the agenda of the NMC, it was in reality still seen as a new innovative tool. Which could and should be used to support and develop pre and post registration students in the perioperative environment. The current challenge facing the National Health Service in the 21st Century is not just providing competent clinical staff but staff who through their own awareness and understanding of their role, can contribute more effectively to the quality of care delivered to their patients.

To support the coaching, I have utilsed the the GROW Model (Goal, Reality, Options, Way Forward) PINNA 2011. ^[3] Whitmore 2009 ^[4] states that when implementing the GROW model, you as a coach have to focus on the application of awareness, responsibility, use of questions and the development of rapport.

This provides a powerful framework that gives structure to the Coaching activity and takes the student on their own individual journey which has a postive impact on their engagement and contribution to their role within the perioperative environment.

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Faculty disclosure: No conflict reported

FP 15

D. LEADERSHIP/MANAGEMENT THEATER MANPOWER: WHERE TO GO?

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At present, more and more non-academic hospitals are facing a loss of theater manpower during surgical procedures. Are we able to face the challenge? Who will be able to provide a surgical help, requiring a special competency? How shall we be able to refund this aid once it is specified?

In Switzerland, foreign medical doctors are providing 40% of the surgical aid¹. In France, the certification IBODE (Infirmière de Bloc Opératoire Diplômée d'Etat)has been created but without a defined juridical status². In Quebec, the nursing staff union has created a specific title for the surgical aid IPAC (Infirmière Première Assistante en Chirurgie). They published

the rules for authorizing some specified medical acts but for the financing of the project³, they adopted the American system of private insurances and Medicaid (Becker 2005). The honorarium for the help of a nurse would be identical to the one of a surgical trainee.

In Belgium, the surgical aid is performed by a medical doctor, a surgical trainee or a nursing staff. The creation of the IPSO (Infirmer en Soins Péri-Opératoire) title is already a first step but one should now define more precisely the frame of the perioperative surgical aid. A list of surgical acts possibly performed by a nurse would fulfill the lack of a juridical frame. This would lead to a nursing code list allowing a refund up to 10% or 15% of the surgical honorarium, depending of the importance of the operation.

Pending the creation of a nursing order in Belgium, who will take the responsibility of writing down the list and submit the project to the country rulers? This must involve all the different concerned parties.

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Faculty disclosure: No conflict reported

FP 16

E. PATIENT SAFETY

REDUCING THE INFECTION RATE WITH LOANER INSTRUMENTATION FOR ORTHOPEDIC PATIENTS IN TAIWAN TEACHING HOSPITAL

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Keywords: loaner instrumentation, loaner implants, instrument processing, sterilization, Surface Test uses adenosine triphosphate (ATP)

In our hospital, we borrow specialty Orthopedic Surgical instruments and implants from vendors and without the burden of purchasing these items. The goal of loaner surgical instrument reprocessing is to provide instruments that are functional and safe for patient use. Borrowing has many advantages, including reduced costs and the ability to expand services offered, but borrowed items must be handled and processed in a consistent way to ensure safe patient care. Before surgery, instruments were come from other hospital and become contaminated from blood, tissue, and bone as well as body fluids that potentially contain infectious, pathogenic organisms making proper surgical instrument reprocessing critical to patient safety. Instruments and implants must be received in time to be properly reprocessed by the borrowing facility. Sometime vendors frequently deliver loaner items to us just before the scheduled procedure; thus, loaner items may arrive at the user facility with insufficient time for them to be appropriately cleaned, inspected, inventoried, wrapped, sterilized, cooled, documented, and tracked to the patient according to published standards and recommended practices. This caused in staff members rushing to process the instrument trays, which often leads to missed steps or errors in reprocessing. If items are not properly cleaned, then they cannot be adequately sterilized; this puts patients at risk. Inadequate decontamination processes also place the health care worker at risk.

There were 6 patients(0.12%0) got high fever after discharged and happened 7 months ago in Dec 2013. To avoid infection control and lack of planning on the part of a hospital or vendors, we arrange orthopedic leader and 2 assistants use Surface Test uses adenosine triphosphate (ATP) bioluminescence technology to assess the cleanliness of a surface and measure the efficacy of cleaning for loaner instruments in Feb 2014 till now (5 months). The selection of instrument sets for testing was left up our schedule with the recommendation that we choose every Monday, Wednesday and Friday loaner instruments that were high risk, difficult to clean and with visible soil levels that range from highly soiled to lightly soiled. Instruments were tested before reprocessing. The result Data (total 180 swabs tested) is shown as RLUs (Relative Light Units) per swab for a series of loaner surgical instruments before sterilization.



After we plan to monitor all of the facility including environment (air dust detection by obtaining bacterial and fungal culture swabs from table and overhead light ect..) surfaces, to detect the vendors to rewash loaner instruments in hospital for 3 months, The levels of contamination on the unprocessed instruments (hand wash) at this site show values that are higher and after re wash it reduces the level of contamination by about 1 to 2 logs, a significantly smaller reduction in comparison. Till June 2014, there was no more patients got fever (0%0 infection) and an effort to reduce the risks of SSIs associated with loaner items. We should develop a standardized, thorough system for handling loaner instruments, implants, and equipment. To implement successful loaner management system begins with a well-written multidisciplinary policy. To improving communication and policies and procedures delineated in the policy should include; ordering, transportation, checking in, and pre-procedure processing requirements; documentation and tracking processes; it can improve the quality and safety of loaner instrumentation and implant use. That can contribute to miss in processing requirements and, ultimately, risk to patients and staff members. For Perioperative personnel addressing the tracking, processing, and sterilization concerns of loaner implants and instruments by developing an intradepartmental policy and monitoring that policy for compliance is instrumental in decreasing the risks of HAIs and SSIs and promoting optimal patient outcomes.

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Faculty disclosure: No conflict reported

FP 17 C. EDUCATION

THE EORNA CORE CURRICULUM FOR PERIOPERATIVE NURSE COMPETENCES: A DE-SCRIPTIVE STUDY.

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Keywords: Nursing, competence, perioperative, operating theatre .

Introduction

In 2012 the educational committee EORNA defined the perioperative nurse competence in 5 domains. Nurses' recognition of their own level of skills and abilities (perceived competence) is a prerequisite for ensuring they can practice in a safe manner. The tool developed can be used by organizations or individual professionals to assess the skills and guide training programs.

Aims of study

The main purpose was to describe the perceived level of competence achieved by a group of operating room nurses in the 5 domains defined by EORNA.

Methodology

A descriptive study involving a group of 31 nurses in the operating room ASUR Marche Area Vasta 1.

To construct the questionnaire were used the 18 general aimof the 5 core domainsof competences: 1-professional, legal, ethical practice; 2-nursing care; 3-interpersonal relationships and communication; 4-organisational, management and leadership skills; 5-education and professional development. The questionnaire wasadministered anony-mously. All nurseswere asked to express their level of competences a scale of to 5.

Results

Nurses have reported high levels of competence in all domains (levels 4 e 5 domain 1 = 69.35%; domain 2 = 80.11%; domain 3 = 81,72%; domain 4 = 74.19%; domain 5 = 77.42%). In domains 1, 4 and 5 nurses have declared lower levels of skills.

Conclusions

The results of this study indicate that the areas of legal practice and ethics, organization, management and leadership skills need further training programs to achieve high levels of competencies. Additionally, findings may assist in the development of an instrument to measure operating nurses' perceived competence.

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Faculty disclosure: No conflict reported

FP 18

B. PERIOPERATIVE/CLINICAL PRACTICE

EFFICACY OF ICE POPSICLE IN THE MANAGEMENT OF THIRST IN THE IMMEDIATE PO-STOPERATIVE PERIOD: RANDOMIZED CLINICAL TRIAL

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Keywords: Thirst; Ice; Water; Perioperative Nursing; Recovery Room.

Background

Perioperative thirst is an intense discomfort with high incidence in the immediate postoperative period, and nonetheless it is highly neglected in clinical practice. Goal: to allow thirst quenching with a strategy that increases safety by employing small water volumes in the postoperative period. Problem: Is there difference in efficacy of ice compared with water at room temperature in relief of thirst in the immediate postoperative period?

Methodology

Randomized clinical trial, with 208 patients in the immediate postoperative period. There were five moments for assessing thirst intensity with a visual analogical scale and subsequent intervention during one hour according to the group:control (10 cc room temperature water) and experimental group (10 cc ice popsicle). The research project was approved by the Research Ethics Committee, CAAE 16707313.5.0000.5231, and is registered in ClinicalTrials.gov, by the identifier number NCT02149394

Theoretical framework

The Symptom Management Theory allows the analysis of a symptom as a multidimensional process based on three dimensions: symptom experience, components of symptoms management strategies and outcomes⁽¹⁾, and three domains: person, environment and health / illness⁽²⁾.

Results

The ice popsicle is more efficacious by 37,8% (p < 0,01) than water at room temperature in regards to the variation of initial and final thirst intensity. The intensity of thirst and number of interventions were different for the two groups from the second time on (p < 0.01). Concerning satiety, the Relative Risk was 41%, the Relative Risk Reduction was 59%, the Absolute Risk Reduction was 31% and the Required Number to Treat was 3, 2.Both groups were homogeneous and comparable regarding demographic and clinical variables.

Implications for perioperative nursing

The ice popsicle stimulates oropharyngeal receptors sensitive to cold temperature, allows patients to have control over the cold sensation, enablessatiety with small volumes, decreasing aspiration riskswhich is desirable in the immediate postoperative period.

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Faculty disclosure: No conflict reported

FP 19

A.SCIENTIFIC RESEARCH

INDEPENDENT AND INTERDEPENDENT PERIOPERATIVE NURSING INTERVENTIONS' IM-PACT ON PREVENTING INFECTIONS DURING THE PERIOPERATIVE CARE CONTINUUM

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Keywords: Perioperative nursing, infection prevention, nursing roles

Background

Perioperative nurses have an essential role in multidisciplinary team caring the surgical patient, but it is challenging to reveal their contribution in perioperative care continuum⁽¹⁾. Postoperative surgical site infections (SSI) are the third most common infection type in health care⁽²⁾ and perioperative nurses' crucial task is to prevent those infections in surgical patient care⁽³⁾.

Theoretical framework

The Nursing Role Effectiveness Model (NREM) presents different nursing roles in patient care: the independent role including functions and responsibilities which only nurses are

accountable for; the interdependent role including activities which nurses perform partially or totally with other healthcare providers; and the dependent role including nurses' functions and responsibilities carrying out medical orders^(4,5).

Purpose

The comprehensive systematic review was conducted to demonstrate the scientific evidence of perioperative nursing independent and interdependent interventions, and their impact on nursing-sensitive outcomes in adult surgical patients during the perioperative process.

Method

The review process according to the protocol by Joanna Briggs Institute⁽⁶⁾ included: selection criteria, search strategy, study selection, assessment of methodological quality, data extraction and data synthesis.

Results

Fifty-two of the eligible studies (n=1047) focused on the interdependent (n=26) and independent roles (n=26). Eleven of those 52 studies related to infection control. In seven studies nursing interventions defined to be independent and in four studies interdependent. Despite the high quality of the studies, for example relating to preoperative disinfection or hair removal, the results did not reveal evidence of best practice to decrease SSIs. However, according to the existing evidence if hair must be removed, clippers are preferable torazors.

Conclusion

Perioperative nurses have both independent and interdependent role in infection control. However, the evidence in reducing SSIs is inadequate, the results offer suggestive operations modelsfor perioperative nursing in infection prevention.

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Faculty disclosure: No conflict reported

FP 20

B. PERIOPERATIVE/CLINICAL PRACTICE NURSE EXPERIENCE AT ROBOTIC SURGERY IMPLANTATION

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Keywords: Nurse Care, Safety, Robotic surgery, Da Vinci, Prostatectomy.

Background

Surgical robotics is a new technology that holds significant promise. This new technology improves the conventional laparoscopic surgery offering a number of attractive features. Surgery times for a radical prostatectomy are shorter and overcomes are better than those obtained by conventional laparoscopy. Several centers are currently using this surgical robots and teams of nurses are improving the care given to these patients.

Purpouse/Goals

The objectives of this paper were to evaluate the effect of different nurse activities on the patient safety and the postoperative outcomes, as well as to implement a proper perioperative protocol based on evidenced practice.

Methodology

We executed a sistematic review of perioperative nurse support given at robotic radical prostatectomies performed at Cruces University Hospital since 2012 until today. We made a study of the relationship between nurse care given during robotic surgery and outcomes achieved, as well as a bibliografic review of recommendations and strategies directed to the patient safety.

Results

Instructing nurse team at patient position, equipment position and robot dressing as well as implanting the perioperative nurse care protocol, we guaranteed the patients safety and improve the outcomes of surgery. Equipment familiarization, anatomic knowledge as well as appreciation between provided nurse care and reached outcomes, are essential to guarantee optimum patient safety.

Conclusions

Robotic technology has been safely integrated into urological surgery room at Cruces

University Hospital, and the early experience has been very promising with no complications related to nurse care at robotic surgery. We can now say that robotically assisted laparoscopic radical prostatectomy is a feasible surgery at our hospital.

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Faculty disclosure: No conflict reported

FP 21

HOW EFFECTIVE IS NURSE-LED AIRWAY MANAGEMENT INCLUDING EXTUBATION IN PAEDIATRIC POST ANAESTHETIC CARE UNIT (PACU).

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Keywords: extubation, PACU, nurse-led, complications, key clinical indicators

Aim

The aim of this study was to assess effectiveness of nurse-led airway management including extubation in the paediatric PACU. This was achieved by collecting data on respiratory complications from 1007 patients over a 10 week period in the paediatric PACU. The frequency and nature of these respiratory complications were then compared with research from similar settings¹⁻⁶

Background

Airway management including extubation in the paediatric PACU is an extended nurses role that has being practiced for over 20 years within this hospital setting. The Association of Anaesthetists in Great Britain and Ireland (AAGBI) extended the role from only anaesthetist extubating to the task being delegated to trained practitioners⁷. There is however very little evidence based research to support the practice especially in the paediatric setting. This study addressed this gap.

Method

Data on respiratory adverse events from 1007 paediatric patients was collected prospectively in the PACU over a 10 week period. All surgical specialties were included with the exception of cardiac surgery. The age ranged from 1 week to 16 years. Airway types were: 73.3% of patients were intubated, 11.5% had face mask, 8.8% laryngeal mask airways, 4.5% mask and oral airway, 0.1% other, 1.8% missing data.

Results

There were a total of 9% adverse respiratory events in the PACU. Off these 93% were managed by nursing staff, 5.7% were managed by anaesthetic staff with 1.3% missing data. The rate of laryngospasm was 2%, re-intubations 0.1%, no unplanned admissions to paediatric intensive care (PICU), the average length of stay in PACU was 20 minutes with 0.1% being longer than 4 hours. The emergency call bell was used once over the 10 week period (0.1%).

Conclusion

This observational study points to effectiveness of practice by nurses in the paediatric PACU when the rates of key complications are compared with other studies in similar settings.

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Faculty disclosure: No conflict reported

FP 22

B. PERIOPERATIVE/CLINICAL PRACTICE HOW TO PREVENT PATIENTS DEVELOPING PRESSURE ULCERS WHEN POSITIONED IN THE SUPINE OR THE LATERAL POSITION WHEN UNDERGOING CARDIO-THORACIC SURGERY

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Keywords: Pressure ulcer, operating theatre, prevention, extrinsic factors, supine position, lateral position

A pressure ulcer (PU) is a severe complication following an operation. It's a setback for the patient; it's painful and prolongs the hospital stay and an unpredictable expense to the hospitals'resources and economy. Several studies show that the development of a PU, from the exposure to pressure until the PU breaksthrough the skin, can take up till four days. This may support the hypothesis that the development of PU originates from the operating theatre.

The purpose of the study was to research the development of PU.

The goals were toidentify risk factors and how to prevent the development of PU in the operating theatre.

The method was a review comprising of:

A) A systematic literature search in CINAHL and PubMed.

B) A critical evaluation of the 25 included academic articles and analysis of content relevance.

Results showed that several factors such as intrinsic, extrinsic factors and comorbiditiesincrease the patient's risk of developing PU. Especially the extrinsic factors such as shearing, friction, moisture, positioning, type of mattress, positioning aids and hypothermia are factors which can be minimized.

Implicationsfor clinical practice

The prevention of PU has become an integrated part of nursing practice. The nursing standardsregarding the extrinsic factors have beenrevised, introducedand implemented interdisciplinarily. The quality of care has improved as standards are based on evidence. Hypothermia and positioning the bariatric patientarebeing researched further. Cooperation between the wards, the operating theatre and the intensive care unit has been established in order to plan the prevention of PU, when the patient is transferred.

Faculty disclosure: No conflict reported

FP 23

B. PERIOPERATIVE/CLINICAL PRACTICE THEATRE CHARGE NURSE IN CENTRAL AFRICAN REPUBLIC

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In February 2014 I went to the Central African Republic (CAR) with Medecins Sans Frontieres (MSF) for an emergency response. That was my first mission. There I ran an operating theatre department. I did not know what to expect in CAR. It was a journey full of excitement and uncertainty. All that I was hearing was 'high violence and an unstable situation'. When I arrived I had to prioritise. I focused on human resources, identifying which areas of recruitment were necessary, which roles were missing; sterilization, introducing new chemicals and equipment to reduce surgical infection, improving staff processes to work smarter and safer; inventory, making overseas orders with a limited budget, being creative, innovative and improvising with the scarce materials in the hospital; hygiene improvement, developing and applying infection control guidelines, changing staff performance. At the same time I was training the local staff. It was a challenging month, working long hours with no resources, living in basic conditions and avoiding being hit by bullets. This has been a unique experience that has made me grow personally and professionally.

POSTERS

POSTERS

PP 001

A.SCIENTIFIC RESEARCH

QUALITY CONTROL OF THE SURGICAL PATIENT WHEN REQUIRING EQUIPMENT FROM EXTERNAL COMPANIES

Leah Agmon Agmon⁽¹⁾ - Tova Klienman⁽¹⁾

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Background

Recently physiciansdirectly order surgical equipment from external companies, allowing for unplanned events to occur as late arrival of equipment causing stress and delay of surgeries; inadequate quality controland safety of treatment. In the Hasharon Hospital 7872 surgeries are performed yearly in ten operation rooms (ORs) in three different sites. These include all fields of surgery and all types of orthopedic surgeries.

Theoretical framework

In the American Medical Institute report "To err is human" an estimateof 44.000-98.000 yearly deaths are due to medical errors. The national annual expenditureon these errors is \$8.5-\$17 billion.¹

A study of 30.000 hospitalizations in New-York reported 3.7% patients suffered from adverse effects associated to medical treatment;13% due to technical complications mainly in ORs. 13.6% of all cases ended in death; 58% were classified as preventable.²

Focus of interest

A thorough intervention was designed defining terms and times of delivery from companies; enhancing efficiency of communication between OR nurses and surgeons by using a special form with relevant information filled by the surgeon at least one day before surgery. This form became operational in March 2012, only with the orthopedic surgeons and 2 main companies (Jonson and CPM).

Conclusions

Interventional approaches using a methodical focused process to guarantee a continuous, safe and clear processof ordering external equipment witha high level of synchronization improve quality control and safety of treatment.

Implications for perioperative nursing: To expand the process with other companies in other fields. To expand the implementation activities with the surgeons in order that this form will become part of the routine activity.

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Faculty disclosure: No conflict reported

PP 002

A.SCIENTIFIC RESEARCH

THE OPININONS OF SURGICAL NURSES ABOUT THEIR ROLES AND RESPONSIBILITIES IN INFORMED CONSENT

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Keywords: Informed consent, nurses role and responsibility, nursing practice, surgical patients and nurses

Background

The outcome of the informed consenting process should be that patients are knowledgeable about their future procedure, but there is no guarentee that patients have understood the information. $^{\rm 12,3}$

Research problems

The big question is nurses don't know how to behave facing with these problems and their roles and responsibilities.⁴Although healthcare professionals try to highlight the importance of informed concent, there are few studies of this issue, especially among nurses.⁵

Purpose of the study

This descriptive study was conducted to determine the opinions of nurses regarding their roles and responsibilities about informed consent in surgical patients.

Material and methods

This study incuded 92 nurses who are working in adult surgery clinics at hospital in Turkey between 10 March–10 April 2014.Data was collected via a questionnaire which is created by the researchers through benefiting from literatüre.

Results

It was determined that 75% of the nurses participating to the study assumed various responsibilities during the informed consent process, which, according to them, included

verifying whether the patients understood the procedures to be performed, and ensuring that the doctors provided further information in case they thought the patients did not sufficiently understand the procedures in question. In addition, 98.9% of the nurses expressed that although patients needed to be informed beforehand regarding the procedures performed by nurses, it was not necessary to obtain written informed consents from them for such procedures. Concerning the difficulties they experienced during the informed consent process, 34.8% of the nurses described difficulties stemming from the patients' ability to understand and their low socio-cultural level; 21% described difficulties associated with excessive work load; and 18.5% described difficulties caused by the lack of specified procedures for the informed consent process.

Conclusion

It is important that perioperative nurses understand their role and responsibilities behind the principles of informed consent. Ensuring that nurses take part in the informed consent process, assist in the finding of witnesses, support the doctor when he/she is providing information to the patients, and assist in the development of policies and procedures regarding the informed consent will contribute significantly to the solving of problems that are encountered during the informed consent process.

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PP 003

NURSING AND TERMINOLOGIES: A LITERATURE REVIEW

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Keywords: literature review, nursing, terminology, taxonomy, classification

Aims

To analyze the use of terminologies in nursing in order to describe the state of the art of nursing classifications

Background

The need for development of standardized nursing classifications systems to describe nursing practice and to incorporate computerized records has been widely acknowledged. Efforts are motivated by the need for structured data, the need for documentation of nursing contributions to patient care outcomes, the demand for evidence-based practice and also the quest to enhance the scientific body of knowledge.

Design

An Integrative literature Review was performed. Data Sources: Academic Search Complete, Cumulative Index to Nursing and Allied Health Literature, Medical Literature Analysis and Retrieval System Online, Mediclatina Database were searched from 2004 up to June 2014.

Review Methods

Studies were included in this integrative review if they were scientific articles describing nursing terminologies or scientific studies that used nursing taxonomies of nursing care documentation, excluding studies using other types of classifications.

Results

Eighty publications were included. The variables analyzed were year of publication, theme or area of the studies, research methodology and terminologies studied. ICNP, NIC and NOC are the most focused taxonomies. Perioperative Nursing had a significant number of studies, a total of nine.

Conclusion and Implications for Perioperative Nursing Practice

Important steps must be taken to overcome the barriers to universal acceptance and use of standardized nursing terminology. Much more studies on this field must be undertaken, regarding the production of consistent and structured nursing data in order to obtain nursing sensitive outcomes for patients. Perioperative Nursing Data Set (PNDS) is the terminology for Perioperative Nursing, created in USA by Association of PeriOperative Registered Nurses. The data produced by perioperative nurses should be structured, and it is therefore necessary the use of a nursing terminology that systematizes such data allowing its use for care, research and education in perioperative nursing.

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PP 004

A.SCIENTIFIC RESEARCH

THE EFFECT OF PROGRESSIVE RELAXING EXERCISES ON ANXIETY AND COMFORT LEVEL OF BREAST CANCER PATIENTS RECEIVING CHEMOTHERAPY

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Keywords: anxiety, comfort, breast cancer, progressive relaxing exercise.

This study has been done to observe the effect of progressive relaxing exercises on anxiety and comfort level of breast cancer patients receiving chemotherapy; With a control group pre test-post test quasi-experimental model. This study has been carried out with experiment (30) and control (30) groups totally 60 patients who accepted to attend this study and were suitable for this study. The data collection was used to 'Personel Information Form, State-Trait Anxiety Inventory and General Comfort Scale. Assessment of data, percentage, mean, standard deviation, chi-square test (X2), independent samples t-test, paired samples t test were used. The average age of the patients attended the study is 49.06+-7.96. 83.3 (n=25) percent of the patients in experiment group and 86.7 (n=26) percent of patients in control group are married.

Patients' state anxiety pre-test mean scores is 42.26,7+-49, in experimental group and 45,03+-5.66 inBcontrol group. TheBdifference between the groups' mean scores is statistically insignificantly (p>0.05). Patients' state anxiety post test mean scoresis 36,20+-8,21 in experimental group and 43,43+-7,96 in control group. The difference between the groups' mean scores is statistically significantly (p<0.05).

General comfort scale pre-testmean scores is 140,46+-13,10 in experimental group and 135,36+-12,06 in control group. The difference between the groups' mean scores is statistically insignificantly (p>0.05).

General comfort scale post-testmean scores is 149,53+-13,92 in experimental group and 137,70+-14,96 in control group. The difference between the groups' mean scores is statistically significantly (p<0.05).

Experimental group patients state anxiety pre test mean scores is 42,26+-7,49 and post-test mean scores is 36,20+-8,21. The differencebetween the point averages is statistically significantly (p<0.05).

Pre-test general comfort mean scores is 140,46+-13,10; post-test general comfort mean scores is 149,53+-13,92 in experiment group patients. The difference between the mean scores is statistically significantly (p<0.05).

As a result, progressive relaxing exercises affect patients' comfort and anxiety levels positively.

PP 005

INVESTIGATION OF THE PSYCHOLOGICAL CONDITION OF WOMEN WITH MASTECTOMY

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Keywords: Mastectomy, psychologicstatus, breast cancer.

This study was conducted to investigate psychological status of women with mastectomy. This research which was planned as descriptive and cross-sectional was conducted in the oncology and surgical operation departments of two public hospitals and oncology department of a university hospital within the Ankara territory in the period between May 2012 and February 2013. Sampling group of the study was consisted of 90 women with mastectomy.Data were collected by the researcher through Data Collection Form and Brief Symptom Inventory (BSI). During data evaluation, descriptive statistics, the Pearson correlation test, Mann Whitney U-Test and Kruskall Wallis Test were utilized.

According to the research results, it was determined that 25.6% of the women with mastectomy were 61 years old and over, 75.6% of them were married; 43.3% of them were graduates of a secondary school. 50% of the sampling group was experienced operation on their left breast; 56.7% of them did not have any aesthetical correctional surgery operation in the post-mastectomy period; 53.3% of them experienced a change in their family life following the mastectomy operation was estimated 1.19±0.59. Moreover, a significant difference between patients' average Psychological Symptom Levels (GSI) of women experienced mastectomy operation, income level, being informant regarding breast cancer, and whether they have children, income level, being informant regarding breast cancer, and whether they have any initiative in regard to aesthetical view was determined. Research findings reveal that average Psychological Symptom Level score was over 1.00; and that there is a psycho-pathological condition among women with mastectomy. Along with these results, it is suggested that nurses must consider women patients with mastectomy in respect to psychological appect and take necessary actions.

PP 006

A.SCIENTIFIC RESEARCH IDENTIFICATION OF MORAL SENSITIVITY OF EMERGENCY HEALTH TEAM

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Keywords: Emergency, Health Team, moral sensitivity

The purpose of this study was to identify moral sensitivity and associated factors of emergency health team. Population of the study which is descriptive is the emergency services of university and state hospitals located in Adana and health team working in ambulance stations at Adana Local Health Authority.

The data were collected through "Personal identification Form" and "Moral Sensitivity Questionnaire (MSQ)" developed by Lutzen. Reliability and validity of MSQ wasenhanced by Hale Tosun. The MSQ 30-item Likert-type instrument has 6 sub-dimensions (Autonomy, Benefit, Totalitarian Approach, Encounter, Practice, and Orientation).

Results show that 69% of the emergency health team are female (n=276), 45% (n=182) are married, 55% (n=220) are single, 64% (n=259) do not have children, 82% (n=331) preferred this occupation themselves, 89% (n=358) love their job, 80% (n=321) have receive ethics education, 87% (n=348) do not follow any publications regarding ethics, and 71% (n=287) do not have ethical committee in their institution.

MSQ mean scores of emergency health team were found 83±16,3, which indicates high moral sensitivity. Benefit subscale mean score of moral sensitivity in health workers over age 40 were higher compared to other groupsand statistically significant differences were found. Conflicts in the sub-dimensions of employees who are married and have children, have found high moral sensitivity and statistically significant differences were found.

PP 007

THE RELATIONSHIP BETWEEN NURSING CARES AND LOW BACK PAIN

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Keywords: Nurse, Nursing Care, Low Back Pain

Background

Low back pain (LBP) is seen most often between the ages of 25-44. People suffering from back pain are encountered different of social, economic and psychological problems. Purpose: Assessment the prevalence and severity of LBP among nurses and relationship between LBP and nursing cares.

Methodology

This descriptive study was realized on nurses who were working at the intensive care units (ICU) of the Adnan Menderes University Training and Research Hospital. 76 nurses participated in this study. The data were obtained by prepared forms in accordance with the relevant literature which prepared by researchers and the Visual Analogue Scale.

Results

88.2% of nurses had LBP, and the severity of LBP in 31.4% of nurses was between 4-6. The highest LBP severity was at emergency and general surgery ICU nurses. The maximum severity of low back in relation on nursing cares were bed making, patient mobilization, change position, make passive exercises, discharge process, opening IVs and drain/s control, respectively. The severity of LBP in nursing care that requires physical strength was increased. The relationship between age, workload, work cycle, sports and LBP was not significant. Furthermore, the relationship between age, workload, work cycle and sports and LBP severity was not significant (p> 0.05).

Conclusion

This study showed that LBP still poses a major problem among nurses. Poor knowledge of back care ergonomics, standing for long time to give cares and manpower supply are major predisposing factors to LBP among nurses. According to the results of this study, provide in-service training about occupational hazards, using body mechanics during patients transform, revise manpower and regular health check-up are recommended.

Implications for Perioperative Nursing

Primary prevention of LBP involves the application of ergonomic principles and training of the nurses. Information about accurate and careful of nursing care play an important role in the prevention of complications during provides care.

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PP 008

PAIN EXPERIENCE IN ABDOMINAL SURGERY PATIENTS AND NURSING APPROACHES FOR THE CONTROL OF PAIN

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Keywords: Abdominal surgery; nursing intervention; postoperative pain.

Introduction

Patients frequently experience moderate to severe pain in the postoperative period. Although the pain management is an integral and important part of the nursing care, studies suggest that nursing management of postoperative pain remains inadequate. Nurses are responsible in assessing the pain, applying the pharmacologic and/or non-pharmacologic methods, monitoring results, training the patient and family, and documenting the implementations.

The nurses' holistic approach to pain management minimizes the patients' pain.

Aim of Study

This study was made to determine opinions of patients undergoing abdominal surgery on the implementations of nursing applied for the control of their pain.

Methodology

This descriptive study was conducted with 103 patients who underwent abdominal surgery in general surgery, urology and gynecology clinics at a public hospital in Turkey between May 1 and June 30, 2013. The data were collected through the questionnaire form that evaluating the participants' socio-demographics and health characteristics, characteristics of postoperative pain experienced by them, and patients' opinions about nursing interventions implemented by nurses for pain management. The data were summarized with number, percentage, mean score, and standard deviation value.

Results

It was determined that 97.1% of patients experienced pain between mild and unbearable levels It was declare that 99% of patients were able to communicate easily with nurses when they experienced pain and nurse believed the presence of pain. All of the patients stated that nurses didn't use a scale which is used for pain assessment when they were evaluating patient's pain. 77,7% of patients have been informed by the nurses for postoperative pain control. It is determined that analgesics were used more frequently but non-pharmacological methods were applied less in pain management.

Conclusions

The results of study, it was found out that the nurses they were all lacking of enough information about identifying pain and non-pharmacological management of pain.

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PP 009

A.SCIENTIFIC RESEARCH

THE EFFECTS OF WORK LOADS OF NURSES WHOM WORK IN SURGICAL CLINICS ON PATIENT'S SAFETY

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Keywords: Patient safety, patient safety and nursery, workload, workload and nursery, medical error and nursery.

The availability of producing high quality health care service depende on the usage of high quality patient care and patient safety. To continously sustain high quality and safe patient care, a more efficient nurse employment strategy must be followed and work amount per nurse needs to be reduced(1). The goal of this research is to examine the effects of workloads of Nurses whom work in surgical clinics on patient safety. The research is descriptive and has been conducted with 107 Nurses whom work in Baskent University Ankara Hospital Surgical Clinics Intensive Care and Surgical Services between the dates 22.08.2013-30.01.2014. During the research; Nurses' descriptive properties, workload, form focusing on experience with patient safety and opinion definition forms, Workload scale, Chenteleman Patient Classification Scale, Workload monitoring forms/Nursing Application List has been used. The majority of the experiment was conducted with women with %36.4 are between the ages of 23 and 25, %59.8 percent were university graduates, %68.2 worked in service and %11.2 worked as head nurses. %43.9 had work experience less than 2 years. According to the nurses the leading cause related to patient safety is "the incapability of nurses, lack of experience and lact of focus, and around half of the nurses suggested "increased number of nurses employed." %43 of the nurses commented that the workload is above acceptable and %30.8 commented that the worload was much above acceptable. %45.8 said the leading cause of the workload increase is due to littleness of nurse employment. The effects of nurse workload on patient safety are listed as decrease in time spent per patient, lack of cautiousness due to too much work and the increased risk of error due to fathigue and loss of concentration. The average workload point of headnurses were less compared to the nurses(p<0.05). As the number of daily surgical appereances increase, the workload point average has been seen to increase. By using these results the error reasons stated by the nurses and their resolution suggestions, increased regulatory activities focused on reducing nurse workload, number of patients per nurse distribution to be more balanced, paying more attention on care requirements, and planning of patient to nurse ratio can be adviced.

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PP 010

A.SCIENTIFIC RESEARCH

EFFECTIVENESS OF PATIENT SAFETY EDUCATION PLAN DEVELOPED FOR PATIENTS WITH LUMBAR DISC HERNIATION SURGERY ON DAILY LIVING ACTIVITIES AND LIFE QUALITY OF PATIENTS

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Keywords: Patient Safety, Lumbar Disc Hernia, Daily Living Activities, Quality of Life

Introduction

In recent years, countries have increasingly recognized the importance of improving patient safety. Patient safety is considered as the iceberg of global public health issue. Globally, numerous organizations have concerns about patient safety. Improving the patient safety will increase the quality of health care and reduce costs at hospitals by eliminating variability and risk to patients. Development of patient safety education plan for patients with lumbar disc herniation surgery may be useful in improving quality of care. (1, 2)

Aim of Study

Evaluation of effectiveness of the patient safety education plan for patients with lumbar disc herniation surgery on daily living activities and life quality was aimed in this study.

Methodology

The sample of this semi-experimental study was included 60 patients (30 controls, 30 experimental) who applied for lumbar disc hernia surgery in a University Hospital Neurosurgery Clinic, Ankara. Patient Description Form, Activities of Daily Living Form and Short Form36 Quality of Life Scale were completed with patients in experimental and control groups on the day that were admitted to the clinic. Patient Safety Education Plan was applied to patients in the experimental group. Patients in control groups received routine nursing care applied in clinic. Forms were again completed with patients in both groups' after 8 weeks from discharge. Application of the research was performed between 01.08.2011 - 12.06.2012. Percentage values, Pearson Chi-Square, Kolmogrov-Smirnov Test, Mann-Whitney U Test, Kruskal Wallis Test and Wilcoxon Signed Ranks Test were used to evaluate the data.

Results

According to the results of the study, the patients in experimental and control groups have similar characteristics. Daily living score medians of patients in experimental group higher than the control groups in second evaluation and this difference was statistically significant (p<0,05). Difference between quality of life score medians of patients in experimental and control groups all dimensions of quality of life were statistically insignificant (p>0,05) in second evaluation. However, the physical function, pain and emotional role dimensions of quality of life scores medians of the patients in the experimental group were higher than scores medians in the first evaluation, and this difference was statistically significant (p<0,05).

It was concluded that, patient safety education plan improved daily living activities scores of patients in experimental group; however, difference between quality of life score medians of patients in two groups were insignificant in second evaluation.

Implications for Perioperative Nursing

Implementation and dissemination of the patient safety education plan for patient with lumbar disc herniation surgery was recommended based on the results of the study.

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PP 011

AN INVESTIGATION OF FALL BEHAVIOR IN THE ELDERLY TO BE OPERATED FOR HIP FRACTURES

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Keywords: Fall Behavior Elderly, Hip Fractures, Orthopaedic Nursing.

Introduction

Falls are the leading cause of morbidity and mortality due to injury in elderly persons and are associated with substantial medical and rehabilitation costs, as well as social isolation and premature institutionalization. Attitudinal factors about falls prevention and home safety have been found to have a large impact on whether people adhere to recommendations for home modification11, 12. Behavioral as well as environmental assessment tools are needed in order to educate elderly people about strategies to reduce their risk of falling. Research has shown that biological, medical, behavioral, environmental and socio-economic factors affect the risk of falls in the elderly1. Risky behavior likely to cause falls in the elderly is being in a hurry, carelessness, fear of falling, misuse of assisting tools, selection of inappropriate shoes and not doing exercise. Since two thirds of falls in the elderly can be preventable, identification of risk factors and taking measures against these factors improve the life quality and self-confidence in the elderly3, 4. The risk of falls is increased in the elderly after surgeries for hip fractures. It is of importance to identify fall behavior and the factors affecting this behavior in terms of prevention of further falls in the elderly.

Aim of Study

This research investigate fall behavior in the elderly patients to be operated for hip fractures.

Methodology

This study is descriptive and cross-sectional and data were collected with Patients Characteristics Form and Fall Behavioral Scale for Older People in Orthopedics and Traumatology Inpatient Clinic of a university hospital between January 2014 and June 2014. The scale is composed of nine subscales5. The sample included 85 patients aged over 65 years, to be operated for hip fractures and accepting to participate in the study.

Fall Behavioral Scale for Older People

FaB scale was initially developed from a content analysis of literature and an expert review process similar to procedures used by Clemson, Fitzgerald, and Heard (1999). FaB scale was a list of, at this stage, 45 behavioral statements "describing things that we do in our everyday lives" with multiple choice responses of never, sometimes, often, always, or does not apply. A brief introductory paragraph included a definition of a fall and instructions.

Items were scored from 1 (never) to 4 (always) with 0 for does not apply. Dimensions of the FaB; Cognitive Adaptations, Protective Mobility, Avoidance, Awareness, Pace, Practical Strategies, Displacing Activities, Being Observant, Changes in Level, Getting to Phone. All analysis was carried out using the SPSS 15.0 statistical program.

Ethical approval was obtained from the ethical committee and permission was obtained from the hospital administration.

Results

The mean age of the patients was 78.78 ± 7.49 years, 70.9% were female and 52.4% were living with their relatives. Thirty-nine point nine percent of the patients had fallen once, 27.1% had fallen twice and 36.7% had never fallen before. 68.2% of patients are living with relatives at home and them of 90.2% is fell in the home (Table 1).

Table1	Demographic	Characteristics	of Patients	with Hin	Fracture
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Characteristics		n	%
Sex	Female	58	70.9
	Male	27	29.1
Age (years)	65-75	30	35.3
	76-85	40	48.2
	86-96	13	15.3
Education	Literate	29	34.1
	Elementary	41	48.2
	High school	13	15.3
	High education	2	2.4
Married	Yes	44	51.8
	No	41	48.2
Living arrangement	Alone	27	31.8
	With Other	58	68.2
Anatomical areas	Femoral neck	23	27.1
	Trochanteric	62	70.6
	Femoral head	2	2.4
Fall number	None	31	36.5
	One	28	32.9
	Two	23	27.1
	Three	2	2,4
	Four	1	1.2
Chronic illness	1≥	60	81.6
	0	15	18.4
Fall place	Home in	63	90.2
	Home out	12	9.8
Total		85	100

The female patients had significantly higher scores for the subscale changes in activities, including behavior to prevent falls (U=549.000, p<.05). The patients living alone had significantly higher scores for the subscale avoidance than those living with their relatives (U=549.000, p<.05). The patients aged 76-85 years had significantly higher scores for the subscale cognitive compliance and safe movements than the other age groups (KW=8.929, p<.05). (Table 2).

Table 2. Correlations Between FaB Scores and Risk Factors for Falls: Age, and Living with Relatives

FaB scales	Age category		Living with their relatives	
	KW	р	U	р
Cognitive adaptations	4.72	0.94	1017.00	.45
Protective mobility	8.92	0.01*	705.50	.53
Avoidance	0.18	0.91	571.50	.05*
Awareness	0.38	0.82	705.50	.53
Pace	0.89	0.63	640.00	.20
Practical strategies	0.01	0.99	745.50	.81
Displacing activities	0.22	0.89	688.50	.39
Being observant	0.77	0.69	767.50	.98
Changes in level	2.02	0.34	601.00	.09
Getting to phone	2.14	0.34	739.00	.75

*Significant at the .05 level.

FaB: Falls Behavior Scale for Older People

The directions of the measured relationships were what would be expected, with more protective behaviors associated with increasing age, reduced mobility, and reduced frequency that the older person left home, which are also known risk factors for falls13. The FaB scale shows potential for measuring behavioral change. In this study the FaB scale suggested that people with a history of falling appear to make adaptations and use safer practices than those who do not have a history of falling. The differences found were statistically significant, though not strong, between those that reported a fall in the previous year and those who did not report a fall. The reasons for making the kinds of adaptations the FaB scale measures may be explained by a number of factors including falling. People make adaptations for various reasons, for example, functional visual loss, or conditions such as stroke that decrease balance and strength13, 10.

Identification of behavioral risks in the patients to be operated for hip fractures will contribute to designing the content of education programs about home care before and after surgery. In addition, identification of fall behavior will prevent repeated falls after all orthopedic surgeries, especially hip surgeries. Knowing the causes of falls and taking appropriate precautions will help to protect the elderly against falls and to reduce the frequency of falls, which will allow the elderly to lead an independent life and to have a high quality of life 8, 9, 10.

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PP 012

A.SCIENTIFIC RESEARCH

AN ABSORBENT TOWEL TO PREVENT OF SKIN LESIONS IN THE OPERATING THEATRE.

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Keywords: Pressure ulcers, surgical patient, intraoperative.

Introduction

Research has shownthat patientsundergoing surgical proceduresmay developskin lesions. To ensure the integrity of the skinis necessary to evaluate the risks and use preventive measures. The moisture of the skin, caused by exposure to cleaning solutions, solutions for skin preparation, may contribute to the development of skin lesions from chemical damage. To reduce the risk were designed device as absorbent to wels to be interposed between the patient and the surgical bed.

Aims of study

The objective of this study is evaluate the effectiveness of an absorbent towel to ensure the dry skin in patients undergoing elective surgery and with the risk of developing skin lesions.

Methodology

The study design was observational descriptive. From January 2014 to May 2014 were included patients undergoing surgery in the operating room ASUR Marche Area Vasta 1, with the risk of pressure ulcers.

It 'been done both in the preoperative patient assessment with the following data: age, gender, body mass index, type of surgery, type of anesthesia, skin temperature, both in the post-operative assessment: skin conditiondue to the presenceofmoistureand integrity, timedurationsurgery and anesthesia. Beforestarting the studywere trainedall nurses.
Results

Theabsorbent towelwas evaluated in297 patientssubjected to the followingsurgical procedures: 37% of Orthopedics, 21% General Surgery, 23% Gynecology, 9% Ophthalmology, 10% otorhinolaryngology. The average durationwas 107minutes (SD 58) and 42% under general anesthesia.

The median age was60 years, 58% are femaleandtheaverageBMIof23.9. In thepreoperative evaluationall patients hadskindry, undamaged, in thepostoperative evaluationshowed85.5% from the skinwhile14.5% had clammy skin, in particular in patients undergoinggynecological surgery

Conclusions

The results show that the absorbent towel is efficacy in ensuring dry skin in patients undergoing orthopedic, otorhinolaryngology, ophthalmology while patients undergoing gynecological and general surgery are excluded because there is a strong exposure to cleaning solutions. The use of this device is recommended in selected cases, but for those with high exposure to cleaning solutions necessary to add additional preventive measures. To assess the effectiveness and cost / efficacy analysis and make quality choices, considering the sharp reduction in economic resources, further studies are needed.

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PP 013

A.SCIENTIFIC RESEARCH

PATIENT'S SAFENESS SYSTEM ORGANISATION CULTURE - THE MANAGMENT OF UNWANTED EVENTS

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Keywords: Organizational culture, patients' safety, management of undesirable events

Summary

The aim of this paper is to present the importance of establishing, maintaining and stability of organizational culture for incidence of unexpected and other undesirable events in the operating theatre. In the paper will be presented the process of establishing the culture of reporting undesirable events in the context of the Law on healthcare quality and required documents and forms for reporting the undesirable event, the procedures in order to develop the conciousness among healthcare practitioners for the necessity of reporting and analysing the event as well the acquirement of preventive and corrective measures.

The approach used in this paper was the review and the analysis of the documentation regarding the frequency and methods of reporting unexpected and other undesirable events before the legal obligations came into force, review of creating forms and documents while confirming the culture of reporting, and at the and the review and the analysis after the patients' safety system was established. Further, results of the investigation among nurses regarding their knowledge about the necessity of reporting undesirable events, as well the possibilities for raising the level of patients' safety system in the operating theatres.

Every hospital is obligated to establish and maintain the patients' safety system and the system for management of undesirable events, which considerably influences the level of the safety and care quality.

Every healthcare professional in the hospital is due to build up an maintain the patients' and personnel's safety system, and to consider this system as integral part of hospital's business strategy, in order to obtain the business excellence.

Further, healthcare professionals must strive that organizational culture of the safety system in its part regarding the undesirable events is stable, with as less undesirable events as possible, either prevented or actual, the stability of that system requires the maximal engagement of all healthcare and non-healthcare professionals, as well as raising their conciousness level about the need for patients' and personnel's safety.

PP 014

A.SCIENTIFIC RESEARCH

THE EVOLVING STATE OF EVIDENCE-BASED PRACTICE AND PERIOPERATIVE NURSING IN AUSTRALIA

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Keywords: Evidence Based Practice; Perioperative;

Background

Evidence-based practice (EBP) has been recognised worldwide by the nursing profession, as well as regulatory agencies, as the gold standard for the provision of safe and effective care ^{(1) (2)}. Despite the wide acceptance of EBP as the foundation for professional healthcare delivery, there still remains a considerable gap between research evidence and current practice ^{(3) (4)}.

Purpose of the study

To describe the self-reported knowledge, practice, attitudes, and perceived barriers to evidence-based practice among Australian perioperative nurses.

Methodology

Eight hundred perioperative nurses from nine metropolitan public and private hospitals were sent a survey comprising two validated tools, the Barriers to Research Utilisation Scale (Barriers Scale) ⁽⁵⁾ and the Evidence-Based Practice Questionnaire (EBPQ) ⁽⁶⁾. Data were entered into SPSS (version 18) and descriptive statistics generated.

Results

493 participants completed the survey (60%). On the 7 point EBPQ scale participants rated their EBP knowledge as 4.65 (1= poor to 7= excellent); their EBP practice as 4.12 (1= never to 7= frequently); and their attitude to EBP as 5.23 (1=negative to 7= positive). On the Barrier scale (1= no barrier to 4= great barrier) issues related to the organisation were identified as the most significant barrier (2.66); followed by research communication issues (2.76); individual adopter related issues (2.65); and issues about the innovation (2.52).

Conclusion

Australian perioperative nurses have a positive attitude to EBP and reasonable knowledge of the topic; however use of EBP in clinical practice is still evolving in Australia. The top 5 barriers identified by participants were related to organisational issues such as lack of time and support and this included lack of access to computers and internet in the work place to allow nurses to search for the evidence.

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PP 015

A.SCIENTIFIC RESEARCH

LITERATURE REVIEW: OPERATING ROOM NURSING RESEARCHES IN TURKEY

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Keywords: Nursing, operating room, research

The nursing researches will allow nurses to develop evaluation skills of their nursing practices critically and create a culture based on the scientific knowledge in nursing practices.

This study was performed as a systematic literature review with the aim of determination of researches with regarding to the operating room nursing in Turkey. The researches which were done in the field of operating room nursing in our country, were published in the national and international journals, were analyzed full text of papers or abstracts books of all congresses and symposiums were investigated. In addition, http://tez2.yok.gov.tr/ web address has been used with the aim to scan Master's and Doctoral theses that were located in the archives of the National Thesis Center of Higher Education Council. Also for the other printed journals were reached by scanning 'operating room, operating room nursing, hand antisepsis, disinfection, sterilization, scrubbing, surgical masks, surgical gowns, wearing gloves, surgical dressings, suture materials' key words in the http:// scholar.google.com.tr web address.

It was determined that researches which were done as mostly descriptive, retrospective, observational and experimental studies in the fields of operating room nursing in Turkey between 1990 and 2014. It was detected these studies were about infection(12), disinfection-sterilization(8), hand washing(6), delays and deferrals of cases in the operating room(2), experiences of patients waiting in the operating room(2), latex allergy(2), cutter and penetration instrument injuries(4), body temperature(4), pressure ulcers(2), music in operating room(3), detection situation in the operating rooms(9), orientation and service training in the operating rooms(6), other studies intended for nurses(22), patient safety(3), approach to the right side surgery, ergonomics and suture materials(5).

Although the studies related to the operating room nursing in Turkey are limited, the number of studies is increasing day by day. More of the studies will be useful to improve the quality of nursing care.

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PP 016

A.SCIENTIFIC RESEARCH

OPINIONS OF THE NURSING STUDENTS REGARDING MENTORSHIP

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Keywords: Clinical training, mentorship, nursing students.

Objective

The study was aimed at evaluation of post training on mentorship in nursing by nursing students.

Methods

This descriptive study was carried out for the period from 30th May, 2014 to the 15th March, 2014. Before the study, it was determined to be mentors nurses and their training was provided on mentorship. And then, 43 students working with mentors have taken the opinion of the mentorship.

Results or Findings

The average age of the students who participated in the survey is 19.2 ± 1.0 . 51.2% of students were volunterily chose the profession of nursing. At the end of the course teaching and clinical practice with mentors and with faculty members, 90.7% of the students' have stated that the profession has evolved positive perspective. 62.8% faculty members, 44.2% mentors has been effective in changing the perspective on the nursing profession.

The students should be identified the roles and responsibilities of mentors; as students gain experience (97.7%), students to support and guidance in situations of fear, anxiety, stress (88.4%), facilitate learning (83.7%), controlled nursing practice with student (83.7%) et cetera. Nursing students sould be contemplating mentors who specialized in the field of nurses (76.7%) and experienced of nurses (65.1%). In addition, students made recommendations to be successful for mentorship.

Discussion

In Turkey, nurses who are acting as mentor is recently used. They have significant influence on clinical education. Therefore, clinical staff, serve as mentors, must have the most upto-date information on the practices in the clinical area. In the present study, the students noted that mentors' attitude and communication skills played a role in learning. Similarly, other researchers reported the students found the assisting role of the mentors as the most important factor and that mentors should create learning opportunities to facilitate learning in clinical environment.

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PP 017

MUSIC INTERVENTION IN PATIENTS DURING DENTAL IMPLANT SURGERY : EFFECT ON ANXIETY LEVELS

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Keywords: Dental Implant, Music Therapy, Anxiety

This purpose of this research was to investigate the effect of music on anxiety levels in patients during dental implant surgery.

The study was consisted of a total of 60 patients who are 30 experimental and 30 control groups. They were voluntary patients (40-60 years of age) in dental clinics of a university hospital. It was taken permission to conduct research from all patients and from the hospital.

We selected same education levels of patients whose implanted 3-6 in surgery with same anastesia for homogeneity in research. And there weren't morbid obesity in them. Experimental groups were listened music during implanted.

Data were collected by the socio-demographic, scale of state-trait anxiety (SF 36). SF 36 scale was applied all of patients before preoperative and pastoperative terms. Experimental groups were interviewed about surgery. (When we find all results we will send your internet system).

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PP 018

INCIDENCE OF A NEGLECTED SYMPTOM: PERIOPERATIVE THIRST

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Thirst in the immediate postoperative period is intense and triggered by a confluence of factors: electrolyte imbalance, hypovolemia, use of anesthetic drugs and intubation. Literature is scarce regarding thirst incidence of the surgical patient.

Objective

To analyze the incidence of thirst in patients in the postoperative period and its correlation with clinical variables.

Method

A descriptive, cross-sectional quantitative study conducted in a university hospital in Brazil, with 386 patients during the immediate postoperative period in the Post Anesthesia Care Unit, from August to September 2012, using a semi-structured instrument. The project was approved by a Human Subjects Committee. Conceptual framework was based on the Theory of Symptom Management.

Results

Male patients were predominant (56.2%), as well as ASA 1 classification (50.3%). The most frequent anesthetic techniques were: regional (35.5%), sedation with regional (25.9%) and general balanced anesthesia (22.3%). The mean preoperative fasting time was 17:53 hours, with a range of 29:35 hours and a SD of 4:54 hours. The overall incidence of thirst was 78.5% (n = 303) and its intensity was measured using a numerical scale from 1 to 10 through patient self-report in the postoperative period. Intensity of thirst was an average of 6.94 (2.22 SD), classified as mild (6, 9%), moderate (49, 5%) and severe thirst (43, 6%). Of these, spontaneous verbalization occurred in 30.1%. The onset of thirst occurred in the preoperative period for 47, 9% of patients. Pearson correlation was not significant between presence of thirst and age, gender, bleeding, ASA score or surgical specialties. Correlation between thirst with intubation was statistically significant (chi-quare p = 0,002) as well as anesthetic techniques (p=0.039).

Conclusion

Thirst was found to be a highly incident and intense symptom in the postoperative period and should be included in nursing priorities for assessment and care in the PACU.

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PP 019

A.SCIENTIFIC RESEARCH

CHEMICAL HAZARDS RELATED TO SURGICAL SMOKE FOR THE WORKERS TEAM: AN INTEGRATIVE REVIEW

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Keywords: workers, occupational hazards, smoke, electrocautery.

The electrocautery smoke has many harmful compounds and leads to several risks to workers, from a chemical risk to a biological hazard. Therefore, this study aimed to examine the scientific evidence on the composition of surgical smoke produced by the use of electrocautery. This is an integrative review and the survey was conducted from April 2014 to May 2014 based electronic data. Controlled descriptors used were: surgery, electrosurgery, occupational hazards; beyond the non-controlled surgical smoke descriptor. We selected 12 articles, with the scientific evidence levels 1, 2, 3 and 4. Was concluded that there is scientific evidence that smoke from electrocautery has several potentially hazardous volatile organic compounds, considered as a chemical risk to the worker of the surgical team that is constantly exposed to this technology in their work environment.

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PP 020

A.SCIENTIFIC RESEARCH

THE EFFECTS OF PEER INTERACTION ON THE MEDICAL PROCEDURES FEAR

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Keywords: Adolescent, fear, medical procedures.

Aims

This descriptive study was conducted in order to determine the effects of the fear of the medical procedures in adolescents in the 8th grade studying.

