

# 2021 ORNAC NATIONAL CONFERENCE POSTER ABSTRACTS



## RÉSUMÉS DES AFFICHES DU CONGRÈS NATIONAL 2021 DE L'AIISOC\*

\*Toutes les présentations ont été effectuées en anglais

### **Charting the future of perioperative nursing practice in Africa with FoAN Canada**

**Presenters:** Margaret Farley RN, BSN, CPN(C), Faculty, Perioperative Nursing Programs, School of Nursing, Saskatchewan Polytechnic and Member-at-Large, FoAN Canada Board of Directors; Mary Knight BScN, MN (retired), Chair of FoAN Canada Board of Directors.

**Educational Theme:** Education

#### **Abstract:**

Friends of African Nursing (Canada) has worked in partnership with Friends of African Nursing, based in the United Kingdom, through joint ventures to facilitate leadership and provide perioperative focused nursing updates to our nursing colleagues in Africa. View and follow the pictorial poster displaying the participation and sharing of perioperative knowledge relating to leadership, and the review and updating of perioperative skills and practices with our African perioperative nursing colleagues over the last decade. Charting the future with our perioperative nursing colleagues assists with the provision of safe and effective care for patients in surgical settings across the globe.

*See poster on page 56.*

### **Naviguer l'avenir de la pratique périopératoire en Afrique avec FoAN Canada**

**Présentatrices :** Margaret Farley, inf., B. Sc. Inf., CSP(C), membre du corps professoral des programmes de soins infirmiers périopératoires, école des sciences infirmières, Saskatchewan Polytechnic et membre hors cadre du conseil d'administration de FoAN Canada; Mary Knight, B. Sc. Inf., M. Sc. Inf. (retraitee), présidente du conseil d'administration de FoAN Canada.

**Thème éducatif :** Enseignement

#### **Résumé :**

Friends of African Nursing (Canada) a travaillé en partenariat avec Friends of African Nursing, qui est basé au Royaume-Uni, par l'entremise d'entreprises en participation afin de faciliter le leadership et de fournir des mises à jour en soins infirmiers axées sur les soins périopératoires à nos collègues infirmières en Afrique. Consultez et suivez l'affiche illustrée montrant la participation et le partage des connaissances périopératoires liées au leadership, ainsi que la révision et la mise à jour des compétences et des pratiques périopératoires avec nos collègues africains en soins périopératoires au cours de la dernière décennie. Naviguer l'avenir de la pratique avec nos collègues

en soins périopératoires aide à offrir des soins sécuritaires et efficaces aux patients chirurgicaux à travers la planète.

*Voir l'affiche à la page 56.*

### **Empowerment strategies to engage frontline perioperative nurses in shared decision making in the development process of clinical decision support tools**

**Presenter:** Te Hsin (Cindy) Chiang MSN, RN, Program Head of Perioperative Specialty Nursing Program, British Columbia Institute of Technology (BCIT) - Burnaby Campus.

**Acknowledgements:** The presenter would like to acknowledge Maggie Theron DCur RN, Assistant Professor from the School of Nursing at Trinity Western University, and Duncan Dixon, TWU librarian, who helped with the literature review process and complete this knowledge translation project.

**Education Theme:** Leadership

#### **Abstract:**

**Background:** Collaboration between professions and practices of shared decision making through a culture of partnership contributes to a positive

workspace for practice change. The identity of a nurse constitutes more than a caring profession. Nursing as a profession impacts major issues in society to better healthcare outcomes. Enacting nursing leadership contributes to professional practice in a multi-level healthcare system and society. Nurses as leaders facilitate collaboration and actively take part in shared decision-making every day as part of patient care. Frontline nurses do not necessarily engage in shared decision-making practices as part of professional practice councils. In addition, these nurses may not comprise the political skills to navigate magnet culture in the development of clinical decision support tools in nursing practice. Gaps arise in the application of these tools geared towards optimal health outcomes for patients due to the lack of frontline nursing perspectives and shared decision-making practices. Unit and organizational culture may influence the level of engagement of these frontline nurses in the development and execution of clinical decision support tools.