Materials and Methods

The universe of study has created 8th grade students of an educational institution. The entire universe have been received sampling. The sample is formed by simple random sampling in Konya. Data was collected by using the Medical Procedures face Scale and the Descriptive Ouestionnaire. The data was evaluated by using means, percentages, T-test, Chi-Square and variance analysis (Anova).

Results

The study's findings constitute age, gender, hospitalization etiology, hospitalization period, previous treatments and examinations, mother and father's occupation, mother's education level and the Medical Procedure Fear Scale. The following independent variables; age, gender, whether or not invasive procedures are applied, fell the fear to face with such an initiative, fear of medical procedures related to the experience of peers sharing situations, the adolescent lived which experiences effect more than, witness to their peers as to whether any medical procedure, In this case, the response of peers which affect the adolescent's fears, depending on the experience whether treatment implement as a regular.

Conclusions and Suggestions

Knowledge of adolescents interact with their peers is important in the development of healthy behaviors and reducing the fear of medical procedures.

PP 021

A.SCIENTIFIC RESEARCH

THE RELATIONSHIP BETWEEN VOCATIONAL-PROFESSIONAL VALUE AND VOCATIONAL-PROFESSIONAL ATTITUDE OF NURSING

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Keywords: Nursing, professional value, nurses' professional attitude

Introduction

Nursing is a professional health vocational which is based on the science, technique and art. Health professionals are expected to behave the competence, intelligent and ethical in practice. Individuals can be forced to comply with the norms but can't compelled to ask for protection of ethical values and to take action to protect. Nurses can transfer their professional lives when they have to recognize their professional value. Professionalist is values, beliefs and attitudes; which is protected the interests of patients, not of individual interests and needs of patients is on the individual needs. While performing the duties of nurses; maleficience-beneficence, autonomy-respect for the individual, privacy and confidentiality, justice and equality, are required to adhere to ethical principles. Professionalism is extremely important in the development of professional standards and in providing quality care.

Aims of Study

This study was conducted as a descriptive and aims to determine the relationship between vocational-professional value and vocational professional attitude.

Methodology

This survey was carried out at the State Hospital and the Medical Faculty Hospital. 457 nurses working in clinics are constitute the population of study and 315 volunteers who agreed to participate in the study have been sampled. Research data was collected using the descriptive questionnaire, with the Nurses' Professional Values Scale which developed by Darlene Weis and Mary Jane Schank (it was adapted to Turkish) and with the 'Professional Attitute Scale' by Erbil and Bakır who study the reliability and validity. Using the tests which number, percentage, mean and cronbach's alpha coefficient, correlation, chi-square and T-test, have been evaluated the data.

Results

When the 315 nurses who participated in the study examined the socio-demographic characteristics; the mean of age is 30.1 ± 7.1 . 75.2% of nurses are female. 59.7% are married, 40.3% are single.

It was determined a correlation moderate strength in the positive direction (Pearson r= 0.523) when examined the correlation of professional values scale and professional attitude scale. And this relationship was statistically significant (p = 0.000).

In this study, the chronbach alpha value of the professional values scale was found 0.97 and the chronbach alpha of the professional attitute scale was 0.94.

In this study, There was no difference between the mean scores of "Professional Nursing Values Scale", according to the age, gender, marital status, institution where they work, to receive training for about ethic.

Conclusion and Suggestion

Professionalism is very important in the formation of professional standarts and in providing of quality of care. Vocational professionalism adversely affected may cause problems to affect individuals as well as institutions and may affected the quality of care. Nurses' professional values scale and professional attitudes scale researching separately although having separate studies, it were not found a study that was assessed together two scales . This project results will be guiding in education of nurses by revealing relationship between professional values and professional attitude.

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PP 022

A.SCIENTIFIC RESEARCH

NURSES' MAKING PHYSICAL EXAMINATION STATUS

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Keywords: Physical examination, nurses, patient care.

Introduction and Purpose

A comprehensive physical examination (PE) should be performed according to age specific preventive health guidelines. So nurses are required to know how to perform PE. The aim of this study was to determine nurse's performing PE status. Research datas as descriptive were gathered with the questionnaire developed by researchers. 400 nurses participated in research and were volunteer to take place in research. Count, percentage, mean average were used in evaluation of the datas.

Materials and Methods

This study was done as descriptive. Four hundred nurses worked in two university and one state hospitals were enrolled to the study. Data were collected from questionnaire forms based on literature. Required permission was received from nurses and hospitals for this study.

Results

The average age of nurses who accepted to take place in research was 31.64 ± 8.59 , 92% of them were women and the average of working year was $79,84\pm81,67$ months. 50% of them have undergraduate education. 89% of nurses are working in university hospital and 91,5% of nurses are working as a clinical nurse. 66.8% of nurses stated that physicians and nurses both should perform PE, 57.3% of them reported that both should evaluate findings. 51% of nurses stated that they received training on PE. 92% of them defined that PE training should be to perform PE, 82% of nurses stated that PE training should be to perform PE, 82% of nurses stated that PE training should be tought as a course in nursing school. 74.8% of nurses stated that PE evaluate the patient's skin color and hydration using inspection, 67% of them evaluate the patient's lung sounds using auscultation method, 69% of nurses evaluate the patient's hygiene requirements using

olfaction, 52.8% of nurses evaluate the patient's reflex with percussion. The causes of omit PE were; firstly not enough time in 21.8% of nurses, secondly PE were not a routine process in 27% of them. 74% of nurses defined PE as controlling patients' vital functions. 72% of nurses stated that they evaluate mass, pain, and tenderness using palpation. 79.3% of nurses defined the aim of PE as making data collection about patients, 78,5% of them defined aim of PE is to plan patient care. 87.3% of nurses replied to the question of when PE should perform, PE should be done when patient first came to clinic question of as stated when patient first came to the clinic.

Conclusion and suggetions

The majority of nurses stated that the PE needs to be done. However, the most frequently used method for PE were skin assessment, listening to lung sounds, edema and hygiene requirements; peripheral pulses, ear, nose and eye evaluation was found out that a very low rate. Half of the nurses reported that they didn't receive education about PE. Nurses should receive training about PE in order to make PE and it should take place between the routine practice of nursing.

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PP 023

PROFILE OF OPERATING ROOM NURSES IN TURKEY

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Objective

The importance of safe operating theater was disputed for a long time. Nursing in a negative work environment tends to impair performance by reducing motivation. In the current study we aimed to determine the working conditions, and the knowledge of nurses regarding the safety of operating room.

Methods

The survey element of this research was conducted in a total of 41 hospitals in Turkey between December 2013 and March 2014. A 63-item questionnaire including demographics, working conditions, physical environment, working safety, sterilization unit, and employee training was used to collect data.

Results

Among the nurses, 84% reported the physical conditions of operating theatre as complying with the standards, 77% feel themselves as part of the team, and 52% use the theater forms in the thought process.

Conclusion

Operating theater nurses have a common understanding of the core of their work, which is to ensure the safety of patients and themselves.

PP 024

A.SCIENTIFIC RESEARCH

THE INFLUENCE OF AN ENVIRONMENT AT THE CENTRAL OPERATING THEATERS IN THE UNIVERSITY HOSPITAL BRNO ON A BODY TEMPERATURE OF THE SURGICAL PATIENT.

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Keywords: perioperative care, thermoregulation, safety, quality

The lecture summarizes the results of an exploratory monitoring of body temperature in patients during their stay at the central operating theaters at the University Hospital Brno, in the Czech Republic.^[1]

The reason for the initiation of this study was a finding out that a large proportion of the patients already has a sensation of cold before surgery. Patients' hypothermia and with it associated discomfort during surgery is not conducive to a good course of treatment. ^[2, 3] This led the authors to prepare and perform an exploratory investigation.

The aim was to record the feelings of patients in an objective way. [4, 5]

A method of quantification was chosen for this exploratory investigation. It means that the detected body temperature of the patient at different stages of perioperative care was recorded.

Measurements were performed in three types of surgical procedures. It was a total arthroplasty of the knee or hip, an operation of intervertebral discs and a digestive tract operation.

Seven measurements were always performed: in the patient lying on the bed before his transportation to the operation theatre, at the beginning of preparation for patient's surgery, during surgery and after the end of surgery.

Values were followed both in patients who had no aids to maintain body temperature and in patients with thermal foil or with a heating pad. A frontal bone (forehead) was an area of body temperature measuring. Non-contact thermometer was used.

Exploratory investigation began in February 2014 and will be completed in October 2014. The results will be used to develop recommendations for the care of the physical well being in patients at operating theaters of University Hospital Brno.

Implementation of these recommendations will contribute to the quality and safety of perioperative care, and thus also to the better postoperative treatment of patients.

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PP025

EDUCATIONAL NEEDS OF NEUROSURGICAL OPERATING ROOM NURSES

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Keywords: Operating theatre, Scrub nursing, Education, Need for education, Nurse, Neurosurgical scrub nursing

This descriptive study was designed to determine the sights of neurosurgical scrub (scout) nurses about theatre nursing. A total of 102 nurses who work in 2 university hospitals, 3 teaching hospitals and 4 private hospitals joined the study between January 2012 and April 2012.

The data were obtained by the interview forms which were designed to describe the educational needs of neurosurgical scrub nurses, to create new programs and to offer suggestions in the light of literature and expert opinions. Statistical analysis was conducted using percentage, arithmetic mean, chi-square and Fisher chi-square tests. This study revealed that 31.4% (32 nurses) of the nurses were between 25-29 years of age, 37,3% had bachelor's degree, 85,3% worked in the neurosurgery unit intentionally, 57,8% were educated for theatre nursing adequately during their basic nursing training, 99% supported the necessity of continuous education, 92,2% of the nurses were taking an educational program about theatre nursing in their working place and 46,1% had partially enough educational programs, 59,8% did not follow literature regularly. 66,7% of the nurses needed education for basic sciences, 56,9% needed education for the types of neurosurgical operations, 68,6% needed education about the techniques in neurosurgical operations and it was assessed that their educational programs should include those subjects.

To conclude, we propose that neurosurgical scrub nurses support continuous education and unit specific programs should be performed. The nurses have better knowledge about operating theatre in general, but they require education for neurosurgery. We can suggest educational and orientation programs to be continuous to meet these requirements and new programs should be established complying with the developing technology.

PP 026

PATIENT SAFETY IN OPERATING ROOMS: AN EXAMINATION OF PATIENT SAFETY CULTURE AND USE OF THE SURGICAL SAFETY CHECKLIST

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Keywords: Patient Safety Culture, Surgical Safety Checklist, Operating Theatre

Introduction

Patient safety is defined as 'the prevention of harm caused by errors of commission and omission'¹². One-fifth of the people in the community are exposed to medical mistakes¹³, and this rate may be as high as 35–42%¹⁴. As a result, millions of people may die or suffer injuries due to preventable medical errors. The widespread nature and heavy consequences of medical mistakes require more studies focusing on patient safety¹⁵. These types of studies generally concentrate on hospital environments. National Health Service hospital trusts report almost 100.000 patient safety incidents annually, resulting in the death of over 2000 patients⁶. The operating theatre (OT) remains the most common site for incidents,⁷ with errors occurring in up to 14,6% of surgical patients.⁸ With 50% of incidents potentially avoidable health services have not responded quickly enough to lessons learnt from error avoidance in other safety-critical institutions9. The Association of Perioperative Registered Nurses recommended cooperation between team members and an error reporting system in addition to simplification and standardization of the work

process to achieve patient safety culture1. It has been reported in the literature that hospital administrations create patient safety promotion activities and an error reporting system to form patient safety culture^{2,3,4}. The World Health Organization developed a surgical safety checklist and put it into practice for patient safety in operational theaters. Using the surgical safety checklist was found to help achieve the right intervention on the right patient and reduce surgical wound infections and other complications and mortality⁵. Aim of study: To reveal patient safety culture among staff in a theater and to investigate use of the surgical safety checklist.

Methodology

Data for this descriptive and cross-sectional study were collected with General Characteristics Form, Hospital Survey on Patient Safety Culture and Surgical Safety Checklist Questionnaire in the operational theater of Dokuz Eylül University Hospital between March 2014 and June 2014. The scale has three subscales, i.e. outcome measures, operational theater patient safety culture and hospital safety culture. Outcome measures are about general safety perceptions and frequency of reported events. The study sample included 64 doctors, nurses and anesthesia technicians working in close contact with patients in the operational theater and accepting to participate in the study. Hospital Survey on Patient Safety Culture (HSOPSC)

We used the HSOPSC developed by the Agency fob Healthcare Research and Quality (AHRQ)10. This instrument contains 12 subscales and 42 items that consider many attributes known to be associated with a culture of patient safety, identified above11. Specifically, the subscales of the instrument include: (i) manager expectations and actions promoting safety; (ii) organizational learning; (iii) teamwork within units; (iv) communication openness; (v) feedback and communication about errors; (vii) non-punitive response to errors; (viii) staffing; (viii) management support fob patient safety; itx teamwork across units and (x) handoffs and transitions. The HSOPSC also includes two subscales that are presented as outcome dimensions: (i) overall perceptions of safety and (ii) frequency of event reporting. Using Cronbach's a, all subscales had acceptable levels of reliability, which varied from 0.84 fob frequency of event reporting to 0.63 fob staffing. The construct validities of each safety culture dimension were shown in composite scores as being moderately related to one another, as indicated by correlations between 0.20 and 0.40. Ethical approval was obtained from the ethical committee and permission was obtained from the hospital administration.

Results

Of 64 participants, 48.4% were nurses, 21.9% were physicians and 29.7% were anesthesia technicians. Twenty-eight point one percent of the participants had a five year or less experience in the operational theater (Table 1).

Table 1. S	ociodemographic	and	professional	characteristics	of	staffs	in	theatre
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Characteristics	N	%
Staff		
Nurses	31	48,4
Doktor	14	21,9
Others	19	29,7
Work experience (years)		
<5	18	28,1
5-14	26	40,6
>15	20	31,3
Years in the operating theatre		
<5	28	43,8
5-14	24	37,5
>15	12	18,8
Hours of work per week		
<40	25	39,1
41-49	23	35,9
>50	16	25,0
Total	64	100

Eighty-four percent of the participants were found not to know about Surgical Safety Checklist, but 86% wanted to use it. Seventy-five percent of the participants never reported an event, but 20.3% reported 1-2 events.Table 2. Percentage of respondents giving their work area/unit a patient safety grade

Operating theatre patient safety grade	N	%
Excellent	1	1.6
Very good	9	14.1
Accaptable	38	59.4
Poor	9	14.1
Falling	7	10.9
Total	64	100

Fifty-nine point four percent considered patient safety in the operational theater acceptable (Table 2). There was a significant, strong positive relation between outcome measures and hospital safety culture (r=0.85; p<0.01). There was also a significant, strong, positive

relation between hospital safety culture and the number of events reported (r=0,84; p<0,01). The results of the study can help nurses in the operational theater to know about and use Surgical Safety Checklist, which may promote their reporting events likely to threaten safety. The results will also contribute to designing education programs about patient safety and improvement of patient safety culture.

The results of this study suggest that patient safety is viewed by healthcare professionals as one of the most critical aspects of the medical service delivery. Those healthcare professionals who see their organization as a workplace with a strong patient safety culture are more likely to notice and report medical errors and view the level of patient safety within their organization positively. A significant segment of health employees prefer not to report the medical errors they witnessed to for various reasons. Providing proper training develops the employees on patient safety appears to be a valuable investment since training develops the employee's ethical perspective/responsibility and ability to notice medical errors and their potential causes.

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PP 027

A.SCIENTIFIC RESEARCH

AMELIYATHANE ÇALISANLARINDA DELICI-KESICI ALETLE YARALANMA DURUMU

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Keywords: Operation room, operation room staff, sharp and penetrating tools, injury, injuries by sharp and penetrating tools

Summary

KÜRTÜNĹÜ S. (2013). Determination of the injuries of operation room staff by sharp or penetrating tools. University of Haliç, Institute of Medical Sciences, Nursing of Surgical Diseases Unit. Master's Thesis, Istanbul.

The research has been conducted with the aim of definitive determination of the injuries arising from sharp or penetrating medical tools. The research has been done during February-May 2013, with the contribution of totally 75 people, consisting of 19 doctors, 46 operation room nurses, 5 operation room cleaning staff and 5 sterilization staff all working in the operation rooms (abbreviated as OR) of Istanbul University Hospital of Faculty of Medicine. The data has been collected via survey forms, which have been prepared with the guidance provided by related literature and the thesis advisor. Arithmetic averages and frequency analysis have been used in analysing the collected data, and chi-square tests have been employed in the comparison of the groups. The error level is set as α =0,05.

The research revealed the following: All of the doctors, %86,96 of the nurses, %80 of the OR staff and %40 of the sterilization staff have been injured by surgical tools at least once. %80 of the nurses and %42,11 of the doctors have been injured by such tools while handing them to others during an operation. %22,50 of the nurses and %50 of the cleaning staff have been injured while dumping injectors to the trash bins. %68,42 of the doctors has been injured by sewing materials while %55 of the nurses and %50 of

the sterilization staff have been injured by a lancet. %89,47 of the doctors, %55 of the nurses and %50 of the sterilization staff have not reported the incident. %47,06 of the doctors did not care about reporting whereas %55,17 of the nurses did not view reporting to be useful. %63,16 of the doctors, %76,09 of the nurses and %80 of the cleaning staff always check whether the patient has a contagious disease before entering in the operation room and the generally or staff wears double gloves and protecting glasses only in such cases. Also, the injury risk increases in the operations lasting more than 3 hours on average.

To conclude; most of the operation room staff is not adequately knowledgeable on not only the standard precautions but also the actions that should be taken after injuries occur. The training programme the cleaning staff should attend should especially cover the topics such as injury risk, possible dangerous situations, the proper usage and dumping of sharp and penetrating tools and instructions on the reporting procedure of injury cases.

PP 030

A.SCIENTIFIC RESEARCH

PERIODICITY EVALUATION IN THE APPLICATION OF THE SAFETY PROTOCOL FOR THIRST MANAGEMENT

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The Safety Protocol for Thirst Management (SPTM) was conceived and validated aiming to fill the gap in the literature concerning safety criteria for clinical assessment of thirsty patients during anesthesia recovery^{1,2}. It assesses level of consciousness, airway protection reflexes (coughing and swallowing) and absence of nausea and vomiting, with a content validity index = 1, high agreement levels (93% -100%) and almost perfect Kappa index (0.968)3. Objective: To apply the SPTM in patients in the Post Anesthesia Care Unit (PACU) correlating approval/disapproval rates with clinical variables, determining the appropriate periodicity to use the protocol. Descriptive transversal, quantitative study in a PACU of a large university hospital in southern Brazil. All ethical issues were addressed. Sample included 109 patients, of which 48, 6% (n=53) were thirsty with a mean intensity of 6.38 (SD 2,42). and 4,6% (n=5) verbalized it spontaneously. Preoperative fasting time ranged from 8 to 64 hours (mean 17; SD 7.05). Anesthetic techniques were General Anesthesia (n 44), Regional Anesthesia with Sedation (n 43) and Regional Anesthesia (n 22). The STPM was used every 15 minutes upon patient's arrival at the PACU, for one hour. Approval rate increased progressively (50%, 59%, 68%, 77%, 78%). First moment assessment demonstrated that general anesthesia was associated with the highest disapproval rate (72%) (Fisher Exact Test p<0,05); criterion "level of conscience" was responsible for the highest disapproval rate as well as anesthetic drugs fentanyl, propofol and rocuronium (p< 0,05). Conclusion: Thirst intensity was high and assessment with the SPTM indicated that after 30 minutes in the PACU most patients (68%) had met all safety criteria, regardless of anesthetic technique employed, being eligible to receive an oral strategy to relieve thirst. Implications: The SPTM can contribute to decrease distress time due to thirst during anesthesia recovery, with early assessment for safety and intervention.

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PP 031

THIRST MANAGEMENT IN THE IMMEDIATE POSTOPERATIVE PERIOD: ANESTHESIOLOGISTS' PERCEPTIONS

Ana Garcia ⁽¹⁾ - Ligia Fonseca ⁽¹⁾ - Leonel Nascimento ⁽¹⁾ - Marília Conchon ⁽¹⁾ - Aline Garcia ⁽¹⁾ Londrina State University, University Hospital / Londrina State University, Londrina, Brazil ⁽¹⁾

Postoperative thirst is highly distressing¹, triggered by prolonged preoperative fasting, bleeding and use of anesthetic drugs². Thirst management - identification, measurement and treatmentis still incipient in clinical practice by nursing staff and anesthesiologists, who are the professionals responsible for the release of fluid intake in the immediate postoperative period (IPO). Objective: To explore the perception of anesthesiologists about the identification and management of thirst in IPO. Qualitative and descriptive study in a large university hospital in southern Brazil, with residents and professors of anesthesiology. All ethical issues were addressed. The conceptual framework was the Theory of Symptom Management³ and the methodological framework by Martins and Bicudo⁴. Two categories were formed: "Perceiving thirst in surgical patients" and "Finding it difficult to assess and treat thirst." Results: Discomforts mostly reminded by anesthesiologists were pain, nausea and vomiting, whereas thirst was only mentioned after being questioned by the researcher. Anesthesiologists identify clinical signs of thirst as dry mouth, cracked lips, thick saliva, and difficulty in swallowing. They do not assess thirst intentionally, nor consider it in their post-operative treatment plan, depending on reports by the nursing staff to know the patient is thirsty, which rarely occurs. There is no consensus on criteria for the release of fluid intake concerning timing, safety measures, counter indication, method of reliefs and volume of liquids released by each professional varies significantly. The anesthesiologist does not mention known effective strategies for managing thirst as ice and menthol^{2,5,6}. Implications for nursing: these results corroborates that thirst remains barely noticed and rarely treated in the recovery period, even though its high incidence, intensity and distress. It is necessary to raise awareness to all members of the surgical team on existing evidence on intensity scales, safety criteria protocols and effective management strategies for thirst relief^{2,7,8}.

Descriptors: Anesthesiology, Thirst, Perioperative Nursing, Recovery.

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PP 032

THE EFFECT OF EXERCISES ON PAIN AND VITAL SIGNS AFTER OPEN HEART SURGERY

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Keywords: Open heart surgery, pain, vital signs, exercises.

The study was planned as a descriptive study to evaluate the effect of exercises on pain and vital signs in patients having open heart surgery. Between May 2012-December 2012 in a private hospital in cardiovascular surgery intensive care unit the study was done with 51 patients who meet the study criteria and accepting the research. For the collection of data, patient identification form and visual analog scale was used. The evaluation of the data was done by descriptive statistics and t-test. Of the patients who participated in the survey 52.9% male, 52.9% are high school graduates.As a result of this study ; mean pain scores of patients first day is significantly higher than second day during all post operative exercises(resting, cough, spirometer use,walking and seat fitting)(p<0.01), and according to resting, walking and seat fitting exercises mean respiratory scores firstday is determined significantly higher than second day(p<0.01), There hasn't been asignificantly difference between the other vital signs and exercises. In line with these results, it can be said that all the exercises increase the severity of pain and aren't significantly effective on vital signs.Pain assessment in patients undergoing open heart surgery not only resting during exercise should also be carried and patients' should be pre-exercise pain control.

PP 033

A.SCIENTIFIC RESEARCH

GETTING SERIOUS ABOUT PREVENTING PRESSURE ULCERS IN SURGICAL PATIENTS

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Keywords: retrospective audit pressure injury prevalence; surgical patients; identification of intrinsic and extrinsic factors.

Background

Pressure injuries (PI) cause significant pain, resulting in longer hospital admissions. The incidence of PIs is reportedly between 0.4% to 38% in the acute setting ⁽¹⁾ with a high incidence reported in surgical patients (66%)^(2:3). Despite these figures this population is often overlooked when exploring prevention of PIs ^(3,4).

Purpose of the Study

The aim of the study was to complete a retrospective, descriptive audit of patient hospital records to identify variables that are predictive of PI formation in surgical patients.

Goal

The goal of the study was to identify risk factors associated with the development of PIs in surgical patients with the results informing a larger interventional study.

Research Problem

Few studies have assessed the risk of PI development in patients undergoing surgery. With the development of more complex surgical procedures, and increasing age of patients presenting for surgery, exploring factors that contribute to the development of PIs in the surgical population is required so that effective strategies can be implemented.

Methodology

A retrospective, descriptive study design was used to identify the incidence of the development of pressure injuries of surgical patients identified on a Pressure Injury Prevention Program during their admission to a major hospital in Melbourne. Data was obtained from patient medical history and surgical records.

Results

A total of 35 surgical patients who developed a PI postoperatively were included in the study with 49% were classified as obese with a Braden score of moderate to severe risk (57%). Sixty five per cent developed a Stage II PI with the scarum and heels the most common site of PI development with supine and lithotomy identified as the most common position used during surgery.

Implications for Perioperative Nursing

Prevention of PIs in surgical patients is achievable with identification of risk factors and use of correct positioning devices during surgery, thereby ensuring patient safety, and reducing an adverse outcome of a healthcare admission (5;6).

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PP 034

DEVELOPING NURSING COMPETENCIES: ARE WE THERE YET?

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Keywords: nursing competencies; specialty clinical practice; assessment; psychomotor skills;

Background

The lack of clarity around competence has led to development of assessment tools with a lack of research on competency-based assessment in specialty areas of nursing highlighted ⁽¹⁾. Indicators used to measure competence, including cognitive, affective and psychomotor skills, need to be integrated into the concept if it is used to assess the degree to which the nurse possesses the skill and knowledge to be deemed a safe practitioner ⁽²⁾.

Purpose of the Study

The aim of the study was to examine the validity and reliability of a Performance Based Assessment Tool (PBAT) that was designed to measure clinical competencies and explore demographic factors likely to influence the performance rating of the instrument nurse in the operating suite.

Goal

The primary purpose of the current study was to develop and validate a PBAT describing the performance of the instrument nurse. The second purpose of the study was to explore the reliability of the judgement of perioperative nurses using the PBAT.

Methodology

A quasi experimental design was selected as the methodological approach for this study, to examine the correlation among selected independent and dependent variables ^(3:4).

Results

Fieldwork observations of 32 nurse educators assessing the performance of instrument nurses in the operating suite were used to calibrate the PBAT. Following a revision of tool, which was based on psychometric analysis and value judgement, the performance of an instrument nurse captured in a video-clip was rated by 313 perioperative nurses in Australia and America.

Acceptable reliability estimates were achieved, as well as empirical support for content, construct and criterion validity for the PBAT. In exploring the relationship between the demographic factors of the raters and rating accuracy, only one background factor was found to be significant. A significant difference was noted between the mean scores for the American and Australian subgroups.

Implications for Perioperative Nursing

The results of this study have direct implications for future development and validation of competencies in nursing, including implications for assessor training and professional development.

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PP 035

THE USAGE OF SURGICAL SAFETY CHECKLIST IN TURKISH OPERATING ROOMS

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Keywords: Surgical safety checklist, patient safety, operating room

The surgical safety checklist is intended to give surgical teams a simple, efficient set of priority checks for ensuring patient safety and improving effective teamwork and communication in every operation performed. The surgical safety checklist came into use in some Turkish hospitals when the Safe Surgery Saves Life programme was established. Turkish Ministry of Health adapted the checklist for Turkey and developed videos, books related using checklist in 2011. The usage of checklist is required since 2011 in all Turkish hospitals ^(1,2,3,4,5,6).

The aim of this descriptive study was to investigating the usage of World Health Organization's surgical safety checklist.

The study was conducted between February 2010 – June 2014 with 527 operating room nurses. Data collection was done using a data collection form developed by researchers. The number and percentages were used for data analysis.

In this study 67.7% of the nurses stated that Surgical Safety Checklist are being used in their operating rooms and 60.5% of the nurses stated that nurses are responsible for filling the checklist. 89.0% of the participants acknowledged that personal information of the patient, the surgical site, type of surgery were confirmed before anesthesia. It was additionally affirmed that 85.0% of the nurses approved sterility before incision, 86.3% evaluated equipments. The nurses stated that 87.8% of them count equipments before the patient left the room. 68.3% of the nurses further confirmed that the surgical team evaluated the general condition of the patient after the operation.

Despite of rules related patient safety efforts, this study results show that there are some gaps between practice and protocols.

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PP 036

INVESTIGATING FIRE SAFETY PRACTICES IN TURKISH OPERATION ROOMS

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Introduction

Of all the potential complications of surgery, a surgical fire is perhaps the most extraordinary. A surgical fire is potentially devastating for a patient. Fire has been recognised as a potential complication of surgery for many years.

Although fires in operating rooms (ORs) are rare events, but they usually have serious if not grave consequences. Prevention of surgical fire is ultimately a team responsibility and depends on the surgeons, operating room nurses and anesthesia professionals working together to identify patients at risk and then following safety practices that have been clearly defined.

Aim of Study

The aim of this descriptive study was to investigate fire safety practices in Turkish operation rooms.

Material and Method

This descriptive study was carried out between February 2010 – June 2014 with 487 operating room nurses who attended Turkish Surgical and Operating Room Nurses Association's scientific meetings. A sampling method was not used; all the OR nurses who agreed to participate, were included within the scope of the research. Data were collected during the scientific meetings of Turkish Surgical and Operating Room Nurses Association. Turkish Surgical and Operating Room Nurses Association gives scientific educations related

with "Fire Safety" regularly. The data collection was done prior to association's meetings about Fire Safety which were conducted in Istanbul, Ankara, Izmir, Bolu and Adana.

For data collection, a questionnaire form developed by the researches in accordance with the related literature was used. The form included a total of 47 questions to determine socio-demographic data as well as the experiences related with fire safety practices and fire stuation.

Inclusion criterions were set for study participation among nurses as follows: (1) nurses who consented to participate in the study, and (2) are presently working as an operating room nurse. In data gathering, respondents were approached personally and professionally at the time convenient to them. After a given time, the test questionnaires were recollected. Written permission to conduct the research was obtained from the Ege University Faculty of Nursing Ethics Committee, as well as board of Turkish Surgical and Operating Room Nurses Association. The purpose and details of the study were explained to the nurses and oral consent was provided by all participants.

Data obtained from this research were analyzed using Statistical Package for the Social Sciences (SPSS) for Windows 16.0 software. Descriptive statistics of nurses were presented as number, percentage and mean.

Results

A convenience sample of 487 operating room nurses from several specialty groups, specifically cardiothoracic, neurosurgery, ophthalmology, orthopedic, plastic and reconstructive, general, gynecological, otorhinolaryngology, outpatients, urology and pediatric surgery were the sample held representative of operating room nurses.

The mean age of nurses was 34.73 ± 7.26 (min:19 max:55) and 93% (n:453) of the participants were female. The nursing educational level of the participants included 17.1% diploma graduates, 28.3% associate degree graduates, 54.4% with bachelor or master's degrees.

It was found that participants have 1 to 34 years nursing experience with mean of $14.25\pm$ 7.94 years and 1 to 34 years operating room nursing experience with the mean of $9.85\pm$ 7.78 years. Majority of the nurses (53.2%) were working at Ministry of Health hospitals.

It was found that 83.2% of the nurses check all the equipment prior to patient use, 79.3% do not allow skin preperation solutions to pool on or around patient, 86.0% prevent any kind of contact between electrical equipment and liquids. 79.1% of them ensured that the patient was covered after the skin antiseptics dried out. But only 48.9% of the nurses ensure that oxygen is not accumulating beneath drapes. 87.1% of the patients stated that the cautery plates were placed so as to assure the best contact with the patient's skin. Also 89.1% of the nurses stated that they are padding the patient from contact with metal. Every member of perioperative team has responsibility for fire prevention. In our study it's found that the majority of operating room nurses pull their weights for fire prevention. AORN advocates that prevention begins with awareness of the issue and education specific to fire risk reduction strategies. Every perioperative team member including nurses should be required to participate in educational offerings on surgical fires. But our results indicate that only 62.4% of the operating room nurses were educated about fire safety. Literature indicates that there has been no repository for statistics on incidence of surgical

Interfault e indicates that there has been no repository for statistics of incontrol of sufgical fires. Based on a literatur review, it is estimated that in the US up to 100 minor surgical fires occur annually. It was found that 10.3% of the operating room nurses had an experience of fire situation. The majority nurses that experienced fire in operating room stated that the leakage of electricity caused the fire. 40.9% of the nurses stated that their patients had experienced burn injuries. It was found that the most common region of burns was upper extremities.

Conclusion

It was found that the nurses carry out the fire safety practices while incidents of fire and burns still occurred, though rarely. With the abundance of high energy surgical ignition sources, flammable surgical materials, and the potential for open oxygen sources, the hazard of surgical fire is clearly still with surgical team. A team approach, including nursing, anesthesia and surgery members, should be used in assessing fire safety in the operating room. It's recommended that institutional policies should be implemented to ensure fire safety in operating rooms.

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PP 037 A.SCIENTIFIC RESEARCH

DIFFERENT MUSIC INTERVENTIONS IN PATIENTS DURING DENTAL IMPLANT SURGERY: EFFECT ON ANXIETY AND PAIN LEVELS

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Keywords: Dental Implant, Music Therapy, Anxiety and Pain

This purpose of this research was to investigate the effects of different music on anxiety and pain levels in patients during dental implant surgery.

The study was consisted of a total of 90 patients. Patients were listened Clasic Music (30 person), Turkish Classic Music (30 person). And the last 30 person weren't listened music. They were voluntary patients (40-60 years of age) in dental clinics of a university hospital. It was taken permission to conduct research from all patients and from the hospital.

We selected same education levels of patients whose implanted 3-6 in surgery with same anastesia for homogeneity in research . And there weren't morbid obesity in them. Experimental groups were listened music during implanted.

Data were collected by the socio-demographic, scale of state-trait anxiety (SF 36), visual analog scale (VAS) . SF 36 and VAS scale was applied all of patients before preoperative and postoperative terms. Experimental groups were interviewed about surgery. (When we find all results we will send your internet system).

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PP 038

FILLING RATE OF SURGICAL SAFETY CHECKLIST AND OPINIONS OF HEALTHCARE WORKERS

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Keywords: Surgical Safety Checklist Filling, Opinions of Healthcare Workers

This purpose of this retrospective research was to determine filling rate of surgical safety checklist and healthcare workers from 2011. Opinions of healthcare workers were interviewed about surgical safety checklist. (When we find all results we will send your internet system).

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PP 039

A.SCIENTIFIC RESEARCH

EVALUATE MASTERS THESES WRITTEN IN TURKEY IN THE FIELD OF OPERATING ROOM NURSING, WITH PARTICULAR REGARD TO THEIR METHODOLOGY AND CONTENTS.

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Objective

Developments in health sciences and nursing specialization in order to increase knowledge have become mandatory. This specialization is in the field of operating room nursing. This study was planned to evaluate masterstheses written in Turkey in the field of operating room nursing, with particular regard to their methodology and contents.

Method

This studyused the descriptive method. The raw material for the study consisted of 40 masters theses that were available online, in full text and summary form and prepared between 1997 and 2012 in the field of operating room nursing. The Turkish Higher Education Council (YOK) National Thesis Center database was used for the study (accessible at www.yok2.gov.tr). During the coding process thetheses were categorised by university, title and profession of the thesis advisor, completion time, study type and data collections tools.

Results

The majority of the theses (65.8%); were written between2010 and 2012, at Marmara University (38%), in the Department of Surgical Nursing (65.5%);In 48.3% of cases, the supervisor's title was professor of nursing and in 86.3% of cases, it was general professor. The time period for thesis preparation was 1-9 months (mean average of 3.78 months). The theses were examined in regard to content and methods and consisted of entirely quantitative research (100%) and descriptive studies (86.2%); the statistical methods were non-parametric tests (48.3%) and questionnaire forms were used (75.9%) for themajority of thetheses . In our study, no statistical difference (p>0.05) was found between groups, in relation to thetitle of the thesis supervisor, the research type of the thesis, data collection methods, statistical analysis and the number of centersat which the study was performed.

Conclusion

Our research was limited to our access to the full text of the theses that were present at YOK national thesis center database.

PP 040

A.SCIENTIFIC RESEARCH

A COMPARISON OF FACTORS AFFECTING JOB SATISFACTION OF NURSES IN OKI AHOMA PUBLIC HOSPITALS WITH HOSPITALS' RECRUITMENT AND RETENTION PRIORITIES

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This study examines the external and internal job satisfiers, as defined by the research models of Herzberg and Maslow. By applying these models to service occupations, is it possible to predict what nurses' identify as important, their perceived job satisfaction and reported intention to stay or leave a current job? Maslow examined how people satisfy needs in relation to work and noticed a pattern of needs and satisfaction that people follow in sequence (1943). In Maslow's theory, a person could not go to the next level until the preceding level is met (1943). This study shows by applying Maslow's theory to a nurse's job satisfaction, organizations can help nurses obtain all levels of need which creates satisfaction and the intention to stay in a job. Similarly, Herzberg defines motivation or satisfaction of workers by the job itself (1959). If organizations' would focus on the internal job satisfiers while providing fair market external satisfiers, the nurse will perceive the job as satisfying and influence their intention to stay. Methodology: The purpose of the study was to describe environmental/external and motivational/internal factors identified by RN's with experience in public hospitals in Oklahoma and their relationship to perceived job satisfaction. The study used descriptive, quantitative methods to perform data analysis. Instrumentation: A researcher-developed questionnaire based on a modification of recent nursing surveys by Hayes, O'Brien & Duffield (2006), Lacey & Shaver (2002) and additional questions added by the researcher. Findings: Nurses in this study placed the highest marks for the relationship and perception of the role of their manager's leadership ability. All responses by the Oklahoma nurses on the survey were consistent with the theories of Maslow and Herzberg and support a conclusion that these motivation theories are useful in explaining and predicting nurses' perceptions of important job satisfaction factors in this study and intention to leave a job.

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PP 041

A.SCIENTIFIC RESEARCH

QUALITY OF LIFE FOR PATIENTS WITH ARTERIO-VENOUS ULCER: A SYSTEMIC REVIEW

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Background

Arterio-venous ulcers are caused by peripheral vascular diseases. The main aims of the leg ulcer care are to relief of pain, prevention of limb loss, improving the quality of life. The nursing care which is given to improve the quality of life of leg ulcer patients is very important.

Goal/Purpose

The purpose of this study was to systematically identify and analyze the available evidence related to quality of life for patients with arterio-venous ulcer and nursing care of them.

Methods

This study was a systematic review of published literature. The search strategy included 5 online bibliographic databases: Cochrane Database of Systematic Reviews, CENTRAL, PUBMED, WOS, SCOPUS and Science Direct. The inclusion criteria consisted of primary research reports thatassess quality of life for patients with arterio-venous ulcers and nursing care of them, written in the English languages, published articlesbetween the years of 2004 and 2014. Key words and subject headings related to arterial, venous, ulcer, quality of life, and nursing were identified prior to initiating the search.

Results

A total of 2,256 titles including arterial, venous, ulcer, quality of life were identified through database searches. Also, 571 articlesincluding "nursing" wordwere retrieved. Of the articles retrieved, 8 satisfied the inclusion criteria. Three of these 8 articles were duplicated and, they removed from this study. Five final reports includedcross-sectionalsurvey (n:2), randomized controlledtrial (n:1), observational study (n:1), two evidence-based pathways design (n:1). Total sample of these articles was 764. According to results of these studies, it was found that patients experienced wound-related pain, itchingetc.(1,2) In these studies, SIP68, SF-12,EuroQoL 5-d have been used as quality of life for leg ulcer. Our study shows that studies be not enough about quality of life for leg ulcer. Our study should be carried out.

PP 042

DOCUMENTATION OF NURSING ACTIVITIES IN DANISH OPERATION ROOMS -A OBSERVATIONAL STUDY INTO DANISH PERIOPERATIVE NURSES PRACTICE OF DOCUMENTATION

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Keywords: Documentation, Observational study, Patient safety

Background

Documentation of nursing activities is recognized as an important factor to ensure continuity, quality of patient care and patient safety ⁽³⁻⁷⁾. Furthermore, documentation is essential for communication between nurses and other professionals ^(6.8). However, there

are no recommendations in Denmark for documentation of the nursing activity in the operating room (OR) $^{\scriptscriptstyle (B)}$ and documentation is not carried systematically out $^{(7-12)}$.

Purpose of the study

To investigate what and how the perioperative nurses document their practice of nursing activity in the OR.

Goals

To gain knowledge of the perioperative nurses' challenges in relation to documentation in their practice at the OR.

Research problems

What kind of documentation does the perioperative nurses do? When do they make the documentation and who makes it?

Methodology

Observational studies in gynaecological surgery departments in two different hospitals in Denmark where 64 observations were performed.

Theoretical framework

J. Spradleys theories on Participant observation and Ethnographic interview has been used (13,14). The epistemological foundation of the study is critical realism.

Results

The preliminary results indicate that there are three main challenges for the perioperative nurses in the Danish OR. 1) The system of documentation does not capture their perception of the essence of nursing. 2) Documentation in the OR is challenged by different perspectives of time, which leads to limitations concerning the nurses' options for documentation. 3) There is an understanding among the nurses that documentation is a necessary evil which removes them from the technical, instrumental and other nursing activities. This understanding contributes to the restricted attention on documentation.

Implication

Knowledge on challenges in nurses 'documentation activities in the OR can enable development of the perioperative nurses skills and improve the patient safety.

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PP 043

A.SCIENTIFIC RESEARCH LIMITATIONS OF A QUALITY PERFORMANCE MEASURE

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Keywords: perioperative hypothermia, safety, evidence-based practice

Background

Quality performance measures have been implemented in order to improve the quality of patient care and patient outcomes. Yet, compliance may not result in positive outcomes. In the United States, The National Quality Forum has endorsed the performance measure Perioperative Temperature Management. ⁽¹⁾ Compliance may be achieved by using active warming intraoperatively or by achieving normothermia near the end of anesthesia. Compliance may actually be achieved by using forced air warming incorrectly and

without maintaining normothermia. The aim of this study was to determine to what extent compliance with this measure is congruent with normothermia.

Methods

A retrospective review was undertaken of patients undergoing surgery with general or neuraxial anesthesia during a 48-month period of time. Inclusion criteria were: surgery duration =/> than 60 minutes, general or neuraxial anesthesia, and admission to the Post Anesthesia Care Unit (PACU). The Iowa Model of Evidence-based Practice to Promote Quality Care (2) was used as a theoretical framework.

Results

10,673 patients were included in the study. 5.8% of patients for whom the quality performance measure was met were hypothermic upon admission to the PACU. The greatest gaps between compliance with the measure and normothermia were found in Urology (8.5%) and Orthopedics (7.7%).

Conclusions

A focus on compliance with quality performance measures is inadequate to achieve positive patient outcomes.

Implications

Perioperative nurses should focus on comprehensive implementation of evidence-based practices, report rates of normothermia in quality improvement reports, and continously strive toward 100% normothermia.

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PP 044

A.SCIENTIFIC RESEARCH

THE SENSITIVITY OF RADIOFREQUENCY TECHNOLOGY FOR THE DETECTION OF SURGICAL SPONGES

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Keywords: safety, sponges, radiofrequency, surgical counts, surgery

Retained surgical items (e.g. sponges, needles, and instruments) occur in an estimated 1:5500 surgeries.¹ These serious adverse events result in negative patient outcomes, including reoperation^{2,3}, readmission/prolonged hospital stay^{2,3}, and infection or sepsis². Sponges account for 48-69% of retained surgical items.¹⁻³ and cause a more serious tissue reaction than metal items. Current standards for prevention of retained surgical sponges rely heavily on manual counting, an ongoing process requiring attention throughout the procedure.⁴ A retrospective review found the sensitivity (ability to identify a sponge is retained when one is retained) of surgical counts to be 77%.5Radiofrequency (RF) technology has been introduced to evaluate for the presence of a retained surgical sponge. We present the results of two original research studiesevaluating the sensitivity of the 1) RF wand and 2) the RF mat in morbidly obese subjects.

Objectives

To evaluate the sensitivity of a RF wand and a RF mat for detection of surgical sponges through the torso of subjects of varying body habitus, including those with morbid obesity.

Method

Two separate prospective, crossover, and double-blinded studies wereconducted. Subjects served as their own controls. RF sponges were used in a ratio of 3 RF sponges to 1 control. Study 1: Subjects were supine. Four spongeswere sequentially placed under the subject's torso, in locations approximating abdominal quadrants. The torso was scanned for sponges using a RF wand. Study 2: Subjects were supine on top of an RF mat. Four surgical sponges were sequentially placed on top of the subject's torso. The torso was scanned for sponges using the RF mat. In a subset of these subjects, the RF wand was also used for detection in a manner used for study 1.

Results

Study 1: 210 subjects were enrolled, 101 with morbidly obese. 840 readings were taken with the RF wand. There were no false positive or false negative readings. Sensitivity and specificity of detection of the RF sponges through the torso of subjects of varying body habitus were 100%.

Study 2: 203 subjects, 129 with morbidly obese, enrolled in Phase I of the second study. 812 readings were taken with the RF mat. A subset of 116 subjects was also enrolled in Phase II, which included 464 readings taken with the RF wand. There were 12 false negatives readings with the mat, exclusively in very, morbidly obese subjects. Sensitivity and specificity of the RF mat were 98.1% and 100%, respectively. In the subset of 116 subjects in whom the RF wand was also used, the sensitivity and specificity of the wand were both 100%

Conclusions

The sensitivity of RF sponge technology is much higher than that of surgical counts (77%) ⁵ or published findings of intraoperative radiographs (67%) ⁵ for retained sponges. The RF wand is more sensitive than the mat in morbidly obese subjects. References

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PP 045

A.SCIENTIFIC RESEARCH

THE HIDDEN COSTS OF RECONCILING THE SURGICAL SPONGE COUNT EX: RECONCILING THE SURGICAL SPONGE COUNT: STEPS TAKEN, RESULTS AND COSTS

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Background

Retained surgical items (RSIs) are serious adverse events that can result in negative patient outcomes. The negative outcomes associated with RSIs are substantial and include medical complications requiring additional treatment, medico-legal ramifications and their respective associated costs. Sponges are the most common RSIs. The primary method to prevent retained surgical sponges is the surgical count. Reconciling the count can be time consuming, pulling personnel away from other high priority activities, thus extending the duration of surgery. The objective of this study is to estimate the time and cost required to reconcile surgical sponge counts to prevent retained surgical sponges.

Study Design

This descriptive study quantifies the time, steps involved, and cost associated with reconciling a surgical sponge count or ruling out a retained sponge. A retrospective review was undertaken of patient surgeries during a nine-month period of time in the operating room of a large, academic hospital.

Results

13,322 patient surgeries were reviewed. 212 surgical sponge counts required additional time for reconciliation. 88% of these searches resulted in a correct count. The following steps were taken: sterile field searched, non-sterile areas searched, surgeon notified, wound searched, and additional assistance requested. The time required for these searches ranged from 1 to 90 minutes. The total annualized cost of searching for missing sponges and ruling out the presence of a retained sponge using radiography was \$218,326.

Conclusions

Time spent searching for sponges draws the attention of personnel and the surgeon(s) away from other high priority tasks and decreases the efficiency. The cost of this time should be included in cost analyses when considering adjunct technology to supplement manual counting.

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PP 046

MICROBIOLOGICAL FINDINGS IN PRESERVATION FLUID OF VASCULAR ALLOGRAFTS

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Keywords: vascular allografts, preservation solution, contamination, infection

Introduction

Most transplant centers keep vascular allografts harvested during the multiorgan procurement procedure, for use when needed to facilitate organ implantation. At our center, vascular allografts are kept in University of Wisconsin (UW) preservation solution (PS) and stored at 4° C for up to 2 weeks.

Objectives

The incidence and significance of bacterial and/or fungal growth in the allograftpreservation fluid varies widely between different studies (1-3). The aim of the study was to determine the incidence of bacterial and/or fungal growth at our institution, and the correlation between PS contamination and the risk of transmission of infection to the recipient.

Methods

From Mars 2010 to May 2013, in a prospective study, a total of 434 consecutive microbiologic cultures were obtained from the PS collected from storage boxes for vascular allografts. The samples were collected either when the box was opened in relation to graft retrievement for use in a recipient, or before the box was discarded due to the time-limit (two weeks). The OR nurse use antiseptic procedures and sterile equipment when collecting samples, to prevent contamination of the vascular allografts and the samples taken.

Results

Vascular allografts from storage boxes were used in 150 patients. Microbiological cultures obtained from these were positive for bacterial growth in 5 boxes (3.5%). While the microbiological cultures from the remaining 284 storage boxes showed bacterial growth in 13 (4.6%). There was no growth of fungi in any of the samples. None of the 5 patients receiving a vascular allograft from a box with a positive bacterial culture, developed clinical infection with the current bacteria.

Conclusion

These data suggest that bacterial or fungal contamination of vascular allografts procured from deceased multiorgan donors are rare, and that the risk of infectious transmission from donor to recipient is minimal when using antiseptic procedure during the sample collection.

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PP 047

A.SCIENTIFIC RESEARCH

THE GENERATIONAL DISTRIBUTION OF NURSES WORKING IN A UNIVERSITY HOSPITAL

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Keywords: Nurse, Generational Differences

Groups made up of people who were born in the same years, have experienced the conditions of the same period and therefore bear similar responsibilities to each other are known as generations ⁽¹⁾.

Due to generational differences, the demographic features of workers are changing, and the obedient workers of the past who were content with very little and accepted authority without question are being replaced by a workforce who are more informed, are not content with very little, question when necesssary, have different expectations and requirements and value their free time ^(2,3).

When individuals from different generations work together, there are effects on management styles, communication techniques and organisational and individual performance ⁽⁴⁾.

Aim

This study aimed to establish the generational distribution of the nurses working in a university hospital and to determine effective management policies according to the results.

Materials and Methods

This was a qualitative study carried out at the Ege University Medical Faculty Hospital between 1-15 January 2014. The data were obtained from information held in the Hospital Information Management System.

Results and Conclusion

The data obtained showed that the minimum age of the nurses was 21 (n=1) and maximum was 61 (n=2), 98% (n=1269) were women and 2% (n=26) were men, and that 39.3 % (n=509) were from Generation X (1965-1980), 55.3% (n=716) were from Generation Y (1981-2000) and 5.4% (n=70) were from the Baby Boom Generation (1946-1964). When the generational distribution of nurses according to departmentwas considered, it was determined that 55.4% of nurses working in surgical departments and 58.9% of nurses working in internal medicine departments were from Generation Y. An examination of the generational distribution of nurses according to clinics revealed that 92.7 % (n=51) of nurses working in the Emergency Department, 76.1 % (n=51) of nurses working in the Anaesthesia Clinic and 72.4% (n=113) of nurses working in the Children's Health and Diseases Clinic were from Generation Y, while 80% (n=8) of nurses working in the Radiation Oncology Clinic and 56.3% (n=9) of nurses working in the Skin and Venereal Diseases Clinic, were from Generation X.

Results

It is recommended that the characteristics of workers are considered in determining human resources management policies, and that a general atmosphere is created which integrates differences.

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PP 048

A.SCIENTIFIC RESEARCH

PRESSURE ULCERS PREVALENCE IN ORTHOPEDIC PATIENTS

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Keywords: Pressure ulcers, orthopedic surgery, nursing care

Introduction and Purpose: Pressure ulcers is a kind of localized tissue damage condition which occurs in the skin and subcutaneous tissues, caused by pressure, friction, laceration and several other factors. Pressure ulcers is considered a major health problem by health care institutions throughout the world. This situation is especially important when it comes to surgical and bedridden patients. Because pressure ulcers affect patients' quality of life and increases health care costs. This is a retrospective research which aims to determine the prevalence of pressure ulcers in orthopedic patients.

Materials and Methods

The research is retrospectively planned on a total of 100 patients who were admitted to the orthopedic clinic of a university hospital in the past. As part of the study, medical files of 100 orthopedic patients were examined retrospectively. Obtained data were recorded on the data collection form developed by researchers. Numbers, percentage, mean and Chi-square test were employed in the research.

Results

The average age of patients is found to be 58.27 ± 15.40 (min: 22, max: 83). 56.9% of patients were female. 81.4% of patients were suffering from coxarthrosis and 65.7% of them were found to have underwent total hip arthroplasty. The average hospitalization time of patients was 14.17 ± 8.63 days. Their average preoperative hemoglobin value was 12.04 ± 2.03 . It was also found that 54.9% of patients were suffering from a chronic disease. Braden scale score average of patients was 19.84 ± 1.24 . It was observed that 20.5% of patients (n=21) had developed pressure ulcers during their hospitalization period. Regarding these cases, 7\% were found to have occurred in the gluteal region while 5% were found to have occurred in coccyx. 10.8% of pressure ulcers were found to be at stage 2 while 9.7% were found to be at stage 1. No statistically significant correlation was found between development of pressure ulcers and age, hospitalization period, diagnosis and chronic illness conditions of patients (p<0.05).

Conclusions and Recommendations

Research shows that 20.5% of patients admitted have developed pressure ulcers. Pressure ulcers development is primarily associated with nursing care. Given these statistics, it was concluded that the amount of patients who develop pressure ulcers cannot be considered a small number. Thus, it can be suggested that, in order to prevent pressure ulcers, nursing care initiatives to be improved and recent literature on the topic to be followed.

PP 049

A.SCIENTIFIC RESEARCH

PATIENTS WITH UROSTOMY: QUALITY OF LIFE AND EXPERIENCED PROBLEMS AFTER THEIR DISCHARGE

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Key words: Post-discharge problems; Quality of life; Radical cystectomy; Urostomy

Surgical outcomes of cystectomy continue to improve, but this is not enough to eliminate all physical, psychological and social problems that the patients experience after discharge and to impact their quality of life positively. Therefore, urostomy, which can negatively impact on health-related quality of life (HRQOL), requires physical, functional, psychological, and social adjustments (1,2,3). The aim of the study was to determine the experienced problems and quality of life of urostomy patients. The data of this cross-sectional and descriptive study was gathered from 17 patients who underwent first and elective radical cystectomy and ileal conduit in one university hospital. Data was collected by using two forms and "Short Form-36 Quality of Life Scale (SF-36)". Number, percentage, mean, standard deviation, the Kolmogorov-Smirnov test, t-test and ANOVA were used for data analysis. The mean age of patients was 64.76 ± 8.81 . Majority of the patients in the study were male (94.1%). It was found that many patients experienced constipation (82.4%), problems related to incision site (64.7%), fatigue (58.8%), myalgia, limitation of movement and difficulties with changing stoma pouch (52.9%). The patients who experienced problems got lower mean QOL scores than patients who did not experience any post-discharge problems. In conclusion, urostomy patients experienced many physical and psychological problems after discharge which affected the patients' QOL. It is recommended that Wound Ostomy Continent nurse services are established in each hospital in Turkey.

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PP 050

AN EXAMINATION OF FEAR OF FALLING, PAIN, ANXIETY AND DEPRESSION AFTER ORTHOPEDIC SURGERIES

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Keywords: Fear of Falling, Anxiety and Depression, Postoperative Orthopedic Surgeries.

Introduction

Due to difficult mobilization and severe pain after orthopedic surgeries, patients experience fear of falls and do not want to walk^{1, 2}. Anxiety about a loss of functional independence increases the fear of falls. Fear and unwillingness to walk affect the quality of life and lead to restriction of daily life and self-care activities, social isolation and depression^{1, 3}. It has been reported that depression, history of falls, the quality of life and perceived health status in addition to the female gender and advanced age are risk factors of falls^{4, 5, 6}. Fear of falling (FoF), in particular, seems to be an important psychological factor, which may have an even greater influence on functional recovery than pain or depression. Fear of falling which results in avoidance of activities, can lead to social isolation and reduced quality of life, and may be risk factor for future (recurrent) falls^{11, 12}. It has been noted that among individuals who fall, there is a high percentage (40-73%) who have a fear of falling. It has also been reported that up to half of older adults who have never fallen have a fear of falling^{9, 10}. Fear of falling, whether or not related to a previous fall, can have a major impact on older adults. Fear of falling may be a reasonable response to certain situations, leading elderly persons to be cautious, and can contribute to fall prevention through careful choices about physical activity¹⁰.

Aim of study

to investigate fear of falling, pain, anxiety and depression after orthopedic surgeries.

Methodology

This is a descriptive and cross-sectional study and data were gathered with Patient Descriptive Characteristics Form, Likert Scale for Fear of Falling, Brief Pain Inventory⁷ and Hospital Anxiety and Depression Scale⁸ in Orthopedics and Traumatology Inpatient Clinic of a university hospital between February 2014 and June 2014. The sample included 61 patients undergoing arthroplasty and surgery for vertebrae and lower extremities and accepting to participate in the study.

Fear of Falling

The simple question, Likert scale response pattern (i.e. "not at all afraid," "slightly afraid,""some what afraid," and "very afraid") to reflect the degree of fear.

Brief Pain Inventory

Brief Pain Inventory - Short Form (BPI): multidimensional instrument that uses a 0-10 scale to rate the following items: pain intensity; interference of pain with the patient's walking ability, daily activities, normal work, social activities, mood, and sleep. The patient assesses his/her pain in the last 24 hours at its worst, at its least, on the average, and right at the time of form completion.

Hospital Anxiety and Depression Scale

This is a validated questionnaire, which has been designed to screen for anxiety and depression in the general hospital setting. The scale was designed to be used in patients with physical illness, omitting physical symptoms, which therefore have no direct effects on the scores. It contains two seven-question scales: one for anxiety and one for depression. The score for each scale ranges from 0 to 21. Each question has four possible answers (scored 0-3).

Ethical approval was obtained from the ethical committee and permission was obtained from the hospital administration.

Results

The mean age of the patients was 58.03 ± 18.94 years, the mean pain severity in the last 24 hours was 4.5 out of 10 and 49% of the patients had total knee prosthesis. Fifty-one percent of the patients experienced fear of falling, but 15% did not (Table 1.)

Table 1	. Demographics	Characteristic and	General	Assessment	Data	of the	Patients.
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Characteristic		n	%
Sex	Women	45	73,8
	Man	16	26,2
Education	Literate	13	21,3
	Elementary	39	63,9
	High school	6	9,8
	High education	3	4,9
Living arrangement	Alone	8	13,1
	With Other	53	86,9
Operation	Total Hip Replacement	15	24,6
	Total Knee Replacement	30	49,2
	Spinal Surgery (scoliosis, LDH)	8	13,1
	Tibia/Fibula Fracture Repair	8	13,1
Fall Number	One	23	20.5
	Two	54	48.2
	Three	31	27.7
	Four	1	0.9
	Five	1	0.9
	Six	2	1.8
Likert Scale for	Ever	15	24,6
Fear of Falling	Light	8	13,1
	Sometimes	7	11,5
	Very	31	50,8
Total		61	100

The mean anxiety and depression scores were 11.80+3.42 and 10.26+2.25 respectively. Fifty-three point two percent of the patients were at risk of anxiety and 89.1% were at risk of depression. There was a statistical significant, moderate positive relation between fear of falling after surgery and mean anxiety scores (r:0.54, p<0.001) and mean depression scores (r:0.44; p<0.001). Seventy-one point two percent of the patients noted that their pain decreased after taking analgesics. There was a statistical significant weak positive relation between fear of falling after surgery and pain severity and effects of pain on functional status (r=0,33; p<0.001). However, there was not a difference in fear of falling after surgery between the patients having an experience of falling and those without a falling experience. The results of this study will contribute to orthopedic nurses' attempts to develop strategies for prevention of fear of falling after orthopaedic surgeries and mobilization of the patients early after surgery, which can reduce duration of healing and hospital stay, prevent social isolation and improve the quality of life. Although a causal relationship between depression and fear of falling cannot be inferred from cross-sectional studies, it is likely that fear of falling can lead to activity restriction or social isolation, which then results in depression in the elderly¹³.

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PP 051

HOW OPERATING ROOM NURSES OBTAIN KNOWLEDGE IN SLOVENIA

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Keywords: perioperative nursing, operating room nurses, education

Background

Perioperative nursing (PN) in Slovenia doesn't have an outlined course in the education system (1) and study programmes don't meet the needs of operating room nurses (OR nurses) for specific knowledge (2, 3, 4). OR nurses gain knowledge directly on the job, when ⁴. Such methods of gaining knowledge don't provide the OR nurses with an appropriate certificate which proves that these nurses are competent to perform their work (3), and is also not in accordance with the education curriculum for the European operating room nurses (5).

Purpose

The purpose of the survey was to determine the conditions for delivering the contents of perioperative nursing at work.

Method

OR nurses - mentors (n = 40) from five medical institutions in Slovenia were included in the survey. A structured survey questionnaire contained a 4-level Likert scale on which the interviewees evaluated nine conditions for delivering the Perioperative nursing contents (1 - very poor, 4 - excellent). The conditions were divided into four categories - time, space, teaching aids and literature, mentorship. The data were analysed with descriptive statistics and a one-way analysis of variance.

Results

The survey shows that the conditions for delivering perioperative nursing content are poor. The interviewees gave the best marks to foreign literature (M = 2.58). Statistically significant differences between institutions in the evaluation of the conditions exist in the evaluation of the literature in the Slovenian language (p = 0.012) and in a foreign language (p = 0.022).

ConclusionsThe results of the survey underline the necessity to introduce the Perioperative nursing education programme in Slovenia which will be in line with the educational curriculum of the European Operating Room Nurses Association.

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PP 052

B. PERIOPERATIVE/CLINICAL PRACTICE

TOTAL KNEE PROTHESIS: CONVENTIONAL ANCILLARY VERSUS SPECIFIC ANCILLARY TO THE PATIENT

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Keywords: Specific ancillary to patient, the total knee prothesis, multipurpose ancillary resterilisable, partial specific cutting guides, définitive implants, ergonomics, MRI, Scanner.

During the past few years, the total knee prothesis surgery (TKP) has progressed a great deal. This has lead to the creation of new and accurate ancillaries which allow more efficient operating results. Since 2012, the orthopedic operating team of Pr Anract of the Cochin Hospital of Paris, France, has started a study on specific knee prothesis ancillary for patients requiring knee operations.

This new generation of ancillary is conceived according to the specific designe (MRI/ Scanner) of the patient's knee. Actually, the cutting guides are partially specific to patients. The future evolution is to have total specific cutting guides. The conventional ancillaries are multipurpose, sterilisable, numerous and heavy to handle.

But this new option of instruments allows to have less number on containers to manage, therefore less sterilization which optimizes the storage space. During the operation, the OR nurse has better ergonomic gestures. A gain of operating time may be noticed.

In the near future, will the OR nurses haveonly one sterilisable container of knee ancillary with total specific cutting guides for patients requiring total knee operations, instead of the numerous containers that they have actually?

Key points

A new generation of instruments, less number of ancilleries, economy in the cost of sterilization, gain of surgical time and better precision in the cutting guides, better ergonomic gestures for the perioperating nurses, optimal management of the storage of implants.

Field of interest

New génération of instruments for the total knee prothesis. Gain of surgery time and more accurate guiding cuts. Optimal storage of the ancillaries and better ergonomics for the operating staff.

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PP053

B. PERIOPERATIVE/CLINICAL PRACTICE MEASURES TAKEN BY OPERATING ROOM NURSES TO PREVENT SURGICAL SITE INFECTIONS ORIGINATING FROM OPERATING ROOMS

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Keywords: Surgical Site Infections, Surgical nurse, Protection.

This descriptive study has been carried out with the aim of determining the measures taken by operating room nurses to prevent surgical site infections (SSIs) that originate from operating rooms, from November 2009 to January 2010. The study included 110 nurses from three University Hospitals in Istanbul.

A surgical site infection (SSI) is an infection that develops within 30 days after an operation or within one year if an implant was placed and the infection appears to be related to the surgery. They also place a financial burden for the national economy on the healthcare system by extending the patient's length of stay in hospital and therefore they are one of the major problems of surgery.

The research data was collected from a survey that was created under the guidelines of the literature review. In the analysis of the data, Cruscal Wallis, Mann Whitney-U and chisquare tests have been used.

20% of the nurses reported taking time off when they had dermatitis, 83.6% had received

Hepatitis B shots, 97.3% cared for their individual hygiene, 98.2% dressed appropriately for the operating room, 42.7% changed their operating room clothes on a daily basis, 97.3% always wore mask and bonnet in the operating room, 90.9% followed the aseptic technique and 91.8% carried out surgical hand scrub with the appropriate technique and time. Hair removal at the operative site was performed in the operating room (50%) by the staff (55.5%) with a razor (65.5%) at the nearest time to surgical intervention

The surgical team members and institutions should take appropriate action to help prevent SSIs from occurring. The nurses have the greatest responsibility in the prevention of SSIs in the operating rooms. It is a part of the nurses' duty of care to recognize these risks and reduce them to the best of their ability.

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PP 054

THE INVESTIGATION OF EARLY MOBILISATION TIMES OF PATIENTS AFTER SURGERY

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Keywords: Postoperative, Early Mobilisation, Surgical Nursing.

Introduction

Early mobilisation in the postoperative period is important for prevention of many complications in patients.

Aim

This study was planned as a descriptive study with the aim of investigation of early mobilisation times of patients which had surgery operation.

Materials and Methods

Population of the study consisted of patients (n=131) who stay in the General Surgery clinics and had an operation of one University Hospital and volunteered to participate in the research. Data were collected between 27 January - 30 June 2014. Ethic approval for this research was taken from Scientific Ethics Committee of Ege University Faculty of Nursing. The data were collected by face to face meetings using a questionnaire developed by researchers. The questionnaire was applied to the patients when they firstly walked after surgery and early mobilisation times were evaluated in the first 72 hours after surgery. Data analysis was performed using the program SPSS for Windows 18. Numbers, percentages and means were used in data evaluation.

Findings

It was observed that the mean age of patients was 50,61 \pm 17,12 and 61,8% of them were female. It was found that 66,4% of the patients had day surgery and 85,5% of them were administered general anesthesia. It was determined that 84,7% of the patients firstly walked in the first 24 hours, 12,2% of them firstly walked in the range of 24-48 hours, 0,8% of them firstly walked in the range of 48-72 hours and 2,3% of them didn't walk in the range of 0-72 hours after surgery because of 02 treatment.

Conclusions

Importance of early mobilisation has been emphasized in Enhanced Recovery After Surgery and preventing circulatory problems for many years. It was concluded that the majority of patients walked in the first 24 hours, in the clinical practices with this research.

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PP 055

B. PERIOPERATIVE/CLINICAL PRACTICE DAY SURGERY PATIENTS' PAINS AFTER SURGERY

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Keywords: Postoperative Pain, Day Surgery, Surgical Nursing.

Aim

This study was planned as a descriptive study with the aim of day surgery patients' pains after surgery of one University Research Hospital in Turkey.

Methods

The research population; Population of the study consisted of patients (n=265) who had day surgery of one University Hospital and volunteered to participate in the research. Data were collected from 01 Jule 2013 to 01 September 2014.

The research data

The data were collected by face to face meetings using pain scales of Nursing Care Forms of Day Surgery. In this study, how many times pain controls were done after the acceptance of the patients to the postoperative units and the intensity of pain were examined pain classified as 0-No pain, 1-Mild pain, 2-Distressing pain, 3-Severe pain, 4-Horrible pain and 5-Excruciating pain. Data analysis was performed using the program SPSS for Windows 18. Numbers, percentages and means were used in data evaluation.

Findings

When evaluated descriptive findings of patients; it was observed that the mean age of participating patients to study was 37,16±17,69 years and % 41,1 were female, and % 58,9 were male. It was determined that pain evaluations of the patients were at least 1 times, at most 10 times and the mean of 3,78 times; the intensity of pain observed in patients after surgery were at least 0 points (0-5), at most 4 points (0-5) and the mean of 0,57 times. After the acceptance of the patients to the postoperative units, it was determined that % 77,7 of patients expressed their pain score was 0 point, % 1,1 of them had 1 point, % 9,8 of them had 2 points, % 9,1 of them had 3 points and % 2,3 of them had 4 points.

Conclusions

We have obtained data about treatment of pain which is considered as the fifth sign of life quality in patient care were statistically significant.

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PP 056

DAY SURGERY PATIENT'S RECOVERY AFTER ANESTHESIA

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Keywords: Recovery Situations, Day Surgery, Anesthesia, Surgical Nursing.

Objective

This study was planned as a descriptive study with the aim of investigation of recovery (Alderate Scale) after anesthesia for day surgery patients.

Methods

Type of study: The population and sample of this study was consisted of 265 patients who had day surgery at Orthopaedic Clinics of one University Hospital in 01 Jule 2013-01 September 2014.

In the research, the data were collected by total of recovery scores which were just in after the operation and in discharge period in the day surgery patients applied anesthesia with general, spinal, local, regional block and sedation. In Alderate numbering system has five sections such as respiration, circulation, consciousness, color and activity in the post-anesthesia care of the patient's. The total is 10 points. Data analysis was performed using the program SPSS for Windows 18. Numbers, percentages and means were used in data evaluation.

Findings

When evaluated descriptive findings of patients; it was observed that the mean age of participating patients to study was 37,16±17,69 years and % 41,1 were female, and % 58,9 were male. It was found that anesthesia was applied to the day surgery patients such as % 14,3 of them had the general anesthesia and 11,3 of them had other methods, % 66,0 of them had regional block, % 4,9 of them had local and % 3,4 of them had local and sedation. After anesthesia recovery scores (0-10 points) include of respiration, circulation, consciousness, color and activity of patients were determined the average score was 8,82 when the acceptance of the patients to the postoperative units and 8,30 at discharge.

Conclusions

The investigation and evaluation of recovery situations after anesthesia for day surgery patients give us more reliable information about recovery situations and discharge of them.

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PP 057

B. PERIOPERATIVE/CLINICAL PRACTICE KEEPING TEAMS ENGAGED: SURGICAL SAFETY CHECKLIST

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Keywords: Engagement; Surgical Safety checklist; interprofessional teams

Background/purpose/goal

The Safe Surgery Saves Lives initiative was established to reduce the number of surgical complications and deaths across the world. The surgical safety checklist (the checklist) is intended to give surgical teams set of priority checks for ensuring patient safety and facilitate communications in each operation performed. The checklist was launched at the Auckland District Health Board as a part of the initial pilot in August 2009. Since this time the process has matured and morphed. The goal of this project was to look at the attitudes towards the checklist and to improve and reduce barriers to the use of the checklist.

Methodology

Through observation and interviews behaviours and attitudes were measured. We learned that some staff are becoming blasé about the checklist. Staff routinely are only using components of the checklist. Disapointlingly most personnel are not seeing the checklist as a team tool to facilitate teamwork communication and ensure patient safety; rather they see it as a compliance document that individuals and some teams feel accountable for. This perception is driven by a number of factors. This presentation discusses the experience at Auckland City Hospital which aims to improve engagement and effectiveness of the checklist. Various challenges and successful stratergies will be discussed that have had an impact on nursing care provision and that of the interprofessional team. The impact of this project is improved attitudes to the checklist, decreased errors and patitent care and staff teamwork have both ibeen enhanced.

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PP 058

CONSIGNEE MATERIAL: WHERE AND HOW?

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Introduction

Rapidly developing technology and increasing power of knowledge have led quick

developments in healthcare sector. Especially, big investments are required to get these new technologies that are used in surgery methods and surgery equipment. Therefore, instead of purchasing these new technologies, loaning them becomes the issue. These applications are generally used in surgical interventions of departments such as orthopedics, neurosurgery, cardiovascular surgery, and totrhinolaryngology, and they are named as consignee material (Cömert 2014, Gürel 2007, NZSSA Guidelines). The word consignee is French originated, and defined as sales done through a commissioner. It also refers to giving materials to external buyers, of which sale will be done later (Biyan, 2008). Lastly, consignee materials are also defined as patient and case specific loaned materials that will be billed when they are used(Cömert 2014, CFPP 2013). These materials are patient specific, such as prosthesis, surgical kits that are specific to surgical operations, and other technological devices (Bryan, 2008); Cömert, 2014). Moreover, these materials are generally not available in the stock, and thus, they are ordered depending on specific case of patient. For patient safety, certain procedures must be determined for the management of consignee materials.

For the surgery materials that are not economic in terms of purchasing, special procedures must be developed. Organizations may lead to increase in rework and de-contamination risks due to their lack of knowledge about these materials (CFPP, 2013). Basic steps in the management of consignee materials are: procurement of the material through communicating with lender firm, delivery and control of materials by operating room staff, sterilization and doing necessary controls of materials before the surgery, doing control of materials after surgery, and giving material back to lender firm (WHC, 2008).

Systems, which help tracking consignee material used patient throughout the decontamination process by developing extensive content lists of these materials and instruction manuals, must be developed. Absence of the awareness related to the control requirements of consignee materials may lead to certain surgical and safety concerns such as time (time limitations related to controlling, washing, packaging, and sterilizing the material), traceability (not monitoring and tracking the kits prepared by the firm), education (lack of knowledge of the staff in operating room unit and sterilization unit), and documentation (absence of washing and sterilization instructions, de-contamination certificates). Moreover, these problems may also cause to delay of the treatment of patient, even to cancellation of treatment (WHC, 2008; NZSSA, 2009; CHRISP&TC, 2013).

Aim

This study was done to define consignee material management processes in operating rooms of a private hospital in Istanbul and a training and research hospital in Izmir.

Methodology

This study was done in descriptive and retrospective manner. Universe of the study is formed by the planned-operations between January (2014) and June (2014) within hospitals' operating rooms, which belong to public and private healthcare groups in Turkey, and sample of the study is formed by the operations, in which consignee materials were used. Necessary permissions were taken from relevant organizations, and data were gathered retrospectively. Descriptive statistical methods were used to analyze the data.

Findings

Between January (2014) and June (2010), 18.204 operations were done within the hospitals in this study, and in 902 (%4.95) of these operations, consignee materials were used. Rates of consignee material usage according to the surgical fields were found to be as orthopedics (%83.1) and brain surgery (%14). Consignee material usage according to the surgical field is shown in Table 1.

Table 1: Consignee material usage according to the surgical field

Surgical Field	Number (n)	%
Orthopedic	750	83,1
Brain Surgery	126	14,0
General Surgery	2	0,2
Thoracic Surgery	1	0,1
Otorhinolaryngology	16	1,8
Urology	7	0,8
Total	902	100

It was found that contacting consignee material lendercompany was done by doctors (%79,4), operating room nurse (%8.5), and scrup and circulating nurse (%5.9). In addition, it was found that surgical team was informed by the doctor (%99.6). Finally, it was determined that %75.1 of this contact were made one week before the operation. Rates of pre-surgery contact time are given in Table 2.

Table2: Rates of pre-surgery contact time

Pre-surgery contact time	Number (n)	%
One week before	677	75,1
One day before	204	22,6
2-6 hours before the surgery	20	2,2
During the surgery	1	0,1
Total	902	100

It was found that %96.9 of the materials used came one day before the operation, and %3.1 of them came 2-6 hours before the surgery. %73.1 of the materials were received by sterilization nurse, and consignee material recipients were given in Table 3.

Table 3: Consignee Material Recipients

People Received the Consignee Material	Number (n)	%
Sterilization Nurse	659	73,1
Nurse on Call	118	13,1
Operating Room Nurse	70	7,7
Scrub-Circulating Nurse	44	4,9
Warehouse Attendant	7	0,8
Sterilization Technician	4	0,4
Total	902	100

It was determined that inventory count of the all materials was done, the content was checked, and all the materials were recorded by controlling their expiration date. Moreover, it was found that before the surgery, all the materials were sterilized (%100), and steam (%98.1), hydrogen peroxide (%1.6), and ethylene oxide (%0.3) were used for sterilization. Furthermore, it was seen that technical support was received from lender company (%87.7), and %98.6 of the materials were not sterilized after surgery. For the management of materials, rate of not using barcode was found to be as %76.8, and it was found that only %23.5 of the materials were recorded when they were given to their lenders.

Discussion

Even though the new developments, technological applications, and decrease of invasive techniques in recent years have made consignee material use in orthopedics and other surgical fields ordinary, it is necessary to develop standards related to management of consignee materials (AORN, 2012). There has been a significant increase in use of consignee material in surgical operations through the developing technologies in surgery, especially orthopedics (WHC, 2008). In this study, orthopedics surgeries constitute %83.1 of the total consignee material used surgeries.

Problems related to consignee material procurement process and use cause to concerns in sterilization departments. In order to ensure patient safety, consignee material lender must fulfill its legal obligations related to use of consignee material. There must be a reliable procedure about consignee material control (WHC, 2008; CHRISP&TC, 2013). General problems related to consignee material management are incorrect material, not coding of materials, absence of control lists, absence of official documents, insufficient information, inconvenient delivery of materials, and application of inappropriate procedures to consignee materials before and after surgery due to the lack of time. As a result of these problems, delay or cancellation of patients' treatment may occur (WHC 2008, NZSSA 2009, CHRISP&TC 2013). There was not a standard control list in the hospitals in this study, whereas consignee materials were only recorded during their delivery. The recipient controlled consignee materials sets, however a control list or something like that did not used.

Consignee materials may create health and security problems. Some of the problems are being heavy and voluminous, having sharp sides, not having wheels in carrying case, and contaminated materials' threat of creating potential infection for patients and employees. Problems related to carrier are based on that unavailability of parking area next to the delivery point, absence of direction signs about delivery point, and not expecting consignee material by sterilization unit.

The reusable circle of consignee materials is based on that first consignee materials are obtained through either purchasing or loan, then they are cleaned and disinfected through new techniques that make toxins ineffective, they are inspected by protein testing and then packaged by scrup nurse or by lender firm, sterilized, transported to relevant place, stored to warehouse, used, and finally re-transported (CFPP, 2013). Sterilization of the consignee materials given to the healthcare organization is compulsory. Consignee materials, before using them, should not be sterilized by flash steam (NZSSA 2009, CHRISP&TC 2013). In line with the literature, it was found that flash steam sterilization was not advised in the hospitals in this study, whereas in %98.1 of the cases steam method was used for sterilization.

Control and record of consignee materials that will be used in surgical operations with higher risks are done by medical personnel. These records must be usable for independent investigation when it is needed, and, at least, a detailed list of the materials in the set must be developed. For the hospital, except the emergencies, appropriate information about process, time and date must be obtained from lender, date and time information of the operation must be stated (operating room, sterilization unit, and warehouse), and patient identities, whom consignee material is used, must be tracked through record by not violating the patient privacy (CFPP, 2013; NZSSA 2009, CHRISP&TC 2013).

For the lender firm, correct checklist must be developed, delivery of consignee materials 24 hours before the surgery must be achieved, and appropriate packaging of the materials for transportation must be done. Moreover, materials that return from hospital must be checked, and sterilization unit must be informed immediately in the case of inconveniency, and related information about using, cleaning, packaging, sterilization of returning materials must be obtained. These processes must be based on written instructions, rather than verbal instructions (NZSSA 2009, CHRISP&TC 2013).

Organization of each consignee material that will be used by surgical team is done within operating room. Surgical nurse must contact with relevant firm for procurement of consignee material needed (WHC, 2008). Ideal time for contacting with lender is offered as a week before surgery, however, this time might be decreased in the cases of emergencies (WHC, 2008). In this study, in line with the literature, it was found that to a large extent doctor contacts with lender (%79.4) one week before the surgery (%75.1). Consignee materials must be delivered to operating room sterilization unit 48 hoursat the latest before to the surgery, except with emergency cases (WHC, 2008). In this study, in parallel with this argument, it was found that delivery of consignee materials to the hospital was done 24 hours before the surgery (%96.9).

Moreover, sufficient time for cleaning, sterilization, and packaging of consignee material before the surgery is needed (minimum 3 hours, maximum 6 hours) (NZSSA, 2009). According to the literature, it is recommended that delivery of consignee material must be

done 4-24 hours before the surgery in order to appropriately complete checking, washing, packaging, and sterilization processes (WHC, 2008). In this study, for emergency cases, consignee materials are delivered to hospitals 2-6 hours before the surgery.

In the literature, it is advised that the weight of the consignee material obtained from lender should not exceed 8 kilograms (WHC, 2008). Surgeon must check the material before the surgery. If it is needed, necessary information about using, cleaning, and sterilization of the material must be given by lender firm personnel to operating room personnel and sterilization unit staff (WHC, 2008). In this study, it was determined that in %87.7 of the cases, in which consignee materials were used, necessary support from lender firm was taken. Consignee materials must be given back to lender firm 24 hours after the surgery. Moreover, if the procedures and instructions in the guideline are not followed, disturbances in operating room may occur, which then lead to surgery delays or cancellations (WHC, 2008). After their use, consignee materials are cleaned and sterilized, and their de-contamination and sterilization documents are obtained, and appropriate packaging must be done for their transportation to lender firm (NZSSA 2009, CHRISP&TC 2013). Material codes must be indicated clearly (CHRISP&TC 2013, NZSSA 2009). In this study, electronic codes of consignee materials are clearly indicated and recorded into registration system; however, rate of putting consignee material label during sterilization is quite low (%23.2).

Detailed checklists of consignee materials must be developed, and they are not accepted if there is missing, deficient or inappropriate material (not appropriate in terms of heat or time). In addition, if there is dirt or residuals on the accepted consignee material, it must be reported to the lender firm (NZSSA, 2009; CHRISP&TC, 2013). For the hospitals in this study, consignee materials were checked and recorded; however, this kind of checklist was not seen.

Conclusion

Even though there are some differences in terms of consignee material management processes of the hospitals, both hospitals defined consignee materials and developed acceptance standards. Training programs, which involve all operating room staff and sterilization unit staff, related to consignee material management and controlling must be developed, information related to changes and content features must be updated, and guides must be used when organizational policies are developed. Future studies may concentrate on detecting problems in steps of consignee material use and patient safety.

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PP 059

B. PERIOPERATIVE/CLINICAL PRACTICE

STOP, CHECK AND LISTEN: MONITORING STAFF ADHERENCE TO THE SURGICAL SAFETY CHECKLIST AND MEDICATION SAFETY POLICIES IN THE OPERATING ROOM

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Promoting evidence-based and best practice in the clinical setting ensures optimum outcomes for surgical patients. The role of Operating Room leaders is to develop policies and procedures that are in line with current research studies and operating room standards. A large tertiary hospital in downtown Toronto decided to conduct an audit to determine how well staff adhere to identified policies and procedures of the OR. This mentorship project was done in collaboration with University of Toronto Lawrence S. Bloomberg Faculty of Nursing from January – March 31, 2014.

The two hospital policies Surgical Safety Checklist and Medication Safety were chosen as the priorities to be audited. The specific policies and procedures were reviewed and audit tools were created in consultation with the OR Patient Care Manager. Data was collected by a graduate student working with the OR APNE utilizing direct observation throughout the entire surgical procedures in Orthopedics, General Surgery and Plastics/Hand. The information gathered was then collated and presented in spreadsheets and graphs.

The results indicated that adherence to the policies and procedures vary considerably among practitioners in different surgical services due to various reasons.

Making the stakeholders aware of their current practice versus what is ideal and what is the rationale behind the best practice evidence will foster engagement in the change process. Increased adherence and awareness of the importance of the policies will aim to decrease intraoperative errors, thereby promoting patient safety and preventing adverse outcomes in surgical patients.

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B. PERIOPERATIVE/CLINICAL PRACTICE

MALIGNANT HYPERTHERMIA: AN ETERNAL CHALLENGE FOR THE PERIOPERATIVE NURSE. ACHIEVING A POSITIVE OUTCOME FOR A GENE POSITIVE 10 YEAR OLD ADMITTED FOR ELECTIVE SURGERY

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Keywords: Malignant Hyperthermia, surgery, perioperative nursing

Background

Malignant Hyperthermia (MH) is a rare life threatening, acute event in genetically susceptible individuals. It is triggered by many of the agents used in anaesthesia including volatile inhalation anaesthetic agents and depolarizing muscle relaxants. In individuals where MH is clinically present significant morbidity and/or mortality can occur. It is for this reason that gene studies are undertaken, and steps can be taken to prevent the occurrence of MH.

Purpose

This case study presents an overview of Malignant Hyperthermia and the manner in which the theatre was prepared for a 10 year old patient who was gene positive for MH. The ultimate aim for the care of all patients who come through the Operating Suite, including those with the propensity to develop clinical MH, is that their surgery and recovery is uneventful. Understanding the triggers and the pathophysiology is vital in securing a positive outcome. Preparing the theatre for a patient who has had a family history of MH and is gene positive for MH requires a team approach. It also requires thorough communication, and meticulous preparation of the staff and equipment in the Operating Room.

Methodology

A Cinahl search and a review of hospital policy were undertaken. An interview with the patient and her mother and a review of all documentation in her hospital file was also undertaken with consent of the mother.

Results

The positive affect that teamwork, preparation and understanding of the triggers and pathophysiology had achieved a positive outcome for this patient.

Implications for Perioperative Nursing

Although MH is a rare event and perioperative nursing staff may or may not be aware of the patients' propensity of developing MH, all perioperative nursing staff must be aware of the effects and treatment of the condition in order to achieve a positive outcome for their patients.

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PP 061

OBSTRUCTIVE SLEEP APNOEA: AN ANCIENT CONDITION, ITS' EVOLVING MANAGEMENT AND SURGICAL TREATMENT IN THE 21ST CENTURY

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Keywords: Obstructive Sleep Apnoea, CPAP, Snoring, surgery

Background

Obstructive Sleep Apnoea (OSA) is a serious breathing disorder affecting around 4% of the population. Although OSA has only been recognised as a distinct condition since the mid 1970's records of symptoms such as heavy snoring can be traced back 2000 years. Knowledge and understanding of OSA has developed markedly since the 1970's and in the 21st century there are many treatment options. The gold standard of treatment remains Continuous Positive Airways Pressure (CPAP) but many are unable to tolerate this and surgery becomes an option.

Purpose

This paper investigates the current surgical treatment options for those with OSA, as treatments options continue to evolve. Those who do manage CPAP may also require surgery unrelated to OSA and are encountered by the perioperative nurse in anaesthetics, surgery and in the Post Anaesthetic Care Unit (PACU). There is no one surgery for OSA and one or a combination of specialties may be required for treatment.

Methodology

A literature search methodology was undertaken utilising Cinahl, Medline and google. Searches under the terms: 'Obstructive Sleep Apnoea'; 'Obstructive Sleep Apnoea' and 'Surgery'; 'Obstructive Sleep Apnoea' and 'history' were undertaken.

Results

There is no single surgery available for all patients as obstruction can be due to varying pathologies in the upper airway. Surgeries include Bariatric, Ear Nose and Throat (ENT) and Oral and Maxillo Facial (OMF) specialities.

Implications for Perioperative Nursing

In the 21st century treatment for OSA continues to evolve. OSA presents a multiplicity of issues for the perioperative nurse. These include anaesthetic and post anaesthetic management as well as existing and evolving surgeries which the perioperative nurse must be familiar with.

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B. PERIOPERATIVE/CLINICAL PRACTICE

RECURRENT CHOLESTEATOMA, FROM THE SIMPLE EVOLVING TO THE INVASIVE DISEASE: A CASE STUDY OF THE SURGICAL INTERVENTION IN A 21 YEAR OLD FEMALE

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Keywords: Cholesteatoma, otology, mastoidectomy

Background

Cholesteatoma is a proliferation of epithelial cells and granulation formation and is associated with otitis media. It can be either congenital or acquired and frequently occurs in the external auditory canal (EAC) but can also occur in the middle ear. It is easily treated by the surgical removal of the cholesteatoma and granulation tissue and may or may not recur. When untreated the cholesteatoma may erode auditory structures and invade the mastoid bone requiring mastoidectomy.

Purpose

The purpose of this paper is to investigate the progress of a recurrent acquired cholesteatoma in a recalcitrant patient who frequently refused to attend outpatient or surgical appointments. It spans the years from when she was 9 years old and the first cholesteatoma was diagnosed until she was 21 and requiring a mastoidectomy. Her outpatient appointments with her surgeon, begin from when she was 3 years old and continue through to the present and are integral to the surgical outcome.

Methodology

A Cinahl and Medline search utilising the terms, 'cholesteatoma', mastoidectomy' and 'surgery', as well as a review of all documentation in her hospital file was undertaken.

Results

Cholesteatoma is easily treated by surgical removal of the cholesteatoma and granulation tissue, it may reoccur if untreated. When untreated the cholesteatoma may erode auditory structures and invade the mastoid bone requiring mastoidectomy. The subject of this case study required a modified radical mastoidectomy.

Implications for Perioperative Nursing

Although the removal of a Cholesteatoma is often thought of as a minor procedure, the perioperative nurse must understand that untreated it can cause significant morbidity. Understanding of the pathophysiology of cholesteatoma, and its progression if untreated will increase the knowledge base of the perioperative nures and in turn improve clinical management.

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PP 063 **B. PERIOPERATIVE/CLINICAL PRACTICE** A DETERMINATION OF POST-OPERATIVE NAUSEA AND VOMITING IN PATIENTS

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Keywords: Surgery, nausea, vomiting, postoperative

It has been reported that post-operative nausea and vomiting can cause aspiration, opening of wounds, an increase in post-operative hospital stay, unwanted re-hospitalization, a delay in return to normal daily life activities, and a loss of time for patients and those close to them. Postoperative nausea and vomiting has been reported to cost several million dollars yearly. The present work was planned as a descriptive study with the purpose of determining the state of post-operative nausea and vomiting in patients.

The population of the study was the patients who had been operated on in the General Surgery Department of a university hospital, and the sample consisted of patients who had been operated on there between 1 January and 30 March 2014, and who consented to take part. Data collection was performed using a form of 33 questions on sociodemographic characteristics and nausea and vomiting.

Data evaluation by computer made use of numbers, percentages and chi-squared statistical methods. The sample for the study consisted of 158 patients. It was established that 17.2% of the patients who participated andwho had had cholecystectomy operations experienced vomiting and 51.7% experienced nausea.

Our findings are similar to those in the literature. Taking into account preoperative and postoperative risk factors, nursing care should plan for nausea and vomiting. It is recommended that studies be conducted on more patient groups in different fields.

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B. PERIOPERATIVE/CLINICAL PRACTICE

CHANGES IN INTRA AND POSTOPERATIVE MANAGEMENT OF THE CHILD WITH HIPOSPADYAS

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Keywords: Hypospadias, bandage, urethral stent.

Definition

We define hypospadias as an anomaly of the penis and urethral meatus, which opens the ectopically in the ventral penile area.

The urethra may be open at any distance from the most distal part, which would be, the more proximal glans would be the scrotal area. Depending on the position of the meatus we define:

- HIPOSPADIAS Penile:
- -- DISTAL: 1/3 distal penile include
- -- MEDIUM: includes the middle third of the penis
- -- PROXIMAL: proximal third
- -- PENOSCROTAL: I meatus in the crease between the penis and scrotum
- -- PERINEAL: located in the perineum
- HIPOSPADIAS CORONALES O subcoronal:

Located in the balanopreputial zone (frenulum)

HIPOSPADIAS GLANULAR: In the glans itself

Hypospadias is associated with a degree of ventral curve curvature known as "chordee".

Consequences

Affects 1 250-300 RN and this rate increases to 10% if the brother suffers and 25% if also the progenitor. It seems that exogenous hormones in pregnancy increases the likelihood of development of hypospadias.

Surgery for three main reasons required:

- FUNCTIONAL: Imposibilidad To urinate standing urination is done sitting, as girls. The management of urinary stream is directed to toe. If the meatus is narrow urination is painful.
- SEXUAL: The curvature prevents penetration, painful erections and inability to fertilization.
- AESTHETIC: Trace psychological disorders: anxiety, shame, isolation

In this paper we show that combining the different surgical techniques (Snodgrass technique, Braka, Dunlay, etc...) along with variations applied to the priests who performed intraoperatively we:

- --Benefits FOR CHILD
- --Benefits FOR PARENTS --Increased EFFICIENCY

Cures clasicas

Classically affected children with hypospadias are operated at the age of 3--5 years, not least because the penis is larger and is thought to improve vision of the surgical field. Postoperative of these children includes:

- Being bedridden 5-7 days
- -- Probing type Foley
- -- Bulky bandage is removed the 3rd-4th day
- -- Mechanical fastening
- -- Arco
- -- Daily Cures

This is a traumatic experience for the child and parents.

We are a child contributor little or nothing hindering the actions of the medical staff and nurses more parental stress when the priests, bandages or drilling is performed. The child suffers fear, anxiety, agitation, pain, environment and risk of infections by practicing soundings among others.

Looking alleviate and improve the postoperative comfort and after observing the experience of the intervention, changes were made to the management of these children, seeking modifications to improve the physical and psychological impact.

Changes

- The modifications were:
- Surgical age (6--18 months) ahead
- -- Bandages and probes (Urethral Stent) are changed
- -- Blocking the neurovascular pedicle was performed

Ideal age surgery

Surgical aged 6--18 months is considered, the child still have not defined their sexual identity minimizing the psychological impact.

Supports and probes

Management is simplified probes and bandages.

We left the use of Foley catheters that produce spasms and time of the withdrawal, to deflate the balloon, leaving a crease that damages the newly operated urethra and introduce the use of probes Nélaton or bladder tubes.

No bags are used diuresis. If used we will require the child to carry around the neck or bedrest.

The approach consists of: Replacement of traditional plastic adhesive bandage around the penis remains erect it prevents blood or swelling and the discomfort of friction with the diaper. He retired a week if it has not fallen before.

DO NOT REQUIRE CURES.

Use probes Nélaton cheaper and maneuverable, which used the previously cut taper leaving about 2cm included in the urethra without actually preventing bladder, bladder spasms and discomfort that cause the child to remove a Foley catheter, then, this urethral stent is fixed with a thin spatula 6--0 absorbable suture Monocryl (suturing at 10 and 2 if we looked at a clock) which spontaneously falls to urinate in one or two weeks.

What do we get?

- -- Remove probes connected to bag.
- -- Eliminate cures postoperative day.
- -- Autonomy in the child's mobility, you can walk and go home on their own feet the same day of surgery.

Children perform their normal lives at home the same day of surgery, without further cures and urinating naturally.

They can not sleep face down and re--review a week.

It has been found that if still carries the plastic is almost detached and is easily removed.

Increasing efficiency

As previously noted these children not admitted, had a surgical process that requires admission to turn it into a CMA (Major Ambulatory Surgery).

As current data and to provide, we referred to the comprehensive report of hospitalization, GRD Area Structure costs by GFH in our hospital during 2012 and the data published in the BORM of 01/29/2014.

No further comprises spending this intervention transformed into CMA as such, but clearly as happens most recently, the hospital cost per day of admission to the pediatric surgery unit represents 600 euros.

The transformation of this surgery CMA has improved postoperative quality of these children who have been assessed by a personalized record of the interventions made during 2012, measuring the possible complications that make them return to the hospital and the new management of probes and bandages.

Using these modifications of the 104 hypospadias surgery in 2012, 80 (76%) were discharged the same day of surgery, 10 (9.6%) 24 remained hospitalized, 4 (3.8%) between 2--4 days and 10 children (9.6%) were more than 5 days in hospital. They went to the emergency 20 children (19.2%) but they just 4 They pointed modification or change the dressing. It was found that children with urethral stent consulted least in emergencies and better rested at night that carriers of urinary catheter.

We see that only 20% made any emergency consultation or consultation and that only 4% was necessary to change or modification of the dressing.

Postoperative discomfort

To study reliability check children who had urethral stent compared with those who had long tube in the bladder, so we picked up a number of children and observe:

-- That both groups had the same discomfort during the day, parents referred to as discomfort when urinating.

- -- That the children carrying tube (cone) consulted least emergency.
- -- And that precisely these children had less nocturnal discomfort than carrying tube bladder.

Conclusions

- Therefore as findings show that these changes have contributed:
- -- Improving postoperative comfort the child, parents and medical staff.
- -- To facilitate and simplify the management of these children.

-- Reduce health costs due to early discharge.

Getting a positive impact on results.

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PP 065

PRECAUTIONS TAKEN BY NURSES AGAINST SURGICAL PATIENTS' RISK OF FALLING

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Keywords: Surgical nurse; falling; fall risk; patient safety

Background

One of the major problems of hospitalized patients is trauma due to falls. In order to protect the patients from falling, nurses should be extremely cautious and take the necessary precautions. We aim to determine the precautions taken by nurses against surgical patients' risk of falling.

Method

210 nurses who were working in surgical units of private hospitals, affiliated to the Ministry of Health in Istanbul and not on leave between May-July 2010, and gave their permission to participate in the study were included in the sample group of this descriptive study. Percentage and mean were used for data analysis.

Results

Mean age of the nurses who participated in the study was 27.78 \pm 5.16. 91.4% were female. 93.3% of the nurses were responsible of preventing patient falls. 91% used fall risk assessment scale. 88.1% assessed every patient for risk of falling and 88.6% thought every patient should be assessed. Only 55.7% gave fall prevention education to either the patient or his/her family. Half of the nurses did not know the need to educate the patient who experiences balance issues. (Table 1)

Table 1: Distribution of statements related to fall risk and fall risk assessment (n=210)

Statements	n	%
Do you thing the nurse has a responsibility in preventing patient falls?		1
No	14	6,7
Yes	196	93,3
Which fall risk assessment scale do you use in the department you work in?		
Hendrich II Fall Risk Model	90	42,9
Fall prevention plan of the related institution	103	49,0
None	17	8,1
Do you assess every patient for fall risk in the department you work in?		
No	25	11,9
Yes	185	88,1
Do you believe that every patient should be assessed for fall risk in the department you work in?		
No	24	11,4
Yes	186	88,6
If fall prevention education given to the patient or his/her family in the de- partment you work in?		
No	93	44,3
Yes	117	55.7

Rate of reporting fall incidences were %73.1. 81.3% of the nurses evaluated the environmental risk factors preoperatively. 99% believed that patients who are under antiepileptic medications such as benzodiazepines have to be evaluated for fall risk. 69.9% of the study group did not use a fall prevention plan for disabled patients (Table 2).

Table 2: Distribution of statements of the nurses who use fall risk assessment scales (n=193)

		No	Yes		
Statements	n	%	n	%	
Do you report patient falls to Nursing Services?	52	26,9	141	73,1	
Do you assess environmental risk factors preopera- tively to prevent falls?	36	18,7	157	81,3	
Do you know that patients who experience balance issues should receive balance education?	100	51,8	93	48,2	
Do you think patients using benzodiazepines (Dor- micum, Diazem, Xanax etc.) should be assessed for risk of falling?	2	1,0	191	99,0	
Do you think patients using antiepileptic medications (Neurontin, Epdantoin etc.) should be assessed for risk of falling?	2	1,0	191	99,0	
Do you have a fall prevention plan for disabled patients?	135	69,9	58	30,1	

Discussion

According to Berke and Aslan (2010), the first approach to prevent falls is asking the patient about previous falls and walking and balance problems, determining the associated risk factors and risk assessment. Using risk assessment forms would be helpful in identifying the problem. Kurutkan (2009) states that patient falls can be prevented if the nurses give fall prevention education and use appropriate assessment scales. The 2006 study by Heinze et al concludes that patient falls in hospital environment cannot be eliminated, but can be minimized with efficient preventive measures. The study by Sulla and Myler (2007) states that all healthcare workers should take responsibility in taking the necessary measures to prevent falls and teamwork is mandatory.

In this study, we found that the majority of the nurses use a preventive fall risk assessment scale, 88.1% assess every patient for fall risk and 88.6% believes that every patient should be assessed (even if there is no risk). 93.3% stating that they have a responsibility in preventing patient falls shows that the nurses are sensitive to the topic. This finding is consistent with previous studies. Only 55.7% of the nurses gave fall prevention education. This result is below the expectations. (Table 1)

In a paper published in 1998, Dienemann pointed out that the most important way to identify the errors in healthcare services, minimize them and prevent the patients from getting harmed is to report the errors. While stating the need to report the incidences that jeopardize patient safety, the author explained that error decreasing process is the first step of quality enhancement programs. Tomey (2000) found that unreported medical errors continue to increase nationwide and only 2 to 3% of major errors are reported. Investigation and discussion of the errors leads to learning from them and thus prevents the same errors from reoccurring. Feedback increases awareness and leads to developing systems to minimize risk factors. Therefore, health institutions should encourage their healthcare workers to report unwanted incidences and the reporting systems should be based on voluntariness as explained by JCAHO. In our study, the 73.1% fall report rate suggests that the sensitivity about this issue is low.

In order to prevent falls, environmental factors should be appropriate for patients in both the house and hospital and the necessary arrangements should be done. In this study, we found that 81.3% of the nurses in the study group assessed the environmental risk factors preoperatively to keep the patient from falling. This finding suggests that patient falls is an important issue for the subjects and preventive measures are taken.

Gemalmaz et al (2004) suggested that cerebellar walking disorders emerge as a result of malfunctions in the connections of cerebellum or central nervous system and these patients have trouble keeping their balance standing up and may even fall down. Presence of a balance disorder or disability increased the risk of falling. Tuncay et al (2011) and Terzi and Terzi (2013) found a significant correlation between Berk balance scale and risk of falling.

Half of the nurses in our study group did not know that patients who experience balance issues should receive balance education to prevent falls and did not use a fall prevention plan for disabled patients. These result show that nurses are either insufficient or lack the information in determining and minimizing the fall risk of specific patient groups. Serious measures related to this issue should be taken.

Ensrud (2002) found that neuroleptics, benzodiazepines and antidepressants distinctively affect the central nervous system; there is no significant difference between the short and long acting benzodiazepines regarding the risk of falling. However, long acting benzodiazepines were associated with falling from heights and the dosage was a more significant risk factor. 66.7% of patients who use such medications are under high risk of falling while only 2.7% of patients who don't share the same risk. In their 2001 study, Karatas and Maral suggest that because of side effects like dizziness, confusion and low blood pressure, certain medications can increase the risk of falling; therefore patients should be questioned about all the prescribed and unprescribed medications they have been using and the exact number should be determined. Using more than 6 drugs is found to be an important factor causing falls and the side effects of medications like confusion, disorientation, elimination changes and vertigo are stated to alter walking and movement.

In this study, almost all nurses believed that patients under benzodiazepines and antiepileptic medications should be evaluated for fall risk. This result indicate that the majority of the nurses in our study group have a high level of awareness regarding this issue.

Suggestions

Continuing educational programs regarding risk analysis and fall prevention of in-hospital patients should be arranged for nurses in order to raise awareness of the subject.

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PP 066

B. PERIOPERATIVE/CLINICAL PRACTICE DAILY AMBULATORY SURGERY CENTER PROCESS

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It is a center that patients admitted to the hospital during the day and where the operations are done from discharged inits. In our center there is an anesthesia faculty member, anesthesiology assistant, pre operative staging sick nurse, operating romm nurse, post operative patient care nurse, anesthesia technician. Our center has accepted nearly 5000 patients in 2005, In 2013 our center has accepted 8200 patients In our center, for patients medical candition assessment, American Anesthesiology Associotion patient classification criteria ore used. P atients refer to the center a week aga, In preparation fort he surgery, laboratory examinotions, ECG, radiography, and the investigations are done from doctor needs.

The Criteria for acceptance of patients to our center;

- Informed written permission
- The initiative will lbe completed in 60 minutes
- Application musn't be caused parenterol analgesic pain
- After intervention, not need for intensive care

The Advantages for patients daily Surgery Center Process

- The quality of patients life affect positively
- There is less anxiety for pattents
- The patients risk of infection is low
- Patients odapted normal life more quickly
- Cost is reduced, pricess fall

In our center, circumcision, cystoscopy, vazektemi, prostate, biyopsy, vitrectomy, cataract, strabismus, keratoplasty, epiduroskopi, dsc, Arteriel ven the opening of fistula, adenoid, tonsilektomy mastoidektomy, cervical biopsy, abortion, arthroscopy, carpal tünel, trigger finger, Rhinoplasty, mamoplasti, nevi, cholecystectomy, hemorroids, anal isfis, breast surgerios are done.

PP 067

COMPUTER AIDED SURGERY

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Objective

Trauma surgeons encounter numerous penetrating injuries nowadays. In some cases, missiles causing infection, pain and discomfort, or those retained within joints, bursae and other strategic sites, must be removed. This paper describes an innovative high-tech modality for use in the immediate removal of shrapnel and bullets from strategic anatomical sites.

Methods

Surgical computerized navigation based on real-time acquisition of fluoroscopic data was employed. Several fluoroscopic images of the required anatomical site were obtained. The accurate spatial location of the foreign object could be seen on the images displayed on the computer screen. No further fluoroscopic radiation was necessary. During surgery, the infra-red camera tracked the position of a surgical probe on the patient's anatomy and continuously updated its three-dimensional position simultaneously on all displayed images until the missile's location was reached. The use of this accurate technique in complex and dangerous situations where the foreign body is located in proximity to blood vessels, nerves and narrow 'safe-zones', is promising. This innovative technique reduces surgical time and radiation exposure. In our experience, it has rendered percutaneous missile removal much safer, even in hazardous situations. Intraoperative fluoroscopically based computed tomography, integrated with a navigation system, holds great potential for improving visualization and navigation in orthopedic procedures. Fracture reduction was performed using a fluoroscopy-based navigation system with virtual intraoperative planning software. The system used 4 sets of lines drawn by the surgeon on the fluoroscopic AP and lateral images. While navigating the reduction of the fracture these lines aligned together, providing graphic and numerical descriptions of the reduction. The lines included the anatomic axis of the bone, the matching of the fracture lines. Computerized navigation improves the accuracy of cannulated screw alsoplacement in the internal fixation of femoral neck fractures. It may provide better mechanical stability and improved fracture outcome.

Results

The use of percutaneous fluoroscopic navigation to remove retained metal objects, including bullets and shrapnel, has proved itself in 12 cases as an accurate measure involving reduced exposure to radiation. In contrast to CT- or MRI-based navigation, computerized fluoroscopic navigation does not require long preliminary preparation. Thus, it is highly efficient in the treatment of acute trauma victim

PP 068

NOVEL APPLICATIONS OF COMPUTER NAVIGATION FOR ORTHOPAEDIC TRAUMA – EXPANDED ROLES AND RESPONSIBILITIES FOR OR PERSONNEL

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Objective

We will illustrate the application of Computer Navigation for fracture reduction, percutaneous screw fixation of hip fractures, and extraction of bullets and shrapnel in a Level I Trauma Center. Using these case examples, we will discuss the expanded roles and responsibilities for OR personnel.

Methods

At Hadassah Medical Center in Jerusalem, we have been using Computer Navigation for Orthopaedic Trauma for the past 15 years for a variety of applications. The primary advantages of computer navigation include increased precision of the surgical procedure, reduced radiation exposure for the patient and OR personnel, and improved patient safety.

Discussion

Integration of Computer Navigation into Orthopaedic Trauma Surgery requires planning and teamwork for successful implementation and use. We recommend that all OR personnel participating in Computer Navigation receive appropriate training in use of the equipment to fully understand its use, care and maintenance. In addition, it is very helpful for OR personnel to visit another hospital where Computer Navigation is in use so they can see its practical application. Computer Navigation requires the OR personnel to have a very active role in all phases of surgery. OR personnel must clearly understand the planned procedure so they can appropriately position the patient, themselves, the C-Arm, and the Computer Navigation Equipment for optimal flow of the procedure. OR personnel must prepare the proper equipment used during the procedure and know if the application involves registration of the patient or equipment or both. The surgical plan must be understood prior to beginning the procedure so that OR personnel can anticipate equipment needs during the procedure efficiently. Finally, at the end of the procedure proper care and maintenance of the Computer Navigation must be performed to ensure constant readiness and excellent function of all the components of the system.

Conclusion

We have found Computer Navigation to have multiple applications in Orthopaedic Trauma. The benefits include improved accuracy of the procedure, less radiation exposure, and improved patient safety. In order to successfully implement Computer Navigation in Surgery, it is critical to undertake a team approach and ensure all personnel acquire proper training so they can fulfill their new and expanded roles in the surgical procedure. We have seen in Hadassah increase of enthusiasm of OR personnel by expanding the role of the nursing care.

PP 069

B. PERIOPERATIVE/CLINICAL PRACTICE DISTRESSING THIRST: PERCEPTION OF THE SURGICAL PATIENT

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Keywords: Thirst, Nursing, Perioperative Care, Perception.

Introduction

Thirst is characterized as a symptom experienced by surgical patients, a subjective experience that encompasses biopsychosocial changes in sensation or cognition and classified as a real and intense discomfort⁽¹⁻³⁾.

Objective

To explore the perception of surgical patients regarding perioperative thirst.

Method

Descriptive and exploratory study with a qualitative approach, conducted at a university hospital in the south of Brazil. Sample included patients who reported thirst in the Post Anesthesia Care Unit. The Symptom Management Model Theory was the conceptual framework and the method of the Collective Subject Discourse⁽⁴⁾ was employed for discourse analysis. The proposal was approved by the institution's Human Subjects Committee.

Results and Discussion

Two categories emerged after discourse analysis. The first category, "Describing thirst", encompasses signs and symptoms perceived by patients: dry mouth, parched lips, thick tongue, thick saliva with a bitter taste, dysphasia, dry throat and feeling suffocated. Patients used analogies to describe thirst, such as "having glue in the mouth", "feeling like a camel". Thirst Experience is present in the preoperative, intraoperative and postoperative periods alike. In the second category, "Thirst: an upsetting distress", thirst was described as a factor more distressing than hunger, characterized by craving for water. Amongst coping strategies developed by patients were: sleeping, being silent, swallowing saliva where there was none, getting distracted, rinsing their mouths and devising strategies to bypass nursing surveillance to drink water. Strategies used by the nursing team contemplated watering the mouth, employing damp cotton or ice chips, the latter being was more effective according to patients.

Thirst is a subjective, present and intensive distress in the perioperative period, responsible for triggering feelings of fear and impotence. Implications: Thirst is undervalued and under assessed in clinical practice but should be understood in its complexity and subjectivity in order support individualized care strategies.