**Aim:** The barriers and facilitators impacting engagement of frontline nurses in shared decision-making practices was explored through a knowledge translation project. Key messages from results may enhance nursing leadership, teamwork, and patient care through the utilization of Professional Practice Councils to encourage shared decision making and create a culture of partnership.

**Methods:** The Knowledge to Action framework developed by Graham and colleagues guided a knowledge synthesis to explore these barriers and facilitators utilizing a CINAHL literature review and secondary analysis of a unit culture survey. Themes derived served as building blocks for multi-level empowerment strategies for frontline nurses to enact their leadership role as part of their nurse identity.

**Results:** Multi-level themes revealed an absence of frontline nurses in shared decision-making processes when clinical

decision support tools are developed and implemented. Decreased professional autonomy and poor teamwork are experienced by frontline nurses when they are not valued as stakeholders or decision makers in the development of these tools, leading to poor patient care. Shared governance and magnet cultures support the establishment of effective professional practice councils. Elements of magnetism are strongly associated with increased nurse autonomy and engagement in shared decision making as nurse leaders.

**Conclusion:** The empowerment strategies ensure linkages throughout the healthcare organization and enhance effective communication between the nursing profession, unit managers/leaders, and the organizational infrastructure. Importance to nursing education in preparing frontline nurses.

*See poster on page 58.*

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Wesorick B. Live a legacy or live a lie: A choice. *Nurs Adm Q.* 2008 Apr-Jun;32(2):142-58.

**Note:** Bibliography does not include CINAHL literature review.

**Stratégies d'autonomisation pour faire participer les infirmières en soins périopératoires de première ligne dans la prise de décisions communes d'un processus d'élaboration d'outils de soutien aux décisions cliniques**

**Présentatrice :** Te Hsin (Cindy) Chiang, M. Sc. Inf., inf., chef de programme du Programme spécialisé en soins infirmiers périopératoires, *British Columbia Institute of Technology (BCIT)* – campus de Burnaby.

**Remerciements :** La présentatrice tient à remercier Maggie Theron, DCur, inf., professeure adjointe de l'école des sciences infirmières de Trinity Western University et Duncan Dixon, bibliothécaire au TWU, qui l'ont aidée lors du processus de recension de la littérature et à mener à bien ce projet de transfert des connaissances.

**Thème éducatif :** Leadership

**Résumé :**

**Contexte :** La collaboration entre les professions et les pratiques de prise de décisions communes par l'entremise d'une culture de partenariat contribue à un milieu de travail positif pour les modifications aux pratiques. L'identité d'une infirmière représente plus qu'une profession vouée au bien-être des gens. Les soins infirmiers à titre de profession ont un impact sur d'importants enjeux au sein de la société dans le but d'améliorer les résultats en soins de santé. L'adoption du leadership infirmier contribue à la pratique professionnelle au sein d'un système multiniveau de soins de santé et au sein de la société. Les infirmières à titre de leaders facilitent la collaboration et prennent part tous les jours de manière active à la prise de décisions communes dans le cadre des soins aux patients. Les infirmières de première ligne ne participent pas nécessairement aux pratiques de prise de décisions communes lors des conseils de pratique professionnelle. De plus, il se peut que ces infirmières ne possèdent pas les compétences politiques pour naviguer la culture à vocation particulière lors de l'élaboration des outils de soutien aux décisions cliniques pour la pratique infirmière. Les lacunes surviennent dans la mise en œuvre de ces outils conçus pour atteindre des résultats de santé optimaux pour les patients en raison du manque de perspectives infirmières de première ligne et de pratiques de prise de décisions communes. La culture organisationnelle et d'unité peut influencer le niveau de participation de ces infirmières de première ligne quant à l'élaboration et la mise en pratique des outils de soutien aux décisions cliniques.

**But :** Les obstacles et facilitateurs ayant un effet sur la participation des infirmières de première ligne aux pratiques de prise de décisions communes ont été examinés grâce à un projet de transfert des connaissances. Les messages clés tirés des résultats pourraient améliorer le leadership infirmier, le travail d'équipe et les soins aux patients avec l'utilisation de conseils

de pratique professionnelle afin d'encourager la prise de décisions communes et créer une culture de partenariat.