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PP 070

PRESSURE ULCER ON INTRA-OPERATIVE OF CRANIOTOMY

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Keywords: Pressure Ulcer, Craniotomy, Intra-operative

Patients undergoing neurosurgery may develop pressure ulcers (PU) on intra-operative. Our objective was to evaluate the incidence of PU in patients undergoing craniotomy. This prospective study was carried out at Hospital Sírio Libanês, São Paulo, Brazil. Patients over 18 years undergoing elective craniotomy surgery lasting longer than two hours and without PU in pre-operative were included. The Braden Scale was performed in pre-operative. After anesthetic induction, the patient was positioned with skin protecting devices. After surgery, these devices were removed and the skin was evaluated in relation to the development, location and stage of the UP. We evaluated 22 patients and all showed greater than 21 points on the Braden Scale in pre-operative. The average age was $51.50 (\pm 14,081)$ years and 50% were male. During surgery, all patients used as skin protective devices for the back a soft foam mattress associated with polymer or pyramid cushion, as well as heel protecting pyramidal cushion, a soft foam cushion with pyramidal cushion for arms and foam pillows for knees. The head was positioned in Mayfield device in 86% patients. Surgical time averaged 229.09 (\pm 124.610) minutes. Concerning surgical risks, 54.5% of patients were classified into risk II, 40.9% risk III and 4.6% risk IV. The surgical position was supine (86.3%) and lateral decubitus (13.7%). At the end of surgery 81% had PU, with 100% grade I. The locations of PU were the scapular region (4.9%), olecranon (40.9%), heels (22.7%), sacrum (22.7%), gluteal region (4.5%) and trochanter (4.5%). This study evaluated the importance of the use of skin protecting devices in preventing PU grade II and III at surgery. This data is of extreme importance and reduces the chances of morbidity and healthcare costs.

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PP 071

OR NURSES APPROACHABILITY AND PRESENCE IN THE OPERATING ROOM MAKES THE DIFFERENCE, WHEN PATIENTS WALK UNACCOMPAGNIED TO SURGERY

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At Rigshospitalet, Universityhospital in the capital of Denmark, mobile, unpremedicated patients are allowed to walk to the surgical theatre without assistance. The aim of this study was to investigate how these patients' experience this type of admission to surgery. The specific goal was to elucidate the factors, which are considered important by these patients in the admission process and thereby to increase the quality of nursing care in the theatre.

Data was collected by qualitative interviews with four patients and analyzed by a model developed by Lindseth&Norberg, who were inspired by the French philosopher Paul Ricoeur. Dataanalysis revealed four main themes, which were further scrutinized through critical interpretation to obtain a deeper understanding.

Four main themes in the process of admission to surgery revealed: Ability to make contact with the staff at arrival to the theatre area, being seen by the nursing staff during waiting time for surgery, inspiration of trust in the nurse-patient relationship inside the operating room and experience of influence on the operation process. The patients were affected by several factors on their way to the surgical theatre for example waiting for the elevator, lack of possibility to make contact to the staff when they first arrived, which the patients felt of great importance. Uncertainty and nervousness were increased when there was waiting time at the surgical theatre balance between uncertainty and coping. Patients had a mainly positive experience of the preoperative periode. The contact with the OR nurses, communication and their commitment are of crucial importance for patients' experiences of the admission to surgery. This study expands our knowledge of patient's needs of perioperative nursing care.

PP 072

B. PERIOPERATIVE/CLINICAL PRACTICE

EVALUATION OF DRESSINGS IN THE CARE OF WOUNDS FOLLOWING ORTHOPAEDIC SURGERY

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Keywords: orthopaedic surgery, wound dressing, blistering

Background

Management of the surgical incision site should focus on minimising wound disturbance, preventing microbial invasion and ensuring patient comfort ⁽¹⁾.

Aims

To compare the performance of different dressing regimes when used on wounds resulting from orthopaedic surgery

Method

Patients (n=201) who had undergone hip or knee arthroplasty (primary or revision) were included in the study and monitored prospectively. The first 100 patients were assigned to traditional dressing regimes (alcohol-soaked gauze and tape / film dressing with absorbent pad). The subsequent 201 patients were assigned to treatment with an absorbent dressing incorporating a soft silicone wound contact layer. The following parameters were assessed in both groups: ease of dressing application / removal; dressing wear time; condition of wound and surrounding skin (evidence of blistering / bleeding / other skin reactions) and dressing-related pain.

Results

The absorbent dressing with a soft silicone wound contact layer was rated higher in terms of ease of application and removal. It was also associated with a longer wear time, and fewer complications (i.e. blistering, bleeding, and other skin reactions). Dressing-related pain was minimal in both treatment groups.

Implications

These findings indicate that dressing regimes vary in terms of their performance on surgical wounds and this factor should be taken into consideration when it comes to dressing selection.

Conclusion

The absorbent dressing with a soft silicone wound contact layer is now considered by the researchers who undertook the study as the dressing of choice for the care of postoperative care of wounds following hip and knee arthroplasty.

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PP 073

B. PERIOPERATIVE/CLINICAL PRACTICE

EVALUATION PEDIATRIC DAY SURGERY PATIENT EDUCATIONAL MATERIALS: TURKISH **EXPERIENCE**

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Keywords: Nursing Document, Instructional booklet, Pediatric surgery nursing.

Day surgery has had a major impact on both staff and patients. Patients experience limited contact with healthcare providers prior to surgery, increased personal responsibilities for perioperative self-care, and early discharge after surgical and anesthetic experiences. Availability of written documents and patient satisfaction is important.

Our pediatric surgery clinic in 2002; "Booklet for the Parents of Patients Undergoing Day Surgery" was prepared for the families, For the children, a coloring book entitled "My Trip to the Hospital," by the American Society of Anesthesiologists (ASA) was translated into Turkish and permissions necessary for its usage were obtained, Usage of the "Day Surgery Nurse Care Form" began for the care of day surgery patients.

"Booklet for the Parents of Patients Undergoing Day Surgery" was rearranged in 2008 in accordance with the modifications in clinic.

In order to examine the availability of documents and patient satisfaction, clinical studies were conducted in different years. These studies "Examination of the quality assurance of day surgery nursing care form (2004)", "The evaluation of booklet for the parents of patients undergoing day surgery by families (2005)", "Investigation of discharge criteria of day surgery in child surgery (2007)", "the evaluation of the painting boxing given to children undergoing day surgery by children and their families (2008)", "Determination of comprehension level of the booklet for training to the families in pediatric surgery clinic $(2013)^{\circ}$

In this article forms and written materials used in day surgery in Pediatric Surgery Unit will be provided with the study results.

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PP 074

B. PERIOPERATIVE/CLINICAL PRACTICE EVALUATION OF PEDIATRIC SURGERY FAMILY DISCHARGE EDUCATION IN TURKEY

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Key Words: Family education, discharge education, pediatric surgery nursing.

Background

Education of family before discharge is a stage which prepares the child and families.

Purpose of Study

The aim of this study is to evaluate the information of hospital discharge education given to families in pediatric surgery

Methods

This descriptive study was done between May 17th - June 30th of 2014. The data were collected by a questionnare applied to families of patients (n=203) treated in the ward. Data analysis was performed using the program SPSS for Windows 18.

Results

The mean age of caretakers of children was found to be 35,31 (STD $\pm 7,01$). It was found that 27,6% had a university degree. Families indicated (100%) that they had education about discharge. This education was given to 92,6% just before discharge and 63,05% stated that it was given by a nurse.

Percentage of families which indicated that they do not need information about drugs was 28,1%; about feeding; 25,6%, about bathing; 22,7%, about behavior changes; 43,3%, about moves of child; 39,4%, about wound dressings; 42,9%, about situations to apply to a hospital; 22,2%, about situations to take care at home; 21,7%, about the beginning to school date; 67%, about control dates; 20,2%

Families scored the education they got in a scale of 1-10. The percentage of families who scored 10 for drugs was 84,2%; for feding; 81,5%, for bathing; 86%, for behaviour changes; 77,4%, for child's moves; 79,7%, for wound dressings; 84,5%, for situations to apply to a hospital; 86,1%, for situations to takecare at home; 83,6%, for the beginning to school date; 83,6%, for control dates; 91,4%.

Conclusion

It was seen that all of the families took discharge education. All of them were satisfied from the education they have taken.

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PP 075

RESPONSIBILITY OF NURSES AT CADAVERIC ORGAN HARVESTING

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Keywords: nursing, cadaveric, responsibility

Organ harvesting is retriveing the organs from the body diagnosed with brain death and donated the organs. Organ harvesting operation aproximately takes 6 to 10 hours of physical and psycological hard work.

Duty of the opeation nurse begins 30 minutes before the donor admitted to the operation theatre if the donor is in the same hospital. The nurse prepares equipments table and back table for perfusion using sterile and waterproof coat. Sterile slash isotonic solution should be kept ready on the equipments table. Skin cleansed with povidone-iodine solution from chin to thigh after patient taken to the operation table and gets covered with sterile gowns while revealing surface of chest and abdomen. If multiorgan removal is planned then a median thoracoabdominal incision is made. Organ retrieval is followed in the order of heart and lung, liver, pancreas, kidneys, iliac vessels, and other tissues (bone, kornea, skin etc). The organs are reperfused at the back table after organ retrieval. Preparing the organ for transport:

- Each organ is packed one by one
- Each one of them are taken into seperate sterile plastic bags filled with the solution according to organ. The solution must cover the organ.
- The first bag is put into the second plastic bag which is fulled with slash solution.
- The second bag is put into the third bag and placed into organ box
- The name of the donor, the name of organ and the side of kidney (left or right) must be written on the organ box.

Responsibilities of the operating theatre nurse end with transportation of the organs.

PP 076

B. PERIOPERATIVE/CLINICAL PRACTICE

EXAMINATION OF PATIENTS' OPINIONS ON OPERATING ROOM NURSING AND ENVIRONMENT DURING POSTOPERATIVE PERIOD

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Key Words. Operating room nursing, operating room environment, Postoperative period.

Aim

The purpose of this study was to determine patients' opinions on operating room nurses and environment during postoperative period.

Material and Method

This descriptive study was conducted using non-probability random sampling method in Atatürk University Aziziye Research Hospital between June 2011 and January 2013. The population was 208 patients, having hernia, femur fracture, and prostate surgery with regional anesthesia betweenJune 2011 and June 2012. 150, 18-year old and older patients, capable to make verbal communication, were included. In additon to questionnaire on patients' descriptive features, 'form for patients' opinions on operating room nursing during postoperative period' and 'form for patients' opinions on operating room environment during postoperative period' formed as per literature were used to collect data. Data were evaluated as number and percentage in categorical measurements and as mean and standard deviation in numerical measurements. Cronbach's α to evaluate internal consistency, and t, F and Kuskal Wallis tests to compare numerical measurements were used.

Results

Nurses' rate was 2.7%- 15.3%, for introducing themselves and environment to patients, informing, protecting privacy, encouraging them to ask and sedating them. Patients' rate was 35.3%-90%, for feeling safe in the environment, getting warm, having good communication, not waiting for surgery, being cared about privacy, and meeting their needs. Difference between descriptive characteristics and opinion mean scores was not statistically significant.

Conclusion

It is asserted that the nurse has roles and responsibilities mainly for assisting the case during intraoperative period; operating room environment is evaluated by patients as being safe and having a good team communication.

In accordance with this conclusion, it is recommended to organize training programs for operating room nurses' duties and responsibilities and continue relevant studies.

INTRODUCTION

Undergoing an operation is a special case in which the individual has a fear of not being able to protect his/her privacy, personal control of the individual decreases, and the individual needs more information and care. Operating room environment can be regarded by the patient, who may have the feeling of isolation and anxiety, as a cold, unknown, and scary place¹. Even if it is for a short time, the individual who will lose his/her control due to anaesthesia needs someone to trust, and care his/her physical, social, psychological, and cognitive privacy instead of him/her^{2,3}. Operating room nurse is legally responsible for providing necessary care at optimum level and meeting his/her needs during the period that individual stays in the operating room⁴. American Nurses Association (ANA), defined the operating roomnurse as "a professional nurse who determines, coordinates, and provides the care by using nursing process to meet diagnosed physiological, psychological, socio-cultural, and spiritual needs of the patients whose self care ability or protective reflexes are potentially under danger because of an operation or invasive intervention"⁵.

However, unfortunately, operating roomnurses take more time to skills such as organising operating room environment, preparing the patient physically for the operation, and helping surgeon during operation than these needs during the perioperative period6. However; when the patient enters to operating room, he/she is frightened and highly stressed. Probabilities such as losing control, obscurity, pain, fear of death, anxiety regarding the change in body structure or function, and disturbance in lifestyle cause anxiety to develop. Moreover, the patients to whom surgical intervention is performed by using regional anaesthesia have such anxieties during the perioperative period since they are consciousand during the waiting period before being taken to the clinic. These fears can increase amount of the anaesthesia and pain level after the operation and affectadversely physiological parameters. These negative situations can cause the operation to be postponed, operation period to extend, and complications to develop during and after the operation^{7,8}. To prevent or decrease these negative situations, it is important for the operating room nurse to adapt to scientific and technological changes, to be aware of the care needs of patients in the operating room, and accordingly to meet individualized care needs of patients^{2,9,10}

What does this paper contribute to the wider global clinical community?

When the studies on perioperative period have been reviewed, it has been determined that they have beenconducted regarding physical environment of operating room such as working conditions^{11,12,13} quality of life^{14,15,16} and training needs¹⁷ of operating room nurses, administrative subjects¹⁸, evaluation of current situation of post-anaesthesia care units in the operating rooms¹⁹, and safe operating room environment²⁰ or regarding effects of operating room environment on nurses. On the other hand, number of the studies mentioningopinions of the patientsabout the intraoperativeperiod is limited^{2,21,22,23}. In the study of Özbayir et al.,²¹ the situations of holding the patients in the operating room and making explanations about the procedures wereexamined. Ter et al.,²⁴ investigated the situations in which the patients felt uncomfortable in the operating room. Leinonen et al.,²² compared evaluations of perioperative care of patients and nurses in 2003. In 2013. Cyclic²³ assessed quality of the nursing care received by patients in the operating room. These studies are crucial in terms of creatingawareness in operating room nurses about how patients evaluate operating room environment and nursing care and shedding light to them on implementing plannings in accordance with this awareness.

The purpose of this study wasto examine the opinions of the on regarding operating room nursing and environment during postoperative period and to make contributions to the awareness about care needs of patients in the operating room.

Materials and method

The study was conducted between June 2011 and January 2013. Population of the study consisted of totally 208 patients (70 operated for hernia (inguinal-umbilical), 72 operated for femur fracture, and 66 operated for prostate) who underwent an operation with regional anaesthesia between June 2011 and June 2012 in the clinics of General Surgery, Urology and Orthopaedics And Traumatology of a university hospital in Turkey. In the study we tried to reach all of the population but 12 of the patients, who underwent inguinal-umbilical hernia operation, 8 of the patients, who underwentfemur fracture operation, and 9 of the patients, who underwent prostate operation, did not accept to participate to the study. Since the researcher could not continually be present in the clinics at which the study was conducted and therefore the patients were discharged earlier than the planned date, we could not reach 29 of the patients. A total of 150 patients, who underwent the aforementioned operations under regional anaesthesia between June 2011 and June 2012, are over 18 years old and literate, and could communicate verbally, were included in the study. 86% of the population was reached.

Instruments

Thequestionnaire on descriptive characteristics of patients, as well as 'Form for patients' opinions on operating room nursing during postoperative period', and 'Form for patients' opinions on operating room environment during postoperative period' which were formed upon literature review were used for the data collection process.

Patient Introduction Form

There were seven questions in the patient introduction form consisting of one section and prepared in line with literature^2.22.25.

Form for Patients' Opinions On Operating Room Nursing During Postoperative Period This form, which was prepared by researcher in line with literature 2,22,25, involved 10 questions with three answer options regarding the opinions of patients about how they evaluatedoperating room nurses after the operation. The answers were assessed as "Could not evaluate" 1 point, "No" 2 points, and "Yes" 3 points. While the highest scoreto be obtained from the form was 30, the lowest score was 1. Cronbach's alpha value of the form was0.75. In this study, the lowest score obtained from the form of Opinions Regarding Operating Room Nursing (ORORN) was 2, the highest score was 20, and the mean score was 15.37 ± 3.73 .

Form For Patients' Opinions On Operating Room Environment During Postoperative Period In this form prepared by Researcher in line with literature 2,22,25there are 13 questions with three answer options regarding the opinions of patients about how patients evaluated operating room environment after the operation. The answers were assessed as "I Don't Agree" 1 point, "I Slightly Agree" 2 points, and "I agree" 3 points. While the highest score to be obtained from the form was 39, the lowest score was 1. Cronbach's alpha value of the form was 0.76. In this study, the lowest score obtained from the form of Opinions Regarding Operating Room Environment (ORORE) was 0, the highest score was 26, and the mean score was 21.24 ± 5.76 .

Procedure

Data of the study were collected by researcher using face-to-face interview technique. In the 1st postoperative day, the patients were visited in the clinic they were staying and they were informed about the purpose of the study and their permissions were taken verbally. Then, data collection forms were executed in their rooms. The implementation of data collection forms lasted about 30 minutes.

Data analysis

Coding and the statistical analysis of the data were conducted by using Statistical Package for the Social Sciences (SPSS) 15.0 statistical software package. Percentage distribution was used for the assessment of patients' descriptive characteristics and ORORN and ORORE forms; measurements of mean and standard deviation were used for mean scores of ORORN and ORORE forms and internal consistency was assessed with Cronbach's **a** reliability analysis. Independent samples t test was used for the comparison of ORORN and ORORE mean scores according to gender; F test for the comparison of ORORN and ORORE mean scores according to the operation the patient underwent; and independent samples Kruskal Wallis test for the comparison of ORORN and ORORE mean scores according to education and the time the patient came to hospital.

When the distribution of descriptive characteristics of patients, included in the sample group of the study, was examined, it was determined that average age of patientswas 52.57 (SD=11.24), 72% of patients were men, 67.3% were married, and 44% were secondary education graduate. 30.7% of the cases were taken to operation in the afternoon and 74.7% of the operations were planned.

Upon examination of Table.1; it was determined that 2.7% of the nurses informed the patient about the environment, 4% introduced themselves to the patient in the operating room; 5.3% called patient with their names; 6% talked to the patient during the operation; 8% protected the privacy of patient, 8.7% encouraged the patient to ask questions; 9.3% provided the needs of patient in reanimation unit; 10.7% calmed the patient down; 11.3% informed the procedures in the operating room, and 15.3% informed the patient about the procedures in the reanimation unit.

Table 1.Distribution of Opinions of the Patients RegardingOperating Room Nurses in the Postoperative Period

	Y	es	No		No Comment	
Operating Room Nurses	S	%	S	%	S	%
introduced themselves to me	6	4	104	69.3	40	26.7
introduced the environment to me	4	2.7	92	61.3	54	36
called me with my name	8	5.3	28	18.7	114	76
informed me about the procedures in the operating room	17	11.3	55	36.7	78	52
protected my privacy	12	8	8	5.3	130	86.7
encouraged me to ask questions freely	13	8.7	28	18.7	109	72.7
calmed down me when I got excited	16	10.7	23	15.3	111	74
talked to me during the operation	9	6	27	18	114	76
informed continuously me about the procedures in the reanimation room	23	15.3	63	42	64	42.7
met my needs in the reanimation room	14	9.3	22	14.7	114	76

When Table.2 is examined, 90% of the patients considered that they were taken to operation table safely; 83.3% stated that their privacy was considered; 82% thought that they acted respectfully towards them; 80.7% considered that their needs were met in reanimation unit; a small rate such as 35% stated that they did not feel cold in operating room.

Table 2.Distribution of Opinions of the Patients Regarding Operating Room Environment in the Postoperative Period

	l do ag	on't ree	l sliq ag	ghtly ree	l ag	ree
In the Operating Room	S	%	S	%	S	%
that I was safe	17	11.3	30	20.0	103	68.7
that the environment was calm	19	12.7	24	16.0	107	71.3
that they acted respectfully towards me	13	8.7	14	9.3	123	82.0
that I did not wait for being taken to operation	24	16.0	33	22.0	93	62.0
that the communication of operating room personnel was good	16	10.7	26	17.3	108	72.0
that I was taken to the table safely	9	6.0	6	4.0	135	90.0
that a comfortable position was enabled for me on the table	8	5.3	11	7.3	131	87.3
that my privacy was considered	9	6.0	16	10.7	125	83.3
that I did not feel cold	26	17.3	71	47.3	53	35.3
that reanimation unit was safe	16	10.7	16	10.7	118	78.7
that reanimation unit was calm	14	9.3	19	12.7	117	78.0
that I did not feel cold in the reanimation unit	16	10.7	33	22.0	101	67.3
that my needs were met in the reanimation unit	11	7.3	18	12.0	121	80.7

When ORORN and ORORE mean scores were compared according to the gender and education level of the patient, type of operation, the time the patient were taken to operating room and whether the operation was planned, the difference between the groups were statistically found insignificant (p> 0.05).

Discussion

Today, it is expected from operating room nurses to approach to the patient in an integrative and patient-oriented way before, during, and after the procedure.26,27lt was determined in this study that majority of the nursesdid not introduce themselves and operating room environment to the patient. In the study conducted byÖzbayr et al.,21 to examine the impressions of the patients regarding perioperative period, it was found that 54.37% of the patients could not distinguish the occupations of the personnel working in the operating room. However, it is one of the duties of the circulating nurse to introduce himself/herself to the patient who come to operating room.28Also, in the study of Özbayr

et al.,21the fact that 21.58% of the patients identifying the operating room with the phrase as "a terrifying place" madeus think that the environment was not introduced to the patient.

One of the foundations of nursing is to have a good communication with the patients. The nurse calling to the patient with his/her name in the operating room makes the person think that he/she is appreciated, to feel safe, and helps to support psychologically by removing their fears. Additionally, calling someone with his/her name means that the person's dignity and uniqueness are respected29,30. In this study, the fact that only 5.3% of operating room nurses calling the patients with their names made us think that an awareness is required to be created in the step of calling a person with his/her name which is the foundation of communication for nurses.

A small rate, 11.3%, of patients who were included within the scope of study stated that the nurses informed them about the procedures in the operating room. In the study conducted by Özbayır et al.,1354.37% of the patients stated that no explanations were made them regarding the procedures in the operating room. Williams31 and Jacobs32determined in their studies that when patients requested information about the procedures in the operating room, they were only informed about the complications of treatment by the physician. In the study conducted by Engström33it was revealed that most of the patients were informed about diagnosis, treatment, the results of treatment and prognosis and the information given to patients were not suitable for the needs of the patient. The studies of Breemhaar et al.,34 and Mordiffi et al.,35 indicated that other medical personnel, including nurses, gave the information they deem appropriate to the patients at a time they deem appropriate rather than patients' needs. The aforementioned literature results are similar to the results of this study.

While a very small rate of the patients, 8%, thought that nurses kept their privacy, 86.7% answered as "no comment" (Table.1). On the other hand, when the opinions of patients regarding the operating room environmentwere assessed (Table.2), rate of the patient who thought their privacy was considered in the environment was 83.3%. It is quite satisfactory to know that patients were feeling as they were protected, but it is also thought-provoking that they could not decide whether those applying this intervention are nurses or not. The reasons of this situation may be most of the nurses not introducing themselves to patient, not explaining the procedures being executed/to be executed, and not conducting nursing services with an individualized care model.

In the studies conducted 36,37it was determined that patients expected from medical personnel to talk in a comforting way, and to show care and toleration towards them. The fact that the rate of patients who stated that nurses were encouraging the patient to ask questions in operating room environment, calming them when they were excited, and talking to them during the operation is low in this study supports the literature36,37. Also, these rates being low also made us to think that individualized patient care was not conducted in the operating room, and nurses were not aware of this duty or they ignored it. On the other hand, the fact that 72.7% of the patients answered to the question about "Encouraging to ask question" as "no comment" and 74% of the patients answered to the question about "Calmed me down when I got excited" as "no comment" made us think that patient does not know the person who talks to and calms down him/her based on the fact that nurses not introducing themselves to the patients. In the study conducted byÇevik23,it was stated that they gave the highest score to the item regarding "Personnel in the operating room talked to me when I got excited in the operating room or the personnel calmed me down by applying sedative" with 4.13 ± 0.77 mean score. In the result of Çevik23 it could be asserted that the mean increased because patients generally assessed the operating room team.

9.3% of patients stating the fact that their needs were provided by nurses in reanimation room made us think that nurses did not perform efficiently in the reanimation unit. In the operating room environment where the study was conducted, the fact that anaesthesia care team member had more efficient role in the reanimation unit may have caused this result. In Çevik's study23it was determined that the mean score of the item "getting continuous information regarding the procedures in the reanimation room"was 2.37 ± 1.51 , which was lower than the other items.

One of the important elements of perioperative nursing is to bring patients into safety23. When the distribution of opinions of the patients regarding operating room environment in the postoperative period was examined (Table 2), most of the patients stated that they felt safe in the operating room environment. Operating rooms with high technological equipment could be environments in which the patients feel safe. In the study conducted by Ter et al.,24 to examine the opinions of the patients regarding operating room environment, 92.5% of the patients stated that they did not feel uncomfortable due to operating room being different environment and they felt safe.

Most of the patients stated that the environment was calm in the operating room. When operating rooms were compared with the clinics by the patients, operating rooms were assessed as calm probably because the operating rooms are closed environments, their entries and exits are under control, and they are working independently from each other because of their architectural structures. In the study of Ter et al., 24 90.8% of the patients stated that they were not disturbed from sound or noise, and 93.3% stated that they did not feel uncomfortable because of the crowd. In the study of Özbayır et al.21it was determined that 71.45% of the patients found operating room traffic normal. Results of all of the three studies are similar. Also, most of the patients thinking that they were behaved in a respectful manner in the operating room was similar to result of the study of Çevik23. Waiting to enter operating room before the operation is an important anxiety reason for the patients38,39. In the studies conducted, it was determined that not being kept waiting before the operation was one of the expectations of the patients from medical team23. In this study, it was determined that 62% of the patients were not kept waiting for being taken to operation in the operating room. In the study of Özbayır et al., 21, 75.73% of the patients expressed that they were not kept waiting in the operating room. Also, in the study of Çevik23 mean score of the item "I did not feel that I had to wait for being taken to operating room more than I should" was found as 2.81±1.18. When it was considered that the highest mean was 4.13±0.77, it could be asserted that this rate is around 60% in the study of Çevik.

In this study, 72% of the patients stated that the communication of the personnel working in the operating room was good. In the study of Özbayır et al.,21 79.61% of the patients indicated that the communication of the personnel working in the operating room was good with each other. In the study of Çevik23mean score of the statement "personnel in the operating room performed concordantly with each other" was found as 3.70 ± 0.93 . When it was considered that the highest mean score was 4.13 ± 0.77 , it was observed that this rate was more than70% in the study of Çevik23.

In the nursing care process of the patient in the operating room, it is required to transport the patient to the operation table safely, take him/her on the table and maintaining a comfortable position on the table for the patient. In this study most of the patients stated that they were taken to the operation table safely and they were given a comfortable position on the operation table. In the study of Ter et al.,24 it was determined that 77.5% of the patients did not feel uncomfortable on the operation table. In the study of Qevik23mean score of the statement "a surgically comfortable position was provided on the operation table" was found as 3.55±1.23.

In this study, 83.3% of the patients considered that they showed respect towards their privacy in the operating room environment. In the study of Çevik23mean score of item "I was not put into uncomfortable or shameful situations in the operating room" was 3.73 ± 0.95 .

In this study; while the rate of the patients who stated that they did not feel cold in the operating room was35.3%, this rate was higher in the reanimation unit (67.3%). A patient feeling cold during the operation is generally a normal situation. However, it is stated in the literature that warming the patient slightly during the operation is effective in preventing hypothermia40,41,42. Age factor, type of operation, period of operation, procedures implemented during operation, and temperature of the room may have caused the body temperatures of the patients to decrease and the feeling of cold. The fact that the rate of the patients who stated they have felt cold in the reanimation unit was low can be associated with the fact that the surgical interventioncausing hypothermia is terminated, the temperature of the reanimation unitswas higher than the operating rooms, wet gown of the patient was taken off and the patient is tried to be kept warm with the help of the blanket. In the study of Ter et al.,24 47.5% of the patients stated that they felt uncomfortable because of the cold. In the study of Çevik23 it was determined that the item"I did not feel cold in the reanimation unit after the operation" had the lowest mean score (1.47±1.41).

78.7% of the patients stated in the operating room that reanimation unit was safe, 78% stated that reanimation unit was calm, and 80.7% stated that their needs were provided in the reanimation room. In the study conducted by Leinonen et al., 3regarding perioperative care, 96% of the patients stated that they felt good in the reanimation unit, their needs were met, and reanimation unit was a safe environment, and they were satisfied with the environment. The study of Leinonen3 showed similarities with the result of this study.

Conclusion

In consequence of this study, it could be asserted that even though nurses prioritise the safety of patient during perioperative period, they do not approach towards patients with an individualized holistic patient care and they are not aware of the individual patient requirements.

In line with this conclusion, it could be recommended to organise training programs regarding duty and responsibilities of operating room nurses and to continue the studies about the subject.

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B. PERIOPERATIVE/CLINICAL PRACTICE

THE IMPACT ON QUALITY OF LIFE OF LEVELS TO CARE DEPENDENCY IN OLD PATIENTS IN THE SURGICAL PROCESS

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Keywords: Care dependency, nurse, old, quality of life, surgery.

Aims

The old age and surgical procedures, care dependency effects in patients. In this study, the relationship 'quality of life' and 'care dependency' is aimed to investigate the factors affecting them.

Methodology

This survey was carried out being treated old patients in the State Hospital and the Medical Faculty Hospital. After receipt of the permit for survey, 354 patients over age of 65 of surgical treatment in clinics have been formed the study sample. The consents were given from the participants, the relevant institutions and ethics committee for survey. Research data was collected by using the descriptive questionnaire, the 'World Health Organization Quality of Life – Old Module' (Turkey) and the 'Care Dependency Scale'. Using the tests which number, percentage, mean and factor analysis, cronbach's alpha coefficient, correlation have been evaluated the data.

Results

The mean age of study participants was 72.2 ± 7.1 . 49.4% of the participants were female and 50.6% were male. Participants were included to the study while 40.4% in the preoperative period and 59.6% in the postoperative period. 66.9% were married, 33.1% are single. Educational level of the participants; 42.9% primary school, 26.8% of high school graduates, 16.1% are not literate.

Correlation Quality of Life Scale (WHOQOL-OLD) and Levels to Care Dependency Scale in Old Patients in the Surgical Process is moderate strength and positive (Pearson r: 0.454). This result is statistically significant (p = 0.000). This results meet the expectation that it will increased quality of life as long as decreases dependency care of old patients.

Conclusion and Suggestion

Nursing interventions to reduce the dependency of patients is important. The determination of the factors affecting the levels of care dependency of hospitalized patients will guide on nursing interventions. When patients gained autonomy in their own care, their quality of life will be affected positively.

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PP 078

B. PERIOPERATIVE/CLINICAL PRACTICE

LAPAROSCOPIC LIVER RESECTION: IMPORTANT CHALLENGES FOR CIRCULATING OPERATING ROOM NURSES CONCERNING PATIENT POSITIONING AND USE OF ADVANCED MEDICAL EQUIPMENT

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Keywords: patient positioning, advanced medical equipment, laparoscopy, liver resection

Introducion

Liver resection is an established method of treatment of selective patient having localized tumor in the liver ⁽¹⁾. It is performed either by open or laparoscopic technique. Since 2009 laparoscopic approach has been increasingly performed at our hospital, and thus this presentation is actualized. It is vital for nurses to focus on preventive measures, perioperative safety and gain knowledge about correct patient positioning ⁽²⁾. Also, qualified use of advanced medical equipment during laparoscopic procedure is of the most importance ⁽³⁾.

Objective

The following topics will be discussed

- correct patient positioning
- to increase the nurses' knowledge concerning the use of advanced medical equipment

Methods

Virginia Henderson is chosen as a theoretical framework for this presentation. Review of Literature review and clinical experience have guided this work.

Results

Correct patients positioning prevents patients injury, and also may have a positive impact on blood circulation and respiration during surgery. Correct used of helping measures (paddings) satisfactory knowledge, competency and understanding of patients positioning is important before positioning the patient (28). The majority of complications such as neuropathies, are caused by inadequate padding and positioning.

The correct used of advanced medical equipment minimize injury. Can be challenging and complicated for circulating OR nurses.

Conclusion

The circulating operating room nurse plays a very important roll in preventing patients' injury during laparoscopic liver resection. Correct positioning is the main focus. Managing the different equipment is challenging and demanding and represents a very important area of responsibility.

More knowledge is needed concerning the use of advanced medical equipment.

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PP 079 CREATIVE NURSING IN THE OPERATING ROOM

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Keywords: iron "boot", fixate, knee replacement surgery

Fixing the foot at different angels during knee replacement surgery is necessary to allow for ease with the surgical approach. It is customary to use a metal apparatus (device) that is boot-shaped and is placed along the back of the foot, which completely covers the heels. The foot is stabilized completely inside the apparatus which uses Kerlicks (tensor bandage) to fixate the foot. This apparatus is heavy, costly, and very cumbersome to install. It also needs to be sterilized at the end of surgery.

You cannot assess the condition of the skin and the perfusion process while the foot is stabilized in the apparatus. The heels are cast in an iron "boot" that allows no movement which creates conditions that increase the risk of soreness from the pressure of the apparatus. The process is which the foot is fixated in the apparatus is performed when the patient is in the operating and under sedation. The mending process takes time, which requires an extended stay for the patient in the operating room. The length of stay depends on the duration of the anesthesia and the need for operating room.

Since the apparatus is heavy, operating nurses have a harder time delivering the apparatus to be sterilized before it can be surgically installed. Also, the patient holding their feet in the air waiting for the apparatus are adding to their own physical loads.

It became necessary for additional apparatus' to be used following the increase of knee surgeries. A newer apparatus was created after brainstorming and reviewing all literature on the matter that allows the apparatus to meet surgical goals while maintaining the safety of the patient.

The new apparatus consists of 2 rods connected to a surgical bed, which makes it very different from the original design. The patient's foot is placed on top of the rods, which have a soft rubber surface. While the apparatus is covered in sterile sheets, displacement is not necessary. The exposed patient's leg rests on 2 poles that are not in an affixing position.

Surgical teams perform numerous amounts of knee surgeries following the creation of the new apparatus. The use of the new apparatus not only reduces costs, but also contributes to the welfare of the patient and the operating staff. In addition, it enables for computerized navigation during knee surgeries which require measurements and tests with a bare foot transducer. This type of surgery was not possible before the creation of the new apparatus. Engineering creativity and the uniqueness of the nursing staff is also reflected in the operating room, which yields an improvement in the clinical outcomes.

PP 080

PREPARATION OF TABLE IN WHIPPLE OPERATION

Arzu Gediz Bekler (1)

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Whipple is an operation in which the edge of pancreas, duodenum and bile ways are completely taken out. The rezections which are applied in whipple operation are classified into four groups. Standard Whipple Operation, Radical Regional Pankreatektomi, Total Pankreatektomi andDistal Pankreatektomi. Standard whipple operation is applied more frequently than the others. Operation is held in 3 sections:

- 1 Assignment of the rezection
- 2 Rezection
- 3 Reconstruction

The nurse starts getting ready for the operation and she tidies the operating room and makes sure that all the equipments are ready.

Preparation before the operation

When the patient is taken into the room, information about him is checked, equipments are counted and Forms are filled in. Equipments are unwrapped onto the packet table and hands are washed due to the surgical hand washing techniques for five minutes. Scrub nurse wears her shirt and sterilized glovesand she helps the other nurses wear theirs. Finally, the operation table is set covering it with a waterproof material.

Phases of whipple operation

In the first phase (decision phase) essential disections are done right after you start the operation. Then, surgical team decides if they will be able to take out the mass and if they decide that it is possible they start the second phase of the operation called rezection. Pancreas, duodenum and bile ways are completely taken out. Unsinat proses disection zone is the most risky part of the rezection phase as it is close to vascular tissues. If the veins in the leg (safen) will be used, that part will also be prepared for the operation. If the operation will be held using Raux-y method there will be four anastomoz. If pilor preserving method is chosen, there will be three anastamoz, Braun anastamoz is also applied when necessary. The third phase is reconstruction phase. These anastamozes are Hepatikojejunostomi, Pankreatikojejunostomi, Gastrojejunostomi and Braun anastomoz. After all, drainage is put into the anastamoz zone. All the equipments; compresses, needles and sponges are counted carefully and the operation zone is sewed up and closed carefully.

PP 081

B. PERIOPERATIVE/CLINICAL PRACTICE A MESSAGE OF HOPE

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Key words: IDF field hospital, Philippines, Haiti

Different events happen in a persons' life that help formulate his worldviews and shape his personality. Delegations to disaster areas are without a doubt one of those significant events in my life.

Currently I hold the position of being the Head of the Orthopedic Department in the operating room at Hadassah Mount Scopus Medical Center. At the same time, I function as an OR nurse at the IDF field hospital for the past 20 years.

IDF deployed a field hospital in Armenia, Turkey, India, Haiti and the Philippines, during disasters that resulted from earthquakes in those countries. Based on these experiences, it was decided that including an operating room and expanding the hospitals activities were very vital. Seeing as how I have the knowledge and experience from working in the operating room (at Hadassah Mount Scopus Medical Center) I was a part of the development from the earliest stages.

I joined the Haiti delegation in 2010 and the Philippines in 2013 with first aid assistants. The disasters that had befallen the local population would require rapid assistance to the wounded and to the many casualties. Israel was one of the first countries to send delegators to disaster areas and provide medical assistance. I was the one responsible for the operating room at the IDF field hospital where life-saving surgeries were being performed, complex trauma was being tended to, broken limbs were being treated and births were being delivered. The IDF field hospital was part of the international aid for disaster-stricken areas.

We saved many lives. True, it might be a drop in the ocean, but it is a bit of hope in a sea of despair. Maybe if we, the State of Israel, (which is half way across the world) got there and reached out to them; we might still have a chance for things to get better. I would like to say a huge thank you to those who:

Engaged in rescuing, assisting, nursing, calming, mending and saving lives, In a frame of work that is unmeasured,

Gave their hearts and souls

To all the people who suffered a terrible blow..... "

PP 082

POST-DISCHARGE LEARNING NEEDS OF GENERAL SURGERY PATIENT Sevban Arslan $^{(1)}$ - Derya Gezer $^{(2)}$

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Keywords:Learning Needs of Patiens, Nursing, Discharge.

Introduction-Aim

This study has been planned as descriptive and sectional to determine post-discharge learning needs of general surgery patients.

Tool and Method

The study has been conducted with 57 volunteer patients aged 18 and over, hospitalized at General Surgery Clinicand operated between April and May. Data were obtained by using "Individual Information Form" and Turkish form of "Patients' Learning Needs Scale (PLNS)". Patients' learning needs were evaluated via "Patients' Learning Needs Scale (PLNS)" within 24 hours prior their discharge. PLNS is consist od 50 articles and 7 sub-scales. Statistical Package Programme of SPSS 16,0, mono direction varience analysis, t-test, pearson correlation technique have been used in analysis of data obtained.

Findings

Average age of patients have been determined as $48,4\pm14$ and average hostpitalization as $9,5\pm6,8$ days. Total average points of PLNS is $215,6\pm27,9$. The most important learning need was determined as society and observing sub-dimension which is $4,46\pm1,69$. Moreover, it has been determined that the highest points average, $39,7\pm3,9$, was derived from sub-dimension of treatment and complications and the lowest points average, $19,9\pm3,8$, was from sub-dimension of emotions related to situation. It has been determined that sub-scale points average of women for relevant emotions, life quality and treatment and complications is lower than men. It has also been determined in the study that there is statistically meaningful difference (p< 0.05) in sub-scale points average of relavant emotions, life quality, treatment and complications between women and men.

Discussion-Result

As a result of the study, PLNS point average was determined as 215,6 $\pm 27,9$. It shows that nurses should organise the discharge trainings according to needs of paints as the total points average of PLNS is high.

PP 083

CASE REPORT - NURSING CARE FOR PATIENT WHO HAD LAPAROSCOPIC GASTRIC **BY-PASS**

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Keywords: Morbid Obesty, Nursing Care, Gastric By-pass.

Aim

In this study pre and post operational nursing care of a patient who had gone through gastric by-pass due to morbid obesity, have been examined.

Method

The patient who constitutes subject of this study is male, 40 years old, 130 kg and 1,75 cm tall (BMI:42kg/m2). He was admitted in General Surgey Clinic on 08.03.2014, his pre-operation preparations have been completed and gone through gastric by-pass operation on 11.03.2014. The nursering care has been applied until the 6th day. Impact of the applied nursing care on recovery duration has been evaluated.

Findings

The day before the surgery, the patient whose tests have been completed was taught breathing, coughing and turning exercises. He was had shower the night before surgery and taught how to clean the surgery area. On the days of surgery, the patient was sent to operation room after his identity was confirmed via secure surgery form. The patient was applied laparoscopic gastric by-pass and observed for 1 day in intensive care unit. During post operation care he was informed about pain management, cut care, venoz tromboemboli profilaksis, breathing exercises, early and frequent mobilization, paying attention on complications, nutrition and care at home.

Result

Our fact has been observed for 3 days before the operation, 2,5 hours during the operation, 1 day at intensive care unit, 5 days at clinic. The patient had been applied all planned nursing interference and has been discharged without any complications. The patient has lost 31 kgs in total in 3 months following the surgery.

PP 084

NONPHARMACOLOGICAL METHODS FOR POSTOPERATIVE PAIN MANAGEMENT: SYSTEMATIC REVIEW

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Keywords:Postoperative pain, nurse, nonpharmacological methods.

Background

Nurses play a pivotal role in the management of postoperative pain as they spend considerable time with thepatient as well as being responsible for assessing pain and making decisions in regard to the need and type of pain relief1.

Today, nonpharmacological methods are used when pharmacological techniques are not available or in order to increase effect of pharmacological techniques.Studies on the effectiveness of nonpharmacological nursing interventions in the relief of pain include: massage, reflexology, therapeutic touch, imagery instruction, relaxation and musictherapy1.

Focus of interest

This study was planned for analyzing and synthesizing researches about nonpharmacological methods which are used for postoperative pain management and for leading to the development of evidence-based guidelines.

Theoretical framework

A total of 680 publications were found in the search from 2004 to 2014. Databases such as Cochrane, Pubmed, Science Direct, Medline, Ulakbim, Cinahl Plus, Wiley were used with the following key words: Postoperative pain, nursing interventions, nonpharmacological methods, massage, reflexology, therapeutic touch, imagery instruction, relaxation and musictherapy. The inclusion criteria for studies identified in the searches were as follows; comparative, longitudinal, retrospective, quasi-experimental and experimental research articles. A total 31 papers retained for inclusion in review.

Presenting relevant literature references

The included studies commonly investigated postoperative pain relief after cardiac surgery2,3,4 with the other mostcommon surgeries being abdominal5 and orthopaedic6. In most of the studies the effectiveness of music3and massage2 has been investigated. The other nonpharmacological methods which have been examined for postoperative pain management were relaxation techniques5, aromatherapy8, reflexology4 and therapeutic touch9. In most of studies nonpharmacological techniques and analgesics has been administered together. Visual analogscale (VAS) was the most common outcome measurement used to measure pain.

Table 1. Nonpharmacological Methods for Postoperative PainManagement: Studies Reviewed (N = 31), 2004-2014

Ikonomidou et al., 2004 The purpose of this study was to test the hypothesis that

listening to relaxation music preoperatively and postoperatively would affect patients' experience of pain, nausea, or well-being and that it would have an effect on vital signs in women undergoing laparoscopic gynecological surgery.

alkonomidou et al., 2004 The purpose of this study was to test the hypothesis that listening to relaxation music preoperatively and postoperatively would affect patients' experience of pain, nausea, or well-being and that it would have an effect on vital signs in women undergoing laparoscopic gynecological surgery.

Design: Randomized controlled trial.

Sample: A total of55 patients (n=29 for Music group, n=26 for control group) with an American Society of Anesthesiologists' (ASA) rating of one to two who were between 25 and 45 years of age and were scheduled to undergo gynecologic laparoscopy under general anesthesia were enrolled.

Results: Pain scores were significantly lower for patients in music and control groups after the session, but there was no significant difference between the groups. Postoperative cumulative opioid consumption was, however, significantly lower among patients in the music group.

Albert et al., 2009 The purpose of this study was to detect whether massage therapy improves postoperative mood, pain, anxiety, and physiologic measurements; shortens hospital stay; and decreases occurrence of atrial fibrillation.

Design: Randomized controlled trial.

Sample: A total of 252 adults undergoing cardiac surgery were randomized to usual postoperative care (n=126) or usual care plus two massages (n=126).

Results: Preoperative pain, mood, and affective state scores were positively associated with postoperativescores; neverthelessthere were no postoperative differences between groups for any measures (p=0.11to 0.93).

Voss et al., 2004The purpose of this study was to test the effectiveness of non-pharmacologicalcomplementary methods (sedative music and scheduled rest) in reducing anxiety and pain during chair rest

Design: Three-grouppretest-posttest experimental trial.

Sample: A total of 61 patients were randomly assigned to receive 30 min of sedative music (n=19), scheduled rest (n=21), or treatment as usual (n=21) during chair rest.

Results:Sedative music was more effective than scheduled rest and treatment as usual in decreasing anxiety and pain in open-heart surgery patients during first time chair rest.

Mitchinson and Geisser, 2007 The purpose of this study was to evaluate the effects of a back massage on patients' self reported perceptions of postoperative pain, anxiety, and functional recovery.

Design: Randomized controlled trial. Sample:A total of 645 patients undergoing major thoracic or abdominal operations were randomized into 3 groups and received routine care (n=220, control group), individualized attention from a massage therapist for 20 minutes but no massage (n=211, individualattention group), or a 20-minute back massage each evening by an massage therapist (n=214, massage group).

Results: Compared with the control group, patients in the massage group experienced shortterm (preintervention vs postintervention) decreases in pain intensity (p=0.001), pain unpleasantness (p=0.001). In addition, patients in the massage group experienced a faster rate of decrease in pain intensity (p=0.02) and unpleasantness (p=0.01) during the first 4 postoperative days compared with the control group. There were no differences in the rates of decrease in opiate use across the 3 groups.

Cutshall et al., 2010The purpose of this study was to determine the difference in pain, anxiety, tension, and satisfaction scores of patients before and after massage compared with patients who received standard care in the cardiac surgery postoperative period.

Design: Randomized controlled trial comparing outcomes before and after intervention in and acrossgroups.

Sample: A total of 58 patients who undergoing cardiovascular surgical procedures (coronary artery bypass grafting and/orvalvular repair or replacement) were randomly assigned to massage therapy (n=30) or standard care (n= 28).

Results: Comparison of the changes in pain, anxiety, and tension between the 2 groups showed a statistically significant improvement in all 3 parameters.

Nesami et al., 2012The purpose of this study was to assess the effects of foot reflexology massage on pain and fatigue in patients after coronary artery bypass graft surgery. Design: Randomized controlled trial

Sample: A total of 80 patients divided randomly into two groups of case and control. Results: There was significant differences in pain and fatigue levels after the interventionamong both groups (p=0.0001).

Kumar et al., 2012The purpose of this study was to test the effect of the classical ragam Anandhabhairavi in Carnatic music on post operative pain relief. Design: Randomized controlled trial

Sample: A total of 60 patients who underwent hernia, appendicectomy, thyroidectomy, breast surgeries (excluding mastectomy) were divided randomly into two groups of case and control. Results: The raga Ananda Bhairavi had an effect in postoperative pain management which isindicated by the reduction in analgesic need by 50 % in those who listened to raga it postoperatively 3 days. A significant P value of <0.001 was gotton.

Roykulcharoen and Good, 2004The purpose of this study was to test the effects of a systematic method of relaxing the body on thesensory and affective components of postoperative pain, anxiety, and opioid intakeafter initial ambulation.

Design:Randomized controlled trial.

Sample: A total of 102 patients who underwentabdominal surgery were divided randomly into two groups of case (n=51) and control (n=51).

Results: The relaxation group had less post-test sensation and distress of pain(26 and 25 mm less, respectively) than the control group (p=0,001).

McCaffreyabd Locsin, 2006 The aim of thisstudy was to examine the effects of music listening in older adults following hip or knee surgery

Design: Bandomized controlled trial.

Sample: A total of 124 patients who underwentabdominal surgery were divided randomly intotwo groups of case (n=62) and control (n=62)

Results: There was a significant reduction in the number of pain medications taken postoperatively in those participants who listened to music when compared with those who did not (p=0.001)

Vaajoki et al. 2010The purpose of this study was to test the effects of music listening on pain intensity and pain distress on the first and second postoperative days in abdominal surgery patients and the long-term effects of music on the third postoperative day. Design: Prospective clinical study.

Sample: A total of 168 patients who undergoing elective abdominal surgery (n = 168) were divided into either a music group (n = 83) or a controlgroup (n = 85)

Results: In the music group, the patients' pain intensity and pain distress in bed rest, during deep breathing and in shiftingposition were significantly lower on the second postoperative day compared with control group of patients. On the thirdpostoperative day, when long-term effects of music on pain intensity and pain distress were assessed, there were no significant differences between music and control groups.

Li, Xiao-Mei et al. 2011 The purpose of this study was to detect the effects of music therapy on pain reduction in patients with breast cancer after radical mastectomy.

Design: Randomized controlled trial.

Sample: A total of120 breast cancer patients who received Personal ControlledAnalgesia following surgery (mastectomy)were randomly allocated to two groups, an case group(n = 60) and a control group (n = 60)

Results: Music therapy had both short- and long-termpositive effects on alleviating pain in breast cancer patientsfollowing radical mastectomy.

Adachi et al. 2014The purpose of this study was to test effects of aromatherapy on postoperative face-down posturing (FDP)-related physical pain after vitrectomy.

Design: Randomized controlled trial.

Sample: A total of 63 patients under FDP were randomly divided to one of three treatment groups, aromatherapy massage with essential oil (AT)(n = 21),oil massage without essential oil (OT)(n = 22), and a control group(n = 20).

Results: The AT group experienced importantly greater decrease in pain at all body regions on both days, compared with the control group. The OT group also indicated significantly greater pain decrease than thecontrol group on both days, in all body regions, exceptfor the arms on the first day. The only difference in painreduction between the AT and OT groups was in thearms on the first day.

Lasaporani et al. 2013 The purpose of this study was to detect the efficiency of the Calatonia technique about clinical parameters and pain in the immediate post-surgical phase.

Design: Randomized controlled trial.

Sample: A total of 116 patients subjected to a cholecystectomy, by laparoscopy, divided into an experimental group (n =58) and a placebo group (n =58).

Results: The case group indicated significant results, and therefore it was possible to deduce that the relaxation caused by the Calatonia technique brought some relief of the general situation of pain.

Wang and Keck 2004The purpose of this study was to test whether a 20-minute footand hand massage (5 minutes to each extremity), which was provided 1 to 4 hours after a dose of pain medication, would reduce pain perceptionand sympathetic responses among postoperative patients.

Design: Pretest-posttest single group design.

Sample: A total of 18 patients who underwent gynecological (n =8), gastrointestinal (n =3), urological(n =3), head and neck (n =3), plastic surgery (n =1) were included Results: There was statistically significant decline in sympathetic responses to pain.

Good and Ahn2008 The purpose of this study was totest the effects of music on pain after gynecologic surgery in women and to compare pain relief between those who choseAmerican or Korean music

Design: Quasiexperimental pretest-posttestdesign.

Sample: A total of 73 patients who underwent gynecologic surgerydivided into an music group (n = 34) and a control group (n = 39).

Results: The postoperative patients in the music group hadsignificantly less pain (sensation and distress) at posttestthan those in the control group.

Braun at al. 2012 The purpose of this study was to determine whether massage significantly reduces anxiety, pain, and muscular tension and enhancesrelaxation compared with an equivalent period of rest time after cardiac surgery.

Design:Randomized trial. Sample: A total of 152 patients who underwent elective cardiac surgerydivided into an music group (n = 76) and a rest time group (n = 76).

Results: Massage therapy produced a significantly greater reduction in pain compared to the rest time.

Allred and Sole 2010 The purpose of this study was to determine if listening to music orhaving a quiet rest period just before and just after the first ambulation on postoperative day 1 can reduce pain and/or anxiety or affect meanarterial pressure, heart rate, respiratory rate, and/or oxygen saturationin patients who underwent a total knee arthroplasty. Design: Experimental design.

Sample: A total of 56 patients having a total knee arthroplasty were randomly assigned toeither a music intervention group or a quiet rest group.

Results: The music group's decrease in pain and anxiety was notsignificantly different from the comparison rest group's decrease inpain (p=0.337). However, statistical findings within groups indicated that the sample had a statistically significant decrease in pain (p=0.001).

Graversen and Sommer 2013The purpose of this study was to test the hypothesis that perioperativeand post-operative soft music decreases pain, nausea, fatigue and surgical stress in patients undergoing laparoscopiccholecystectomy as day surgery. Design: Randomized clinical trial.

Sample: A total of 88 patientswere included and randomized to either soft music (n =48) or no music(n =40) perioperatively and post-operatively.

Results: Music did not lower pain 3 hours after surgery, which was the main outcome. The music group had less pain day 7 (p=0.014).

Coakley and Duffy 2010 The purpose of this study wasto test the efficacy of Therapeutic Touch on pain and biobehavioral markers in patients recovering from vascular surgery. Design: Non-randomized controled study.

Sample: A total of 21 patients participated in this study with 12 in the experimental Therapeutic Touch group and 9 in the usual care control group.

Results: Compared with those who received usual care, participants who received Therapeutic Touch had significantly lower level of pain, lower cortisol level, and higher natural killer cells level.

Good et al. 2005 The purpose of this study was to test the efficacy of three nonpharmacological nursing interventions, relaxation, chosen music, and their combination, for pain relief following intestinal surgery.

Design:Randomized clinical trial

Sample: A total of 167 patients wererandomly assigned to one of three intervention groups or control

Results: The study indicated significantly less post-test pain in the intervention groups than in the control group on both days after rest and atthree of sixambulation post-tests (p=0.024-0.001), resulting in 16-40%less pain

Nilsson et al. 2005 The purpose of this study was to evaluate, first, whether intraoperative orpostoperative music therapy could influence stress and immune response during and after general anaesthesia and second, if there was a different response between patients exposed to music intraoperativelyor postoperatively

Design:Randomized controlled trial.

Sample: A total of 75 patients undergoing open hernia repair as day care surgery were randomly allocated tothree groups: intraoperative music(n =25), postoperative music (n =25) and control group (n = 25)

Results: Thepostoperative music group had less anxiety and pain and required less morphine after 1 hour compared with the controlgroup.

Good et al. 2010The purpose of this study was to test anintervention of patient teaching for pain management and compare it with relaxation and music for immediate and general effectson postoperative pain.

Design: Randomized controlled trial with pretests and posttests.

Sample: A total of 621 patients having abdominal surgery and receiving patient-controlled analgesia were randomized to four groups: patient teaching for pain management (PT)(n= 152), relaxation and music(RM) (n=153), a combination (PTRM)(n=169), and a control (n=147). Results: Using multivariate analysis of covariance with contrastsand pretest control, immediate RM-Effects on pain were found at Day1 a.m. (p.001), Day 1 p.m. (p = .04), and Day 2 a.m. (p = 0.04). No PT-Effects or nonimmediateRM-Effects were found.

Asadizaker et al. 2011 The purpose of this study was to test the effects of foot and hand massage on postoperative pain andsedative drug use in cardiac surgery patients. Design:Randomized controlled trial.

Sample: A total of 65 patients wereselected based on aim and randomly assigned to either control (n = 33) or massage group (n = 32)

Results: There was statistically significant difference on the pain intensity and type, and amount of sedative drug used between the two groups after intervention (massage) (p= 0.000)

Allred et al. 2008The purpose of this study was to determine if listening to music orhaving a quiet rest period just before and just after the first ambulation on postoperative day 1 can reduce pain and/or anxiety or affect meanarterial pressure, heart rate, respiratory rate, and/or oxygen saturationin patients who underwent a total knee arthroplasty.

Design:Experimental design.

Sample: A total of 56 patients having a total knee arthroplasty were randomly assigned to either a music intervention group or a quiet rest group.

Results: The music group's decrease in pain and anxiety was not significantly different from the comparison rest group's decrease in pain (p= 0.337) or anxiety (p= 0.206) at any measurement point. However, statistical findings within groups indicated that the sample had a statistically significant decrease in pain (p= 0.001) and anxiety (p= 0.013) over time.

en et al. 2009 The purpose of this study was to determine that addition of musicotherapy in the preoperative period would have favorable effects pertaining topostoperative pain. Design:Randomized controlled trial.

Sample: A total of 100 patients, between the ages of 20-40 years, who were undergoingelective caesarean delivery under general anaesthesia, were enrolled. The patients were randomlyallocated into two groups (with 50 patients in each).

Results: Music therapy given before surgery decreases postoperative painand analgesic requirement.

Lincoln et al. 2014 The purpose of this study was to test detect whether the use of healing touch and healing harpconcomitantly was more effective in reducing pain, anxiety, and nausea than the use of healing touchalone.

Design:Retrospective analysis

Sample: Included in the analysis were Healing Touch patients (n = 3223) and Healing Touch/ Harppatients (n = 94).

Results: The effectiveness of using concomitant Healing Touch and Healing Harp to significantly reduced moderate to severe pain and anxiety in this patient population

Sadeghi and Ebadi 2009 The purpose of this study was to determine the effect of foot reflex massage on sternotomy pain of patients aftercoronary artery bypass graft surgery.

Design: Quasi-experimental study.

Sample: A total of 90 patients were randomly divided into three groups of case, control and placebo.

Results: The mean of pain intensity before and after intervention had significant difference in three groups (p<0.001)

Özer et al. 2010 The purpose of this study was to detect the effect of listening to personalchoice of music on self-report of pain intensity and the physiologicparameters in patients who have undergone open heart surgery.

Design: Quasi-experimental study.

Sample: A total of 87 patients who underwent open heart surgery: (n = 32 for music group, n=43 for the control group.)

Results: In themusic group, there was a statistically significant and a lower pain score (p=0.001) than in the control group.

Ucuzal and Kanan 2012The purpose of this study was to detect the effect of foot massage onpain after breast surgery, and supply guidance for nurses innonpharmacologic interventions for pain relief.

Design: Quasi-experimental study.

Sample: A total of 70 patients who had undergone breastsurgery (n=35 for the experimental group and n=35 for the control group).

Results: Patients in the experimental group experienced remarkably less pain (p=0.001).

Vaajoki et al. 2013 The purpose of this study was to define the effect of listening tomusic on pain intensity and pain distress during bed rest, during deep breathing and position shifting, physiologicalparameters such as blood pressure, heart rate and respiratoryrate, analgesia, adverse effects and length of hospitalstay after major abdominal surgery.

Design: Quasi-experimental repeated measure, pretest-posttestdesign.

Sample: A total of 168 patients were shared out into the music groupn=83, in whichpatients listened to music 30 minutes at a time, or the control groupn=85, in which patients did not listen to any music during the same period.

Results: Experimental group who received standard care and listened to music after surgery had less pain intensity and pain distress thanthose in the control group.

Lin et al. 2011 The purpose of this study was to estimate the effects of music therapy on anxiety, postoperative pain and physiological responses to emotional and physical distress in patients underwent spinal surgery

Design: Quasi-experimental study design

Sample: A total of 60 patients were shared out into the music group (n=30) and the control group (n=60).

Results: There was statistically notable differences between the two groups throughout the entire observation period, with the lower pain level of the study group after music therapy.

Conclusions

Research results indicated that nonpharmacological therapy is effective and supportive for postoperative pain management of different patient groups and advised perioperative nurses to use effective nonpharmacological interventions for postoperative pain management.

Implications for perioperative nursing

This study may increase awareness of the perioperative nurses for nonpharmacologicalmethods for postoperative pain management and promote the use of nonpharmacological interventions.

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PP 085

PREDICTION MODEL FOR 30-DAY MORBIDITY AFTER GYNECOLOGICAL MALIGNANCY SURGERY

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Keywords: Perioperative morbidity, gynecologic malignancy

Objective

Gynecological malignancy surgery undertaken in a specialized gynecologic oncology unit may be associated with significant perioperative morbidity (1-5). Validated risk prediction models are available for general surgical specialties but currently not for gynecological cancer surgery (6). The objective of this study is to construct a preoperative nomogram predicting 30-day morbidity after gynecological malignancy surgery.

Methods

The medical records of 460 patients with elective gynecological cancer surgery in our center during 2005 and 2013 were reviewed. All peri- and postoperative complications within 30 days after surgery were registered and classified according to the definitions of the National Surgical Quality Improvement Program (NSQIP) (7). To investigate independent predictors of 30-day morbidity, a multivariate Cox regression model with backward stepwise elimination was utilized. A nomogram based on this Cox model was developed and internally validated by bootstrapping. Its performance was assessed by using the concordance index and a calibration curve.

Results

The median age was 49 (range, 13-81) years. Eighty-three (18.0%) patients had at least one peri- or postoperative complication within 30 days after surgery. Multivariate regression analysis revealed that age (odds ratio 1.023, 95% Cl 1.002-1.044 P=0.031), operation time (odds ratio 1.005, 95% Cl 1.002-1.008; P=0.001), and serum albumin level (odds ratio 0.627, 95% Cl 0.389-1.009; P=0.054) were independent predictors of postoperative morbidity. The nomogram incorporating these three predictors demonstrated good discrimination and calibration (concordance index=0.743; 95% Cl, 0.665–0.820). Conclusion: 30-day morbidity after gynecologic cancer surgery could be predicted by age, operation time, and serum albumin level. If externally validated, the constructed nomogram could be valuable for predicting operative risk in the individual patient.

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PP 086

B. PERIOPERATIVE/CLINICAL PRACTICE NURSE'S RESPONSIBILITIES IN FACE TRANSPLANT OPERATIONS

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Composite tissue is defined as vascularized composite allograft, which is made of anatomical and structural units collected from a human donor to be grafted to a human recipient and involves multiple tissues. Face transplant, a composite tissue transplant, is a treatment that is considered as the gold standard for severe facial injuries. Because of this operation isComplex, long-term and intensive operation that requires attention, it is a fairly new specialized area in the operating room nursing.

In the face transplant operation process, terms of the preparation of the operating and perfusion table and transfering face are very critical steps for nursing. Facial tissue to be placed in a way that does not occur folds on the wet floor and protection of the configuration of the face is vital. Which will be used for the perfusion solution (University of Wisconsin) and organ preservation of the cold chain is the responsibility of the nurse directly.Face the transfer phase is quite capable and for the surgical team is a traumatic situation as visually. This process can be performed by a team of nurses who skilled, experienced and qualified.In this context, Akdeniz University Plastic and Reconstructive Surgery nursing team is a group of indispensable in face transplant operation.

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B. PERIOPERATIVE/CLINICAL PRACTICE FACTORS AFFECTING THE PERIANESTHESIA PATIENT COMFORT

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Keywords: Perianesthesia nursing care, patient comfort, surgery

Patient comfort is one of the important concepts used in assessing the quality of nursing care, and stands as a primary concept in all attempts. Comfort is defined as the absence of pain, distress, sadness and anxiety and is assessed in four fields that are physical, psychospiritual, socio-cultural and environmental. On the other hand, surgery causes the emergence of experiences affecting the patient comfort adversely. The most frequently

encountered experiences are nausea and vomiting, anxiety, hypothermia and pain. After the comfort necessities of the patient are determined, the nurse must research the factors affecting the comfort adversely and attempt to reduce the effects on patient. With the implementation of oral carbonhydrate solution before surgery, the patient experiences less preoperative feeling of hunger, anxiety, thirstiness, dryness of the mouth, the feeling of nausea; and after the surgery, nausea and vomiting frequency and necessity to analgesia decrease. To inform patients before surgery about how they will feel after surgery, where they will be when they wake up, and which restrictions will come up reduces the level of anxiety after surgery and pain scores are at lower levels. The factors that may cause to fall body temperature before, during and after the surgery must be taken into consideration. With the preservation of normothermia, time to stay in reanimation unit after surgery shortens, less blood loss occurs, and development of infection and cardiac complications decrease. It is stated that relief of pain is closely related to comfort, one of the most important standards in perianesthesia patient is pain assessment, and also institutional support and the education of medical staff play a key role. As a conclusion, with the increase in patient comfort during perianesthesia period, complications decrease, early mobilization is provided and oral intake starting time shortens. As a result of these, the cost reduces, duration of stay in the hospital shortens, personel employment period shortens, and the satisfaction of patient, nurse and staff increases.

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PP 088

ELECTRONIC DOCUMENTATION OF PERIOPERATIVE NURSING WITH REGARD TO EFFECTIVE USE OF WORKING TIME

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Keywords: electronic documentation of perioperative nursing

Introduction

Documentation of perioperative nursing is an important element for providing safe, qualitative and continuous nursing care. It is also important for research work and as legal protection for performers of nursing care. Electronic documentation of perioperative nursing ensures a large progression, because it enables a standardized documentation of perioperative nursing in a hospital. It gives healthcare professionals the ability to search specific patient information and to copy documents. All the documentation of perioperative nursing is saved in electronic form because handwriting can sometimes be illegible, the possibility of losing a document is smaller and the ability to search specific patient information is available.

Copying the documentation of perioperative healthcare enables us the insight into what is happening during an operative procedure. Electronic documentation takes the operating nurse quite a lot of time and it often seems that the nurse spends more time with the computer than with the patient.

Methodology: Presentation of a case from clinical practice. Analysis of the data from the information system Kocka for the year 2014. Monitoring the time used by the operative nurse for documentation of perioperative healthcare.

Goals

- Managing time effectiveness.
- · Managing the process of operations.
- · Managing the potentially imperfect upgrade of electronic documentation.

Conclusion

With the support of a data collection computer programme we have the ability to keep the record of a large number of data. One of the goals of managing the process of operations is managing time effectiveness. We would like to present a research proposal about time consumption used by the operative nurse for noting perioperative nursing and the imperfections which she encounters while electronically documenting. We would also like to indicate the possible improvements.

PP 090

B. PERIOPERATIVE/CLINICAL PRACTICE

SURGICAL PATIENTS' QUALITY OF LIFE AND THEIR PERCEPTION OF CARE USING CBI QUESTIONNAIRE

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Keywords:quality, nursing, care, CBI, SF-36, surgical ward.

Background

Caring is a complex concept that is often contextually defined ⁽¹⁾. In a previous research it was stated that patients' opinions about the care they received were highly influenced by personal characteristics, such as age, gender, education, and past experiences with health care⁽²⁾.

Purpose of the study

to investigate the relation between surgical patients' personal characteristics as well as their quality life and their perceptions of care.

Research problems

How are patients' gender, age, educational background and quality of their life related to surgical patients' perceptions of caring behaviors?

Methodology

It is a quantitative research study. All the participants completed the translated selfadministered CBI-24, the SF-36 and a personal characteristics data sheet. The CBI-24 has four factors: "Assurance of human presence;" "Knowledge and skill," "Respectful deference to others;" "Positive connectedness" ^(3,4). SF-36 consists of eight scaled scores and the higher the score the better the quality of life. The analysis was conducted using SPSS 19.0. In the univariate analysis, the relationships between the patients' personal characteristics, their quality life and the CBI were tested using Students't-tests and one-way analysis (ANOVA). Pearson correlation coefficients examinedif there was a relationship between patients' quality life and perceptions of caring. The level of significance was set at p< 0.05.

Results

The total study sample consisted of N = 107 patients. Approximately half of the patients were female (59%). The mean age was 53.2 (SD20.4) years. Most of them had a primary education 39.3%. The majority of the patients had previous hospitalization experience(44.9%) and had undergone surgery. Mean time of their hospitalization was 27 days. The level of education was not a significant predictor for patients' perceptions of caring in this study. Older patients are more positive in their evaluations of nurse caring behaviors. Length of hospitalization was not related to patients' perceptions of satistically significant correlation was found between Physical Component Summary Mental Component Summary and CBI-24 in surgical patients.

Implications for perioperative nursing

Quality life of surgical patients that took part in the study was not really low and it was not found to correlate with patients perceptions of nursing care. Our findings may have been influenced by rapid turnover early hospital discharge after surgical care.

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PP 091

B. PERIOPERATIVE/CLINICAL PRACTICE

MINIMALLY INVASIVE SPINE SURGERY: X-RAYS AND IMPACT ON OPERATING THEATRE STAFF

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Keywords: minimally invasive surgery, radioprotection, spinal surgery

Background

The evolution of surgical techniques provides many advantages but also some risks that did not exist before. Previously, interventions of the spine used large carries surgical approaches allowing a direct view of the surgical field. Nowadays, an increasing number of spinal procedures use conservative mini incisions without direct view of the surgical field. Surgeonsthus depend on visualization of the anatomical structures using x-ray imagingduring

Surgeonstrus depend on visualization of the anatomical structures using x-ray imagingduring the procedure.

Focus of interest

The use of x-rays in minimally invasive surgery changes working conditions and professional hazards that the operating room staff is exposed to.

Reminder, a short exposure repeated to x-rays is more dangerous than a single therapeutic dose very important.

X-rays are known to be harmful, but to what degree? How to combine radioprotection, efficiency and quality of care in spine surgery? What can we do to protect us from excessive x-rays exposure?

Method

Using bibliographic search, the author redefines types of risks associated with exposure to x-rays, current dose limits for operating theatre staff, as well as the importance of the exposure-dose reduction principle are updated.

These data are crossed with cumulative doses study survey and dosimetric records. Measures of radioprotection are explained, and thesemost adequate in the operative

theatre are identified. Conclusions:

Various risks associated with x-rays exposure in the operating room in spine surgery are defined and x-ray dose-reduction measures for the operating room staff are reviewed. A poster containing all of this information was created.

It can be used to support the incentive to radiation protection and the prevention of professional accidents.

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PP 092

B. PERIOPERATIVE/CLINICAL PRACTICE

THE IRISH PATIENTS UNDERGOING KNEE AND HIP REPLACEMENTS ARE GETTING HEAVIER.

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Abstract

Background

There is evidence that patients undergoing surgery are getting heavier and this requires special consideration, equipment and handling for appropriate peri-operative management¹.According to a piece ofBritish research, the Irish will be the fattest Europeans by 2030.² Currently the orthopaedic centre where I work does not have a specific policy / protocol outlining the care and needs of these patients.

Purpose

The purpose of this piece of work is to carry out an audit to identify the issues that need to be addressed for managing this group of patients effectively, taking the best practice into account.

Goals

To highlight the importance of having in place a risk management policy or protocol for detailing the management of these patients.

Methods

Data is currently been collected using a questionnaire on obese patients (obesity defined as a BMI higher than 30 kg.m-²), a minimum of 50 patients will be included in this audit. The information gathered will include, timing of surgery into motion, co-morbidities as delay in completing surgical process due to anaesthetic and theatre/patient management issue and patient demographics. This information will inform the development of a policy / protocol to manage these patients effectively.

Results and implications for peri-operative nursing practice

As the data collection is still in progress the results cannot be reported at present.

It is planned to make recommendations forbest practice in our setting according to the results, taking into account the key recommendations published by the Association of Anaesthetists of Great Britain and Ireland¹ and by the Association of Operating Room Nurses (AORN)³.

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PP 094 B. PERIOPERATIVE/CLINICAL PRACTICE INTERNAL CAROTID ARTERY INJURY: THE COLUSSEUM OF INJURY

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Keywords: carotid artery, injury, skull base, endoscopic sinus surgery, hemostasis

The modern day operating room (OR) has under gone many changes over the past decade and so has the way we do many of our surgeries. With technology moving in leaps and bounds Otorhinolaryngology (Ear Nose & Throat) specialty has embraced this onslaught of technology and incorporated it into providing functional and improved patient outcomes.

Improving visibility and equipment allows the modern day Rhinologist to venture from the simplest of sinus surgery, to mastering the mysteries beyond the sphenoid and into the skull base. Procedures, for skull base tumours that were once removed only by craniotomy, causing disfiguration and long-term recovery, are now almost a thing of the past for some particular tumours. ^(1,2,3) This is one specialty that is definitely External Evolving...

With the advent of new skills, new approaches to unlimited cranial boundaries, we all need to be aware and prepared for any complications that may occur. "Internal carotid artery (ICA) injury has been considered the most dramatic and challenging intraoperative complication. This creates an immediate challenging surgical scenario with rapid blood loss that may result in exsanguination of the patient."⁽¹⁾ This is the real 000 emergency.

A routine day in the OR, as I had done for the past 12 years ... ESS (endoscopic sinus surgery) Modified Lothrop ... when I glanced away for just a split second only to return my eyes to my patient and see a tidal of blood pouring from both nostrils...

This is a true real life case study; one that I hope I never have to relive again... by sharing this, you may be a little more prepared.

I shall also share with you the development of an animal model we use to train surgical teams to assist in the management of the surgical field during a catastrophic vascular event.

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PP 095

OPERATING ROOM NURSING IN LIVER TRANSPLANT SURGERY: CASE REPORT

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Keywords: Operating Room Nursing, Liver Transplant surgery

Introduction

In recent years, liver transplant surgery is a very special specialization area for operating room nursing with new experiences. There are two goals of perioperative nursing care for liver transplantation surgery; one of this goals is to improve the quality of the care and the other one is to reduce the surgical intervention time and the workload by systematic planning approach of the nursing interventions. In this case, preparation and control of the surgical operating tables, surgical instruments and the other materials, maintain of sterilization and all nursing initiatives for patient's safety will be defined.

Case

The patient (M.Ç.) is a 66 years old male. He was admitted to hospital on 20 April 2013. Meanwhile, operating room was prepared by nurse (cautery, LigaSure, argon, sutures, medical supplies, sets, retractors). After induction of anesthesia, a urinary catheter was inserted. Patient's entire body except the surgical area was covered with blankets to prevent the hypothermia. Patient was painted from chest to the top of the knee. The whole body was covered with a sterile surgical drape except the surgical area of the skin. The number of the compresses, buffers and Buldoxes which have been used in the operating room were counted and registered to the Cencus Form by a nurse. The patient's abdomen was opened by the Mercedes's method of incision and placed a Thomson's retractor. Finally countdown of the number of the compresses, tampons and Buldox which were used was made by nurse and the incision area was closed. After 4 hours after the surgery the patient was transferred to PACU (post anesthesia care unit).

The perioperative nursing care to be carried out systematically improve the success of the surgery and also shorten the surgery operation time.

PP 096

B. PERIOPERATIVE/CLINICAL PRACTICE TO EFFECTIVE USE OF SAFETY CHECK LIST IN SURGICAL AREA

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Key Words: surgical area, safety check list, operating room procedures

Introduction

Surgery is a central element of health care with an estimated 234 million surgical procedures performed each year worldwide ⁽¹⁾. Since the publication of the Institute of Medicine report, safety of surgery and the prevention of adverse events have gained increasing attention ⁽²⁾.

Patient safety in operating rooms aims to reduce risks to patients receiving surgical care and improve safety. Operating room staff has a common unders tanding of the core of the ir work, which is to ensure patient safety during operations ⁽³⁾.

The World Health Organization which was launched in 2008 'Safe Surgery Saves Lives' project ⁽⁴⁾. In 2009, investigators documented a significant reduction in mortality and other postoperative complications with use of the WHO surgical safety checklist ⁽⁵⁾. The purpose of the formation; political commitment and clinical targets, security applications of inadequate anesthesia, between avoidable surgical infection and the study team, including poor communication, to guide the important security issues. This problem is common in the environment of the whole country and is found to be deadly and preventable problems ⁽⁴⁾. Studies, the use of an effective World Health Organization Surgical Safety Checklist has shown that half of preventable complications related to the surgery ⁽⁴⁾.

The implementation of a checklist in surgery not only is an effective tool for decreasing the burden of morbidity and mortality but also represents an opportunity to save costs in hospitals. Semel et al estimated that with the use of the checklists \$103,829 could be saved annually in a hospital conducting 4000 noncardiac operations. For highly effective implementation, the acceptance of the hospital staff and the adaption to the specific context, for example, different settings or circumstances of the hospital are important. Further research is necessary about organizational and cultural factors influencing the success of the implementation of safety checklists in surgery ⁽²⁾.

Checklists are effective and economic tools that decrease mortality and morbidity. Compliance of surgical staff with checklists was good overall. Further research in particular relating to implementation is needed $^{(2)}$.

Netherlands' Surgical Patient Safety System documented a significant reduction in in-hospital mortality (from 1.5% to 0.8%) and in overall complications (from 27.3 to 16.7 per 100) after implementation of a comprehensive surgical checklist ⁽⁶⁾.

To impact outcomes, the checklist must be effectively implemented by hospitals that adopt it ^(a). The medical and the financial significance of so-called adverse events (negative incidents) have been examined in several publications In the United States, for example, additional costs as high as \$17–29 billion result due to avoidable mistakes in patient management ⁽⁷⁾.

The implementation of the 'Surgical Safety Checklist', which was promoted by the World Health Organization (WHO), caused a significant reduction in the incidence of complications and mortality among patients who underwent surgery ⁽⁶⁾.

Several authors have indicated the use of a safety checklist to be a beneficial procedure ^(5,8,9). Checklists or protocols are instruments that are completed or marked preoperatively or during the operation from one or more responsible persons with the aim of increasing the safety of surgical interventions. They consist of a verbal verification by operating teams in terms of implementing the basic steps ensuring the safe delivery of anesthesia, effective teamwork, and other substantial steps or practices with in the range of surgical interventions, which pass a well-defined process ⁽²⁾.

Compliance. This is the frequency and completeness of checklist usage. All studies were included which cover information about compliance, as well as studies that described factors associated with a high compliance rate or reasons for a poor compliance were included (2).

Critical factors and attitudes. Studies are any actions or behaviors, attitudes or training associated with a highly effective checklist implementation or compliance. All studies were included if they assessed empirically any factors associated with effectiveness of or staff compliance with surgical safety checklists. Studies were also included if they assessed the attitudes of staff members using the checklist ⁽²⁾.

Worldwide, there is now undisputed evidence that an overall incidence of adverse events in a hospital setting approximates 10%.1 Further, there is a realisation that 50% of these incidents are avoidable, and that inadequacies at the 'systemic' level play a major role in the causation of adverse events. Hence, improvements must be made within the systems to improve patient safety. World Health Organization (WHO)'s World Alliance for Patient Safety has launched the 'Safe Surgery Saves Lives' campaign. It has developed a surgical safety checklist, which is aimed to improve patient safety by ensuring basic minimum safety standards. Worldwide, different countries have adopted different approaches to the introduction of the checklist.

The checklist (Fig. 1) has three good practice stages

(1) sign in: before administration of anaesthesia;

(2) timeout: immediately before the surgical incision; and

(3) sign out: at the end of operation before the patient is removed from the operating theatre.



Health Ministry, Service Quality Standards, giving place to a safe surgical procedure was implemented in this project in Turkey. Process in research and surgical underlying the safe surgical procedure with feedback from the field safety checklist has been further developed and extended to 4 parts of 3 parts and made available to all health professionals with the Safe Surgery Checklist TR name. The aim of the study was to ensure patient safety in surgery application ⁽⁴⁾.

Fig. 2: GÜVENLI CERRAHI KONTROL LISTESI TR Hastanın Adı Soyadı Ameliyat/Bölgesi Ameliyat Tarihi

I. Klinikten Ayrılmadan Önce

1. Hastanın; Kimlik bilgileri Ameliyatı Ameliyat bölgesi

dogrulandı. 2. Hastanın rızası kontrol edildi mi? Evet

3. Hasta aç mı? Evet Hayır.....

4. Ameliyat bölgesi tırası yapıldı mı? Evet Hayır.....

5. Hastada makyaj/oje, protez, degerli esya var mı? Evet...... Hayır

6. Hastanın kıyafetleri tümüyle çıkarılıp ameliyat önlügü ve bonesi giydirildi mi? Evet Hayır.....

7. Ameliyat öncesi gerekli özel islem var mı? Lavman Mesane Kateterizasyonu Varis Çorabı Özel Tedavi protokolü DigerHayır

8. Ameliyat için gerekli olacak özel malzeme, implant, kan veya kan ürünü hazırlığı teyit edildi mi? Evet Hayır

9. Hastanın gerekli laboratuvar ve radyoloji tetkikleri mevcut mu? Evet

II. Anestezi Verilmeden Önce 10. Hastanın kendisinden Kimlik bilgileri Ameliyatı Ameliyat bölgesi

Hastanın ameliyatı ile ilgili rızası

Dogrulandı. 11. Ameliyat bölgesinde isaretleme var mı? Var Isaretlenme uygulanamaz

12. Anestezi Güvenlik Kontrol listesi tamamlandı mı? Evet

13. Pulse oksimetre hasta üzerinde ve çalısıyor mu? Evet

Hastanın Risk Degerlendirmesi

14. Hastanın bilinen bir alerjisi var mı? Yok Var

15. Gerekli görüntüleme cihazları var mı? Yok Var

16. Hastada 500 ml ya da daha fazla kan kaybi riski var mı?

Yok Var; uygun damar yolu erisimi ve sıvı planlandı

III. Ameliyat Kesisinden Önce

17. Ekipteki kisiler kendilerini ad, soyad ve görevleri ile tanıttı mı? Evet

18. Ekipten bir kisi sesli olarak hastanın kimligini, yapılan ameliyatı, ameliyat bölgesini teyit etti mi?

Evet

19. Kritik olaylar gözden geçirildi mi?

Tahmini ameliyat süresi Beklenen kan kaybı Ameliyat sırasında gerçeklesebilecek beklenmedik olaylar Olası anestezi riskleri Hastanın pozisyonu

20. Profilaktik antibiyotik sorgulandı mı?

Kesiden önceki son 60 dakika içerisinde uygulandı Kullanılmaz 21. Kullanılacak malzemeler hazır mı? Evet Hayır

22. Malzemelerin Sterilizasyonu uygun mu? Evet Hayır

23. Kan sekeri kontrolü gerekli mi? Evet Hayır

24. Antikoagülan kullanımı var mı? Evet Havır

25. Derin Ven Trombozu profilaksisi gerekli mi? Evet Hayır

IV. Ameliyattan Çıkmadan Önce
 26. Gerçeklestirilen ameliyat için sözlü olarak
 Hasta,
 Yapılan ameliyat,
 Ameliyat bölgesi,

teyit edildi. 27. Alet, spanç/kompres ve igne sayımları yapıldı mı? Evet/Tam Hayır

28. Hastadan alınan numune etiketinde Hastanın adı doğru yazılı

Numunenin alındığı bölge yazılı

29. Ameliyat sonrası kritik gereksinimler gözden geçirildi mi? Anestezistin önerileri:

Cerrahın önerileri:

30. Hastanın ameliyat sonrası gidecegi bölüm teyit edildi mi? Evet

* Her bölüm, ilgili sorumlular tarafından sesli olarak kontrol edilerek isaretleme yapılmalıdır

Aim of study

this study aimed to determine effective using of safety surgery check list in surgical area

Methodology

this research is retrospective study, between november 2011 and june 2014 lay a state hospital patient who have undergone surgical intensive care unit, surgical clinics and operating room. Population of the study 159 consisted of underwent surgery patient files. Determined using the method of total files.

Results

The implementation of a checklist in surgery not only is an effective tool for decreasing the burden of morbidity and mortality but also represents an opportunity to save costs in hospitals. Semel et al estimated that with the use of the checklists \$103,829 could be saved annually in a hospital conducting 4000 noncardiac operations. For highly effective implementation, the acceptance of the hospital staff and the adaption to the specific context, for example, different settings or circumstances of the hospital are important.

Further research is necessary about organizational and cultural factors influencing the success of the implementation of safety checklists in surgery $^{\scriptscriptstyle (2)}$

Implementation leaders to persuasively explain why and adaptively show how to use the checklist.

Table 1: Patients Gender

gender	Frequency	Percent
male	84	52,5
female	73	45,6
Total	157	98,1

According to the assessment result, incomplete values; the patients' identities 1.25 %, surgical site 57.23 %, date of surgery 59.74 %, It is determined that safety surgery checklist was used by them. According of the nurses safety surgery checklist was effective in the prevention surgical errors. All of the forms were filled by surgical staff.

Though safety surgery checklist was used efficiently used by nurses, there were some things that are lacking in the forms, such as it should be used in service training according to feedbacks taken from nurses.

Coordinated efforts to explain why the checklist was being implemented and extensive education regarding its use resulted in buy-in among surgical staff, and ultimately, thorough and sustained implementation. Further research is needed to confirm these findings and reveal additional factors supportive of checklist implementation.

Table	ο.	Alagant	ب طالعا العبر
Idule	Ζ.	AUSEIII	Vallully

	Frequency	Percent
Site	98	61,3
Date	99	61,9
1-idendification	19	11,9
1-operation	38	23,7
1-Side	29	18,1
2-Compliance	12	7,5
3-hungry	14	8,8
4-shave	16	10,0
5-Make up, nail polish	15	9,4
6-dress	14	8,8
7-special process	24	15,0
8- implant blood	17	10,6
9- laboratory	16	10,0
10-questioning himself	19	11,9
11-side sign	21	13,1
12-anestezi safety	18	11,3
13-pulseoksimetr	16	10,0
14-allergy	23	14,4
15-images device	19	11,9
16- blood lost	20	12,5
17-team introduced	8	5,0
18-audible confirmatio	8	5,0
19-critical period	7	4,4
20-antibiotic	20	12,5
21-materials ready	7	4,4
22-sterilization	6	3,8
23-blood glikoz	17	10,6
24-anticoagulan	16	10,0
25-deep vein	17	10,6
26-verbal confirmation	7	4,4
27-instrument counts	13	8,1
28-right sample name	77	48,1
28-samples taken area	99	61,9
29-anestesi	158	98,8
29-surgeon	159	99,4
30-go to section	16	10,0
Total	160	100,0

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PP 097

PERIOPERATIVE NURSING CARE OF PATIENTS WITH RISK OF DEEP VENOUS THROMBOSIS AND PULMONARY EMBOLISM FOLLOWING BARIATRIC SURGERY

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Keywords: Bariatric surgery, deep venous thrombosis, obesity, perioperative nursing, pulmonary embolism.

Background

Obesity is currently a major healthcare concern in the Western world, and is also increasingly affecting populations in the developing world. The World Health Organization estimates that 1 billion people in the world are currently overweight (BMI 25-30 kg/m2) and another 300 million to be obese (BMI \ge 30 kg/m2). Morbid obesity is defined as a BMI \ge 40 kg/m2. Bariatric surgery has become an increasingly popular treatment option for individuals with morbid obesity or those with less severe obesity accompanied by significant comorbidities.

Obesity is a risk factor for deep venous thrombosis (DVT) and pulmonary embolism (PE), and the contribution of obesity. Thromboembolic risks of surgery would suggest that patients undergoing bariatric surgery would have a particularly high risk of postoperative PE and/or DVT.

Focus of interest

This review was conducted to review the risk of DVT and/or PE following bariatric surgery, and to summarize related peripoperative nursing interventions.

Theoretical framework

Searching the PubMed database, a computerized search of PubMed, ScienceDirect, Google Scholar, and OVID (CINAHL) (from 2008 to present) identified literature for this review.

Presenting relevant literature references: Preoperative teaching is an important component in order to prevent DVT and PE. Part of this deals with explaining to patients about surgical procedures and what to expect after surgery. Discussions include specific measures to prevent DVT, including turning and positioning at least every 1 to 2 hours, and performing foot and ankle exercises. Leg exercises may be added to further enhance venous return to the heart and prevent venous stasis. Demonstrating exercises to patients and then have the patients perform a return demonstration helps to acknowledge patients understandings of these procedures.

Elastic stockings or sequential compression devices may be applied in the immediate preoperative period for DVT prevention unless contraindicated. Explaining to patients they can expect early ambulation after surgery, and to be prepared to take an oral or injectable medication to prevent DVT should be considered as standard procedures. Low-molecular-weight heparin or low-dose unfractionated heparin can be used for prophylactic reasons. The intraoperative nurse who receives patients into the operating room (OR) should review all preoperative patient histories and physical findings to determine if their patients are at risk for complications, including DVT. After taking preoperative patient histories and physical findings, perioperative nurse should be notified to not place pressure on anesthetized patients to avoid circulatory compromise. Extra padding on pressure points can prevent tissue damage and circulatory impairment.

Immediate postoperative nursing care begins when the OR nurses give a complete verbal report or generates an electronic documentation of the intraoperative events to postanesthesia nurses. After assessing airways and breathing, circulation should be maintained, Extremities should be inspected for clinical manifestations of DVT, and comparisons of circumference, color, and temperature of one leg to the other should be made. Unless contraindicated, elevating the foot of the bed also promotes venous return. Avoid placing pillows under the patient's knees as this can compress the popliteal veins. Elastic stockings or sequential compression devices may be applied.

Conclusions and implications for perioperative nursing

For patients to experience the potential health benefits of bariatric surgery, postoperative DVT and PE imposed by their obesity must be managed carefully by perioperative nurses.

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PP 098

SURGICAL NURSE'S ROLE DURING A DISASTER

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Keywords: Disaster, role, response, surgical nurse, triage.

Background

Recently, natural and man-made disasters have influenced the life of many patients hospitalized in surgical clinics. Estimates in the past decade alone show about 2million deaths due to disasters, 4,2 million injuries, 33 million left homeless, and about 3 billion affected due to disasters. The impact and ongoing natureof many of these events highlight the need for surgical nurses to be prepared to work effectively in disaster situations.

Focus of interest

The purpose of this review is to increase the awareness of the responsibility of surgical nurses in disaster situations and emphasize the importance of development, implementation, and evaluation of disaster training programs.

Theoretical framework

Searching the PubMed database, a computerized search of PubMed, ScienceDirect, Google Scholar, and OVID (CINAHL) (from 2005 to present) identified literature for this review.

Presenting relevant literature references

In order to utilize all possible health services efficiently and in coordination for all victims of disaster, surgical services and clinics, operating rooms and intensive care departments must prepare for disaster events and be supported byhealth systems.

It is generally accepted that nurses are the key professionalsto respond to disasters. Service begins with search and rescue operations. Triage, patient evacuation and transport come next. The emergency process, inter-hospital patient transport follows. Operation and intensive care roomsare the end process for the basic stages of disasters.

It is necessary that surgical clinics prepare for possible increased capacity plans for mass casualty incidents. This planning results in disaster-site triage to separate and distribute patients to ensure the most efficient use of available facilities and surgical services. Therefore, information about employees and operation teamsshould beavailable to disaster command centers. Operating room materials should be controlled, ongoing cases and ready roomsshould be reported to the disaster command center, and sterile materials should be provided by surgical nurse who should have complete and accurate records.

The principles of emergency management must be a part of emergency operations plans that includes a comprehensive plan for tackling all potential and actual hazards because the primary goal is the protection of the community. The emergency operation plans must be coordinated in advance to achieve a single common purpose, yet must be flexible enough to adapt to any situation. Predetermined organization is essential to minimize confusion, ensure that all key operations are directed, and promote a well-coordinated response.

Essential components of the emergency operations plan include the following:

- An activation response: The emergency operations plan activation response of a health care facilities defines where, how, and when the response is initiated.
- An internal/external communication plan: Communication is critical for all parties involved, including communication to and from prehospital arenas.
- A plan for coordinated patient care: A response is planned for coordinated patient care into and out of facilities, including transfers to other facilities. The site of the disaster can determine where the greater number of patients may be self-referred to.
- Security plans: A coordinated security plan involving facility and community agencies is key to the control of an otherwise chaotic situation.
- Identification of external resources: External resources are identified, including local, state, and federal resources, and information about how to activate these resources.
- A plan for people management and traffic flow: "People Management" includes strategies to manage patients, the public, media, and personnel. Specific areas are assigned, and a designated person is delegated to manage each of these groups.
- A data management strategy: A data management plan for every aspect of the disaster will save time at every step. A backup system for charting, tracking, and staffing is developed if the facility has access to a computer system.
- Demobilization response: Deactivation of the response is an important as activation; resources should not be unnecessarily exhausted. The person(s) who decides when a facility resumes daily activities is clearly identified. Any possible residual effects of a disaster must be considered before this decision is made.
- An after-action report or corrective plan: Facilities often see increased volumes of patients 3 months or more after an incident. Postincident response must include a critique and a debriefing for all parties involved, immediately and again at a later date.

- A plan for practice drills: Practice drills that include community participation allow for troubleshooting for any issues before a real-life incident may occur.
- Anticipated resources: Food and water must be available for staff, families, and others who may be at the facility for an extended period of time.
- Mass Casualty Incident (MCI)planning: MCI planning includes such issues as planning for mass fatalities and morgue readiness.
- An education plan for all of above: A strong education plan for all personel regardingeach step of the plan allows for improved readiness and additional input for fine-tuning of the emergency operational plans.

Conclusions and implications for perioperative nursing:Surgical clinics should have an organized plan for caring for mass casualties. Training programs should be developed, implemented and evaluated to increase the awareness about disaster response for surgical nurses.

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PP 099

B. PERIOPERATIVE/CLINICAL PRACTICE

RISK FACTORS AND PREVALENCE OF DISAGREEMENT AND AGGRESSIVE BEHAVIOUR AMONG HEALTHCARE WORKERS IN OPERATIVE THEATRES IN GREEK SETTINGS

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Keywords: aggression, multidisciplinary team, patient safety, perioperative nursing, quality of care

Introduction

The operating theatre has been described as the most typical example of an interdisciplinary team working in healthcare (Timmons & Tanner, 2005). Effective multidisciplinary communication secures cohesive teamwork and links to quality of care and patient safety (Schaefer, Helmreich, Scheidegger, 1995). Furthermore, disagreement and aggression between different health care professional groups in the operating theatre is directly related to surgical errors and job dissatisfaction (Wiegmann, ElBardissi, Dearani, Daly, Sundt, 2007).

Aim

To assess the prevalence of aggressive behaviour among healthcare professionals in operating theatres in Greece and to identify the underlying risk factors.

Results

High percentages of both physicians and nurses that reported to be aware of an aggressive behaviour (92.0% and 96.0%). Nurses were found to be witnesses of a conflict between different professions, with a total personal experience of an aggressive behaviour in higher percentages when compared to the physicians. Almost all physicians (94.0%) and all nurses (95.0%) were witnesses to an episode of a conflict between other professionals in the operating room. Working in a University hospital and total years of experience were listed among the two major risk factors for aggressive behavior in the operating theatre. In specific, witnesses were more frequent among healthcare professionals working in the University hospital.

Conclusion - Implication for perioperative nurses

Professional group, type of hospital and years of experience were found to affect the frequency of both awareness and personal experience of an aggressive behaviour between healthcare professionals. Teamwork is an integral part of patient safety in the operating room and our findings comprise a starting point for further research. Specific interventions should be adopted from stakeholders with the aim to cultivate respect and peaceful collaboration between healthcare professionals to foster high standards of patient safety.

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B. PERIOPERATIVE/CLINICAL PRACTICE

POSTOPERATIVE ACUTE PAIN IS NOT INEVITABLE, AND THE OR NURSE HAS A ROLE TO PLAY

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Keywords:pain, life skills, drug combination

Pain is an unpleasant sensory and emotional experience associated with tissue damage or potential present and described in terms of damage. It is a subjective experience, dependent of individual. This pain has different sensory aspects, affective and emotional, cultural, cognitive, ... and requires a multidisciplinary approach. It is not the prerogative of only the anesthesiologist.

In contact with the patient, the type of surgery and the surgical approach, the OR nurses and PACU (post anesthesia care unit) nurse have an important role in the management of this pain. They will be involved in five chronological stages: patient information, the application of drug combinations, assessing pain, his support in the recovery room and the organization of this support.

If the OR nurse is not the main actor in the management of pain in intraoperative stage, its place in the recovery room gives it a key role where knowledge, life skills and know-how will of great importance for each patient. The pain can no longer be regarded as inevitable and should be treated without compromise. InFrench, there is only one letter that changes between pain (douleur) and sweetness (douceur). This is where the OR nurses how sall his professionalism and human investment.

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PP 101

B. PERIOPERATIVE/CLINICAL PRACTICE "MY NAME IS..."

IMPROVING THE PATIENT'S EXPERIENCE IN THE OPERATING THEATRE DEPARTMENT USING PERSON-CENTRED LANGUAGE

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When implementing The Productive Operating Theatre(TPOT) Programme, the perioperative team aims to continuously improve the patients experience and outcomes. Walking with the patient along the stages of their surgical patient pathway makes usaware of what the patienthears at different stages of their journey. How many of us have ever stopped and listened to the language used in the Operating Theatre Department which can often be heard by patients and their relatives?Patients often wait inthe theatre holding bay/ reception areas, anaesthetic rooms prior to their procedures and are very conscious of their surroundings.

Common language spoken in the Operating Theatre Department and heard by patients: - "Is the next down?"

- "Your next is over there"
- "Will you send for the next?"
- "There is a delay with the lap"
- "We are on our last"
- "I'm sending for the wire"
- "The hernia isn't ready"
- "He is not in my section"
- "We're closing in theatre x so will you get our next down".

Is this patient centred? How does your patient feel?Put yourself in the patient's position lying on a trolley, waiting to have a procedure,apprehensive and being referred to as the "next", "last", "lap", "wire"....?

Conclusion

"I am a patient, having a procedure but remember I am a person with a name".

Make a difference to your patients experience in your Operating Theatre Department. Focus and encourage the use of patient centred language amongst your team. Take notice of patients in your environment; beaware and sensitive to what is being said. Stop. Look. Listen.

The power of change is in your words so"Tweak it before you speak it"

PP 102

PAIN LEVEL, INFLUENCING FACTORS AND APPLIED NURSING INTERVENTIONS IN PATIENTS UNDERGOING GIS SURGERY

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Keywords: Pain, postoperative pain, Gastrointestinal operation, Nursing, Care, Nursing intervention

The aim of this study was determined to pain levels anf influencing factors in patients undergoing GI (Gastrointestinal) surgery and nursing interventions related to pain management. Data were collected by questionnaire, visual analog scale, and evaluated with Mann-Whitney U and Kruskal Wallis tests. It was determined that all of the patients were experienced moderate level of pain according to visual analogue scale (6.19 ± 2.18). felt It was determined that the patients were felt 15.1% mild, 31.7% medium, 53.2% the severe pain. It was found significant differences between scale scores and diagnose types, education level of the patients. However It was not found significant differences between pain level and gender, marital status, live with family or alone, have an operation, chronic illness, get training about pain. It was found that nurses were the most common applied painkillers treatment (46%), monitoring of vital signs (42.1%), observing of drug side effects, ilac yan etkilerini gözleme (31.7) in patient with pain. This study was showed that the patients were experienced severe pain the early period after abdominal surgery and that frequency of non- pharmacological methods of nurses was very few.

Introduction

Pain is a complicated situation, which is affected by emotional and behavioral factors such as the individual's environment, gender, culture, education and experiences, differs from individual to individual, subjective and difficult to identify. Pain can be seen in surgical patients before, during and after the surgery. Before surgery pain comes out because of diseases requiring surgical intervention whereas during surgery it comes out because the secreting chemicals stimulate the nerve endings or because of the disruption of tissue bloodshot due to pressure, muscle spasm and edema. The pain after the surgery is a pain which starts due to reasons such as the patient's position during surgery, the interventions and tissue damage and which gradually decreases with tissue healing. Effective pain treatment in surgery patients is important, if not eliminated it negatively affects the patient both psychologically and physically. Pain causes emotions such as irritability, helplessness, anger, anxiety and fear, it can affect negatively the person's physical activity and social relationships, can make the person inadequate and can reduce the quality of life of the person. Besides, ineffective pain management may increase the rates of readmission to hospital and the treatment costs by extending the duration of hospital stay (Faydali 2010, Düzel, 2008, Topçu, 2008, Ramsay 2000). It is reported in the recent studies that the pain management is inadequate in the postoperative period and, therefore, approximately 50-80 of the patients have experienced pain from medium-level to severe (Yılmaz, Gürler 2011; Pöpping, Zahn, Van Aken, Dasch, Boche & Pogatzki-Zahn 2008 Apfelbaum, Chen, Mehta & Gan 2003). The pain must be identified and closely monitored in the postoperative period, as well as the patient's vital signs, hematological parameters, liquids received and excreted. Pain management must be provided with the painkillers pharmacologically and with other ways. The application of non-drug methods such as non-pharmacological methods as providing information, distraction, making them listen to music, massage, changing the position are extremely important in the surgical patient care (www.tard.org.tr.2011; Çetinkaya F, Karabulut N 2010; Bacaksiz, Çöçelli, Ovayolu, Özgür 2008; Carr, Thomas, Wilson-Barnet, 2005; Özer, Bölükbas 2001; Ramsay 2000; Karayurt 1998)

Nurses are the members of patient care team who are with the patients the longest time to perform maintenance and interventions in the postoperative period. Therefore, they have an important role in the control of pain (Ay & Alpar 2010; Özer, Bölükbas 2001). Their being knowledgeable and experienced in pain affects the success of the treatment (Çöçelli, Bacaksız, Ovayolu 2008, Topçu 2008; Eti A, Badır 2005; Özer, Bölükbas 2001; Rundshagen, Schnabel, Standl, Esch, 1999). However, it is reported in the result of the studies that nurses do not have sufficient knowledge and experience in pain (Çalik 2013; Özer, Akyürek, Basbakkal 2006; Eti, Badır, Seliman 2003; Özer, Bölükbas 2001).

Aim of study

This study was planned and practiced to determine that the patients in general surgery services with GIS history experienced pain at what level, the factors affected the pain and the nursing interventions applied for pain management in the first 48 hours after surgery.

Methodology

This cross-sectional descriptive study was held in Samsun Ondokuz Mayis University, Health Application and Research Center (OMU SUVAM) between 13/01/2014 and 25/04/2014. Permission was obtained from OMU SUVAM in order to conduct the study. Each patient to whom a questionnaire would be conducted was made statements about the study and consent was obtained from the patients. The sample of the study was 126 people who were in general surgery services, had GIS surgery history, were in the first 48 hours postoperatively, were able to do verbal communication, were conscious and willing to participate in the research and had no mental problems. The data was collected through face to face interviews by the questionnaire on the socio-demographic and pain status of the individuals, which was prepared by the researchers using the literature and visual analog scale (VAS). Vertical type was used between VAS 0-10 cm. The patients were evaluated by the number, percentage, mean, standard deviation, Mann-Whitney U and Kruskal-Wallis tests using SPSS 15.0 packaged software.

Results				
Table 1.	Patient's	Sociodemographic	Charecteristics	(N=126)

Varlable	Mean±Sd(mln-max)				
Age groups	51	.0 ± 11.6 (21- 65)			
	Ν	%			
<40 years yaS altı	54	42.8			
40 and above	72	57.2			
Gender					
MaleFemale	59	46.8			
	67	53.2			
Level of education					
Illiterate	9	7.1			
Literate	84	66.7			
Prlmary school	12	9.5			
High school	21	16.7			
Marltal status					
Single	28	22.2			
Married	98	77.8			
Lives					
Alone	11	8.7			
With family	115	91.3			
Smoking habit					
Yes	40	31.7			
No	86	68.3			
Chronic Disease					
Yes	44	34.9			
No	82	65.1			
Total	126	100.0			

It was determined that 53.2% of the patients taken in the study was women, 66.7% was literate level of education, 77.8% was married, 91.3%, lived with family, 31.7% had smoking habit. It was identified that all of the patients taken in the study had surgery with general anesthesia, 31% had colectomy, 22.2% had gastrectomy, 20.6% had appendectomy, 14.3% had cholecystectomy, 7.1% had liver operation, 4.8% had intestinal obstruction surgeries, only cholecystectomy interventions were laparoscopic, the other operations were carried out by open surgical technique. When the durations of the operations were analyzed, it was determined that 7.1% was less than 1 hour, 33.3% was between 1-2 hours, 23% was between 2-3 hours and 36.5% was 3-4 hours.

The duration assessed for pain after surgery was determined approximately 28.7 \pm 13.7 hours (min: 7-max: 48). It was stated that 39.7% of the patients had surgeries before, 31% had information about pain and 34.9% had a chronic illness. The average pain score of all the patients is moderate according to the visual analog scale (6.19 \pm 2.18) whereas it was stated that 15.1% of the patients felt mild, 31.7% felt moderate and 53.2% felt severe pain when the pain level was analyzed.

Table 2. Charecteristics of Patients' Operation (N=126)

Varlable	Mean ±Sd (mln - max)				
The period after the operation	28.7±13.7 (7- 48 saat)				
Level of the pain	Mean±Sd=6.19 ±2.18 (1-10)				
	N	%			
Mild	19	15.1			
Moderate	40	31.7			
Severe	67	53.2			

Operation experience in the past		
Yes	50	39.7
No	76	60.3
Obtain information about pain		
Yes	39	31.0
No	87	69.0
Anesthesia type		
General Anesthesia	126	100.0
Duration of the operation		
0-1 hour	9	7.1
1-2 hour	42	33.3
2-3 hour	29	23.0
3-4 hour	46	36.5
Operation Type		
Cholecystectomy	18	14.3
Gastrectomy	28	22.2
Colectomy	39	31.0
Liver operation	9	7.1
Intestinal obstruction	6	4.8
Appendectomy	26	20.6
Analgezics		
NSAI	92	73.0
Dolantin	11	8.7
Both of them	23	18.3
Total	126	100.0

When the patients were asked during which activities they experienced pain, it was stated that 70.6% of the patients had pain while coughing, 69.8% while moving, 55.6% while sleeping and 46% while breathing. It was stated in Yilmaz & Gürler's (2011) study that the patients with upper abdominal surgery had intense pain in the operated area while coughing and getting out of the bed and they had difficulty in doing activities such as breathing, sleeping, coughing and moving due to pain. (Yilmaz & Gürler, 2011) The type of the surgery and the surgery area affect the incisional pain experienced after the surgery. For example, abdominal surgeries are the surgeries in which the most severe pain is experienced because the incision is close to the diaphragm and due to heavy nerve network in the abdominal area (Roykulcharoen & Good, 2004). When the patient experience severe pain, s/he cannot do activities such as deep breathing, coughing, mobilization and sleeping which will promote healing and complications can develop (Haljamäe & Stomberg, 2003). In a study which was conducted to reduce the pain and anxiety of the patients in abdominal surgery it was emphasized that it was important to use non-pharmacological methods due to their having no side effects in addition to the analgesics (Roykulcharoen & Good, 2004).

Table 3. Conditions which patients' experienced pain in postoperative period (N:126)

Conditions which experienced pain	Ν	0/.
	l'i	70
Pain during breathing		
Yes	58	46.0
No	68	54.0
Pain during sleeping		
i an daning biooping	70	55.6
Yes		
	56	44.4
No		
Pain during coughing		
r an admig bodgring	80	70.6
Voc	00	70.0
165	07	00.4
	37	29.4
No		

Pain during the movement		
N	88	69.8
Yes	38	30.2
No		
Pain during dressing		
	70	55.6
Yes	56	44.4
No		

It was determined in our study that 73% of patients took NSAI, 8.7% took pethidine, and 18.3% took both of the drugs together as pharmacological interventions for pain management. A relationship was found between the education levels and types of diagnosis of the patients and their pain score averages and it was determined that the difference was statistically significant. It was determined that there was not a relationship between the level of the patients and their gender, marital status, with whom they lived, operation history, the state of chronic disease and receiving information about pain.

Table 4. Sociodemographic Characteristics of the Patients and Comparisons with VAS Scores (N=126)

CharacterIstIcs	VAS score	Test and p value
	(Mean rank)	
Age groups		
<40 years yaS altı	61.46	U= 1315.000
40 and above	64.08	P=0.735
Gender		
Male	61.56	U= 1862.000
Female	65.21	P= 0.571
Level of education		
Illiterate	25.50	KW
Literate	67.20	x ² =13.906
Primary school	50.00	p= 0.003
High school	72.69	p<0.05
Marltal status		
Married	56.89	U=1187.000
Single	65.39	p= 0.272
Lives		
Alone	74.41	U=512.500
With family	62.46	P= 0.294
Smoking habit		
Yes	70.23	U= 1451.000
No	60.37	P=0.154
Chronic Disease		
Yes	59.41	U =1624.000
No	65.70	P=0.351

Table 5. Charecteristics of Patients' Operation and Comparisons withVAS Scores (N=126)

CharecterIstIcs of Patlents'	VAS Scores	Test and p value
oporation	Mean±Sd	
Operation experience in the past		
Yes	62.61	U: 1832.000
No	64.86	p: 0.731
Obtain information about pain		
Yes	61.54	U: 1620.000
No	64.38	p: 0.683
Duration of the operation		
0-1 hour	58.80	Kruskall Wallis
1-2 hour	60.00	x²=1.045
2 + hour	66.38	p=0.593
Operation Type		
Cholecystectomy	38.03	x ² =230.263
Gastrectomy	79.38	p=0.000
Colectomy	72.68	p<0.005
Liver operation	72.33	
Intestinal obstruction	89.00	
Appendectomy	41.33	
The period after the operation		
0-24 hour	64.10	U= 1940.500
24-48 hour	62.84	P= 0.845

According to the statements of the patients it was stated that the nurses applied interventions to eliminate the pain respectively and the most common; analgesic therapy (46%), following vital signs (42.1%), monitoring side effects of drugs (31.7). The interventions which the patients stated that the nurses applied often were determined as evaluating the frequency (31.7%) and location (19%) of pain, preparing a comfortable and quiet environment for the patients (25.4%), changing positions, (25.4%), giving information about disease and drugs (24.6%) and helping mobilization (% 19.8).