**Méthodes :** Le cadre conceptuel pour le passage des connaissances à la pratique élaboré par Graham et ses collègues s'accompagnait d'une synthèse des connaissances pour examiner ces obstacles et facilitateurs à l'aide d'une recension de la littérature CINAHL et d'une analyse secondaire d'une enquête sur la culture d'unité. Les thèmes dérivés ont servi d'éléments constitutifs pour les stratégies d'autonomisation multiniveaux pour les infirmières de première ligne afin qu'elles jouent leur rôle de leaders dans le cadre de leur identité infirmière.

**Résultats :** Les thèmes multiniveaux ont révélé une absence des infirmières de première ligne dans les processus de prise de décisions communes lorsque les outils de soutien aux décisions cliniques sont élaborés et mis en œuvre. Ces dernières connaissent aussi une autonomie professionnelle réduite et un travail d'équipe déficient lorsqu'elles ne sont pas considérées comme des intervenantes ou des décideuses lors de l'élaboration de ces outils, ce qui entraîne des soins aux patients médiocres. Les cultures de gouvernance commune et à vocation particulière soutiennent la création de conseils efficaces de pratique professionnelle. Les éléments de cette vocation particulière sont fortement associés à une plus grande autonomie des infirmières et à leur participation dans la prise de décisions communes en tant qu'infirmières leaders.

**Conclusion :** Les stratégies d'autonomisation permettent de faire des liens au sein de toute l'organisation de soins de santé et d'améliorer la communication efficace entre la profession infirmière, les gestionnaires/leaders d'unités et l'infrastructure organisationnelle. Elles sont importantes pour l'enseignement des soins infirmiers afin de préparer les infirmières de première ligne.

*Voir l'affiche à la page 58.*

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Wesorick B. Live a legacy or live a lie: A choice. Nurs Adm Q. 2008 Apr-Jun;32(2):142-58.

**Remarque :** La bibliographie ne comprend pas la recension de la littérature CINAHL.

### Improved operative efficiency for minimally invasive mitral valve surgery at a low-volume center

**Presenters:** Monica Fowler MNRN; Jeffrey B MacLeod BSc; Alexandra M Yip BSc; Zlatko Pozeg MD; Rand Forgie MD; Craig D Brown MD; Jean-François Légaré MD; Ansar Hassan MD.

**Educational Theme:** Perioperative Practice

#### Abstract:

**Introduction:** When implementing a minimally invasive cardiac surgery program, increased surgical times may serve as a deterrent. Results demonstrating parity in operative times between minimally invasive (MIMVR) and conventional mitral valve replacement/repair (CMVR) have been limited to high-volume centers. The purpose of this study was to examine operative efficiency for MIMVR in a low-volume center.

**Methods:** All patients having undergone non-emergent, isolated MIMVR or CMVR at the New Brunswick Heart Centre from 2011-2017 were considered. Detailed peri-operative data, including cross clamp (XC), cardiopulmonary bypass (CPB), skin-to-skin (SS) and total operative (TO) times, were collected. Patients were assigned to one of 3 eras: 2011-2013, 2014-2015, 2016-2017. Unadjusted comparisons were made between MIMVR and CMVR over the entire study period and within each era.

**Results:** A total of 168 patients were included (MIMVR: 64; CMVR: 104). There was an increase in the number of MIMVR cases over time (2011-2013: 19; 2014-2015: 17; 2016-2017: 28). Patients undergoing MIMVR were less likely to be  $\geq 70$  years (29.7% vs. 47.1%,  $p=0.04$ ) and to have had NYHA-IV symptoms (17.2% vs. 41.3%,  $p=0.002$ ), previous

cardiac surgery (4.7% vs. 23.1%,  $p=0.003$ ) or urgent presentation (12.5% vs. 35.6%,  $p=0.002$ ). Intra-operatively, MIMVR patients were more likely to have undergone a mitral valve repair (65.1% vs. 29.1%,  $p<0.0001$ ). No differences were noted in rates of in-hospital mortality (0.0% vs. 5.1%,  $p=0.29$ ). Median operative times were uniformly longer among MIMVR patients between 2011-2013. However, in 2014-2015 and 2016-2017, these times improved to the point where no significant differences in operative efficiency were noted.

**Conclusions:** Improved operative efficiency may be safely achieved for MIMVR in a low-volume center. It is evident that conventional bypass surgery when compared with minimally invasive cardiac surgery (MIS), has shorter CPB/XC.<sup>2</sup> However, evidence suggests that equality between the two types of techniques can be achieved through experiences gained in high volume centers and even can see decreases in operation times.<sup>1</sup> Surgical experience of the different surgeons involved in introducing a minimally invasive cardiac surgery into a heart program, combined with the experiences of the surgical team, are two important factors that influence the outcome and effective implementation of any program.<sup>3</sup> Beyond that it has been identified that even when there are comparable learning opportunities between centres, the concept of “organizational learning effects” are considered important factors which affect the learning curve.<sup>4</sup> An organization with a strong “learning culture” and “learning effectiveness”, whereby education and training, having a dedicated team to begin with, are all necessary factors, which will influence the learning curve. The results of this study should encourage low-volume centers to adopt a minimally invasive approach to isolated mitral valve surgery.<sup>5-7</sup>

*See poster on page 62.*

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**Efficacité opérationnelle améliorée pour les chirurgies minimalement invasives de la valve mitrale dans un centre de faible volume**

**Présentateurs :** Monica Fowler, M. Sc. Inf., inf.; Jeffrey B. MacLeod,

B. Sc.; Alexandra M. Yip, B. Sc.; Zlatko Pozeg, M.D.; Rand Forgie, M.D.; Craig D. Brown, M.D.; Jean-François Légaré, M.D.; Ansar Hassan, M.D.

**Thème éducatif :** Pratique périopératoire

## Résumé :

**Introduction :** Lorsqu'on met en œuvre un programme de chirurgie cardiaque minimalement invasif, il se peut que les temps chirurgicaux accrus soient un élément dissuasif. Les résultats démontrant la parité dans les temps opératoires entre les remplacements/réparations minimalement invasifs de la valve mitrale (RMIVM) et les remplacements/réparations conventionnels de la valve mitrale (RCVM) ont été limités aux centres de volume élevé. Le but de cette étude visait à examiner l'efficacité opérationnelle d'un RMIVM dans un centre de faible volume.

**Méthodes :** Tous les patients ayant subi un remplacement minimalement invasif de la valve mitrale ou un remplacement conventionnel de la valve mitrale non émergent et isolé au Centre cardiaque du Nouveau-Brunswick de 2011 à 2017 ont été pris en considération. Les données périopératoires détaillées, y compris la fixation par serrage (XC), la dérivation cardiopulmonaire (CPB), le peu à peu (SS) et le temps opératoire total (TO), ont été recueillies. Les patients ont été affectés à l'une des 3 périodes : 2011-2013, 2014-2015, 2016-2017. Des comparaisons non ajustées ont été effectuées entre les RMIVM et les RCVM tout au cours de la durée de l'étude et dans chacune des périodes.

**Résultats :** Un total de 168 patients ont été inclus (RMIVM : 64; RCVM : 104). Avec le temps, il y a eu une augmentation du nombre de cas de RMIVM (2011-2013 : 19; 2014-2015 : 17; 2016-2017 : 28). Les patients qui subissent un RMIVM étaient moins susceptibles d'être âgés de  $\geq 70$  ans (29,7 % vs 47,1 %,  $p=0.04$ ) et d'avoir

eu des symptômes de catégorie IV selon le NYHA (17,2 % vs 41,3 %,  $p=0.002$ ), de chirurgies cardiaques antérieures (4,7 % vs 23,1 %,  $p=0.003$ ) ou de présentation urgente (12,5 % vs 35,6 %,  $p=0.002$ ). Pendant l'intervention, les patients de RMIVM étaient plus susceptibles d'avoir subi une réparation de la valve mitrale (65,1 % vs 29,1 %,  $p<0.0001$ ). Aucune différence n'a été signalée dans les taux de mortalité à l'hôpital (0,0 % vs 5,1 %,  $p=0.29$ ). Les temps opératoires moyens étaient uniformément plus longs chez les patients de RMIVM entre 2011-2013. Cependant, en 2014-2015 et en 2016-2017, ces temps se sont améliorés au point où aucune différence significative en matière d'efficacité opérationnelle n'a été signalée.