50% of patients in this study stated that a pain assessment scale was not used to evaluate pain. As is known, it is important in the pain management process to know the patient at all points because the pain is an idiosyncratic symptom. Therefore, the nurse should have sufficient knowledge about the methods to get the right story, make continuous observation and appropriate pain assessment (Eti-Aslan 2002). It was found in the study conducted by Eti-Aslan and Badir (2005) that nurses had insufficient knowledge about evaluating and easing the pain. Dihle et al. (2006) also emphasized that the most important obstacle in effective pain management was that a systematic data collection and evaluation were not made.

Table 6: The frequency of Interventions of Nurses For Pain Relief

	Never Rarely		Rarely		SometImes		SometImes		Frequently		Always	
Nursing Inter- ventions	n	%	n	%	n	%	n	%	n	%		
Evaluation the pain with a scale	63	50.0	19	15.1	20	15.9	15	11.9	9	7.1		
Evaluation the location of pain	19	15.1	25	19.8	38	30.2	24	19.0	20	15.9		
Evaluation the frrequency of pain	19	15.1	16	12.7	36	28.6	40	31.7	15	11.9		
Measurement of vital signs	-	-	-	-	28	22.2	45	35.7	53	42.1		
Preparing a comfortable environment	4	3.2	20	15.9	54	42.9	32	25.4	16	12.7		
Changing the patients position	14	11.1	40	31.7	31	24.6	32	25.4	9	7.1		
Dolng massage	87	69.0	23	18.3	10	7.9	6	4.8	-	-		

HelpIng mobIII- zation	22	17.5	31	24.6	30	23.8	25	19.8	13	10.3
Distracting attention	41	32.5	47	37.3	26	20.6	12	9.5	-	-
Implementation of the relaxation technics	57	45.2	26	20.6	37	29.4	6	4.8	-	-
Giving infor- mation about disease and drugs	16	12.7	16	12.7	34	27.0	31	24.6	29	23.0
Supporting the incision site during the cough	35	27.8	27	21.4	27	21.4	15	11.9	22	17.5
Giving the orde- red medication	-	-	13	10.3	38	30.2	17	13.5	58	46.0
Observing side effects of drugs	9	7.1	35	27.8	21	16.7	21	16.7	40	31.7
DreamIng	108	85.7	16	12.7	2	1.6	-	-	-	-
Listening to music	104	82.5	22	17.5	-	-	-	-	-	-

When the patients were asked whether they were applied non-pharmacological pain control methods to stop their pain, 11.1% of patients stated that the position change, 17.5% the help for mobilization, 27.8% supporting the location of the surgery during the cough, 69.0% massage, 32.5% distracting attention, 82.5% making them listen to music, 85.7% dreaming were never used. It was found in this study that the nurses used only analgesic drugs for postoperative pain of the patients but they did not use non-pharmacological pain relief methods. It is pointed out in the results of the previous studies that non-pharmacological interventions are not applied as required by nurses (Çelik, 2013; Yılmaz & Gürler, 2011).

CoclusionIt was determined in this study that more than half of patients (53.2%) experienced severe pain in the early stage after GIS surgery and the pain was mostly felt during coughing and movement. It was shown in our study that although the nurses did their duty effectively

(\approx 90%) in the pharmacological treatment in pain management, the frequency of using non-pharmacological methods was low. It was found that the pain killers given for pain management were unable to provide optimal effect in relieving pain and the pain level of the patients who were applied combined modality therapy was lower than the others.

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PP 103

NEW DEVELOPMENTS IN THE ROLE OF OR NURSE IN ADMINISTRATING A HUMAN BONE BANK

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The purpose of a bone bank is to provide bone transplants with minimal antigenicity and maximum ostegenic potential. There are multiple indications for use of bone transplants, i.e. pseudoarthrosis, bone defects or complete absence of bone. Tissue banks in general and bone banks in particular have advanced to the point where the use of such grafts is now daily practice. Protocols for proper handling of bone minimize the concern for transfering disease or triggering a rejection reaction.

A bone bank is indispensable in modern surgery. Yet costs of equipment and strict protocols for graft preparation make it difficult to establish a bone bank even in larger clinics.

Our poster explains how to choose a donor and displays the statistics of our bone bank in University clinical center Maribor. A bone bank can function properly only under strictly defined conditions. Various problems may occur during the standard operation of a bone bank. The primary procedure has to be safe for the patient, graft harvesting has to be performed correctly and storage methodology has to be thoroughly supervised. The whole team needs to be informed about harvesting the grafts and spread of disease to the receiving patient has to be performed under aseptic conditions. We provide a detailed diagram of the core activities and all the needed paperwork and protocols.

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B. PERIOPERATIVE/CLINICAL PRACTICE INTRAOPERATIVE HANDOFF FOR OPERATING ROOM NURSES

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Key words: handoff, handover, delivery of patients, communication, checklist, information, safety.

Problems in the "transfer of patients" (handoff or handover) on the shift change during the perioperative process, derived from a deficient and/or wrong communication among professionals,⁽⁷⁾ are a constant concern for surgical nurses.

A standardized perioperative handoff process guiding the transfer of information and care responsibility⁽⁶⁾ between nurses reduces the risk of missed information.⁽³⁾

Focus of interest

The development of a standardized hand-off communication tool for the perioperative environment, allows operating theatre nurses to improve the delivery of patient care and responsability, on an ongoing operation

Theoretical framework

Communications leading to an incomplete exchange of information can contribute to a significant patient adverse or sentinel event and tragic error resulting in death. $^{(1)}$

Our hospital lacked of a standardized communication procedure between nurses during the intraoperative shift change. Therefore, nurses themselves decided to develop and use a basic structural toolkit⁽⁸⁾ in the form of a checklist type report (it is a printed and laminated document that is displayed in every emergency operating room). The procedure is carried out orally in a face-to-face basis⁽⁵⁾ between the nurses who go in and out shift⁽²⁾. The purpose of this procedure is to transfer the most accurate information that ensures patient's safety.⁽⁴⁾

Conclusions

With the development of this handoff, we intend to facilitate and improve information in the transfer of patients, during the shift change of nurses in the operating room

Implications for perioperative nursing: The goal of the handoff is to provide accurate information, both about the patient and the surgical process of an ongoing operation, to the nurses who start the shift so as to guarantee the continuity of care and help to minimize risks.

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PP 105

LAPAROSCOPY VERSUS LAPAROTOMY IN THE MANAGEMENT OF ECTOPIC PREGNANCY WITH MASSIVE HEMOPERITONEUM.

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To compare the safety and feasibility of operative laparoscopy versus laparotomy in women with ruptured ectopic pregnancy and massive hemoperitoneum.

Method

Records of women with ruptured ectopic pregnancy and massive hemoperitoneum between 2000-2007 were reviewed. The inclusion criteria were ruptured ectopic pregnancy and hemoperitoneum greater than 800cc. Patient characteristics and perioperative data were compared between the groups.

Results

During the study period 701 patients with ectopic pregnancy were hospitalized. 60 women were diagnosed with ruptured ectopic pregnancy and massive hemoprtioneum, 48 of which had emergent laparoscopy and 12 had emergent laparotomy. There was no difference regarding patient hemodynamic status on presentation, including blood pressure, heart rate, and hemoglobin level. The duration of the operative intervention was significantly shorter in the laparoscopic group (median, 50 min; range, 30-90 min; vs. 60 min; range, 20-160 min, P=0.01, laparoscopy vs laparotomy, respectively), while intra abdominal blood loss was significantly greater in the laparotomy group (median, 1500cc; range, 800-2500cc; vs. median, 1000cc; range, 800-3000cc, p=0.02). There was no difference between the groups regarding treatment with blood products, perioperative complications and hospitalization period.

Conclusion

In patients with hemodynamic instability, laparoscopy is feasible and safe with significantly shorter operative times compared to laparotomy. The significantly smaller amount of hemoeritoneum found in laparoscopy, albeit similar admission characteristics and blood counts may be a reflection of the shorter operative times and quicker hemorrhage control with this operative intervention.

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B. PERIOPERATIVE/CLINICAL PRACTICE

WARMING SYSTEMS AND STRATEGIES FOR PREVENTION OF HYPOTHERMIA WITHIN PERIOPERATIVE PERIOD

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Keywords: perioperative hypothermia, warming strategies.

Background

Hypothermia is a common problem of surgery. Inadvertent hypothermiacan causes many complicationssuch as prolonged wound healing, increased risk of wound infection, a higher rate of cardiac morbidity, coagulation disorders, prolonged nausea-vomiting during postoperatively, prolonged effect of hypnotics and neuromuscular drugs, prolonged length of hospital stay, and increased costs.^{1:3}

Objective

This review summarizes current evidence on the effective strategies for prevention and management of hypothermia within perioperative period.

Methods

Three reviewers examined systematic reviews(2000 to 2010),meta-analysis (2000to Apr 2009), and all randomized and quasi-randomized trials published in English on the Cochrane Central Register of Controlled Trials, MEDLINE, CINAHL (2010 to May 2014). We foundfour systematic reviews and one meta-analysis, sevenexperimental studies about prevention of hypothermia within perioperative period in adult patients.

Results

According to experimental studies, forced-air warming systems was significantly effective than passive insulation (such as blankets, socks or elastic bandages, surgical drapes) and radiant warming systems in preventing hypothermia.⁴⁻⁸However, circulating water garments tended to be more effective than forced-air warming systems.⁹⁻¹¹ Active warming systems when the body temperature is under 36 degrees C within preoperative period should be applied both preoperatively and intraoperatively.^{16.9}Passive warming systems were found to be ineffective in reducing the incidenceof hypothermia.⁴⁻¹¹According to studies, active warming systems are suggested to be used when there is usage of general anesthesia and duration of operation is than 30 minutes. Skin surface warming for 20 min immediately before induction of anaesthesia minimizes initial redistribution hypothermia.^{1,3,12-14}Temperature of intravenous fluids given to patients during the operation must be 37 degrees C. Irrigating fluids must be 38-40 degrees C.^{1,3,8,15}

Authors' Conclusions

Nurses must assess hypothermia in perioperatively. Active warming systems are beneficial to reduce the complications ofperioperative hypothermia. Some warming methods (heating blanket and dressings, warmed irrigating fluids) are practically applicable when low-cost method is indeed needed.

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RISK FACTORS AND PREVENTIVE STRATEGIES IN INTRAOPERATIVELY-ACQUIRED PRESSURE ULCERS

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Keywords: Intraoperative, pressure ulcer, risk factors, perianesthesia care

Background

Intraoperatively-acquired pressure ulcers (IAPUs) are a serious health care problem.1-3 They are responsible for 46.1% of immediate postoperative pressure ulcers.2 Healing of pressure wounds is delayed because it is difficult to mobilize patients especially after major surgeries. This leads to the postponement of the patient's discharge and an increase in health care costs.1,3

Objective

This review summarizes current evidences on the effective strategies for preventions and risk factors of IAPUs. Also, it provides suggestions for proper nursing care of patients.

Methods

In this study, we have reviewed studies published (2004 to Jun 2014) in English on the Cochrane Central Register of Controlled Trials, MEDLINE, CINAHL, and found two prospective studies, two retrospective observational studies, one retrospective explanatory study, one longitudinal study, three experimental researches (two randomized control trials), one descriptive study, one cohort model study, four systematic reviews, and one case analysis.

Results

According to evidence-based studies, there are many crucial risk factors for IAPUs; such as position (supine,6 lateral,4,6,7 knee-chest,6 prone,6 park-bech,6 sitting,5,6 hair extension8), hypothermia,2,9,10 sex,4,11 age,4,11 surface of the operating room bed,11 duration of surgey (≥90min),2,3,11,12 health conditions,2 blood loss,4 number of monitoring devices, 11 hypotension (a diastolic blood pressure of lower than 50 mmHg). 13, 14 The evidence-based studies have recommended dynamic pressure-relieving devices (eg, 4-cm thermoactive viscoelastic foam pad),14,15 preventive strategies for hypothermia (eg, forced air warming therapy),9,10 and assessment of high-risk patients for reduce incidences of IAPUs.16

Authors' Conclusions: All surgical patients should be considered at-risk for pressure ulcer development; therefore, perioperative departments should develop and implement strategic plans for the prevention of pressure ulcers in patients who will undergo scheduled surgical procedures lasting ≥90 min. Perioperative nurses must take a proactive and comprehensive approach to protect their patients from IAPUs.

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B. PERIOPERATIVE/CLINICAL PRACTICE

PREDICTION MODEL FOR 30-DAY MORBIDITY AFTER GYNECOLOGICAL MALIGNANCY SURGERY

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Objective

Gynecological malignancy surgery undertaken in a specialized gynecologic oncology unit may be associated with significant perioperative morbidity. Validated risk prediction models are available for general surgical specialties but currently not for gynecological cancer surgery. The objective of this study is to construct a preoperative nomogram predicting 30-day morbidity after gynecological malignancy surgery.

Methods

The medical records of 460 patients with elective gynecological cancer surgery in our center during 2005 and 2013 were reviewed. All peri- and postoperative complications within 30 days after surgery were registered and classified according to the definitions of the National Surgical Quality Improvement Program (NSQIP). To investigate independent predictors of 30-day morbidity, a multivariate Cox regression model with backward stepwise elimination was utilized. A nomogram based on this Cox model was developed and internally validated by bootstrapping. Its performance was assessed by using the concordance index and a calibration curve.

Results

The median age was 49 (range, 13-81) years. Eighty-three (18.0%) patients had at least one peri- or postoperative complication within 30 days after surgery. Multivariate regression analysis revealed that age (odds ratio 1.023, 95% Cl 1.002-1.044 P=0.031), operation time (odds ratio 1.005, 95% Cl 1.002-1.008; P=0.001), and serum albu-min level (odds ratio 0.627, 95% Cl 0.389-1.009; P=0.054) were independent predictors of postoperative morbidity. The nomogram incorporating these three predictors demonstrated good discrimination and calibration (concordance index=0.743; 95% Cl, 0.665-0.820)

Conclusion

30-day morbidity after gynecologic cancer surgery could be predicted by age, operation time, and serum albumin level. If externally validated, the constructed nomogram could be valuable for predicting operative risk in the individual patient.

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MOVEMENT OF HIGHER ACUITY CASES TO AMBULATORY SURGERY CENTER (ASC) SETTINGS

Ruth Shumaker (1)

Shumaker Perioerative Consulting, N/a, Germantown, United States (1)

In the 1970's ambulatory surgery centers (ASC) began to join the healthcare market. Since the humble beginnings of the ASC where only ASC I and II patients were being considered as appropriate for the ASC environment and the type of procedures being performed were those that did not require greater than 90 minutes for procedures and no longer than 6 hours of recovery, a lot has changed. Today, we find ASCs perform procedures on ASA III and IV patients. ASCs, thanks to technology, can perform complicated and complex procedures on high acuity patients. You will hear how high acuity patients are being migrated from the hospital to an ASC and why. Learn what procedures are being performed safely with excellent patient outcomes in the ASC today

Bibliography Ruth Plotkin Shumaker

Qualification Summary & Experience

Excellent blend of clinical and corporate experience. Successfully engaged at the senior executive and consultant level. Intimate knowledge of hospital operations, perioperative, perianesthesia, ambulatory surgery centers, endoscopy lab & sterile processing departments. Focus on assisting government agencies, ambulatory surgery centers, not-for profit and private-corporate hospitals.

- 2010 AORN Recipient: Award for Excellence in Perioperative Nursing
- 2014 AORN Foundation Outstanding Nurse Philanthropic Award
- AORN Foundation, Inc- Established the Ruth Plotkin Shumaker endowment
- 1977-present: Active member in the Association of Perioperative Registered Nurses (AORN)
- AORN National: President 1998-1999. Vice-President 1994-1996 Board of Directors 1990-94, Nominating Committee 1987-1989 AORN Foundation Vice-President 1991-1993, Board of Trustee 1991-2002
- Former Vice-President of the National Federation of Specialty Nursing Organizations

(NFSNO) representing all specialty nursing organizations- collective representation 330,000 members

- Member Sigma theta tau
- Member American Nurses Association
- Member of the Nurses in Business, Industry & Consulting Specialty Assembly.
- Member of Multicultural Nursing Specialty Assembly
- Member National Organization of Nurse Executives
- Member American College of Healthcare Executives
- Former AORN International Advisory Board member

PUBLICATIONS Extensive publications provided upon request

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- Shumaker, R.P. (1997) Medical-Surgical Nursing: Clinical Management for Continuity of Care "Perioperative Nursing," Black & Matassarin-Jacobs, W.B. Saunders, 5th edition
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MALE URINARY STRESS INCONTINENCE-ADVANCE SLING

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Keywords: Male urinary stress incontinence, sling procedure, quality of life, minimally invasive procedure (AdVance Male Sling Sistem), result of operation procedures in the pelvis; mostly after radical prostatectomy.

Men usually encounterstress urinary incontinence after prostate surgery. It is the involuntary leakage of urine while performing activities such as coughing, running, jumping etc. Despite a relativly small amount of patients, to them souch leakige represents a big medical and social problem, as they have to quit regular daily activities and are more restricted to home ground. One of the chances of curing the desease at men is so called AdVance system that offers urination control. It is minimal invasive procedure in regional or general anestesya. Nurses job is to get the patient into correct position for sergury and allow the procedure to be well done. Aseptic conditions are very important for the quality of the procedure - the patient has to be tought the importance of personal hygiene until the wound heals. Polypropylene net which is set through small cuts, suports urethra and allows the control of urination. Most of the patients can leave the hospital after two or three days and can soon get back to their regular lifestyle.

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B. PERIOPERATIVE/CLINICAL PRACTICE

WEB TEXT -REDUCING THE NUMBER OF NON ATTENDEES AND LATE CANCELLATIONS AT THE PRE ADMISSION CLINIC, SLIGO REGIONAL HOSPITAL

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Key Words: Web Text, SMS, Pre assessment, Non Attendees, Rework, Savings

The model of care of Elective Surgery "Safe and efficient surgical and anaesthesia practices requires an optimised patient" ⁽¹⁾ states that 75% of patients who require in-patient surgery are admitted on the day of surgery. This is now the National Target in Ireland ⁽²⁾. An average of 50 patients present for Day of Surgery Admission (DOSA) at Sligo Regional Hospital. The present capacity of the Pre-Admission Clinic (PAC) is 35 assessments weekly, a shortfall of 15 assessments. A review of the PAC statistics found that 24 to 30 patients per month either "Did not attend" (DNA) or gave little notice of cancellation.

Aims: Our aim was to reduce the number of DNA's and late cancellation by introducing a web text service (SMS). Guy et al conducted a Meta analysis and systematic review which found that SMS is a simple and efficient option for health services to improve service delivery $^{(3)}$.

Methodology: Patients' mobile contact details are available on the PAC referral card. The PAC secretary sends a text message to the patient 1 week before their appointment with a request to contact the clinic if they are unable to attend.

Results: Following the introduction of the web text, DNAs and Late Cancellation reduced to 6 in June 2014. Cancelled appointments were rescheduled thus increasing clinic activity. Conclusions: Improvement in the attendance by the introduction of a web text service has resulted in an increase in PAC activity of 33% in June 2014. With the rework costs of a patient who DNA for their clinic appointment estimated at Euro 300, the savings identified in both time and money for the clinic is evident.

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SIX MAIN USERS - ONE WELL ORGANISED STOREROOM

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Keywords: TPOT, Lean thinking, standardise, overstocking, waste walking

The store room in the Day Services Unit (DSU) at Sligo Regional Hospital has evolved to incorporate six services and more recently the staff from the main theatres provide staff cover in the DSU. The theatre store rooms at DSU and General Theatre were stocked differently and inappropriate placement of equipment in the Day Services Store Room resulted in hazardous floor space, overstocking, out of date stock, staff time loss and waste walking. Aim, Our aim was to standardise the DSU Store to mirror the store room in the main theatre using a uniform colour identifier for each specialty. Methodology, All main users met to discuss the reconfiguring of the store room. After a site visit, showing the visual management and the layout in the main theatre store, staff members were given a blank plan for their input into the new layout. The principals of the 5s's (Sort, Set in Order, Shine, Standardise, and Sustain) were displayed from The Productive Operating Theatre (TPOT) Well Organised Theatre Module ⁽¹⁾. Additional storage units were sourced from other sites. After reconfiguration a new stock sheet was designed detailing minimum and maximum stock levels. Specialised equipment was allocated an area with designated floor marking. Outcome/Results; We have achieved good visual management of the storeroom with standardisation of all consumables and reduced stock levels. Equipment now has a designated named area. Clear floor spaces for improved staff access to storage racks ensuring a safer working environment. Racks are clearly identified to facilitate the 3 second rule (2). Agreed standardisation for all multi-users has increased staff satisfaction. Plan for Sustainability/future plans; Six monthly reviews to maintain sustainability. Implementation of KANBAN $^{\odot}$ to enhance the stock control system and release the nursing staff for "TIME TO CARE".

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B. PERIOPERATIVE/CLINICAL PRACTICE HOW TO REPLACE A MISSING BONE?

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Keywords: cranial implant, addition of technologies in medicine, new technologies, perioperative nursing

New technologies offer better chances for treating serious diseases and improving the rehabilitation process. Perioperative nursing care follows this development of new technologies and implements them into clinical setting. In cooperation with clinical experts from University Medical Centre Maribor, a cranial implant was designed at the Faculty of Mechanical Engineering, University of Maribor. It is a result of collaboration with researchers and surgeons from both institutions, connecting the two completely different fields of science. The first project resulted in a construction of an artificial skull implant needed for replacement of the removed skull bone due to brain haemorrhage. The function of such skull implant is to replace the missing skull bone resulting from brain or skull injury or disease. After recovery, the missing part of the skull may be replaced with implants made of biocompatible materials. In the laboratory, a copy of the implant is initially designed, a silicone mould created and then filled with bone cement (1). The final product is implanted into a patient after the sterilization. Scrub nurse prepares the implant for gas sterilisation and arranges appropriate storage of the sterilised product before the implantation. Prior such advanced technologies were available, titanium implants and original bone stored in the bone bank were also used.

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FLASH STERILIZATION - A RETRO-PROSPECTIVE STUDY ABOUT THE PRACTICE OF FLASH STERILIZATION

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Keywords: flash sterilization

Introduction

Effectiveness of sterilization procedures is crucial to eliminate dangers occurring from the usage of medical equipment, which contacts human body, during operations. Flash sterilization (FS) has been used as an emergency procedure, initially in the US, in many operating rooms.

Objective

The purpose of this study is to identify if Flash Sterilization is used in the Hospital of northern Greece, under which circumstances, conditions and specifications. Data are collected to monitor existing processes and identify changes to develop guidelines for the practice of FS.

Methods

Data were extracted from questionnaires given to all major Northern Greece's hospitals (n=38), about the usage of FS, filled up by operating stuff. The procedure started in 2012 and held for two years.

Statistical analysis

Data were analyzed in SPSS 21.0 (IBM, Chi, III), at a significance level of .05. Sample was calculated by G-Power at a 0.80 power level (n=426). Normality was checked by Kruskall-Wallis and x2. Measures of central tendency were extracted. Significance was calculated by Mann-Whitney U-test, and a logistic regression analysis was used to determine the affections. All these, in bootstrap level of 999.

Results

The results showed an extended usage of FS. Critical to that, found to be conditions of usage (p, 05), maintenance (p, 05), bio indicators (p, 05), chemical indicators (p, 05) and level of training (p, 05).

Conclusions

Proper and wise usage of Flash Sterilization is important to insure immunity. Effectiveness depends on procedures and level of training.

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DETERMINING THE SAFETY ATTITUDES OF OPERATING ROOM NURSES

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Keywords: Safety; safety attitudes; nurse; operating room

Background

Due to their complex internal structure, stressful working environment, wide variety of medical equipments used and intricate working process; operating rooms are unique places that require special knowledge, skills and attention. When in the operating room (OR), nurses need to determine the risk factors that threaten the patient's safety, take the necessary precautions, control and record the process and follow the written instructions thoroughly. It is very important that the operating room nurses should be careful with the multidimensional factors that jeopardize patient safety, evaluate the patients comprehensively and care to protect and improve patient safety in individual care applications.

Purpose

We aim to determine the attitudes of nurses, who play an active role in the operating rooms, towards institutional safety.

Goals

Short term goal of the study is to determine and improve the institutional safety attitudes of nurses.

Long term goals of the study are to decrease or eradicate the factors that negatively affect the safety attitudes of nurses, to support the factors that have a positive effect on it and to help building in-house systems that prevent errors in health care delivery and protect the patient from possible harms of those errors.

Research Problems

(1) What is the mean safety attitude score in the operating room? (2) Is there a significant correlation between the number of years worked in the institution and the institutional safety attitude or mean subdimension scores? (3) Is there a significant difference between the educational status of the nurses and the institutional safety attitude or mean subdimension scores?

Method

61 nurses who were working in an operating room of a university hospital in Istanbul between May-July 2014, were not on leave and gave their permission to participate in the study were included in the sample group. Data were acquired using the "Identification Form" developed by the researchers with the help of the related literature and "The Safety Attitudes Questionnaire (SAQ)". Face-to-face interview technique was used to collect the data within the working hours of the nurses in times that did not prevent their work. Written permission of the related institution and of Istanbul University Cerrahpasa Faculty of Medicine Clinical Studies Ethics Committee was obtained prior to the study. Nurses were informed about the purpose and content of the study before data collecting tools were applied. Oral and written permission of the nurses were obtained. Frequency, percentage, mean, Pearson correlation test and Tukey's HSD Post Hoc test were used for data analysis. Results: Mean age of the nurses who participated in the study was 33.52±6.19. 75.4% of the nurses had a graduate degree. Mean number of years worked in the same institution was 9.75±6.90, while mean number of years worked in the operating room was 7.16±6.09. 67.2% of the nurses had patient safety training and 50.8% had quality training (Table 1).

Table 1. Descriptive Characteristics of Nurses (N=61)

Characteristics	n	%	X±SS
Age			33.52±6.19
Gender			
Male	2	3.3	
Female	59	96.7	
Education			
Assoclate degree	3	4.9	
Bachelor degree	46	75.4	
Master degree	12	19.7	
Have you received patient safety training?			
Yes	41	67.2	
No	20	32.8	
Have you received quality training?			
Yes	31	50.8	
No	30	49.2	
The years worked in the same institution			9.75±6.90
The years worked in the operating room			7.16±6.09
General Total	61	100	

Mean SAQ score of the nurses was 128.09 ± 26.89 . The highest subdimension mean score was of teamwork subdimension (35.62 ± 8.09), while the lowest was of stress recognition (14.81 ± 4.10) (Table 2).

Table 2. The Safety Attitudes Questionnaire subdimensions mean scores

Subdimension	Number of items	X±SS
Job satisfaction	11	25.03±8.85
Teamwork	12	35.62±8.09
Safety climate	5	15.09±4.05
Perception of management	7	19.75±5.45
Stress recognition	5	14.81±4.10
Working conditions	6	17.77±3.80
SAQ score	46	128.09±26.89

The educational status of the nurses did not cause a significant difference in mean total SAQ score (p>0.05), while there was a significant difference in the mean perception of management subdimension score (p<0.05). Patient safety and quality training status of the nurses did not cause a significant difference in the mean total SAQ score (p>0.05). The mean total SAQ score (p>0.05) and the nurses did not cause a significant difference in the mean total SAQ score (p>0.05). The mean total SAQ score (p>0.05) are difference in the mean total SAQ score (p>0.05).

Table 3. Comparison of Mean SAQ Score by Some Characteristics of Nurses (N=61)

Some Characteristics of Nurses	Job satisfaction	Teamwork	Safety climate	Perception of management	Stress recognition	Working conditions	SAQ
Education							
Associate degree Bachelor degree Master degree	30.00±3.60 24.19±9.10 27.00±8.50 KW: 2.52 p>0.05	39.66±7.57 34.36±8.31 39.41±6.12 KW: 1.27 p>0.05	15.33±5.03 14.82±4.13 16.08±3.67 KW: 0.58 p>0.05	21.00±6.55 18.71±5.40 23.41±3.89 KW: 0.59 p<0.05	16.66±2.88 14.65±4.38 15.00±3.24 KW: 0.63 p>0.05	20.33±3.78 17.36±3.95 18.66±3.05 KW: 2.03 p>0.05	143.00±27.87 124.13±27.34 139.58±21.77 KW: 1.72 p>0.05
Have you received patient safety training?							
Yes No	25.43±8.11 24.20±10.39 MW-U:368.50 p>0.05	35.65±8.03 35.55±8.43 MW-U:406.50 p>0.05	15.19±3.81 14.90±4.59 MW-U:394.00 p>0.05	19.65±5.31 19.95±5.85 MW-U:383.50 p>0.05	14.39±4.02 15.70±4.23 MW- U:346.00 p>0.05	17.51±3.89 18.30±3.67 MW- U:358.50 p>0.05	127.85±27.47 128.60±26.35 MW-U:410.00 p>0.05
Have you received quality training?							
Yes No	26.12±8.16 23.90±9.51 t: .98 p>0.05	36.16±7.87 35.06±8.42 t: .52 p>0.05	15.96±4.11 14.20±3.85 t: 1.73 p>0.05	20.38±5.24 19.10±5.67 t: .91 p>0.05	14.09±4.31 15.56±3.80 t: -1.41 p>0.05	17.64±4.08 17.90±3.56 t:26 p>0.05	130.38±27.31 125.73±26.70 t: .67 p>0.05

There was a significant positive correlation between the age of the nurses and the mean total SAQ score (r: .287 p<0.05), mean job satisfaction subdimension score (r: .304 p<0.05), mean teamwork subdimension score (r: .285 p<0.05) and mean perception of management subdimension score (r: .292 p<0.05). No significant correlation was found between the working hours in the operating room and mean total SAQ score (r: .224 p>0.05) while there was a significant positive correlation with the job satisfaction subdimension (r: .291 p<0.05) (Table 4).

Table 4. Distribution of Relationship Between Mean SAQ Score by Age and Institution Working Year of Nurses (N=61)

Some Characteristics of Nurses	Job satisfaction	Teamwork	Safety climate	Perception of management	Stress recognition	Working conditions	SAQ
Age	r: .304	r: .285	r:.195	r:.292	r:039	r:.133	r:.287
	p: .017	p: .026	p: .132	p: .022	p: .767	p: .307	p: .025
Years worked in the	r: .291	r: .185	r:.190	r:.151	r:013	r:.110	r:.224
operating room	p: .023	p: .153	p: .143	p: .245	p: .922	p: .399	p: .082

Discussion

Institutional safety attitudes of operating room nurses were evaluated in this study. Considering that one can get a minimum of 46 and a maximum of 230 points, mean total score of the nurses in the safety attitude scale was found to be 128.09 ± 26.89 . This result may be interpreted as medium level safety attitude among operating room nurses. A minimum of 12 and a maximum of 60 points can be scored in the teamwork subdimension. The mean teamwork subdimension score, which was the highest among other subdimensions, was 35.62 ± 8.09 and can be interpreted as medium level safety attitude. A minimum of 5 and a maximum of 25 points can be scored in the stress recognition subdimension. The mean stress recognition subdimension score, which was the lowest among other subdimensions, was 14.81 ± 4.10 and can be interpreted as medium level safety attitude. Medium level safety attitude of the

nurses is thought to be caused by working in the operating room of an institution with no quality certification for long years. Results indicate a need to improve the safety attitudes of nurses. 67.2% of the nurses working in the hospital where the study was conducted had received patient safety training and 50.8% had received quality training. The findings of Makai et al (2009) are similar to our results. There was no significant difference between the educational status of the nurses and mean total SAQ score (p>0.05) yet the difference in the mean perception of management subdimension score was significant (p<0.05). Tukey's HSD Post Hoc test results revealed that nurses with a postgraduate degree differ from the nurses with a graduate degree. Balık (2014) found no significant difference between the educational status of nurses working in emergency rooms and safety attitudes. In a review article by Rosseter (2014), educational status is counted among the important factors that affect quality care and patient safety. There was no significant correlation between the number of years worked in the OR and the mean total SAQ score (p>0.05), while there was a significant positive correlation with the job satisfaction subdimension (p<0.05). A study by Forsman et al (2011) showed that increased experience of nurses affect patient safety positively. This finding supports our results.

Suggestions

Nurses should detect the risk factors that jeopardize patient safety in the OR, take the necessary precautions, control and record the process and follow written instructions completely

In-house systems that ensure safety for the health care provider and receiver by creating a physically and psychologically positive environment and by diverting them from harming applications and dangers should be established.

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B. PERIOPERATIVE/CLINICAL PRACTICE

DETERMINING THE PERCEPTION OF PATIENT SAFETY CULTURE AMONG OPERATING ROOM NURSES

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Keywords: Patient safety; patient safety culture; nurse; operating room

Background

Due to their complex internal structure, stressful working environment, wide variety of medical equipments used and intricate working process; operating rooms are unique places that require special knowledge, skills and attention. Nurses working in the operating rooms have an important responsibility for forming and developing patient safety culture and reflecting it to service delivery. Nurses should be careful with the multidimensional factors that jeopardize patient safety, evaluate the patients comprehensively and care to protect and improve patient safety in individual care applications.

Purpose

We aim to determine the perception of patient safety culture among nurses who play an active role in the operating rooms.

Goals

Goal of the study is to help the nursing services management to form and develop patient safety culture, and develop strategies and plan the necessary regulations to reflect it to service delivery.

Research Problems

(1) What is the mean patient safety culture score in the operating room? (2) Is there a significant correlation between the number of years worked in the institution and the patient safety culture or mean subdimension scores? (3) Is there a significant difference between the individual characteristics of the nurses and the patient safety culture or mean subdimension scores?

Method

60 nurses who were working in an operating room of a university hospital in Istanbul between June-July 2014, were not on leave and gave their permission to participate in the study were included in the sample group of this descriptive study. "Identification Form" developed by the researchers and "Patient Safety Culture Scale (PSCS)" were used to collect the related data. Face-to-face interview technique was used to collect the data within the working hours of the nurses in times that did not prevent their work. Written permission of the related institution and of Istanbul University CerrahpaSa Faculty of Medicine Clinical Studies Ethics Committee was obtained prior to the study. Nurses were informed about the purpose and content of the study before data collecting tools were applied. Oral and written permission of the nurses were obtained. Frequency, percentage, mean and Pearson correlation test were used for data analysis.

Results

Mean age of the nurses who participated in the study was 34.43±6.60. 81.7% of the nurses had a graduate degree. 93.3% were female. Mean number of years worked in the same institution was 10.37±7.28. 63.3% of the nurses had patient safety training and 50.0% had quality training (Table 1).

Table 1. Descriptive Characteristics of Nurses (N=60)

Characteristics	n	%	X±SS
Age			34.43±6.60
Gender			
Male	4	6.7	
Female	56	93.3	
Education			
Associate degree	3	5.0	
Bachelor degree	49	81.7	
Master degree	8	13.3	
Have you received patient safety training?			
Yes	38	63.3	
No	22	36.7	
Have you received quality training?			
Yes	30	50.0	
No	30	50.0	
Institution working years			10.37±7.28
General Total	60	100	

Mean PSCS score of the nurses was 2.38±0.39. The highest mean score was of staff behavior (2.51±0.43), while the lowest was of care environment (2.17±0.52) (Table 2).

Table 2. Patient safety culture scale subdimensions mean scores

Subdimensions	Number of items	X±SS
Management and leadership	18	2.35±0.43
Staff behavior	15	2.51±0.43
Unexpected event and error reporting	5	2.42±0.49
Staff education	7	2.45±0.52
Care environment	8	2.17±0.52
PSCS score	53	2.38±0.39

There was no significant difference between the educational status or patient safety and quality training status of the nurses and mean total PSCS or mean subdimension scores (p>0.05) (Table 3).

Some Characteristics of Nurses	Management and leadership	Staff behavior	Unexpected event and error reporting	Staff education	Care environment	PSCS
Gender						
Female	2.36±0.44	2.52±0.45	2.43±0.50	2.48±0.47	2.21±0.51	2.40±0.38 2.11±0.38
Male	2.27±0.26	2.38±0.08	2.25±0.41	1.96±0.96	1.68±0.51	MW-U:60.00
	MW-U:89.00	MW-U:67.50	MW-U:85.50	MW-U:85.0	MW-U:47.00	p>0.05
	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05	
Education						
Associate degree	2.48±0.30	2.71±0.30	2.73±0.30	2.38±0.54	2.37±0.45	2.53±0.34
Bachelor degree	2.33±0.40	2.49±0.42	2.38±0.50	2.44±0.53	2.17±0.54	2.36±0.38
Master degree	2.46±0.62	2.60±0.55	2.55±0.48	2.51±0.47	2.14±0.47	2.45±0.47
	KW: .28	KW: .62	KW: 1.92	KW: .15	KW: .11	KW: .37
	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05
Have you received						
patient safetytraining?						
Yes	2.41±0.42	2.53±0.46	2.42±0.53	2.53±0.49	2.15±0.55	
No	2.25±0.44	2.49±0.50	2.42±0.44	2.30±0.53	2.21±0.48	2.41±0.42
	MW-U:312.00	MW-U:375.00	MW-U:412.50	MW-U:319.00	MW-U:383.50	2.33±0.33
	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05	MW-U:359.00
						p>0.05
Have you received						
quality training?						
Yes	2.38±0.48	2.54±0.51	2.46±0.60	2.57±0.55	2.15±0.58	2.42±0.47
No	2.33±0.37	2.49±0.35	2.38±0.36	2.32±0.45	2.19±0.46	2.34±0.29
	t: .39	t: .39	t: .66	t: 1.88	t:27	t: .76
	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05	p>0.05

No significant difference between the numbers of years the nurses worked in the institution and mean total PSCS score (r: .252 p > 0.05), while a significant positive correlation was present for unexpected event and error reporting (r: .332 p < 0.01) and care environment (r: .300 p < 0.05) subdimensions. Age of the nurses had a significant positive correlation with mean total PSCS score (r: .324 p < 0.05), staff education (r: .277 p < 0.05), unexpected event and error reporting (r: .333 p < 0.01) and care environment (r: .370 p < 0.05), unexpected event and error reporting (r: .332 p < 0.01) and care environment (r: .377 p < 0.05), unexpected event and error reporting (r: .353 p < 0.01) and care environment (r: .377 p < 0.05), unexpected event and error reporting (r: .353 p < 0.01) and care environment (r: .377 p < 0.05), unexpected event and error reporting (r: .353 p < 0.01) and care environment (r: .377 p < 0.05), unexpected event and error reporting (r: .353 p < 0.01) and care environment (r: .377 p < 0.05), unexpected event and error reporting (r: .353 p < 0.01) and care environment (r: .335 p < 0.01) (Table 4).

Table 4. Distribution of Relationship Between Mean PSCS Score by Age and Institution Working Year of Nurses (N=60)

Some Characteristics of Nurses	Management and leadership	Staff behavior	unexpected event and error reporting	staff education	Care environment	PSCS
Age	r: .069	r: .249	r:.353	r:.277	r:.335	r:.324
	p: .602	p: .055	p: .006	p: .032	p: .009	p: .011
Institution working years	r: .032	r: .188	r:.332	r:.144	r:.300	r:.252
	p807	p: .150	p: .010	p: .272	p: .020	p: .052

Discussion

One of the important aspects of quality management in health care delivery is patient safety. In this study, patient safety culture was found to be low in the operating rooms that the nurses worked in. In a study conducted in different hospitals by Çakır (2007), patient safety culture of hospitals with a quality certification was found to be higher than hospitals with no quality certification. Quality studies have been going on in different levels in the hospital that this study was conducted in. Low safety quality may be a result of this issue.

There was no significant difference between the numbers of years the nurses worked in the institution and patient safety culture. Results of the study by Göz and Kayahan (2011) are similar to ours. Aiken et al (2003) showed that rather than the level of experience, higher education level of the nurses affects the quality of patient care. Saraç (2009) found that as the healthcare worker gets older, their patient safety knowledge score decreases. Considering that mean age of the nurses was medium in our study (34.43±6.60), this may work as an advantage for patient safety.

Suggestions

Nurses should take responsibility about patient safety in the operating rooms. Patient safety should be addressed in detail in the in-service training programs of hospitals. Patient safety culture brings out development opportunities for a higher quality service delivery and thus contributes to quality management system. Efficient and productive quality management system, in return, increases patient safety.

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PP 118 B. PERIOPERATIVE/CLINICAL PRACTICE COACHING TOOLS AT THE PREADMITION CLINIC

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Keywords: Health coaching, bariatric surgery, motivational interviewing, behavior change, coping.

Background

Bariatric surgery is the most effective treatment for patients with class 2 and class 3 obesity, with long-term success in treating the severely obese. (1, 2

Still, despite the detailed information regarding self management behavior given in the preadmission clinic, approximately 20%-50% of patients begin to regain their weight within the first 2-3 years following bariatric surgery.⁽³⁾ Therefore, a different Using the "Health Coaching" approach at the preadmission clinic, enables giving an effective

"tailor made" preparation in a very short time.

The term "Health Coaching" has emerged from the motivational interviewing concept. It is a specific conversation within a special framework that guides the patient to discover his or her own personal ambivalence to health behavior change, and the change is directed by the patient. (4

The structure of change has six stages. ⁽⁵⁾ Knowing the stage where the patient is, enables the nurse to use the most effective support. Identifying the coping style of the patients from the "BASIC PH" coping model, (6) using strategies from the positive thinking and "Health Coaching", enables patients to identify difficulties before they occur, find solutions that are suitable for their lifestyle and start making small steps towards the change, even before the surgery.

Results

50 patients were treated with "Health Coaching". One patient canceled the surgery and made the changes alone. He lost 35 kg in 6 months. The others reported that the changes they began making before the surgery, strengthened their self-confidence and the ability to keep the change in their lifestyle for a long time.

Conclusions

An extended research is needed to see the long term effect of the short coaching intervention.

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B. PERIOPERATIVE/CLINICAL PRACTICE

THE INVESTIGATION OF ERGONOMIC CONDITIONS OF THE OPERATING ROOM NURSES

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Keywords: Operating room, nurse, ergonomy.

Introduction

Unsuitability of the working environment of the operating room nurses cause ergonomic problems. This study was planned as a descriptive study with the aim of investigation of ergonomic conditions of operating room nurses of Ege University Research Hospital in Turkey.

Methods

Population of the study consisted of 65 operating room nurses who work in the operating rooms of one University Hospital and volunteered to participate in the research. Data were collected between 01 January 2014 and 15 JuNe 2014. The researchers explained the guestionnaire forms and the purpose for which they were used to the nurses included in the study and obtained their verbal consent, after which the forms were distributed, and left with the nurses to be answered. A questionnaire was used consisting of 26 questions for determining identifying characteristics, operating status of nurses, physical properties of the operating rooms and person's posture properties and Cornell Muscuoskeletal Discomfort Questionnaires in order to determine ergonomic conditions intended for muscuoskeletal system. Data analysis was performed using the program SPSS for Windows 18. Numbers, percentages and chi-square were used in data evaluation.

Findings

The study included 65 nurses who were the avarage age 35.06 ± 7.17 of. It was deter-

mined that % 90,7 of the nurses worked upright standing posture (balanced on two leg), % 92,3 used knee bending down most of the dual position, % 93,8 used sitting upright and % 90,8 used incorrect position for pulling the patient in the bed the right way. It was found out that, % 33,8 of the nurses had musculosceletal diseases and % 36,4 of them had waist diseases. It was determined that % 89,2 of the nurses experienced problems related to inappropriate height of the table and % 87,7 of them constant body position.

Discussion and Conclusion

It was concluded that operating room nurses experienced ergonomic problems depending on incorret posture and inappropriate physical conditions of the working environment.

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Faculty disclosure: No conflict reported

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B. PERIOPERATIVE/CLINICAL PRACTICE

AN EXAMINATION OF ENVIRONMENTALLY FRIENDLY PRACTICES IN THE OPERATING THEATRE

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Keywords:environmentally friendly, operating theatres, nursing

Introduction

The harmful effects on the environment of medical waste from the practice of health care have been seen for centuries. Thus, waste management is of great importance. Operating theatres are small in area but account for a fifth to a third of all hospital waste The purpose of this study was to determine environmentally friendly practices in operating theatres in Izmir province in Turkey.

Methods

Data collection was accomplished using an Operating Theatre Identification Form developed by the researchers and the Checklist of Environmentally Friendly Practices in the Operating Theatre developed in 2011 by GreenhealthPractice after testing for language validity. Data was collected from nurses responsible for operating theatres by face-to-face interview. The population of the study was formed all hospitals in Izmir province (50 hospitals), and the study sample was the hospitals in Izmir province which consented to take part in the research (8 hospitals, 15 operating rooms). The study was conducted between 15 January and 30 May 2014.

Findings and Results:

The operating theatres included in the study had on average seven rooms and 15 working nurses, and performed 25 operations a day. It was found that 87% of the operating theatres always monitored their waste, and 93% gave their batteries to recycling; 73% renewed their surgical sets so as to reduce excessive use of materials, and 67% preferred reusable materials to single-use materials in their surgical sets. However, 60% of operating theatres had no environmental team, 93% did not use a surface cleaner which did not harm the environment, and for lighting, 84% did not use sensors and 60% did not use LEDs.

Results

Nurses in operating theatres can make a great contribution in the future by playing an active role in environmentally friendly practices.

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B. PERIOPERATIVE/CLINICAL PRACTICE

SURGICAL CASE CANCELLATIONS IN DIFFERENT GEOGRAPHICAL REGIONS OF TURKEY

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Keywords: Cancellation of surgery, Elective surgery, operating room, Surgical procedures

Introduction

Cancellation of planned surgical intervention is an important subject that needs to be taken into consideration. Cancellation may involve either stoppage of surgical operation until next time or total withdrawal (Dadas and Eti Aslan 2004). Hospitals aim to achieve constant patient flow and to operate at an effective capacity. However, cancellations impede patient circulation and cause to wasting operating room resources (Haana and et al 2009). Short-term cancellations of planned surgical interventions also affect the quality of surgical treatment. According to the current literatüre, cancellation prevalence for planned surgical interventions varies between %5 and %20 (Schuster and et al 2013).

Operating room, which is one of the important investment areas of hospitals, is an important place in terms of efficient use of resources (Knox and et all 2009). The main aim of planning of surgical interventions is to ensure efficient use of highly expensive resources. Cancellation of cases prevents this aim because cancellations require more time and resources (Schuster and et all 2013).

Moreover, delay of planned surgical intervention also affects healthcare quality through hindering the efficient use of resources and increasing costs. Reasons behind the cancellation might be related to patient-related issues, as well as it might be related to clinical staff and institution (Hovlid and et all 2012). Some cancellation reasons are inappropriate preparation of patient before the intervention, health problems, delay or change of surgical team, administrative problems, time limitations, or giving priority to emergency conditions (Dadas and Eti Aslan 2004).

Cancellations, in addition to creating costs, might influence patient and patient family emotionally. Cancellations done in the last minute create stress for patients, leading to anxiety, dissappointment, and even anger (Knox and et all 2009, Schuster and et all 2013). Moreover, negative physiological factors derived from hunger, which is caused by delay of the intervention, also harm the patients (Hovlid and et all 2013). In addition, in certain conditions, health insurance firms may demand for extra costs due to the extended treatment process (Schuster and et all 2013). In the hospital side, inefficient use of operating room, and organizational problems related to surgical and anesthesia lead to increases in cost, whereas in the patient side, duration of hospital stay increases, which then leads to increases in hospital charges, anxiety levels rise, and changes in certain physiological parameters occur (Schuster 2011).

Aim

This study was done retrospectively in orderto determine rates and causes of surgical interventions in the different regions of Turkey.

Methodology

This study was conducted in 16 hospitals belong to a healthcare group, which are located in different regions. Necessary permisions were taken from relevant institutions. Universe of the study is formed by the planned-surgeries between March (2014) and April (2014), whereas the cancelled surgeries constitute the sample group. Data were taken from automation systems of hospitals retrospectively. For the analyses of the data gathered, descriptive statistical methods were used.

Findings

According to the data collected between March and April in 16 hospitals, 15.271 surgeries were planned, and 13.901 (%91.02) of these surgeries were completed; however, 1.370 (%8.9) of these surgeries were cancelled.

Surgical Branch	Number (n)	%
General Surgery	240	17,5
Otorhinolaryngology	239	17,4
Plastik Surgery	219	16
Gynaecology	143	10,4
Cardiovascular Surgery	132	9,6
Urology	129	9,4
Orthopedics	92	6,7
Neurosurgery	57	4,2
Eye	35	2,6
Other	38	2,8
Orthodontics	22	1,6
Thoracic surgery	14	1,0
Organ transplantation	9	0,7
Hematology	1	0,1
Total	1370	100

Surgery cancellation reasons were examined in 10 different groups, and the most frequent reason was determined as "patient's withdrawal" (%40.3). Reasons such as patient's withdrawal, not reaching to the patient, patient's not coming to hospital for registration procedures etc. were grouped within this topic. The second most frequent cancellation reason is "medical reasons" (%21.7). Having a differet disease, in addition to the patient's existing necessity for surgical intervention, and having unsuitable medical inspection reasons is shown in Table 2.

Table 2	2.	Distribution	of	cases	based	on	cencellation	reasons
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Cancellation Reasons	Number (n)	%
Patient's Withdrawal	552	40,3
Delay due to medical reasons	297	21,7
Doctor's decision	274	20,0
Insurance based	112	8,2
Cost	48	3,5
Disappear of Surgical Indication	36	2,6
Delay	31	2,3
Patient's decision to be operated in a different hospital	18	1,3
Intensive Care Demand	1	0,1
Operating Room based	1	0,1
Total	1370	100

Discussion

Cancellation of surgical interventions causes certain problems for different groups: for inpatients, extending duration of hospital stay, workforce loss, and interruption of daily life, for nurses, patients with increased anxiety, for surgeons and anaesthetist, managerial and administrative problems such as schedueling for next day with more constricted agenda (Knox and et all 2009, Schuster and et all 2013).

In another study done retrospectively in order to determine cancellation reasons, it was seen that, within 12 months period, 16.559 operating room reservations were done, and 1198 (%7.2) of them were cancelled on the day of operation (Haana 2009). In this study, surgical case cancellation raito, in line with the literature, was found to be %8.9. In a hospital in Spain, within 52 months duration, case cancellation ratio was found to be %6.5 (González-Arévalo and et all 2009). Another retrospective study done in Hong Kong, case cancellation ratio was found to be %7.6 (Chiu and et all 2012). Lastly, in a similar study done with 329.784 cases, cancellation ratio was found to be %12.4 (Argo and et all 2009).

Cancellations cause disappointment for patients, nurses, anaesthetist, and surgeons. Cancellation reasons may vary depending on hospital characteristics. According to a study, in which cancellation reasons within general surgery, orthopedics, urology, and gynaecology departments in 25 different hospitals (university hospitals, big public hospitals, small public hospitals) were examined, it was seen that cancellation ratios of university hospitals (%12.4) were 2.23 times higher thn cancellation ratios of small-to-medium public hospitals (%5). Moreover, it was also found that cancellations in general surgery department were significantly higher than those of in gynaecology department (Schuster 2011).

This study was done in a hospital belong to a private healthcare group, and, because of the lack of sufficient studies about this topic, it could not be compared to other private hospitals in Turkey. Distribution of the cancellations in terms of the academic field of study was found to be as, respectively, general surgery (%17.5), otorhinolaryngology (%17.4), and plastic surgery (%16). The reason behind this might be thatin this hospital most of the operations were done in these areas. In the literature, the most frequent cancellations occur in general surgery (%20), urology (%13), orthopedics (%8), and thoracic and cardiovascular surgery (%6) (Chiu and et all 2012). According to Boudreau et al (2011), the highest rate of cancellation was seen in otorhinolaryngology department, and it was followed by, respectively, urology, orthopedics, general surgery, and plastic surgery departments.

Although it might be predicted with foresight, whether the surgeries of patients with highrisk will be cancelled or not cannot be known completely. Cancellations of surgeries with long duration cause more problems in terms of time and resource management, compared to cancellations of surgeries with short duration (Tung and et all 2010). Reasons of cancellations show variance: medical reasons (not doing efficient pre-surgery evaluation), reasons related to operating room organization (inefficient use of capacity, lack of materials or insufficient personnel), and managerial reasons (insurance processes) (Schuster 2011).In this study, cancellation reasons were grouped, and it was found that patient's withdrawal is the most frequent reason of cancellation. Among the patient's withdrawal reasons, it was detected that patients gave up having a surgery, and as a result, they did not apply to the hospital. Because this study was done in a private hospital, it might be thought that patients did not informed sufficiently about costs and surgical intervention. In a different study, it was found that %65 of cancellations were patient-related; patient is not medically ready (%25), surgery is considered as unnecessary (%17.6), general condition of patient (%12.9), not reaching to patient or patient's late arrival to intervention (%11.3) (Haana and et all 2009).

According to Bahtla and colleagues' (2010) study done with 2.473 pediatric cases, cancellation rate was found to be %7.64, and the most frequent reasons were determined as upper respiratory tract infections (%30.68) and time limitations (%29), of which %38.6 were preventable. In this study, it is thought that more than half of the cancellation reasons are preventable reasons due their patient and hospital related characteristics. In retrospective study done by Knox and colleagues (2009), it was stated that most frequent hospital-related reason was lack of bed, the most frequent patient-related was patient's unwillingness, and most frequent medical reason was inappropriate treatment (coumadin, aspirin, oral contraceptive). Furthermore, in the same study, it was argued that cancellation rates were decreased with a ratio of %12.7 through applying systematic evaluation prior to surgery (Knox et all 2009). According to a different study, it was found that%50 of the cancellation reasons were medical reasons. Among these categories, respectively, infection-fever, patient's unwillingness, not having available time in operating room were found (González-Arévalo and et all 2009). Dimitris et al. (2013) found cancellation rate as %5.19, and most frequent cancellation reasons were, respectively, inconvenience of patient (%33.73), lack of available beds, (%21.79), time limitations related to operating room (%17.31). Initiatives toward reasons lead tosurgical interventions must be determined. According to the studies cited above, it is seen that the most frequent reason of cancellation selated to operating room was found to be the most frequent reason (Chiu et all 2012), whereas,in this study, operating room related limitations (%0.1) was found to be one of the least frequent reasons.

According to a observational study done by using daily surgery lists, cancellation rate was found to be %21, and patients' inconvenience (coming to the hospital in the day of surgery) and time limitations related to operating room were found to be the most frequent reasons (Jawaid and et all 2014). In that study, when the cancellation reasons are examined, it was seen that the cancellation reasons are, respectively, patient-related (%35), medical condition changes (%28), institution-related (%20), surgeon (%8), and anaesthesia (%1). Decreasing interventions may decrease patient-related cancellations, and it is important to configure factors related to organizational policy for elective surgery interventions. Unexpected cancellations affect efficient use of operating rooms, and they also affect patient satisfaction and employee motivation in a negative way (Argo et all 2009).