**Conclusions :** L'efficacité opérationnelle améliorée peut être réalisée de manière sécuritaire pour les RMIVM dans un centre de faible volume. Il est évident que la chirurgie de dérivation conventionnelle comparativement à la chirurgie cardiaque minimalement invasive (CMI) possède des temps CPB/XC plus courts.<sup>2</sup> Par contre, les données probantes suggèrent que l'égalité entre les deux types de techniques peut être atteinte grâce à l'expérience acquise dans les centres de volume élevé et peut même observer des diminutions en termes de temps opératoires.<sup>1</sup> L'expérience chirurgicale des différents chirurgiens participant à l'introduction de la chirurgie cardiaque minimalement invasive dans un programme cardiaque, combinée aux expériences de l'équipe chirurgicale, sont deux facteurs importants qui influencent le résultat et la mise en œuvre efficace de tout programme.<sup>3</sup> Par ailleurs, il a été déterminé que même lorsqu'il y a des opportunités d'apprentissage comparables entre les centres, le concept « d'effets d'apprentissage organisationnel » est considéré comme un facteur important qui affecte la courbe d'apprentissage.<sup>4</sup> Une organisation dotée d'une solide « culture d'apprentissage » et d'une « efficacité d'apprentissage », qui se

traduisent par de l'enseignement et de la formation ainsi qu'une équipe dévouée, sont tous des facteurs nécessaires, qui influenceront la courbe d'apprentissage. Les résultats de cette étude devraient encourager les centres de faible volume à adopter une approche minimalement invasive à la chirurgie isolée de la valve mitrale.<sup>5-7</sup>

*Voir l'affiche à la page 62.*

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### Promoting perioperative practice through an innovative undergraduate education program

**Presenter:** Julie Cinel RN, MSN, Associate Teaching Professor, Thompson Rivers University

**Acknowledgments:** The presenter would like to acknowledge the TRU School of Nursing and the Royal Inland Hospital for supporting this student learning initiative

**Education theme:** Perioperative Education

#### Abstract:

This research poster outlines the process and outcomes of an undergraduate perioperative clinical rotation aimed to increase exposure of students to this practice setting and provide a quality learning experience. Over a period of six years, groups of third-year Bachelor of Science in Nursing students participated in a 6-week practicum where they spent time in Daycare Surgery, the Operating Room, and the Post-Anaesthesia Recovery Room.

Learning outcomes included enhanced competency in clinical decision-making, prioritization, critical thinking, collaboration, communication, multidisciplinary teamwork, anatomy and physiology, patient centered care, advocacy, relational practice, and transferable skills. Other outcomes included enhanced quality of care for the patients, and recruitment and retention potential for the hospital. Evaluation outcomes found that students highly valued the experience, were challenged to do their best work, and were left with

an increased appreciation for the practice environment.

*See poster on page 64.*

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### Promouvoir la pratique périopératoire par le biais d'un programme novateur d'enseignement d'études de premier cycle

**Présentatrice :** Julie Cinel, inf., M. Sc. Inf., professeure agrégée, Université Thompson Rivers

**Remerciements :** La présentatrice tient à remercier l'école des sciences infirmières de l'UTR et l'Hôpital Royal Inland d'avoir appuyé cette initiative étudiante d'apprentissage.

**Thème éducatif :** Enseignement périopératoire

#### Résumé :

Cette affiche de recherche passe brièvement en revue le processus et les résultats de stages cliniques d'études de premier cycle en soins périopératoires visant à augmenter l'exposition des étudiants de ce milieu de pratique et à

fournir une expérience d'apprentissage de qualité. Sur une période de six ans, les groupes d'étudiants en troisième année du baccalauréat en sciences infirmières ont participé à un stage de 6 semaines durant lequel ils passaient du temps en chirurgie ambulatoire, en salle d'opération et en unité de soins postanesthésiques.

Les résultats d'apprentissage incluaient de meilleures compétences en prise de décisions cliniques, priorisation, pensée critique, collaboration, communication, travail d'équipe pluridisciplinaire, anatomie et physiologie, soins axés sur les patients, défense des droits, pratique relationnelle et compétences transférables. Parmi les autres résultats, notons: des soins de qualité supérieure pour les patients et un potentiel accru de recrutement et de rétention pour l'hôpital. Les résultats de l'évaluation ont révélé que les étudiants accordaient beaucoup d'importance à l'expérience, étaient mis au défi d'accomplir le meilleur travail possible et qu'ils appréciaient davantage l'environnement de pratique.

*Voir l'affiche à la page 64.*

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# Charting the Future of Perioperative Nursing

## Friends of African Nursing

Margaret Farley, RN, BSN, CPN(C)

### FoAN Canada

*FoAN Canada\* is celebrating over 10 years of offering leadership and perioperative focused updates to our African perioperative colleagues!*

FoAN Canada's Goal: To facilitate the development & improvement of patient care and perioperative nursing practice in Africa, by:

- ✓ Advancing knowledge & skills in African perioperative nurses
- ✓ Providing education, training & practical guidance thru hands-on sessions, providing educational materials or financial support
- ✓ Raising awareness regarding issues facing African Nurses

Joint venture programs with FoAN (UK) have been delivered in:



*\*FoAN Canada is a registered Canadian charity*

### Botswana 2012



- 5 day Train the Trainer Program, worked with 11 senior nurses
- Topics included communication skills, lesson planning, teaching & learning theory

### Zambia 2017



- Worked 5 days with 19 nurse educators & leaders to develop Zambian Perioperative Standards
- 20 standards finalized
- Each participant received eyewear, certificate & textbook



# Cooperative Practice in Africa

## Nursing (Canada)

& Mary Knight, BScN, MN (retired)



### Ghana 2018

- 3 programs delivered over 5 days
- 2 day Patient Safety Program delivered twice - in Accra (capital city) and Kumasi – total of 66 nurses attended
- Topics included: Understanding medical error, communication, Hospital acquired infections, documentation, ensuring safe surgery, teamwork, etc.



- 1 day Perioperative Nursing Update - 96 nurses attended!



- Topics included: Patient safety, workplace bullying, surgical site infection & hypothermia
- Many nurses attending were from rural or outlying areas

### Ghana 2020

- Return to Accra; provided 3 day Leadership Program (50 nurses)
- 2 day Perioperative Nursing Care (34 nurses)
- Nurses travelled up to 8 hours to attend, showing their passion for learning & developing their practice



### 2021

- Pandemic has brought many challenges, including how to fundraise and continue to deliver educational programs
- Possibility of mailing textbooks to known contacts in outlying rural areas e.g. Zambia, Ghana
- FoAN UK organizing virtual conference in June 2020 for African Perioperative Nurses; FoAN Canada is both supporting and participating

# Empowerment Strategies to engage frontline Perioperative Nurses in the Development Process of Clinical Decision Support Tools

## Background

Frontline perioperative nurses who enacts shared decision making (SDM) practices as part of their nursing professional practice council contributes to a positive culture of partnership for practice change and impacts major issues in society to better healthcare outcomes.

A low engagement in perioperative professional practice councils has been observed and SDM practices, particularly in the development of clinical decision support tools (CDSTs) such as, Clinical Practice Guidelines (CPG's) and Clinical Policies.

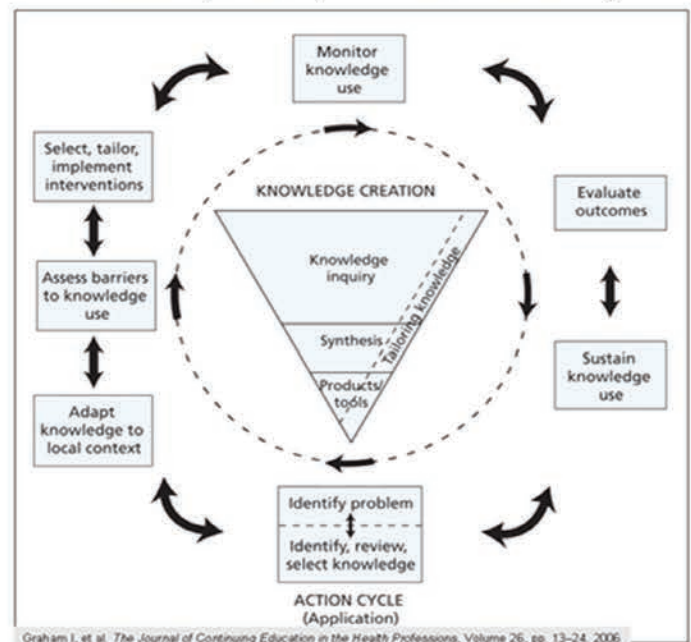
Gaps arise in the application of these CDSTs geared towards optimal health outcomes for patients due to the lack of frontline nursing perspectives and shared decision making practices. Unit and organizational culture may influence the level of engagement of these frontline nurses in the development and execution of clinical decision support tools.