While cancellation reasons show variance, demand for hospitals emergency services, its region of service, and population also influence this situation. For instance, in a hospital located in where the homeless people population is high it was found that patients' not being ready for surgery is higher. In the literature, removing shortcomings in polyclinic and outpatient services and detailed evaluation of patients with high risk are offered to prevent case cancellations (Basson et al 2006). In a study focused on the affect of cancellations on patients and patient relatives, it was seen that negative emotions developed in %30 of the patients, even %54 of them cried. In addition, %30 of the families reported that they felt desperation, and shared their sadness with their relatives (DadaS and Eti Aslan 2004). What is more, cancellation of planned surgical intervention can also lead to job losses for patient and patient relatives, and then causes to problems in re-arrangement of surgical intervention. According to the findings of a comparative study investigating the cancellation reasons and extra cost caused by this delay, in the eastern region of Turkey, it was found that existence of upper respiratory infection and transportation difficulty is an important reason for delay, and average cost per cancelled case was found to be 227 TL for thestudy group, whereas it was found to be 70 TL for the control group (Sekmenli and Salman 2013).

Conclusion

Case cancellation reasons show great variety, and patients' withdrawal was detected as the most frequent reason among the patient-related cancellations. Reason behind patients' withdrawal is thought to be either doctors' insufficient information or insufficient conviction of patient about the necessity of the surgery. In this study, it is argued that more than half of the case cancellations were preventable. Cancellation or delay of planned surgical intervention negatively affects both patient and patient relative. Therefore, it is offered that first cancellation suggestions must be determined, and then solution suggestions must be developed depending on the characteristics of the institution.

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PERIOPERATIVE NURSING JOB SATISFACTION INCREASE THROUGH CCR (CASE CART ROOM) SET STANDARDIZATION.

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Keywords: CCR(CASE CAER ROOM), Perioperative NursingJob satisfaction

Background

CCR SET refers to a set of surgical materials that are required for surgery in each of the operation room and is delivered by the central processing unit that manages surgical equipment. Therefore, in order to efficiently manage the CCR, it is essential to analyze the list of good and apply standardization.

Through the process map, processes conducted in the surgery department, materials management and distribution center according pre-op, during-op and post-op, were analyzed and the results showed a total of 16 problems. In particular, non-value-added times spent verifying and organizing the quantity of CCR, due to a large quantity of return and re-order rate, were verified to be the biggest problem. Also 88% answered "yes" to the need for standardization of CCR, confirming the high need for standardization.

Seoul National Univ. Bundang Hospital, at the same time of it's opening in 2003, introduced and implemented the CCR System, striving for specialization of the treatment materials management of the operating room. However, as the medical technology advances, the severity of the surgery is also growing with it, the complexity of the surgery increased and treatment materials for the operating room diversified, leading to an increased work related to CCR and decreased job satisfaction according to nurses, requiring improvement activities to standardize the CCR SET.

- 1. Target: 4 departments with high standard indicators based on the CCR transferred Data from January 1, 2013 June 18
- Duration: Before improvement April 1, 2013 ~ April 30, 2013, after improvement from September 1, 2013 to September 30, 2013
- Perioperative Nursingjob Satisfaction Evaluation: Survey targeting operating room nurses from 4 selected departments

Methods

- CCR SET Standardization: 167 CCR set were standardized in consultation with the department based on CCR data from the recent 6 months and operating procedures
- 2. Standardization of the Drape Package: As the draping method changes, cases of lacking or excess materials occurred, so based on the recent 6 months of operational procedure and draping methods, deleting the excess materials and adding the material, previously used as a single item, to the package so that performing the operation is possible by using only a single package.
- 3. CCR Transfer Program Improvement: By displaying the interdisciplinary surgical data from the CCR transfer screen, CCR omission regarding the interdisciplinary surgical operation were prevented. Also, by adding a re-issuing function to reissue the items with the same item code, reduction of the return and re-ordered rate were attempted
- 4. CCR bag packaging improvements
- 5. Staff Training

Results

- 1. Return Rate: Reduction from 21.59% to 9.06% (58% decrease)
- 2. re-ordered Rate: Reduction from 25.43% to 9.89% (61% decrease)
- 3. Job Satisfaction: Accession from 40.3 points to 60.29 points (47% increase)

The great significance of this study lies with the point that it became a turning point to re-establish and standardize regarding the CCR System through this QA activity. Also, decreased non-value-added activities in relation to return and re-order activities lead to increased job satisfaction and efficiency and in addition, nurse direct care time with patients is expected to increase. Therefore, proposal to expand application of standardization of CCR transfer SET to all treatment departments is suggested.

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B. PERIOPERATIVE/CLINICAL PRACTICE

IMPROVEMENT ACTIVITIES WITH THE TARGET OF ZERO ERROR IN SURGICAL SITE MARK

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Kaorn, Seoul National University Bundang Hospital, Seoul, Korea, Republic Of (1)

Keywords: Surgical site mark, Patient safety

Background

We have commenced improvement activities to reduce the errors in surgical site mark in order to be established as a patient safety culture of the surgical site mark, which is an essential requisite (the 4th edition of the JCI Hospital Certification Standard) of the International Patient Safety Goal (IPSG) in accordance with the International Hospital Standard. The our operating room began to monitor the errors after having established the surgical site mark guidelines in 2008. However, errors in the indication of the area of surgery continued to occur, thereby presenting the risks of occurrence of dangerous incidents. And we set to reduce the errors in surgical site mark by 70% in order to improve the awareness of the importance of surgical site mark.

Methods

1. Feedback

The details of the errors were reported to operating surgeon on monthly basis in order to prevent recurrence.

2. Education

Notice boards for surgical site mark were posted in all the hospital wards.

3. Promotions

Promotional video was produced several times with participation of all medical treatment departments.

4. Reinforcement of execution

A. Outstanding medical resident in indication of the area of surgery will be selected and announced once a month.

B. Item of "has accurate surgical site mark been made?" was added to the record chart filled in by the doctors prior to the surgery.

Results

1. Marker errors: Decrease from 24 case to 3.7 case (84.6% decrease)

2. The average error rate of the medical treatment department: Decrease from 1.28% to 0.15% (88.3% decrease)

Conclusion

The New order related to surgical site mark began medical staffs and the awareness of its importance was made more consistent by the doctor in charge who stand at the entrance waiting for the patients in order to proceed the surgical site mark.

We are developing CDW(Clinical data warehouse), which is a program that, in the event of occurrence of error in the area of surgery, enables the medical staffs to easily monitor and manage the errors for each of the causes.

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C. EDUCATION REFLECTIVE WRITING: AN INNOVATIVE WAY TO LEARNING

Cora Bagaoisan (1)

University Health Network, Toronto Western Hospital, Toronto, Ontario, Canada (1)

We often hear the term reflection, reflective practice, reflective thinking in our clinical practice. It is regarded as an important skill to develop as it enables the nurse to have self-awareness. Mastering this skill facilitates lessons learned from what was observed and experienced and aids in professional growth and development of the nurse. It is also a formal process in which the College of Nurses expects its members to engage in inorder to maintain their competence in today's changing environment. Meeting these requirements is an essential component to reaching ones potential.

This presentation will highlight different theoretical models of reflection currently being use in academic centers in Canada and how it was adapted and applied in perioperative setting at our institution. The use of reflective writingas part of the orientation process for new staff at Toronto Western OR will also be discussed. Adapting these concepts as a new approach to learning emphasizes critical reflection to promote transformation in beliefs and learning necessary for reflective practice. Some of the examples of reflective writing submitted will be presented and discussed as well as benefits gained from the experience.

PP 127 C. EDUCATION

FAILURE, POWER AND TREATMENT OF BARIATRIC SURGERY PATIENTS

Raiq Bshara (1)

Tel Aviv Medical Center, Sourasky Medical Center, Tel Aviv, Israel (1)

The consequences of obesity, espicially in its most advanced level, such as reduction in the expectation And quality of life, psychosocial problems and a high incedince of degenerative diseases.

Obesity has become epedemic and public health problem througout the world. The failure rate in the conservative treatment includes increasing the disease in the surgical sphere which included gastric banding and sleeve gastrectomy as restrective procedures and rygb, dudenal switch and biliopancreatic diversion as malabsorbtion procedure.

While the experts were busy to treat the failure with multidisciplinary team the mini gadtric bypass surgery approved its power to treat the obesity simply, shortly, with less comlications and show same results to manage diabetes.

The american society metabolic an bariatric surgery has described clinical pearls for postoperative care of bariatric surgery patients and emphasizes that nursing diagnosis and interventions can save bariatric patient life.

The whole content of this abstract is based on personal education from world wide studies.

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C. EDUCATION

TURKISH SURGICAL ASSOCIATION EDUCATIONAL ACTIVITIES

Senay Kaymakci $^{(1)}$ - Meryem Yavuz $^{(2)}$ - Yelda Candan Donmez $^{(2)}$ - Eda Dolgun $^{(2)}$ - Esma Ozsaker $^{(2)}$ - Aliye Okgun Alcan $^{(2)}$

Turkish Association Of Surgical And Operating Room Nurses, Turkish Association Of Surgical And Operating Room Nurses, Izmir, Turkey ⁽¹⁾ - Ege University, Ege University Nursing Faculty, Izmir, Turkey ⁽²⁾

The Turkish Association of Surgical and Operating Room Nurses was founded in Izmir in 1998 as the Association of Operating Room Nurses. In 2002, the association made necessary revisions and took the name of the Association of Surgical and Operating Room Nurses. On 22.06.2005, the Turkish Interior Ministry gave written permission for the word "Turkish" to be used in the title of the association, which then became the Turkish Association of Surgical and Operating Room Nurses. In 2011, the association applied for membership of the European Association of Surgical and Operating Room Nurses.

Since its foundation, the Association has arranged many scientific events. Within the country, it has arranged 12 congresses and symposia, 12 courses, 37 monthly scientific meetings in Izmir province, three European Perioperative Nursing Day events, 9 approach update meetings and four other scientific meetings. Outside the country, it has participated in ten scientific meetings. The Bulletin of the Turkish Association of Surgical and Operating Room Nurses is published twice yearly. The Association has carried out two projects and has published nine books.

In this study, the activities of the Turkish Association of Surgical and Operating Room Nurses presented.

THE ACTIVITIES OF THE TURKISH ASSOCIATION OF SURGICAL AND OPERATING ROOM NURSES

CONGRESS & SYMPOSIUM

1) I. National Symposium on Operating Room Nursing 26-27 September 1996 Izmir

- 2) II. National Symposium on Operating Room Nursing 16-17 September 1999 Izmir
- 3) III. National I. International Congress on Operating Room Nursing 25-27 October 2001 Istanbul
- 4) National Surgical Congress 2002 Nursing Section 15-19 May 2002- Antalya
- 5) 4. National Surgical and Operating Room Nursing 22-26 October 2003- KuSadasi-Aydin
- 6) National Surgical Congress 2004 Nursing Section 26-30 May 2004- Antalya
- 7) VIII. Nursing Section of the National Breast Diseases Congress 21-24 September 2005-Istanbul
- 8) National Surgical Congress 2006 Nursing Section 24-28 May 2006-Antalya
- 9) Turkish Surgical and Operating Room Nursing Congress 04-08 September 2007-Gaziantep
- 10) VI. Turkish Surgical and Operating Room Nursing Congress 3-6 May 2009- KuSadası-Aydın
- 11) VII. Turkish Surgical and Operating Room Nursing Congress 5-8 May 2011- ÇeSme-Izmir
- 12) VIII. Turkish National Congress of Surgery and Operating Room Nursing 21-24 November 2013 - KuSadasi-Aydın

COURSES

- 1) Laparoscopic Surgical Nursing Course 14-15 September 1999-Izmir
- 2) Operating Room Nursing Course II, Infection Control 22-24 November 2001-Izmir
- 3) Operating Room Nursing Course II, Infection Control 29 November -1 December 2001 - Izmir
- Operating Room Nursing Course II, Infection Control 23-25 January 2002- Gaziantep
 Operating Room Nursing Course II, Infection Control 12-14 June 2002- Erzurum
- 6) Operating Room Nursing Course II, Infection Control 19-21 June 2002-Trabzon
- Operating Room Nursing Course II, Infection Control 6-8 November 2002- EskiSehir
- 8) Operating Room Nursing Course II, Infection Control 22-24 January 2003- Bursa
- 9) Operating Room Nursing Course II, Infection Control 31 January 01 February
- 2003Konya
- 10) Operating Room Nursing Course II, Infection Control 1-3 September 2003- Adana
- 11) Operating Room Nursing Course II, Infection Control 08-09 June 2006- Aydın
- 12) Operating Room Nursing Course II, Infection Control 30 May-1 June 2007- Afyon

MONTHLY SCIENTIFIC MEETINGS

Date	Subject	Place
20.12.2002	Time Management	Ege Üniversitesi AraStırma ve Uygulama Hastanesi
03.03.2003	Team Creation	SSK YeniSehir Egitim ve AraStırma Hastanesi
04.04.2003	Communication	Hatay Mevki Askeri Hastanesi
16.05.2003	Surgical and Operating Room Nurse Duties, Powers and Responsibilities	Dr.Behçet Uz Çocuk Hastanesi
30.09.2003	Effect of Hospital Infection Control Infection Control and Closed System	Ege Saglik Hotels with EczacıbaSı Health Cooperation
25.12.2003	Positive Thinking Habits	Ege University School of Nursing
23.01.2004	Recording of Perioperative Nursing Practice	Dokuz Eylül Üniversitesi AraStırma ve Uygulama Hastanesi
26.03.2004	Handwashing Surgery	Hatay Mevki Askeri Hastanesi
07.05.2004	Family Violence: Causes, Consequences and Solutions	Izmir Atatürk Egitim ve AraStırma Hastanesi
28.12.2004	Central and Peripheral Venous Catheters in Infection Control	Ege Üniversitesi Atatürk Kültür Merkezi
23.02.2005	Preoperative Patient Preparation	Hava Hastanesi
30.03.2005	Isolation	Ege Üniversitesi Atatürk Kültür Merkezi
20.04.2005	The Importance of Early Mobilization	Ege Üniversitesi Atatürk Kültür Merkezi
01.06.2005	Transport of Patients	Ege Üniversitesi Atatürk Kültür Merkezi
30.11.2005	Ethics in Nursing	Ege Üniversitesi Atatürk Kültür Merkezi
28.12.2005	Powered Support for Wound Healing Methods	Hatay Askeri Mevki Hastanesi
25.01.2006	Recording of Perioperative Nursing Practice	Ege Üniversitesi Atatürk Kültür Merkezi
22.02.2006	New Regulations of The New Turkish Penal Code and Bring Nurse	Ege Üniversitesi Atatürk Kültür Merkezi
29.03.2006	Nursing Approach Pain	Dokuz Eylül Üniversitesi Hastanesi
26.04.2006	Patient Safety in Surgery	lzmir Atatürk Egitim ve AraStırma Hastanesi
31.05.2006	Safe Medication Practices	Ege Üniversitesi Atatürk Kültür Merkezi
28.06.2006	Alternative Medicine	Ege Üniversitesi Atatürk Kültür Merkezi

27.12.2006	Transport of Patients	Ege Üniversitesi Atatürk Kültür Merkezi
31.01.2007	Innovations That Nurses Bring to The Turkish Penal Code	Saglık Bakanlıgı Tepecik Egitim ve AraStırma Hastanesi
28.02.2007	Informed Consent	Nevval Salih ISgören Alsancak Devlet Hastanesi
28.03.2007	Pressure Wounds and Nursing Care	Ege Saglık Hastanesi
25.04.2007	After Epidural Anesthesia Patient Care	Ege Üniversitesi Atatürk Kültür Merkezi
30.05.2007	Patient Care After Mastectomy	Özel Gazi Hastanesi
31.10.2007	Evidence-Based Practice in Pain	Kent Hastanesi
28.11.2007	Wound Assessment	Ege Üniversitesi Atatürk Kültür Merkezi
26.12.2007	Informed Consent	Ege Üniversitesi Atatürk Kültür Merkezi
30.01.2008	Sterilization Applications in The Operating Room	Ege Üniversitesi Atatürk Kültür Merkezi
27.02.2008	Preoperative Patient Education	Saglık Bakanlıgı Bornova Acil Yardım ve Travmatoloji Hastanesi
26.03.2008	Patient Care in Open Heart Surgery	Ege Üniversitesi Atatürk Kültür Merkezi
15.04.2008	Waste Methods	Izmir Egitim ve AraStırma Hastanesi
28.05.2008	Bloodborne Pathogens and Prevention Methods	Izmir Egitim ve AraStırma Hastanesi
28.01.2009	Preventing Infection After Heart Surgery	Özel Ege Saglik Hastanesi

CURRENT APROACHES IN SURGICAL AND OPERATING ROOM NURSING

- 1) Current Approaches in Surgical and Operating Room Nursing 24 September 2011 Izmir
- 2) Current Approaches in Surgical and Operating Room Nursing 31 March 2012 Adana
- 3) Current Approaches in Surgical and Operating Room Nursing 06 April 2012 Edirne
- 4) Current Approaches in Surgical and Operating Room Nursing 12 May 2012 Istanbul
- 5) Current Approaches in Surgical and Operating Room Nursing 12 September 2012 Izmir
- 6) Current Approaches in Surgical and Operating Room Nursing 14 September 2012 Bolu
- 7) Current Approaches in Surgical and Operating Room Nursing 29 September 2012 Ankara
- 8) Current Approaches in Surgical and Operating Room Nursing 01 December 2012 Karaman
- 9) Current Approaches in Surgical and Operating Room Nursing 25 May 2013 Ankara
- 1) Evidence-Based Practice DuringPreoperative, Intraoperative and Postoperative 21 October 2009 Izmir
- 2) Turkish Surgical and Operating Room Nurses Association of 12th Anniversary Events 06 January 2010 Izmir
- 3) Surgical Care and Quality of Life Symposium 04 May 2012 Manisa
- 4) Ege University Surgical Nursing Days 2013, "Care Quality Indicators" 5-6 April 2013 Izmir
- EUROPEAN SURGICAL AND OPERATING ROOM NURSES DAY MEETINGS

1) European Surgical and Operating Room Nurses Day. Promoting a Positive Environment 15 February 2012 Izmir

- 2) European Surgical and Operating Room Nurses Day. Perioperative Nursing A humane profession 15 February 2013 Istanbul
- 3) European Surgical and Operating Room Nurses Day. Be Seen, Be Safe, Be Heard. 19 February 2014 Izmir

PUBLICATIONS

- 1) I. National Operating Room Nursing Symposium Book 1997
- 2) II. National Operating Room Nursing Symposium Book 2001
- 3) National Surgical Congress 2002 Nursing Section of the Book 2003
- 4) IV. National Surgical and Operating Room Nursing Congress Book 2005
- 5) National Surgical Congress 2004 Nursing Section of the Book 2005
- 6) Turkish Surgical and Operating Room Nursing Congress Book 2007
- 7) VI. Turkish Surgical and Operating Room Nursing Congress Book 2009
- 8) VII. Turkish Surgical and Operating Room Nursing Congress Book 2011
- 9) VIII. National Surgical and Operating Room Nursing Congress Book 2013

PROJECTS

- 1) Determining The Current State of The Operating Room in Turkey 2009
- 2) Investigation of The Practices Safe Surgery, Smoke and Fire in Operating Room 2013

INTERNATIONAL MEETINGS

- 1) Association of Perioperative Registered Nurses -AORN Congress Colorado-Denver 11-13 March 2010
- 2) "Association of Perioperative Registered Nurses (AORN) Massachusetts Chapter 1 Board of Directors" ve "People to People Citizen Ambassodor Programmes Perioperative Nursing Delegation to South Africa-Capetown in November 2010

- OTHER ACTIVITIES

- 3) Professional Education Covidien Energy-Based Devices Global Perioperative Summit Dublin-Ireland 26-27 May 2011
- 4) EORNA Board Meeting Helsinki-Finland 17-20November 2011
- 5) EORNA Board Meeting Lizbon/Portugal 24-26 April 2012
- 6) 6. EORNA Congress Lizbon/Portugal 26-29 April 2012
- 7) EORNA Board Meeting Zagreb/Croatia16-18 November 2012
- 8) Congress of the International Federation of Operating Room Nurses Ottowa-Canada 21 -25 April 2013
- 9) EORNA Board Meeting Prag/Czech Republic 1-5 May 2013
- 10) EORNA Board Meeting Stockholm-Sweden 07-11 May 2014
- 11) EORNA Board Meeting Estonya-Talin 30 October-01November 2014

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URL: www.tcahd.org

e-mail: tcahd.tcahd@yahoo.com.tr

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C. EDUCATION

POSTGRADUATE EDUCATION IN SURGICAL NURSING AT EGE UNIVERSITY

Meryem Yavuz (1) - Eda Dolgun (1) - Fatma Demir Korkmaz (1) - Turkan Özbayir (1) - Selda Karaveli (1

Ege University Faculty Of Nursing, Ege University, Izmir, Turkey (1)

Keyword: Surgery, Postgraduate Education, Ege University, Nursing

Background

The Surgical Nursing Department of Ege University Health Sciences Institute commenced postgraduate education in 1982. The Masters programme consists of two semesters of theoretical and practical education and a one-year thesis, while the doctorate programme comprises two years of theoretical and practical education and a two-year thesis.

Purpose of the study

The purpose of this study was to introduce the Masters education programme of the Surgical Nursing Department of Ege University Health Sciences Institute.

Methods

An examination was made of the postgraduate programme of the Surgical Nursing Department of Eqe University between 1982 and 2014. Data for the study was obtained by the researchers from the Ege University Health Sciences Institute and the national thesis centre website. Numbers and percentages were used in evaluation of the data.

A total of 80 students have graduated from the Department, of whom 42 were Masters students and 38 doctoral students. Regarding the topics of the theses submitted to the Department, in the Masters programme 81.0% were on clinical practice, 16.6% on education, and 2.4% on care at home; in the doctoral programme, 89.5% were on clinical practice, 7.9% on education, and 2.6% on care at home. In the educational year 2013-2014, 21 Masters students and 15 doctoral students were enrolled in the postgraduate education programme.

Conclusions

Ege University Surgical Nursing is foremost in the country in the number of Masters and doctoral students which it accepts. The topic of 75% of theses relate to clinical practice. Surgical nursing postgraduate education provides professional development.

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PP 131

C. FDUCATION INFORMED CONSENT: IS IT ENOUGH?

Darlene Kulhawy (1) Alberta Health Services, Royal Alexandra, Edmonton, Alberta, Canada (1)

Keywords: Informed consent, communication

It was investigated to determine how effectively an individual would retain and recall information delivered to them approximately 6 months prior to cataract surgery. Further research was completed to determine effective ways to deliver information to patients by clinicians to achieve increased results in treatment outcomes.

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C. EDUCATION TALKING ABOUT TROUBLES IN OUR JOB

Filippo Lauri (1) Azienda Ospedaliera San Camillo- Forlanini, Carlo Forlanini, Rome, Italy (1)

I would like to illustrate what happens.

Many events that could cause some trouble are due to wrong communication inside the operating theatre.

In the past our profession was based on executing orders prescribed by the surgeons; now it is not so.

We are practitioners and we must know what to do or not to do. We must know the boundaries of our behaviour and actions.

Becoming practitioners has increased our responsibilities. What really is responsibility? What does it mean: "being responsible"?

What do you think about he increase of our responsibilities??

Many times I have seen some strange actions carried out by my colleagues; in most cases these wrong actions were caused by wrong attitudes and communication. In my opinion it is better to encourageour knowledge about our responsibilities.

Being prepared and qualified means having the capacity to reduce wrong actions, malpractice and mistakes.

If we know what we can or cannot do, we will avoid mistakes and trouble; my message should be a stimulus to improve our profession and the assistance to every patient.

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C. EDUCATION THE IMPORTANCE AND CONSEQUENCES OF RECEIVING NURSING STUDENTS DURING THE TRAINING IN THE OPERATING ROOM.

Fivet Marie (1) Afiso, Clinique Et Maternité Sainte Elisabeth, Namur, - (1)

Keywords: welcome, student, training, operating room

Question: a structured welcome developed for the operating training can make it less stressful for the students and more formative through better lived. Stress occuring prior te training, we must act mainly before and at the beginning of the internship. A questionnaire was sent to two groups of students.

One for a test group and the other to a group of students who receive a structural welcome: meeting with an OR nurse and the delivery of a home notebook before the training. In the test group, 83% of students want written information prior the training and the topics they would like addressed at a future meeting include reception, acces to the operating room and the locker room.

Students in the second group no longer mention these themes.

They focus instead on the details of daily life in the operating room such as contact with physicians and surgical disciplines.

The quality of the prepartory work done before the course and at the beginning of this one helps students in the second group to live their arrival in training so less stressful than other students

There is a relatively large difference when analyzing the state of mind described by the students in both groups

From the answers we can conclude that the structured welcome received in the second group favorably influences the desire to work in the operating room.

Il is therefore interesting for both the students and the hospital institution to enjoy and to offer a structured welcome (meeting, home notebook and a support at the arrival to the training). This particular welcome as statictically improves the experience in training that want to purse a career in the operating room.

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C. EDUCATION

MANUAL SUTURE: OR NURSE QICK REFERENCE USED GUIDE

Carmela Monsalve Linares $^{\rm (1)}$ - Maria Sandra Monsalve Gomariz $^{\rm (1)}$ - Francisco Daniel Leon Esparrell $^{\rm (1)}$

Hospital Universitario Infanta Leonor, Hospital Universitario Infanta Leonor, Madrid, Spain (1)

Keywords: manual suture, types of material suture, types of needle.

Introduction

The word "suture" describes any strand of material used to ligate (tie) blood vessels or approximate (bring close together) tissues. Sutures are used to close wounds. Both the Egyptians and Syrians used sutures and ligatures as far back as 2,000 B.C.

Objetives

 Knowledge and improve the different types of suture materials and needles types in the surgical procedure.

2) Manual suture: Nurse quick reference used guide.

Teorical frameworks

- Describes different types of suture:
- Materials types (natural, synthetic);
- Materials structures (monofilament and multifilament);
- Material degradation type (absorbable and non-absorbable: time degradation);
- Different sizes;
- Different types of needles (circles, triangles, tappercut...);
- More common used in OR (operating room)
- The correct form of use the sutures.

Design OR nurse quick reference used guide. They can use it in the work place without a distingued comercial register

Conclussions

The big variety of the combination sutures characteristics made sometimes difficult the correct election and also to know disposal in the OR.

The correct and complete knowledge of the sutures, permit to the OR nurse realises the best and the quick practices in the surgical procedures.

The quick reference guide used guide is good tools for the OR nurse beginners and experts.

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PROMOVED SECURITY IN THE OR: CORRECT USED OF BASIC TOOLS

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Keywords: Control of infections, surgery, surgical clothing, hand washing and asepsis.

Introduction

Aseptic control measures are an essential key to reducing infections. One of the most important sources of microbial contamination is the surgical staff. The proper use of surgical attire and proper placement of protective barriers by the surgical team is essential.

Objectives

To emphasize the importance of understanding and applying the surgical attire basic rules. Promote the protective barriers that OR nurse must full pay attention:

- Correct placement of surgical attiring (cap, mask, eye protection, hose, gloves).

- Preparation of hands before a surgical scrub.

Teorical frameworks

We have used the material obtained from different articles, protocols and literature re-

viewed as well as their own professional experience and consulted other health partners. After analysis of the material obtained, we performed a graphical description using vignettes showing different activities to challenge and give a quick overview of both the wrong way and the right, at the time of the activity.

Conclusions

Shaping wrongdoings performed in the surgical unit impact graphically intend to catcher. Using protective barriers against different risks posed by biological, physical, chemical and mechanical agents, apply quality care . Provide health services with security and safety is a duty of the healthcare team and your responsibility is to meet the standards correctly.

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C. EDUCATION

PREVENTING ELECTROSURGICAL BURNS DURIGN MINIMAL INVASIVE SURGERY

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Keywords: Electrosurgical teniche. Preventing burns. Minimal Invasive Surgery.

Introduction

Electrosurgery may be dangerous to patients; it's associate adverse events can include third degre burns, perforations, and even surgical fire.

Patient burns associated with the use the monopolar electrosurgery occurs in varios ways, but the most dificult electrosurgical burns identify are the internal and unintended burns that occur from stray energy when the electrosurgical instruments are use it durign the minimaly invasive surgical procedure.

Objectives

To emphasize the importance of understanding and know the electrosurgery tecniches.. Prevention the unintencion injuries during the use electrosurgery.

Teorical frameworks:

The harzards associate with the used of electrosurgery include: unintended burs, fire/ explosion, interference, and surgical smoke.

During laparosocpy, three primary harzards increase the patient risk for electrosurgical are: direct coupling, capacitive coupling and insulation faliure. To know this risks (mechanis) are important and we described

Conclusions

This knowledge permit the prevention and apply the perioperative safety measures. And in consecuences reduce thepatient's morbilyty and mortality

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PP 138 C. FDUCATION

ADVANCED COURSE FOR THE OPERATING THEATRE NURSE.

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Keywords: theatre nurse, professional, competence, evidence-based practice, education

This advanced course turns to post graduated theatre nurses, active in the operating room (OR). The purpose of this education was to develop theatre nurse's skills and professional progress. The goal was to upgrade and broaden their competence and mainly about new working methods and evidence-based practice, in accordance with the formal responsibility. ⁽¹⁾

The education in Sweden, for a theatre nurse has a history from late 19th century. Along with the changes of our society, the education changed as well. In the 1960s, a student could go to a vocational school to become a surgical assistant. In 1982 the education became a university education. In 1993 the requirements changes, to become a theatre nurse, you must be a registered nurse primarily.⁽²⁾ The Bologna process was implemented and training for theatre nurse will change again. The education to become a nurse is, three years, on a basic level and the course to become a theatre nurse is, one year, on an advanced level and possesses a Bachelor's degree.⁽³⁾ The theatre nurses of today have different kinds of education, with big variations in both skills and knowledge.⁽²⁾

Consequently this advanced course gives the opportunity to exchange experience in education and careers and to initiative an innovative dialogue, for operating theatre nurses. Training methodology is based on active participation from the participant through practical exercises and with interesting lectures and skilled speakers. Subject areas are, among other things; methodology in surgery, anatomy, microbiology, ventilation in the OR, preceptorship, technique of suture. Diplomas are given by the full participation of the entire course. An evaluation is done, to obtain a good quality, in the end of every course.

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C. EDUCATION

OBSTRUCTIVE SLEEP APNOEA: IT WILL TAKE YOUR BREATH AWAY, CURRENT RE-SEARCH AND TREATMENT OPTIONS

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Keywords: obstructive sleep apnoea, snoring, sleep, pickwick,

Snoring and Sleep Disordered Breathing Syndromes are now being recognised as one of the increasingly more prevalent diseases of this century. Although not new, as William Shakespeare eludes to the condition with his character "Falstaff" a fat, vain, cowardly knight, and Charles Dickens also, in "The Posthumous Papers of the Pickwick Club". The novel features "Joe the fat boy" who has all the classic symptoms of the condition. In fact, Obesity Hypoventilation Syndrome (OHS), a condition related to sleep apnoea, was first called Pickwickian Syndrome.

In the USA reports are showing that the co-morbidities from Obstructive Sleep Apnoea, (OSA) is reaching that of diabetes and asthma. Statistics show that 25% of middle age men and 9% of middle age women suffer from OSA. Treating all drivers in the USA who are suffering from OSA would reportably save \$11.1 billion in collision costs and save 980 lives annually.

The co-morbidities of long term OSA include Cardiac and vascular diseases, diabetes, and sufferers are 6-9 times more likely to have a motor vehicle accident. OSA has significant quality of life symptoms and adverse affects on health and mortality.

OSA comprises of a continuum from partial airway collapse with vibration of the upper airway to complete airway obstruction. It can occur at singular sites or can be multi level, as a syndrome it was identified over 3 decades ago. The majority of physicians have no formal training in recognizing or treating the condition.

The scary fact is that most patients with treatable sleep-related breathing disorders currently remain undiagnosed, approximately 75% in the USA alone. Surgical techniques have improved with resultant better outcomes for treating OSA.

This talk will look at this life changing syndrome and the current "Gold Standards" for diagnoses, treatment and discuss the compliance and effectiveness of these...

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EDUCATION AND RECRUITMENT ASSISTANCE STAFF IN OPERATING DEPARTMENTS AND CENTRAL STERILE SUPPLY DEPARTMENTS (CSSD)

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Keywords: Education, recruitment assistance staff, supplies and stock records in operating departments

There is a shortage of professionally qualified assistant staff in surgical and sterilization departments. It is important to increase the number of assistants in these departments. Major changes have been in the Operating theatres the last couple of years, technological advances have been significant, the Medical devices are more complicated and expensive. Therefore it is crucial that the assistant staff have more knowledge to oversee procurement in operating departments. Another demand is the increasing Healthcare Associated Infections caused by resistant bacteria which are more difficult to deal with.

The goal of the project is to customize education for the assistance staff in surgical and sterilization departmental to increase the likelihood of willingness to work on the wards and make staff happier professionally. The products of the project are an education plan for sterile technician and another one for specialized assistant nurses, both projects received grants from the Ministry of Education, Science and Culture in Iceland.

Learning objectives for sterile Technicians is to prepare students for careers in CSSD. The jobs are diverse and based on production, disinfecting and sterilizing surgical instruments and Medical devices ⁽¹⁾.

Specialized assistant nurses have careers in CSSD and Operating departments. The specialized educations main focus is on one hand about production and disinfection, sterilization surgical equipment and Medical devices. And on the other hand about the procurement processes and the maintenance of stock records in operating departments. Emphasis is also on good skills in handling and storaging the sterile specialized medical equipment. They also need to have a good insight into the quality, safety and traceability processes in both areas ⁽²⁾.

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C. EDUCATION

KNOWLEDGE FOR SAFE BEHAVIOURS IN THE OPERATING ROOM

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Keywords: medical device company representative: safe practice: education: safe patient care.

Learning objectives

- Identify how knowledge about the risks of a perioperative environment can improve the safety of practice
- To demonstrate what knowledge is incorporated into an education programme for medical device representatives
- To review briefly the global picture of education for medical device company representatives

Visitors to the Operating Room can be distracting to the team, exhibit behaviours which are not consistent with safe practice and come to harm by being unaware of the potential hazards in the environment. Medical device company representatives no longer come from a healthcare background but are usually graduates of degrees which have not given them insight into the hospital environment. We expect those visiting the Operating Room to know the written rules and also the unwritten rules.

Two experienced perioperative nurses designed a workshop to highlight to medical device companies the risks in the environment. Since then hundreds of representatives have undertaken the training, and passed the final questionnaire testing their knowledge and being able to demonstrate that they understand the risks.

This EORNA accredited education is now also available as an on-line course, together with others which are being developed, and which is now available in translation to companies across Europe. Those who have taken the course and passed the exam, receive a badge to show this. We need Theatre Managers to ask for this badge so that patients and staff can be assured of the knowledge the representatives have.

The paper will describe the course, updating and the benefits to the industry as well as the protection offered to increase safe patient care in the perioperative environment.

THE EFFECT OF EGE UNIVERSITY NURSING FACULTY ON SURGICAL NURSING EDUCATION

Meryem Yavuz ⁽¹⁾ - Esma Ozsaker ⁽¹⁾ - Arzu Aslan ⁽¹⁾ - Turkan Ozbayir ⁽¹⁾ - Fatma Demir Korkmaz ⁽¹⁾ Nursing Faculty, Ege University, Izmir, Turkey ⁽¹⁾

Keywords: surgical nursing, education, Ege University

Ege University Department of Surgical Nursing was established in 1982. In the same year, a Masters programme in Surgical Nursing was opened in Ege University Health Sciences Institute. Ege University Department of Surgical Nursing started in 1982 with two lecturers and three research assistants, and by 2014 it had eight lecturers, one instructor and six research assistants.

A total of 42 nurses completed their masters degrees in the Department of Surgical Nursing between 1982 and 2014. These graduates of our department are currently working in many different parts of the country but a majority (29/42) are employed in Izmir province, where our university is located. While 23 (55%) of our masters graduates are doing academic work, 19 (45%) are working in the clinical field.

Between 1982 and 2014 a total of 32 nurses completed their doctoral education in our department. Of these, 14 (37%) are working in Izmir province, and 18 (47%) are working in other provinces of Turkey.

Also between 1982 and 2014 a total of 57 persons completed their postgraduate studies in our department. Of these, 39 (68%) are working in the academic area and 18 (32%) are working clinical area.

Ten (25.6%) of the postgraduate students working in the academic field are employed in Ege University Nursing Faculty, while 29 (74.4%) are working in other universities in Turkey.

The number of masters students enrolled in the Surgical Nursing postgraduate education programme of the Surgical Nursing Department of Ege University in the academic year 2013-14 are 21, and there are 15 doctoral students. Thirteen of the students enrolled (36%) are working in the academic area and 22 (61%) are working clinical area. One (3%) is retired.

The 47 academicians who are graduates or students of the Surgical Nursing Department of Ege University are currently serving in 24 universities in 15 provinces of Turkey, and are making a contribution to the development of Surgical Nursing education.

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Faculty disclosure: No conflict reported

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C. EDUCATION

DOUBLE WINS STRATEGIES OF PERIOPERATIVE EDUCATIONAL PROGRAM IN TAIWAN

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Keywords: perioperative, educational program

The four weeks program describes collaborative framework between fucaulty and adminstrator and identifies responsibilities and articulates learning outcome of students in perioperative environment of a medical center in Taiwan.

Perioperative clinical practice could achieve much beneficial learning experience for student nurses. First of them is technical nursing skill application,just like sterilization related skills. The second is knowledge integration just like sterilization, aseptic, preoperative and postoperative related knowledge. Third of them is team work just like collaboration among surgeon, anesthetist, technician, perioperative nursing practitioner, scrub nurse and circulating nurse. The final portion is communication skills among surgeons, anesthetist, technician, perioperative nursing practitioner, scrub nurse.

Since complexity of perioperative environment, nursing students are vulnerable and unable to maintain their learning autonomy in perioperative curriculum. Collaboratively teaching strategies are necessary in perioperative environment. Focaulty members acknowledge generalist aspects of surgical team members' practice to contextualize broader learning experience within a specialist environment, including skills, knowledge and communication skills. Deconstruct the procedures and skills and become repetitive and descriptive in nature. Students practice technic and communication skills with peer groups in limited time. Keeping reflexive diary is the strategy to intergrate knowledge of anatomy, diseases and operation procedures and introspect their learning needs. Clinical nursing staff tutors nursing student's performance during the operations. Focaulty and administrator are moderators to maintain efficient teaching performance.

This program have increased satisfied rate of perioperative units, increased perioperative nurses retained rate and decreased turnovered rate in this medical center.

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BRINGING ORGANIZATIONAL STRATEGY AND GOALS TO THE PERIOPERATIVE DEPARTMENT: GOOD FOR STAFF GOOD FOR PATIENTS

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Keywords: operational performance; operating System; strategic goals; teamwork; quality

Linking strategy to action and operational performance is a key part within any organisation. Auckland District Health Board has been developing a system for engaging with teams at each level of the organisation to align focus and performance throughout every level of the organisation.

When perioperative teams focus on day to day operational issues strategic goals were not fully realised. By introducing a management operating system, we were able to better manage team objectives and align then to organisational priorities such as Ministry and management set targets.

This System was implemented across clinical departments with daily, weekly and monthly meetings established with visual management tools where applicable. The daily meeting provided immediate feedback on performance to targets and allowed timely corrective action on issues & risks to optimal patient care. Constant team focus & visibility of what was important meant that established targets were achieved reflected by less errors and improved quality of care. The effect of the change is a noticeable improvement engagement & communication within teams and key stakeholders resulting in more effective quality patient care. The initiative also brought increased feeling of staff wellbeing and improved teamwork

This presentation will include the lessons learnt and also examples of improvements made to the quality of care patients received in the perioperative department. We describe how teams can apply the Management Operating Principles to their own theatre department so that they can build a process & visual tool to suit their needs.

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D. LEADERSHIP/MANAGEMENT THE PROFILE OF PLACE

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Keywords: competence, profile, responsibility.

The profile of place is an official document of french inspiration⁽¹⁾, with which an organization, declares the standard of competence for the management and the development of the personnel, in a perspective of empowerment.

The concept of competence and the professional responsability are important for the professional, to the light of the legislative evolution, scientific and code of ethics.

The profile of skilled professionals is also important for the health organisation that must respond to a request for health increasingly complex in the face of a limited nature ⁽²⁾ of resources as well as the educational system needs to support professionals and companies responding to their needs updating and training ⁽³⁾.

For this reasons, the profile were built inside of a healthcare company in northern Italy. The planning is concluded in March 2010, with the layout of 59 profiles of place, approved by the business direction

For the preparation of the instrument has been chosen bottom-up model: one hundred and six referents were identified belonging to sixteen different professional background who have partecipated in the training for the conceptual and methodological framework and the construction of the profile. The profiles were implemented in 2013 an it was investigated the impact occurred on the professional and the organization through a descriptive study that was conducted using an interview professionals referents in the project.

The results of the study, in the different areas (included operating room) you/they have defined the level of implantation of the tool and the perception of the self-determination.

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D. LEADERSHIP/MANAGEMENT THE SHOCKING STOCKING AUDIT.

AN AUDIT ON THE USE OF TEDS FOR PATIENTS HAVING SURGERY AT SLIGO REGIONAL HOSPITAL

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Keywords: Surgery, Venous Thrombo Embolism (VTE), Deep Vein Thrombosis (DVT), Thrombo Embolic Deterrent Stockings (TEDS), Measuring, Documentation

Venous Thrombo Embolism (VTE) is a collective term for both Deep Vein Thrombosis (DVT) and pulmonary embolism (PE). A DVT is a blood clot in the deep veins of the leg. A PE is when all or part of the DVT breaks off, travels through the body and blocks the pulmonary arteries. Most hospital-acquired VTE occur AFTER discharge - the average DVT after surgery is on day seven, the average pulmonary embolism is on day 21. Cost of VTE £26.3 million annually UK. One in three surgical patients can develop a DVT if no preventative measures are given. 25,000 people in the UK die from preventable hospital-acquired VTE every year (UK DOH, 2005). Roughly half of patients with DVT involving the thigh will go on to develop a pulmonary embolism. One person in three patients who suffer a PE will die. One in every 1,000 women will develop deep vein thrombosis during pregnancy. (RCN, 2014). Women are affected by DVT roughly twice as often as are men. Most often in patients over 40 years old (Moll & Severson, 2004). The National Institute for Clinical Excellence (NICE, 2010) recommends that all patients should be assessed for risk of developing thrombosis (blood clots) on a regular basis, as follows

1. Every patient should be assessed on admission to hospital

2. Every patient should be assessed again, 24 hours after admission to hospital

3. Every patient should be assessed again, whenever their medical condition changes

4. Every patient should be assessed again before discharge

5. Every patient should receive information on how to continue preventative measures at home.

The pathophysiology of DVT was described by Virchow in 1846 as a triad of changes in the vessel wall (injury), changes in the pattern of blood flow (venous stasis), and changes in the constituency of blood hypercoagulability (Yang 2005). Because DVT, and the follow-up complication of PE are preventable, nursing assessments and follow-up interventions for patients at risk for DVT while hospitalised are essential (Deagle et al, 2005). Risk factors for DVT include surgical procedure with a total anaesthetic and surgical time of more than 90 minutes, or 60 minutes if the surgery involves the pelvis or lower limb (NICE, 2010). Thrombo Embolic Deterrent Stockings (TEDS) apply the clinically proven graduated pressure pattern of 18mmHg at the ankle, 14mmHg at the calf, 8mmHg at the popliteal, 10mmHg at the lower thigh and 8mmHg at the upper thigh.

It is important to measure the patient's two leg sizes to assure that the appropriate pressure pattern is applied. TEDS are clinically proven to reduce DVT by 50% and to promote increased blood flow velocity in the legs. TEDS have been clinically proven to prevent the damaging effects of venous distension that occurs during surgery and hospitalisation.

Aims and Objectives

- To determine if current practice is adhering to the recommended guidelines regarding TED Stocking use, application and documentation for patients admitted to the operating room for surgery
- Develop recommendations from the audit findings if practice is not meeting the recommended standard
- To improve the quality and safety of the care the patient receives in the Operating Room (OR).

Methodology

- This concurrent audit was undertaken by the Clinical Nurse Manager 2 in the General Operating Theatre over a 4 week period.
- Data was collected on 30 surgical procedures.

- Information was gathered on:

- (a) Type of surgery
 - (b) Was patients leg measurements taken
 - (c) Was patients leg measurements recorded in the nursing notes
 - (d) Was patient given information on TEDS post operatively
 - (e) Did patient put TEDS on lying down

Results



	Yes	No
Was the patient's leg	17%	83%
measurements signed by nurse	10. m/ł	
Was TEDs explained to the	73%	27%
patient		
Did the patient put on TEDs	40%	60%
lying down		
Did the patient get information	43%	57%
on post op use of TEDs		

Conclusion

Findings from this audit provided information on TEDS use. It highlighted failings in the measuring for TEDS and nursing documentation. It identified poor practice. There needs to be an increased awareness about national and international guidelines regarding the use and application of TEDS. Because DVT, and the follow-up complication of PE are preventable, nursing assessments and follow-up interventions for patients at risk for DVT while hospitalised are essential (Deagle et al, 2005).

Significant findings regarding the measuring and documenting of TEDS. Recommendations have been drawn up based on the findings. A TEDS policy has been implemented.

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D. LEADERSHIP/MANAGEMENT

CONTROL OF UNINTENTIONAL PERIOPERATIVE HYPOTHERMIA: GUIDELINE FOR THE PORTUGUESE CONTEXT

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Keywords: perioperative hypothermia, guideline

The unintentional perioperative hypothermia (UPH) affects 60-90% of people undergoing surgery longer than 60 minutes. In several surgical situations, namely in neuro-axial anesthesia, it's quite difficult the continuous monitoring of the core temperature. Hence the importance of strict protocols for management of perioperative temperature.

The purpose of this study was to write a guideline for the control of unintentional perioperative hypothermia for the Portuguese context.

The UPH increases, among others, the risk of surgical site infection by 300%, cardiovascular events by 50%, blood loss by 16 to 20%, the recovery time and hospital stay by 20%, with the consequent increase in costs for the individuals, families and institutions. The guidelines allow to know the best resources and implement more effective and safe practices.

The methodology involved three stages: (1) systematic review of literature about international guidelines, (2) production of a guideline (3) discussion of the guideline with experts, members of theClub of Perioperative Nurse Managers, in a focus group.

The importance of scientific reasoning procedures, the organization of information, a quick access to the action protocols, a description of nursing interventions at all times of the perioperative period and suggestions for research, were the most important issues that the prior literature review arose. The guideline was built around the following parameters: practical and theoretical background, glossary, description of the pre, intra and post-operative action protocols, algorithms for fast access to information and suggestions for further research

It's unquestionable the need for stringent action protocols for the control of UPH, given its complexity and level of incidence. This guideline will be proposed to the Portuguese Operating Room Nurses Association for publication. The resulting action protocols, shall be submitted to the Portuguese General Health Agency, in order to be included in the national standards for infection control.

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D. LEADERSHIP/MANAGEMENT

THE RELATIONSHIP BETWEEN SURGICAL CLINIC NURSES' QUALITY OF WORKING LIFE AND INTENTION TO LEAVE

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Keywords: Nursing, intention to leave, work life, quality.

Background

Nurses' turnover has a profound impact on healthcare organizations in terms of associated costs, perceptions of quality of care and a negative impact on the capacity to meet patient needs. Quality of work life is very important consistent predictor of nurses' intention to leave.

Aim

The purpose of the study was to identify the relationship between surgical clinic nurses' quality of working life and their intention to leave.

Methods

The cross-sectional survey was conducted at two university hospitals between December 9, 2013 and January 7, 2014. Data were collected using Turkish version of the Quality of Nursing Work Life Survey (T-QNWL), a questionnaire of intention to leave the organization (ITLorg), and a demographic questionnaire. A total of 305 surgical nurses in Konya, Turkey, completed the questionnaire (RR=72,4%). Descriptive statistics, chi-square, student t tests, and logistic regression were analyzed.

Results

64,3% of the nurses reported that they had intention to leave. Besides, certain demographics (age, having/not having a child, length of service as a nurse, working status, length of service at the current unit, willingness/unwillingness to work at the clinic) and the T-QNWL and its sub-dimensions had influences on nurses' ITLorg ($p_{<},05$). Risk factors for intention to leave were determined with the logistic regression. According to logistic regression, significant risk factors were lower score of work condition sub-dimensions (OR=,92 GA=,87–,97) and being between the ages of 21 to 30 (OR=2,06 GA=1,16–3,67), but working willingly in the clinic was a protective factor (OR=2,58 GA=1,32–5,04)

Conclusion

The certain demographics and the QNWL and its sub-dimensions had influences on IT-Lorg. It is recommended that factors in intentions to leave should be taken into consideration and particular practices should be planned and evaluated in a way that will increase nurses' job motivation.

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D. LEADERSHIP/MANAGEMENT

ANALYSIS ON NURSING INTENSITY OF NURSING ACTIVITIES IN OPERATING ROOM US-ING THE RELATIVE VALUE SCALE FOR NURSING COST

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Highest Qualification / Year

1) Bachelor's Degree/Registered Nurse/1986

2) Master's degree/1992

3)The doctor's course/From 2012

Prizes / Awards / Distinctions

- 1. Citation signed by the Lions International
- 2. Appreciation plaque by Governor

Academic Interests

I'm interested in human resources management in clinical practices, especially in a logical and systematic theory on job satisfaction and effective distribution of human resources.

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D. LEADERSHIP/MANAGEMENT

TEN YEARS OF LEADERSHIP STUDIES: THEMES, CONCEPTS AND RELATIONSHIPS

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Keywords: Leadership, Citation Cnalysis, Co-Citation Analysis, Factor Analysis, Intellectual Structure, Network of Knowledge

To explore the intellectual structure of leadership research in the last decade, this study identified the most important publications and the most influential scholars as well as the correlations among these scholar's publications. In this study, bibliometric and factor analysis of the co-citation data are used to investigate the intellectual pillars of the leadership literature. By analyzing 120866 citations of 2265 articles published in SSCI journal in leadership between 2002 and 2011, this study maps a knowledge network of leadership studies. The results of the mapping can help identify the direction of leadership research and provide a valuable tool for researchers to access the literature in this area. This could function as a concise reading list for Ph.D.students and assist them by economically providing material that acts as a roadmap for preparation for exams and assists in research work. Further, it could guide students in deciding their future research streams.

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D. LEADERSHIP/MANAGEMENT OPERATING ROOM MANAGER'S PROFILE

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Keywords: Operating Room, Management, Operating Room manager

Background

The Operating Room (OR) manager role is becoming more common in recent years because they can help their departments save money. This requires motivated personnel and teamwork.

Focus of interest

OR management is an important skill to efficiently run an operating room. This skill needs to be studied, practiced and honed over years of experience by medical professionals.

Theoretical framework-presenting relevant literature references

The OR Manager's responsibilities are to manage the billing function, purchasing of OR supplies and equipment and working with vendors for pricing. Also gathers information and develops reports for cost-benefit analysis when new technology is requested; prepares business plans for new programs and equipment; tracks profitability of service lines; tracks supply expenditures; and monitors productivity. Such position requires a bachelor's degree with a master's degree preferred in business, economics, or a related field. In some countries also requires an RN license. Leadership skills and emotional intelligence are equally important as credentials. The specialty or profession of the leader is of secondary importance.

Conclusions

Studies shown that OR management improve operating room productivity which lead to greater operating room capacity, appropriate scheduling behavior and management methods to realign interests. Prior to looking for a future OR manager it is mandatory to develop a profile of qualifications tailored to the hospital. In the election process the important thing is to identify the candidate who fits best to the developed profile. On the basis of knowledge, skills and characteristics, different manager typologies are developed, facilitating the successful evaluation in a selection process for both the company and the candidate.

Implications for perioperative nursing

Clear goals for OR management which in some countries mostly is performed by OR nurses, are essential: improving productivity and efficiency while maintaining high quality of care at all times.

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Keywords: excellence, nursing health care

Background

Excellence in any field comes only from those who specialize and connotes the "superiority" and "eminence" representing a behavior or attitude which is "extraordinary".

Focus of interest

Excellence in nursing caremeans to deliver care with professionalism, to deliver the best practice by providing holistic care and to deliver care with humanism which facilitates the interpersonal relations in the patient-centered care.

Theoretical framework - presenting relevant literature references

The meaning of excellence held by nurses, is that at all times the patient is the center of nurses' concern. This concern is grounded in professional practice, delivered in the form of holistic care for the patient and the family. Other definitions depict excellence as the practice which upholds the highest standards in a "skill-based" interaction. Nurses delivering excellent nursing care implement nursing in a professional and competent manner, demonstrate a holistic approach to caring, possess certain personal qualities which enhance practice and relate to patient, families, peers, hospital administrators and community members in a competent, cooperative manner. Key factors for achieving excellence is collaborative work, patient-focus care, continuous quality improvement, performance management and measuring efficiency and effectiveness.

Conclusions

The patient is the central focus of excellence in nursing care at all times. Adopting the pursuit of excellence as an ideal in nursing care, will ultimately generate innovations in care and better health outcomes.

Implications for perioperative nursing

As professional nurses, our challenge is to promote nursing by providing the highest level of care. It takes commitment, determination and hard work tofurther improve our care and enhance the profession of nursing.

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D. LEADERSHIP/MANAGEMENT

THE ROLE OF REUSABLE INSTRUMENTS IN ORDER TO REDUCE THE COST OF LAP-AROSCOPY.

EXPERIENCE OF A SINGLE CENTRE

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Keywords: instruments, cost reduction, laparoscopic cholecystectomy, reusable, single use laparoscopic instruments.

Background

Financial crisis highlighted the importance of reducing cost of services. As a result there have been many changes in every day practices in our health system. Choice of surgical instruments and specifically of those that are used in laparoscopic surgery plays a crucial part in this effort.

Purpose of the study/Goals

The aim of our study is to make a retrospective cost analysis of the surgical instrument sets that were used for laparoscopic cholecystectomy in Hippocration Hospital of Athens in a seven year period from 2007 to 2013. Moreover to quantify the possible reduction in cost from the introduction of reusable instead of single use instruments. In the period from 2007 to 2010 only single use instruments were used. In the period from 2011 to 2013 only reusable instruments were used.

Research Problems / Methodology

We recorded the number of laparoscopic cholecystectomies each year and made a comparison of the cost between the two periods. In addition, we calculated the amount of economy made after the introduction of reusable instruments as well as its influence on operative duration and results.

Results and implications for perioperative nursing

From 2007 to 2010, 863 laparoscopic cholecystectomies were performed. Cost of single use instruments was 819850 euros. From 2011 to 2013, 845 operations were performed. Cost of reusable instruments was 31150 euros. If instead single use instruments were used cost would be 571954 euros. There is a significant instrument cost reduction of 94,55%. This change had no effect whatsoever in operative duration and results.

Conclusions

With well-planned and well-focused reforms in every day health practices a significant amount of economy can be made. This means better use of a limited budget and better allocation of financial resources without affecting the quality of services offered.

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D. LEADERSHIP/MANAGEMENT

HUMAN FACTORS AWARENESS: THE FOUNDATIONS FOR COMPASSIONATE, SAFE CARE

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Keywords: human factors, compassion, caring, dignity, patients, staff, resilience

Nursing staff are key to assuring the quality of patient care and the achievement of good clinical outcomes, but it is not without demand and emotional burden.

Given the competing pressures of financial shortfalls, capacity/ demand management, exacerbated by increasing patient acuity, all nursesneed to be sensitive to their impacts. In the UK two Inquiries (Francis 2010, 2013) identified the failings of a major hospital that resulted in the avoidable deaths of patients, the associated Reports described staff as lacking in care and compassion. Media reporting and Patient Groups assert, that a lack of care and compassion is not unique to the hospital subject to review and tragically can be found in most organisations.

Any suggestion of lack of care or compassion on the part of individuals or groups of staff, should be an alarm bell for everyone, triggering assessment of staff wellbeing, notably for stress, burnout and emotional resilience.

To achieve compassionate patient oriented care at the outset, staff need to verbalise what 'good' care looks and feels like and build shared mental models, of how it can be provided. To sustain it, compassion for the carer as well as the cared for, is of equal importance, for caring invokes feelings and can be demanding and painful (Rappaport et al 2006). Giving of oneself can be incredibly hard, due to all manner of competing and constraining forces, not least the pressures of repeated demand.

Compassion fatigue is well recognised in the literature, (Ulrich & Fitzgerald 1990, Welsh 1999), although sometimes difficult to differentiate from similar conditions (burnout and post traumatic stress disorder), compassion fatigue can develop in staff, irrespective of environment or speciality (Wee & Myers 2003).

Schwam (1998) and Reid (2012) describe compassion fatigue, as a unique form of burnout in the care giving professions and identify staff as particularly vulnerable to it, due over exposure to traumatic events, patient distress, unsafe systems and routinely feeling compromised that the care provided, wasn't good or timely enough.

Session Objectives

This session will

- 1) Explore compassionate care in context and the emotional labour of caring
- 2) Examine compassion, care and respect as shared rights and responsibilities for the 'cared for' and 'carers'.

3) Discuss how human factors awareness/understanding (Board to the frontline) can build emotional and organisational resilience by supporting staff, in their care giving role in the operating theatre.

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D. LEADERSHIP/MANAGEMENT

MISE EN PLACE D'UN PROCESSUS D'AMÉLIORATION CONTINUE AU SEIN D'UN DÉPAR-TEMENT DU QUARTIER OPÉRATOIRE Stéphanie Straet (1)

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The nurse's daily work within the operating room theatre is often disrupted by small incidents that, if taken individually, only have a weak impact on the patient's security and/or on the organisation of the day's workdaily work management. These incidents are rarely taken into account and tend to occur on a regular basis.

The conjunction of several incidents can jeopardize the patient's safety and/or the daily management of the operating surgical unit. This can compromise the optimization of the organisation of the service and the adhesion to the national policy of patient security. The progress in operating unit is characterised by a highly technological environment with all its security for patients and users. The level of required quality is very high. There is a wide expand of skills and the list of practices is forever evolving.

The aim of this work is to put forward a process for the continuous progress in a department of the surgical unit, based on the analysis of unwanted adverse events collected via an adverse event incident form form of declaration of incidents filled in by different actors: OR nurses, operating theatresurgical assistants, anaesthetists, surgeons of the ortho neuro - ENT operating surgical unit in Hôpital Erasme (Belgium).

An enquiry has been carried out amongst the nurses and operating theatre assistants of the ortho-neuro ENT department. A first census of incidents was made via a form of incident declaration where the incident was described, what was/were its consequence(s) and the informant estimated its severity and frequency. An audit was conducted on the basis of data issued from the operating surgical program, tools for improvement were implemented or are being implemented. A second census is then carried out.

The majority of declaration of incidents was done by nurses. Three main groups of malfunction were noticed: «medical tools and equipment»; «treatment procedures and process and resources», «organisation and management».

The benefits of actions taken suggest the generalisation and the durability of the project within the operating unit. We have observed an approbation of the project guarantying the continuity of it. The change will be made with the objective of the security of our patients and will be made progressively with the utmost efficient communication according to a transversal axis from top to bottom but also from bottom to top.

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D. LEADERSHIP/MANAGEMENT

A QUALITATIVE STUDY OF OPERATING ROOM NURSES: WHAT INCREASES YOUR ANXIETY?

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Objectives

Anxiety is one of the most common reaction and somatic symptoms of stress (Tehrani, 2014). As known, nursing is a highly stressful occupation and job related stress is an important factor predicting satisfaction among nursing staff, particularly in operating room (OR) (Kawano 2008, Topp 2012). Nurses experience considerable stress in their job because they have long working hours, a wide range of tasks, and complicated relationships with patients, their families, doctors and other co-workers (Maslach et al.2001, Shimizu et al. 2003). On the other hand, studies show disparities in the quality of communication among members of the operating room team (Makary, 2006, Mills, 2008).

The purpose of this study was to investigate what increases OR nurses' anxiety in a qualitative study design.

Methods

This study was carried out between February–May, 2014 on 65 voluntary nurses working in state and university hospitals. Because of nurses' strict working times, data were collected with 3 simple open-ended questions instead of interviewing. Except the demographic ones, questions were; "are you satisfied with working as a OR nurse?", "are you satisfied with your working field?", "what increases your anxiety level in OR?". Data were analyzed by thematic analysis. The themes identified from nurses' answers were; (a) satisfaction, (b) working field, (c) anxiety.

Results

The mean age of nurses was 32.09 ± 6.75 and they were working 5.32 ± 1.52 hours intermittently per day. Out of 57 nurses, others were not satisfied with working as an OR nurse and 64.6% (n= 42) of all were satisfied with working in their working field. According to nurses, surgeons were reflecting their own stress to them and it was sometimes occurring as insulting. Nurses reported that their supervisors were mostly capricious and this was one of the reasons of anxiety. Twenty-nine of nurses stated that their working field was full of stress because of inadequate air-condition systems, long working periods and inefficient equipments. Four nurses pointed to anxiety which occurred because of urgent operation cases. They stated that the main reason was poor communication between OR team. Nineteen nurses indicated that, they were psychologically tired because of the nervous team workers and insensitive co-workers.

Discussion

Literately, it was found that, OR nurses develop fatigue independently of job-related stress factors (Kawano, 2008). Similar in this study, nurses stated that their working field was full of stress because of inadequate air-condition systems, long working periods and inefficient equipments. It is mentioned that, if there is a positive role relations with physicians and other units/departments, it effects satisfaction and psychological well being. Also it was found that positive relations with the head nurse and coworkers increase job satisfaction and decrease psychological distress (Blegen, 1993, Decker 1997, Robinson, 1993). Parallel to these findings, in this study nurses indicated that, they were psychologically tired because of the nervous team workers and insensitive co-workers. Also nurses reported that behaviorally capricious supervisors were one of the reasons of anxiety.

Nurses in this study stated that the main reason of anxiety was poor communication between OR team. In the literature, Halverson et al (2011) stated that seventy-six communication failures were observed over 150 hours of observation and they resulted in inefficiencies, delays, and increased tension among members of the OR team. In another study, it was found that coordinating the equipment was the most frequent subject of communication between charge nurses and other members of the OR team (Moss, 2004).

Conclusion

Nurses were pleasant to be an OR nurse and to work in their working field but they were face to face with conditions that cause them have more anxiety during daily working times. Unless it is not possible to change the OR environment, it is recommended to give some supporting educations about communication, managing with nervousness and stress to nurses and all other OR team workers. Learning better communication ways may help workers to ease and improve the relationships with co-workers. By the way, it would be beneficial to help worker to improve their physical and emotional well-being via supportive activities (like monthly anxiety managing programmes). Attending or generating seminars about being a good manager may be useful for supervisors.

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D. LEADERSHIP/MANAGEMENT

HIGH PERFORMING TEAMS; EVIDENCE BASED SKILLS REQUIRED FOR SUCCESS IN A CHAOTIC PERIOPERATIVE ENVIRONMENT

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Keywords: High Performing Teams, Leadership, Effective Communication, Teamwork, Collaboration

Perioperative Departments can be one of the most unpredictable work environments in the hospital. Perperative personnel must be prepared and ready for any type of patient or situation to occur without advanced notice. Working in today's Perioperative environment takes skill, motivation, teamwork, collaboration and leadership. Coupled with the lack of predictability, the work environment is further challenged with poor communication between providers, lack of teamwork and poor operational patient throughput. Due to the constant changing environment, Perioperative staff must learn to transform unproductive confusion and disorder into controllable challenges - with less stress and greater clarity. A high-performance Perioperative team is a group of staff with specific roles and complementary talents and skills; aligned with and committed to a common purpose; who consistently show high levels of collaboration and innovation; that produce superior results. The high-performance team is regarded as tight-knit, focused on their goal and nothing else. Team members are so devoted to their purpose that they will surmount any barrier to achieve the team's goals, high quality and timely patient care.

Objectives

- 1. Participants will complete a self- assessment on how they are viewed by others as a leader or team player
- 2. Participants will identify skills required to lead in highly complex environments
- Participants will discuss core characteristics of high performing teams in critical environments and techniques to develop skills to further enhance team work
- 4. Participants will learn how to apply the appropriate techniques to alleviate, clarify and eliminate chaos within your control.

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D. LEADERSHIP/MANAGEMENT

IMPROVING THE DELIVERY OF HEALTHCARE IN SURGERY THROUGH PERFORMANCE IMPROVEMENT, EMPOWERMENT AND ACCOUNTABILITY

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Keywords: Performance Improvement, Lean, Governance, Empowerment, Leadership Accountability

Across the world; inefficiencies, poor patient throughput, lack of coordination and poor quality care drive costs in our healthcare systems, hospitals and Perioperative Services. In many countries it is estimated that 30% of spending on healthcare is related to these inefficiencies and lack or care coordination.

With Nursing and other healthcare professionals at the front line caring for patients, we first-hand see the impacted related to broken processes in our daily work. As a result, in many situations, workarounds have been developed in order for us to carry out our daily patient care activities. Workarounds seem to become the "new normal" in order for us to provide care to patients. In many cases, patients' lives are at risk when this new normal becomes routine in providing care.

There are numerous performance improvement methodologies capable of eliminating waste and poor care in our hospitals and operating rooms. These methodologies help us redesign patient care and nursing care processes in order to: improve efficiencies and throughput; coordinate care; improve quality and safe patient care. In order for processes to be redesigned and implemented, nursing and other healthcare professionals must have the understanding and skills to think, redesign and implement new processes.

No matter what performance improvement methodology is utilized, a key aspect of sustaining the effects of the performance improvement is nursing empowerment and leadership accountability. Without these core skills and competencies, the improvement efforts realized will be short lived and quickly return to their prior, inefficient and unsafe state.

Objectives

1. Discuss drivers of inefficiencies in our Operating Rooms and their effect on patient care.

- 2. Discuss the various performance improvement methodologies related to improving patient care, cost, quality and throughput.
- Discuss the roles, responsibilities and skills for Nurses and other healthcare professionals in leading performance improvement in our surgical departments
- Discuss leadership and staff responsibilities in sustaining effective change in our work environments

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PP 160

GLOBAL HEALTHCARE TRANSFORMATION, WHY IS PERIOPERATIVE SERVICES IN THE SPOTLIGHT?

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Keywords: Health Status Indicators, Healthcare Reform, Healthcare Transformation, Quality Life Indicators, Healthcare Cost, Surgical Performance Improvement, Cost Reduction

Although contexts differ, all countries around the world are struggling with balancing affordability, quality, and access in the health sector. The healthcare systems in America, Canada and throughout Europe and the world are in trouble. In the United States there is a crisis that will fundamentally cripple the ability to provide care to those who need it most – the elderly, the uninsured and the underinsured.

This crisis is a direct result of rising healthcare costs that simply are not sustainable – not for businesses, not for government and certainly not for families. America must learn from other countries throughtout Europe which have some of the best healthcare systems in the world. However, the US is not alone in this crisis since most countries across the world are struggling to deliver quality, efficient healthcare that is affordable. The delivery of surgical and perioperative services is one area being the most closely scrutinized in our heathcare systems since these programs are the largest drivers of cost and inefficiency in our healthcare systems.

Objectives

- 1. Compare and contrast core quality and cost statistics across the US/Canada, Europe and Asia
- 2. Compare differences in healthcare delivery across Europe and the world
- 3. Discuss cost and quality drivers of healthcare related to Perioperative Services
- 4. Identify strategies to reduce costs and improve quality care in Perioperative Services

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E. PATIENT SAFETY

SLEEP TIGHT, BREATHE RIGHT: PERIOPERATIVE MANAGEMENT OF PATIENTS WITH OB-STRUCTIVE SLEEP APNEA (OSA)

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Keywords: Obstructive Sleep Apnea, postoperative complications, perioperative management

Obstructive Sleep Apnea (OSA) is characterized by repeated partial or complete upper airway obstruction during sleep characterized by episodes of shallow breathing or cessation of breathing lasting 10 or more seconds. The repeated airway obstruction during sleep causes repeated arousal from sleep to reestablish breathing (America Society of Anesthesiologist, 2014). At a glance, OSA may not seem a serious condition. Individuals can resume a regular daily routine feeling tired, sleepy, or experiencing cognitive and psychological disturbances as a result of disrupted sleep. Hence OSA is often left undiagnosed, and the initial identification often occurs when patient attend the preadmission assessment prior to surgery (Adensanya, A. Et al, 2010).

However, a closer look at OSA shows that the prevalence of OSA in the surgical population is higher than in the general population (Shafazand, S., 2009) Surgical patients with OSA also has increased risk of postoperaive respiratory and pulmonary complications (Memtsoudis, S. et al, 2014 Roop, K. et al 2014). Complications that develop after surgery can include oxygen desaturation, respiratory failure, and cardiac ischemia. This underscores the importance of preoperative screening of patients for OSA. Careful identification of patients with OSA enables implementation of strategies to manage and mitigate the patient's risk. This ensures all patients with OSA receive quality, safe, and consistent care throughout their perioperative journey.

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E. PATIENT SAFETY

ORGANIZATIONAL SAFETY CULTURE: DIFFERENCES BETWEEN NURSES AND PHYSI-CIANS IN ADVANCED SURGICAL SETTING

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Ke words: safety culture, organization culture, organization commitment and organization value.

Background

Safety culture is crucial for healthcare organizations. Understanding the concept of safety culture as well as the attitudes, beliefs and perceptions of the concept by personnel will motivatestaff to ensure patient safety.

Focus of interest

The goal is to investigate the difference in perception of safety culture between nurses and physicians in the operating room and gastroenterological unit.

Theoretical framework

The survey based on questionnaire includes investigation of 42 nurses and 37 physicians in Hasharon Hospital, Israel. The questionnaire's three sections examined the participants' views and perceptions of the safety culture in their workplace at three levels (organizational, departmental and individual performance). Pearson correlation coefficients, ttests and multiple regression analysis were used to analyze the data.

Results

There is a distinct difference between academic nurses and physicians in their perception of the organizational culture.

Sectorial comparison showed significant differences in the perception of the importance attributed to organizational culture in a department/unit. An examination of the variables found a negative relation between the degree of importance of safety culture on theorganizational level and the importance of the concept on the level of units and outputs.

Conclusions

It is very important to considerate gender as well asethnic and professional differences whenplanning measures to promote and establish a culture of safety in hospitals. It is also important to compare the attitude to the concept in different departments and different hospitals. The findings emphasized the importance of implementing the concept at all levels, from the personal level to administrative level.

Implication for perioperative nursing

A positive, carefully planned organizational safety culture that includes reference of multidisciplinary and multicultural staff can improve patient safety in the operating room.

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E. PATIENT SAFETY QR CODES IN CLINICAL PRACTICE - ONLY IMAGINATION SETS THE LIMITS

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Keywords: QR, iPad, nursing, instructions, manuals, patient safety, visual, auditory

Background

The operating theatre is a high-technological area which requires instant specialised knowledge to whole range of different technical devices. Previously, instructions and manuals were the only available tutorial tools on how to handle the devices, until the employees began to demand other leaning methods. This became the starting point for QR (Quick Response) codes, which was implemented during spring 2013. The operating theatre has now stored all instructions, manuals and practical guidelines in a secured IT system and by the use of QR codes and iPads the employees have easy access to updated information such as pictures, videos or text.

Method

To evaluate the outcome of the implementation we used the Plan-Do-Study-Act methology. We tested the use of QR codes at a chosen technical device (an autoclave) and after each test the employee had to complete a questionnaire. 23 employees participated.

Conclusion

After testing of the chosen device the response rate was 100 %. 74 % responded that they were not able to operate the autoclave before the new technology was implemented, but by using the QR codes it was now possible. 26 % responded that they already knew how to operate the autoclave, but five of them answered that they will definitely use the technology for support if necessary. One employee was not able to use the QR codes due to technical difficulties.

Implications

This study shows that QR codes have a solid place in the operating theatre. The technology ensures that our technical knowledge is always updated and will thus take patient safety to a higher level. The visual and auditory approach to demonstrate technical devices and procedures appeals to the young generation and also allow us to ensure competency development among our present employees.

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E. PATIENT SAFETY

THE THOUGHTS OF SURGERY TEAM TOWARDS IMPLEMENTING SAFE SURGERY CHECK-LIST: AN EXAMPLE FROM TURKEY

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Keywords:Nursing, operating room, safe surgery, safe surgery checklist, surgery team, patient safety.

Background

With the "Safe Surgery Checklist" (SSC) established in relation with "Safe Surgery Saves Lives" project; enabling safety in surgery was aimed. Safe Surgery Checklist is used under the name of "Safe Surgery ChecklistTR" (SSCTR) in Turkey.

Purpose

The study was planned in order to determine the thoughts of surgery team members towards implementing safe surgery checklists in operating rooms.

Methodology

The study was conducted with 303 surgery team members working in the operating rooms of seven hospitals. The data were gathered using a questionnaire form and evaluated by chi-square tests.

Results

It was found out that nearly three fourth of the surgery team members believed that SSCTR made contributions to the safety of patients, but only half of them thought that SSCTR was used properly in their institutions. Most of the participants pointed out that the implementation of SSCTRvaries depending on whether the surgery being urgent or planned, the scale of the surgery and the attitudes of surgery team members towards the implementation. It was seen that the surgery team members who stated that all the items in the list were fully answered outnumbered those stating the contrary. The items that were implemented the most were noted to be questioning the patient's allergy history, preparation and sterilization of the kits to be used in the surgery and confirmation of "Anesthesia Safety Checklist", presentation of the surgery team members and confirmation of the patient's identity, type and area of surgery were implemented the least.

Implications for perioperative nursing: This research providedus with detailed information about surgical team's opinions related to SSCTR. Also, the study's results will make significant contributions to the planning of the attempts made to increase the implementation of SSCTR.

PP 165 E. PATIENT SAFETY

DETERMINING OF PATIENT SAFETY CULTURE PERCEPTION OF OPERATING ROOM NURSES

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Keywords: Operating room nurse, patient safety; patient safety culture

Patient safety is known as a practice towards preventing errors, elimination of the injuries and death caused by health care itself. Patient safety culture as well, is the acceptance of making patient safety a top priority and a common value among the institution.

The purpose of this study is to define the perception of the nurses working in surgery operating in the province of Afyonkarahisar over patient safety culture. this study is a descriptive study which aims to define the present situation of the patient safety culture." Hospital Survey on Patient Safety Culture" survey was used as data collection method. This survey was conducted on 61 nurses working in the surgery departments of hospitals based in Afyonkarahisar city centre. The collected data is analyzed within SPSS for Windows software programme and individual spresifications of the nurses are submitted with frequency and percent distribution but also described with arithmetic avarage and standard deviation rates.

In this study, the perceptions of operating room nurses over patient safety culture is

overviewed in five dimensions (working unit, administration, communication, reporting and general patient safety); overall perception within each dimension is detected to be in moderate level. In addition to this, nurses working in state hospitals are found in a more negative perception when compared with the nurses working in private hospitals. On the other side, nurses under the age of 21 are determined to have more positive perception on working unit, communication and reporting dimensions of patient safety culture when compared with the nurses from the other age groups. Also nurses who are single are found to have more positive perception on working unit and communication and the nurses from the countryside with more positive perception on reporting dimension of patient safety culture.

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SAFETY ATTITUDES BETWEEN OPERATING THEATRE NURSES AND NURSE ANESTHE-TISTS AT TAIWAN

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Keywords: patient safety attitude, Safety Attitude Questionnaire, operating theatre nurses, nurse anesthetists

Objective

Safety attitudes of healthcare works has been addressed in recent year because of its relationship with quality of patient care. However, there are only few studies focus on the operating theatres. The purpose of this cross-sectional survey is to explore and compare the safety attitudes between operating theatre nurses and nurse anesthetists at Taiwan.

Methods

Two hundred and thirty-one nurses and nurse anesathetists were recruited from a 3000bed medical centre by convenient sampling. A 30-item Chinese version of Safety Attitude Questionnaire (SAQ), developed by Sexton (2006) and translated by Lee (2009), was administered. The SAQ is a 5-points Liker't scale and presents excellent validity and reliability. The questionnaires were returned to the principle investigator directly with anonymity after completion.

Results

Response rate of this study was 92.4% (n=231). The result indicated the safety attitude among nurses and nurse anesathetists from moderate to high (3.51±0.64). The highest score in six domains was Stress recognition (4.03±0.86) and the lowest one was Perception of management (3.32±0.77). There were significant differences between operating theatre nurses and nurse anesthetists in total score (p < .001) and five domains except the stress cognition domain.

Conclusions

We suggest, besides the organizational wide and unit-based survey, disciplinary -based survey is still needed in developing tailored improvement project. Team-approached training and effective communications among different professions might be the potential solutions to minimize the gap of safety attitudes between operating theatre nurses and nurse anesthetists .

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TWO, FOUR, SIX, EIGHT.... STOP AND COUNT BEFORE IT IS TOO LATE! AN AUDIT ON SWAB, NEEDLE AND INSTRUMENT COUNTS IN THEATRE AT SLIGO RE-GIONAL HOSPITAL

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Keywords: Abdominal surgery, Four counts, Time of counts, Communication, Documentation.

Patient safety is one of the most pressing challenges in health care. Incidents compromising patient safety, such as unintended retention of swabs or instruments, are regarded as 'never events'. Jackson and Brady (2008) suggest that retention of swabs and instruments following surgery may occur as often as 1 in 100 procedures. There were 111 never events in the UK last year (DOH 2013). The WHO (2009) issued a surgical safety checklist and its aim is to reduce the incidences of error in the Operating Room (OR). Although law does not dictate what method of swab, needle and instrument comp should be carried out, local policy has been adapted using recommended standards from professional organisations such as the Association of Operating Room Nurses (AORN 2011) and Association for Perioperative Practice (AFPP 2011). Theatre nurses are the core care providers in the perioperative environment. The use of audit can ensure our care is continually improving and has the potential to make huge improvements in patient safety (Thomas 2011).

The aim of the audit was to determine if current practice is adhering to the recommended guidelines regarding swab, needle and instrument counts on patients admitted to the operating room for abdominal surgery. The local policy for abdominal surgery states that each count must be performed by two registered practitioners. Four counts should take place. The initial count immediately prior to surgery commencing, the second before closure of a cavity within a cavity, the third count before wound closure begins and finally at skin closure. The surgeon should allow adequate time for counts. All counts should be complete, verbalised as correct or incorrect by the scrub practitioner and acknowledged by the surgeon before the patient leaves the OR. The counts should be documented accurately and signed by both registered practitioners. Theatre personnel are the core care providers in the perioperative environment. The audit also wanted to ascertain length of time each count takes.

This concurrent audit was undertaken by the Clinical Nurse Manager 2 in the General Operating Theatre over a 4 week period. Data was collected on 30 surgical procedures. Information was gathered on:

1. Type of surgery

- 2. Qualifications of scrub and circulating nurse
- 3. Length of time of each count
- 4. Counting technique
- 5. Verbal confirmation of counts
- 6. Documentation and signing of counts

The number of procedures audited: 29 Type of surgery: Major 21(72%). Minor 8(28%)

Staff skill: Scrub nurse: Senior 15(52%) Junior 14 (48%)

Circulating nurse: Senior 19 (65%) Junior 10 (35%)

Findings from this audit provided information on how long each count took. It highlighted failings in the count process. It identified poor communication within the Multidisciplinary Team (MDT) as a cause for local count policy not being adhered to.

Significant findings regarding the length of time for counts and poor MDT communication.

This audit provided valuable information regarding counting procedures in the OR. In addition to highlighting that poor communication is a common cause for non-adherence to local policy it also measured the length of time it took to carry out counts. This new information is beneficial to have an estimated guide to advice colleague's especially junior and new staff. It is crucial that policy and procedures are observed to reduce the incidences of counting errors in the OR.

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- Winner of poster competition at Annual Operating Department Nurses Conference, Ireland, 2014

Faculty disclosure: No conflict reported

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E. PATIENT SAFETY

A STUDY TO ENHANCE DOSING TIME OF PROPHYLACTIC ANTIBIOTICS ON SURGICAL PATIENTS VIA CROSS-TEAM COLLABORATION

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Keywords: Team collaboration, Prophylactic antibiotics, Wound infection

Background

Prophylactic antibiotics can prevent post-surgery infection. However, the overuse of antibiotics may cause drug abuse. How to give antibiotics at the right time to achieve favorable outcome is a great challenge to medical teams.

Objective

Currently, the use of prophylactic antibiotics on patients going for surgery in Taiwan is lower than that planned by Taiwan Quality Indicator Project. It is hoped that the goal to use prophylactic antibiotics correctly can be achieved and surgery care quality can be enhanced by increasing the awareness of medical professionals.

Methodology

This study employs retrospective data review method, with 1549 medical records reviewed beginning January 2011. A total of 50 nurses participating in surgery administered prophylactic antibiotics on patients.

Results

The study found that the use of prophylactic antibiotics was low because physicians have different awareness about the use of such drug. Also, dosing time of surgical staff and staff administering anesthesia was different, medical information was not compiled, there was no standard operating procedure, and the drug was administered late during surgery. Intervention measures were inclusive of on-the-job education, establishment of a standard operating procedure to foster awareness of surgical team members, establishment of medical information system, purchase of a suitable timing indicator, and the development of a monitoring system. After implementation of the above, the use of a first dose of prophylactic antibiotics correctly increased from 75.6% to 97.1%, and the second dose from 32.8% to 91.3%.

Conclusion

Awareness of surgical team members is heightened to prevent surgical wound infection in patient. A surgical team is mainly comprised of and led by surgeons. However, to ensure standardized medical quality, more and more medical quality committees are set up in different hospitals. Various empirical care indicators are used to educate medical teams to improve on and request for quality of care to maintain a good quality of post surgical care.

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E. PATIENT SAFETY

A STUDY TO ENHANCE PATIENT SAFETY AND QUALITY OF CARE VIA COLLABORATION OF MEDICAL TEAMS

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Keywords: Team collaboration, Surgical safety, Identification system

Background

Surgery involves the participation ofmany disciplines and departments. Collaboration of medical teams can affect the prognosis and safety of a patient. In June, 2010, a patient was operated on the wrong leg in one hospital. In this hospital, there had been an error where the surgery was scheduled for a wrong part of the body, and there had been patient complaints due to delay in surgery time. It is hoped that medical quality can be raised to ensure safety of patients.

Objective

This study aims to determine whether a surgical safety identification system has been established by examining surgery operating procedures. The system is to be implemented by medical teams to ensure medical safety and reduce incidence of medical negligence.

Methodology

This cross-sectional study with purposive samplingwas conducted in a hospital at southern Taiwan from June to December 2010. A total of 60 nurses, 20 anesthesiologists, and 15 surgeons were recruited as subjects.

Results

On-the-job observations in the study found that consensus was lacking among medical professionals. There was no "Surgical Time-out" and electronic information system was complicated and unfriendly. Intervention measures included compilation of team opinions to develop a surgical patient safety identification standard operating procedure, review and amendment of standard operating procedures, development of medical information system, compilation of surgical information distribution procedures, organization of education and training programs, and establishment of e-data and its monitoring procedures. The barcode system was used to correctly check patient identify and the identification time was reduced to 2 to 3 minutes. Safety of patients undergoing surgery and quality of care was raised from 88.7% to 100%.

Conclusion

The operation room is a busy and functional place. Communication among surgical team members is very important, and team members must be responsible for the work they are participating in. Via communications, discussions, and development of consensus, surgical team members are encouraged to enhance surgical "safety", be responsible for safety management, and ensure safety of patient.

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E. PATIENT SAFETY

NURSING CARE AND NITRIC OXIDE INHALATION THERAPY IN PATIENT WITH CONGEN-ITAL DIAPHRAGM HERNIA

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Congenital diaphragm hernia is a disorder characterized by dislocation of viscera in the thoracic cavity as a result of pleura-peritoneal duct's failure to close during embryonic phase. The viscera located in thoracic cavity cause hypoplasia on the lung facing that side in turn the hypoplasic lung causes an elevation in mortality rate by leading an increase in pulmonary arterial pressure. Nitric oxide inhalation has recently started being used in respiratory insufficiency therapy in hypoxic infants since it leads to relaxation on smooth muscles and as a result causes vasodilation especially on pulmonary artery.

The male case who received diagnose of left diaphragm hernia at prenatal 17 weeks was delivered through caesarean section at 38 weeks and admitted to newborn intensive care unit. His preductal-postductal oxygen saturation was observed and he connected to mechanic ventilation. Since pulmonary hypertension was detected on echo, nitric oxide inhalation and sildenafil was initiated on patient and a primary repair was performed through laparatomy at the first day of his life.

Patient was included into highly dependant patient group using the RUSH-Medicus patient classification criteriaand was given nursing care suitable for standarts with the following nursing diagnoses; change in respiratory functions, insufficiency in gas exchange, ineffectiveness in airway cleanness, deterioration in fluid-electrolyte equilibrium, pain, bleeding, risk for infection, deterioration in skin integrity, ineffectiveness in nutrition patern and anxiety in family. In the nursing care related to use of nitric oxide, he was followed-up in terms of equipment control, monitoring of vital findings, symptoms of nitric oxide toxicity (cyanosis on periphery, decrease in oxygen saturation, deterioration in gas exchange, deterioration in tissue perfusion, dyspnea). The case who received nitric oxide therapy for 15 days was followed-up on ventilator for 23 days, in newborn intensive care unit for 37 and in service for 3 days and finally discharged with cure.

The mortality rate is considerably high in cases with diaphragm hernia who received early intrauterine diagnosis. The mortality rate can be reduced through the benefits provided by qualified nursing method, care with multidisciplinary insight and nitric oxide inhalation.

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E. PATIENT SAFETY

INVESTIGATION OF THE ATTITUDES OF USING OF ADULTS PATIENTS' RIGHTS OF PA-TIENTS HOSPITALIZED IN THE SURGICAL WARD AT A UNIVERSITY HOSPITAL

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Keywords: Patients rights, patient, attitude

Background

One of the conditions of well-qualified life is to be healthy and receive appropriate health care during illness. Individuals who receive health care have the right to know what their problem is and which procedures and interventions they will undergo. Term of patients' rights defines rights and responsibilities between health care organizations and patients. Health careof the individualin the process ofgettingto knowhisnext-owned rightsof those who providehealth care services in this regardare expected tobe knowledge-ableenoughandisa desirable situation. Both patients' and health professionals' awareness of patient rights is fundamental for health care quality.

Purpose

This study was performed to determine the attitudes of using of patients' rights of patients hospitalized in the surgical ward.

Method

This descriptive study was conducted with 174 adult patients hospitalized in the surgical clinics at a university hospital in Konya between April 1 and May 31, 2013. Data were collected using individual characteristics form and the Scale of Patient Rights Using Attitude. Data were summarized using number, percent and mean. Comparison of data was used Mann Whitney U and Kruskal Wallis test.

Results

In this study, it was determined that 39.1% of patients had knowledge about the patient rights of and 28.7% of these patients learned about patient rights through the media. The mean total scores of patients were 125.01 ± 15.68 . As a result of study it found that some variables (age, sex, place of residence, economic status, status of information for patient rights, and status information by health care workers) affected attitudes of using of patients' rights of patients.

Conclusion

As a result of research findings, scores of attitude using patient rights of patients is high, and this condition is affected by some variables related to patients.

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E. PATIENT SAFETY SURGICAL FIRE PREVENTION

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Keywords: Perioperative Nursing; Surgical Risk; Surgical Fire.

This articleaims toidentify the mainrisk factorsassociated to asurgicalfire, allowing creating the correctstrategies thatare correctin fightingthis rarecomplicationthatcan occurduringcommondaily practiceinthe operating room. To achieve the objective, we promoted anreview and analysis of the literature, that able us to expose this theme that is almost unexplored in Portugal. With this article, he whant to show that the perioperative nursecan play an important role anticipating therisks, minimizing them and ensuring the quality of care provided to the patient in the intraoperative context.

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E. PATIENT SAFETY 'RED ZONE'

HOW A SIMPLE COLLABORATIVE IDEA LED TO IMPROVING QUALITY AND SAFETY OF CARE IN THE OPERATING ROOM.

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Keywords: Clinical Incident, Debriefing, Adverse Clinical Event, Multi-Disciplinary Team, Collaboration, Improvement, Quality, Safety Care.

Florence Nightingale once said "The hospital shall do the sick no harm" http://thinkexist. com/quotes/Florence-nightingale. A recent clinical incident led to a review and the introduction of an innovative idea to minimise the risk of a similar event reoccurring. During an emergency, equipment that was needed urgently was not at hand and had to be obtained from another department thus causing a delay. A debriefing session following the incident identified several failings. A recent revamp of the store room meant that equipment had been moved around. Equipment not frequently used wasn't labelled and some junior and new staff was not familiar with some equipment that would be seldom used.

Evidence suggests that one in ten inpatients is subject to adverse clinical events (Mengis and Nicolini, 2010). 1000 adverse incidents occur in Irish hospitals weekly (Brady et al 2009). Indications are that system problems and lack of information is more often the cause of errors than negligence. Areas identified for improving healthcare include safety, patient centeredness, efficiency, effectiveness, timeliness and quality (Dupree et al, 2011). Investigations and reports nationally and internationally highlight the impact of healthcare failings. National inquiries and reports indicate individuals were not wilfully negligent but that there were systemic weaknesses in management and governance structure (GOI, 2006). International reports highlight similar findings. Effective workplace interventions are necessary to support transformative learning opportunities at work that improve the quality of care (Riehle and Hyrkas, 2012).

All members of the Multi-Disciplinary Team (MDT) were invited to put forward suggestions as to how practice could be improved. And so the RED ZONE was conceived! It was decided to set aside an area in the store room and designate it for equipment rarely used but would need to be accessed swiftly. We are in the midst of difficult financial times so we knew we had a limited budget. We identified a set of shelves that was in direct vision once one entered the store room. With a bit of reorganising we had empty space. Everyone worked together with one member of staff bringing in red paint and others taking it in turn to paint the area bright red. The shelves were stocked with items rarely used. Those that were good at typing drew up a list of what and where everything is. There were several education sessions held to inform all members of staff and feedback suggested that it was a great learning experience for everyone.

The use of a quality improvement approach interlinks four processes which are selecting, adapting, applying and evaluating (Ruhe et al, 2009). Evidence suggests that barriers to quality improvement initiatives include lack of knowledge of evidence based practice, poor resources such as staff and time, inadequate communication and involvement of frontline staff and perceived conflict between care providers and management. Facilitators of quality improvement in our department include educating and empowering frontline staff, flexible suggestions and time to implement any changes (Colon-Emeric et al, 2007). This simple idea shows how by working together we can improve our practice. Improving quality of health care is a continual challenge that we must all strive for. This quote by a famous world war 11 hero sums it all up "Quality is never an accident, it is always as the result of high intention, sincere effort, intelligent direction and skilful execution. It represents the wise choice of many alternatives". http://thinkexist.com/quotes/williamafoster.

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E. PATIENT SAFETY

SAFE TEAMWORK AT THE CHILDREN OPERATING THEATRE

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Keywords: Crew Resource Management, Communication, Multidisciplinary team, Patient Safety, Teamwork.

Background

Nearly every tenth patientin contact with the Swedish Health Care system endures a health care related injury. Hence, issues relating to Patient Safety have been brought to the fore. Sources to these deficiencies are often identified within the organization or from routines at the workplace. Lack of Communication, between individuals or within the team, is an acknowledged Patient Safety risk (1).

Focus of interest

The lack of Teamwork and Communication routines constitutes an element of risk, especially in handover situations⁽²⁾. Optimized Teamwork and structured Communication can lead to increased Patient Safety (3)

Method

The methodoriginates from Crew Resource Management, CRM, which is a security concept widely used in high-reliability-organizations, e.g. aviation, and is now also conformed to health care (4) The improvement has consistently focused on CRM-skills in order to create conditions for a safe Teamwork. The entire implementation process was performed withMultidisciplinary Teams, including Surgeons and Anesthesiologists. All staff participated in interactive lectures which were complemented with workshops. These were performed with smaller Multidisciplinary Teams in order to create safety tools e.g. checklists, structures for surgical briefings/debriefingsandpatient handovers. Pre- and post implementation observations were made as well as follow-up observations at several occasions.

Result

Follow-up measurements, of patient handovers, showed that the use of structured handover proceduressignificantly increased the amount of transferred relevant patient information. Observations and measurements connected to the Surgical Safety Checklist were performed and the result showed improved teamwork skills and increased compliance and quality of use of the checklist.

Conclusion

Education, training and the use of safety tools within Multidisciplinary Teams can improve PatientSafety.

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E. PATIENT SAFETY

ELECTRONIC REGISTRY FOR SURGICAL SPECIMEN TRACKING AS A STRATEGY FOR PATIENT SAFETY

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Keywords: perioperative patient safety, specimen management, pathology specimens

Descriptive study on implementation of computerized record of surgical specimen after identification of adverse events related to improper disposal of surgical specimens. This institution is characterized as a tertiary hospital with 393 beds, 13753 surgical patients and 20887 surgical procedures per year.

A study in Hospital John Hopkins1 evaluated events related to surgical specimens, and found, in a six-month period, 91 specimen misidentification errors and other related, involving: laterality error, reservoir, wrong patient, specimen mismatch, incomplete label.

A study of adverse events in Brazil2 showed that 92.9% of professionals in the perioperative area consider improper disposal of a surgical specimen as an adverse event. In an American study3, 35% of the professionals named care and handling of surgical specimens as a priority for patient safety.

These events are critical to patient safety and may interfere on the diagnosis and treatment. Thus, through the management of this institution's occurrences, it was possible to identify the events associated to surgical specimen forwarding, specially inadvertent disposal. After the root cause analysis of these events, an electronic portal was deployed to record and track the surgical specimens using bar code. This increased the reliability of the process.

The new process starts after the withdrawal of surgical specimen. The nursing technician accesses the system, confirms the name of the patient, records the identification of the surgical specimen, generates a label with barcode and print it. The label is placed on the surgical specimen, checked against the medical claim, rescanned and dispatched. The pathology lab scans the piece after arrival and forward it to the pathological examination. Through this process, you can trace amount of parts, identification and arrival in the pathology laboratory. The computerization of the process has ensured greater safety to surgical patients.

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E. PATIENT SAFETY

BURNS AND PRESSURE SORES IN THE O. R - ETIOLOGY, DIAGNOSIS AND PREVENTION METHODS

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An effective laying down of the patient for a surgery is a subject of great importance. A patient undergoing a surgery poses a unique challenge in the prevention of pressure sores because the patient lies immobile and unable to respond to stress-induced discomfort lasting.

According to Land (1995), even though the treatment in the pressure areas is so basic in the nursery routine, many therapists do not recognize the importance and the need to keep up with developments on this subject.

One of the risks to the patient in the operating room is the formation of a burn resulting from the use of electrodes. Such burns may, as in the case of pressure ulcers, cause patient irreversible damage to the nerves, muscles and skin.

Sometimes, the damage to skin integrity and/or the patient's tissue is attributed to a burns resulting from the use of electrode, whereas the damage is caused by stress, or prolonged lying in a wet environment.

The lecture will review the risk factors for the development of pressure sores in patients during surgery; the ways in reducing and preventing the stresses that lead to the formation of the wound. We will also discuss factors to the formation of electrical burns or chemical burns electrical warning signs, and we will discuss the differential diagnosis between burns and bedsores.

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E. PATIENT SAFETY

EFFECTIVE STRATEGIES FOR THE PREVENTION OF PERIOPERATIVE HYPOTHERMIA

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Keywords: perioperative hypothermia, safety, evidence-based practice

Perioperative hypothermia is a serious, preventable complication that increases the risk of serious negative outcomes, including: surgical site infection, morbid cardiac events, increased blood loss, increased duration of action of anesthesia, and increased postanesthesia

recovery time. Unaware of the evidence, clinicians often use ineffective strategies, including: increasing ambient temperature of the operating room, warmed cotton blankets, and heating intraperitoneal gases during laparoscopy. New evidence has demonstrated that for forced air warming to be most effective, it needs to be applied preoperatively in addition to in the operating room before induction of anesthesia. This places patients at unnecessary risk of hypothermia and the negative outcomes associated with this complication.

This presentation will review published evidence, including new information, about the risk of perioperative hypothermia, negative outcomes, and the effectiveness or ineffectiveness of frequently used strategies for prevention of perioperative hypothermia. Discussion will include: warmed cotton blankets, IV fluid warming, irrigation fluid warming, increasing the room temperture, preoperative forced air warming, intraoperative forced air warming, and warming of intraperitoneal gases for laparoscopy. Recommendations will be made to enhance adoption of effective, evidence-based strategies.

PP 178 E. PATIENT SAFETY

"SAFE SURGERY SAVES LIVES" WHO CHALLENGE IMPACTS ON DAILY CSSD ACTIVITIES.

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Keywords: sterilization, checklist, patient safety

WHO identifies, for action over a 2-3 year cycle, a topic that covers a major and significant aspect of risk to patients receiving health care. The 1st Global patient safety challenge focused on "Clean care is safer care" and the second in 2009 focused on "Safe Surgery Saves Lives".

CSSD is concerned by every WHO topics and EORNA has endorsed a position statement supporting the second challenge.

Surgical care has been an essential component of health care worldwide and the impact of surgical intervention on public health systems will continue to grow. Every year, many millions of people are under surgical treatment and surgical interventions. Unsafe surgical care can cause substantial damage:mortality after major surgery, complications after inpatient operations, adverseevents ...

This second challenge define a core set of safety standards that could be applied in all WHO Member States, on four areas in which dramatic improvements could be made in the safety of surgical care: surgical site infection prevention, safe anesthesia, safe surgical teams and measurement of surgical services.

Much of this work has been initiated by the global implementation of the WHO Surgical Safety Checklist, a 19-item tool created by WHO and supported by a lot of countries and professional associations.

What is the daily impact of this surgical safety checklist on sterilization department? What is the responsibility of CSSD in achieving this objective applies to any patient for any type of surgery under any circumstance.Sterilization professionals has a role to play at all times.

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F. HEALTHY WORKPLACES

ADVANTAGES AND DISADVANTAGES OF BEING A SURGICAL NURSE

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Nurses are assigned to clinic or operating rooms according to hospital needs without special education in Turkey. It puts stress to nurses. Surgical nurses are a part of surgery team with increased responsibility (1) This study was performed to investigate the advantages and disadvantages of being a surgical nurse in order to make improvements, to increase work satisfaction, to emphasize the importance of communication and teamwork and increase the awareness to provide better quality professional services. For this purpose, 21 question survey was performed. Nurses were divided into 3 groups. Group 1 included nurses who have only worked in surgical room while group 2 nurses were the ones who have only worked in the clinic and group 3 nurses worked at both places. Survey was completed by 45 nurses. The 3 most important advantages of being a surgical nurse were: the opportunity to work only in the morning (55%), working in a more specialized and professional way which is more satisfying (57.7%), limited duration of contact with patients and their relatives (46.6%). The 3 most important disadvantages were their mandatory physiological needs cannot be met in a timely manner (35.5%), stress and risk factors were high (33.3%) and possible hazardous effects of anesthesia gas and X-Rays during pregnancy (28.8%). Job satisfaction rate in 3 groups were 65.2%, 68% and 65% respectively and no significant difference was observed. Four indispensible criteria for surgical nurses were having sufficient knowledge and skills (53.3%), quick decision making (46.6%), having more responsibility (37.7%), being able to participate in teamwork (35.5%). Survey showed that 88.8% of all nurses believe not every nurse has capacity to become surgical nurse. When all working conditions of nurses in 3 groups were equilized, it was found that being a surgical nurse is more advantageous and prestigious.

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F. HEALTHY WORKPLACES OCCUPATIONAL INJURIES IN CENTRAL OPERATING ROOMS I

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Keywords: Occupational injuries, risk factors, occupational disease

During the practice of a medical occupation, it relatively often comes to occupational injuries that happen from various causes. In the majority of cases, a contact with the patient's biological materialoccurs. The study is aimed at the number of recorded occupational injuries in years 2006-2013 in the Central operating rooms I (COS I) in the University Hospital Brno (FN Brno). During the observed period, 174 medical employees worked in COS I. Injuries of the doctors caused during their work in COS lare also included in the study. The total number of recorded injuries for the period is 412. The most frequently injured part of the body was the index finger (77) and the thumb (46) of the left upper limb. Occupational injuries were reported by all categories of employees in COS I FN Brno.

Diseases caused by HBV (hepatitis B virus) and HCV (hepatitis C virus) belong to the most frequently parenterally transmitted diseases^[2]. During the observed period of five years, no professional viral hepatitis infection of any type occurred (including HIV/AIDS) in COS I FN Brno^[1]. No transmission of HIV/AIDS from patient on medical personnel had been recorded by the end of 2011^[3]. Almost 75% of employees have suffered at least one sharp object injury during their careers^[4]. In years 2006-2013, approximately 235 000 surgeries were carried out. The data imply that there was one reported occupational injury in 570 surgeries. However, occupational injuries cannot be completely avoided due to the nature of the work and the operations performed. The occurrence of risk factors during the work in medical facilities is considerable. For this reason, it is necessary to strictly obey the rules and regulations of health and safety at workand use all the available means of protection in direct risk factor intervention.

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F. HEALTHY WORKPLACES

NURSES WORKING IN SURGICAL CLINICS' QUALITY OF WORK LIFE AND RELATED FACTORS

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Keywords: Nursing, quality, work life.

Background

Quality of work life (QWL) is defined as the extent to which an employee is satisfied with personal and working needs through participating in the workplace while achieving the goals of the organization.1 It seems that the relationship between QWL and the degree of nurses' involvement in their work is the critical factor in achieving a higher level of guality of care delivery.2 Therefore it is important that is determination their quality of worklife and related factor of nurses

Aim

The aim of study was to determine nurses who work in surgical clinics' the quality of worklife and related factors.

Methods

This study was conducted with 305 nurses who work in surgical services, surgical intensive care units and operation rooms at two university hospital in Turkey between 09 April 2013 and 07 January 2014. Data were collected using Turkish version of the Quality of Nursing Work Life Survey (T-QNWL) and a demographic and professional life questionnaire. Descriptive statistics, independent sample t test, and ANOVA student t tests were analyzed.

Results

Nurses' total mean score of scale is 97,74±21,91. Some socio-demographic (gender, age, marital status, and educational level) and professional life characteristics (job status, working year as a nurse, working voluntarily in the clinical, work unit and duration of work in the current position) had influences on nurses' T-QNWL total mean score (p<,05). Conclusion: It was found that the nurses working in the surgical units have lower quality of work life. Therefore, it is recommended that practices should be planned to improve nurses' quality of work life and their results should be evaluated.

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PP 182 F. HEALTHY WORKPLACES OPERATING ROOM NURSES' PROFILE IN TURKEY

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Keywords: working condition, operating room nurse, nurse profile

Operating theatres show rapid changes due to the development of science and technology, and have difficult conditions with its dynamics and work pace (1, 2). In Turkey, there is in-service trainings are designed for nurses who want to specialize in operating room nursing. However, operating room nurses are needed to create educational opportunities for their professional development, as well as improvement of their working conditions.

The studies, which show the profiles of operating room nurses, must be made in order to plan the policies and activities of their needs. In this context, a total of 726 operating room nurses from public and private health institutions were analyzed. The socio-demographic characteristics, education and employment status of them were collected via a survey to obtain their profiles.

The average age of the study group was 33.87, and 94.1% were women and 5.9% were male. 49% of nurses have undergraduate degree, and the mean of employment period in the operating room was 9.5 years. One of the key findings of the survey is that a high percentage of nurses (88.6%) gave negative reply for the question: "If you were given a second chance to choice your job place would you choose the operating theater again?" Another finding of the study was that the participation rate of different activities: 67.1%, mentioned that they spent time for scientific meetings, 98% for social activities, and 61.8% of Turkish Surgical and Operating Room Nurses Association activities. Nearly half of the participants (43.9%) were members of the association.

As a result, it was determined that the majority of the nurses were willing to work when they start working at the operating room, but due to the challenging working conditions they lost their willingness. Operating room nurses should receive in-service training and orientation programs including standardized content and time.

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G. INNOVATION IN PERIOPERATIVE CARE I AM BENEFICIAL - I RECYCLING USABLE MATERIALS

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Keywords: recycling, natural enviroment

The concern for the natural environment is not receiving enough of our attention. We exploit natural resources at every step. We almost never ask ourselves what kind of the world we will leave behind for future generations. Thinking about recycling materials and the economic aspect of recycling has led to the idea of recycling material. The reuse represents the use of on object after it has already been used. This includes a conventional reuse, where the product is reused and is intended for a different function. The advantages of reuse contribute to reducing the production of paper, plastic and glass, slow down the consumption of natural resources, encourage environmental consciousness of people, conserve natural resources, save space in landfills, save energy and they also have the economic aspect. Innovative ideas are a chance to reflect on what we can do today for a better tomorrow and for future generations.

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G. INNOVATION IN PERIOPERATIVE CARE

THE ANXIOLYTIC EFFECT OF AROMATHERAPY ON PATIENTS AWAITING AMBULATORY SUR-GERY: A RANDOMIZED CONTROLLED TRIAL

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Keywords: anxiolytic effect, aromatherapy, ambulatory surgery, randomized controlled trial

Aim

The aim of this study was to determine if aromatherapy could reduce preoperative anxiety in ambulatory surgery patients.

Methods

A total of 109 preoperative patients were randomly assigned to experimental (bergamot essential oil) and control (water vapor) conditions and their responses to the State Trait Anxiety Inventory and vital signs were monitored. Patients were stratified by previous surgical experience, but that did not influence the results. The changes in STAI, heart rate, and blood pressure between the two groups were assessed with the non-parametric Mann-Whitney test and other continuous data between groups with the two independent samples t test.

Results

All those exposed to bergamot essential oil aromatherapy showed a greater reduction in preoperative anxiety that did those in the control groups. With the use of a random number table, the 109 subjects were randomly assigned into two groups: bergamot essential oil (n = 53) and control (n = 56). The STAI scores decreased more in the bergamot group than in the control group (-3.0 vs. -2.0, p = 0.021). The STAI score, heart rate, and blood pressure in the bergamot group significantly decreased from baseline, as the median changes in STAI, heart rate, systolic blood pressure (SBP), and diastolic blood pressure (DBP) were -3.0 (p < 0.001), -6.0 beats/min (p =0.015), -11.0 mmHg (p <0.001), and -5.0 mmHg (p =0.012), respectively.

Conclusion

Regardless of previous surgical experience, patients exposed to bergamot essential oil aromatherapy were less anxious than controls. Aromatherapy may be a useful part of a holistic approach to reducing preoperative anxiety before ambulatory surgery.

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E. PATIENT SAFETY

TO PREVENT WRONG SITE SURGERY: DEVELOPMENT OF A GOOD PRACTICES GUIDE

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Keywords: Best Practices, wrong site, communication, patient safety, risk

Context: wrong site surgery is one of the major risks. The implementation of the WHO checklist preoperative has reduced many site errors. These seem exceptional but they are unfortunately still common.

The fight against wrong site surgery is part of major European initiatives to improve the quality and safety of care in Europe.

The international literature shows that there are multiple sources of error:

- They may be linked to written documents:
- on the surgery program,
- In the patient's file (lack of information)
- Errors in transcription

They may be due to exchanges among professionals and patients patient's ignorance or confusion

Finally, they may be related to perioperative acts:

- Error while preparing surgical site
- Surgical drapes on the wrong side

Objectives

To write under the auspices of the SOFERIBO, a good practices guide for health professionals to prevent wrong site surgery

Method

- Establishment of a group of experts
- Conducting a literature review to identify errors declared and prevention strategies developed
- Identification of risk factors and severity for the patient
- Writing the guidebook presenting a method on how to take care of the patient: at each step of the surgical procedure the risk factors are identified and the OR nurse can intervene positively.

Results

The good practices guide has been developed and validated. It is now distributed to professionals by UNAIBODE. Its impact in terms of improving patient safety must now be evaluated. It is a priority for all professionals. As in the aerospace sector, each health professional is involved and must be vigilant to ensure patient safety on operating rooms.

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B. PERIOPERATIVE/CLINICAL PRACTICE CIRCUIT HIGH RESOLUTION CATARACTS TO DOUBLE OPERATING ROOM

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Keywords: Optimization resources, cataracts, high resolution

Background

Reducing costs and use of resources is a priority objective in times of crisis in which we live. High Resolution Circuit Cataracts of the Malvarrosa Hospital has taken a further step in this respect, re-designing his circuit in order to make the most of the resources, happening of realizing 14 interventions of cataracts in an operating room to realizing 24 interventions of cataracts in two operating rooms simultaneously for the same ophthalmologist.

Focus of interest

Gestion.

Theoretical Framework

Organizational changes in the Hospital led an opportunity to implement a program "Circuit High Resolution Cataracts to double operating room" that seeks to optimize resources, reduce costs while maintaining customer satisfaction.

We intend to show through a poster on adaptation, the role of nursing in it, the experience and the implementation of this circuit

Conclusions

In the Malvarrosa Hospital are operated up to 24 patients per session to double operating room with high quality standards and patient safety as measured by the rate of nosocomial infections and patient satisfaction survey. Organizational change has increased the number of cataracts done per day with decreased personnel costs and maintenance of user satisfaction at similar levels to the previous year.

Implications for nursing

In High Resolution Circuit Cataracts of the Malvarrosa Hospital the involvement of all team personnel is the key factor for its development, being nurses the largest and most developed activities.

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