## Aim

The barriers and facilitators impacting engagement of frontline nurses in shared decision making practices was explored through a knowledge translation (KT) project. Key messages from results may enhance nursing leadership, teamwork, and patient care through the utilization of Professional Practice Councils to encourage shared decision making and create a culture of partnership.

## Method

The Knowledge to Action framework developed by Graham and colleagues guided a knowledge synthesis to explore these barriers and facilitators utilizing a CINAHL literature review and secondary analysis of a unit culture survey. Themes derived served as building blocks for multi-level empowerment strategies for frontline nurses to enact their leadership role as part of their nurse identity.



## Results

Multi-level themes revealed an absence of frontline nurses in shared decision making processes when clinical decision support tools are developed and implemented. Decreased professional autonomy and poor teamwork are experienced by frontline nurses when they are not valued as stakeholders or decision makers in the development of these tools, leading to poor patient care. Shared governance and magnet cultures support the establishment of effective professional practice councils. Elements of magnetism (EOM) are strongly associated with increased nurse autonomy and engagement in shared decision making as nurse leaders.

# Perioperative Nurses in Shared Decision Making in the Clinical Decision Support Tools

Te Hsin Chiang, MSN, RN  
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## Results (Continued)

### Barriers to SDM derived 3 themes

#### Multi-Level Themes:

- **Theme 1: Lack of Clarity in One's Own Nursing Professional Identity (Nursing Level)**
- **Theme 2: Lack of Leadership Skills and Visionary Leaders for the 21<sup>st</sup> Century (Management Level)**
- **Theme 3: Failure of Integration of Professional Practice into the Organizational Infrastructure. (Organizational level)**



### Success Factors for KTA Implementation

Target Audience: Multi-Level Approach

- **Level 1: Perioperative nurses**  
(e.g. stakeholders, end users, knowledge workers of CDSTs)
- **Level 2: Leadership level**  
(e.g. unit-based care leaders, educators, managers)
- **Level 3: Organizational level**  
(e.g. decision makers, infrastructure & networking)

## Results (Continued)

### Multi-level facilitators/recommendations:

**Nursing Level** - To raise awareness among the nursing profession regarding their professional autonomy, and accountability as nursing leaders in today's healthcare system require continuous learning and professional development that emphasize their role as valuable stakeholders who need to be engaged in the research development process of CDSTs to increase uptake of EBP.

**Management Level** - Leaders and managers are well poised in a position for change; therefore, they need to be able to clearly articulate and practice the leadership style of the 21st century. It involves role modeling shared unit and organizational values and visions by promoting EOM and SDM.

**Organizational Level** - To create a culture of partnership in order to foster successful integration of professional practice into the organizational infrastructure.

## Conclusion

The empowerment strategies ensure linkages throughout the healthcare organization and enhance effective communication between the nursing profession, unit managers/leaders, and the organizational infrastructure. Fostering a culture of partnership for frontline perioperative nurses to enact nursing leadership through SDM practices is not only a shared responsibility, but a way for charting the future of perioperative practice.

## References/Acknowledgement/Contact

Please see next slide.

# Empowerment Strategies to engage frontline P in the Development Process of

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**Note:** Reference list incomplete (does not include CINAHL literature review)

# Perioperative Nurses in Shared Decision Making Clinical Decision Support Tools

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## **Acknowledgements**

I would like to acknowledge Maggie Theron DCur, RN, Assistant Professor from the School of Nursing at Trinity Western University and Duncan Dixon, TWU librarian who have helped me with the literature review process and complete this KT Project.

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# IMPROVED OPERATING MITRAL VALVE SURGERY

New Brunswick Heart Centre, Saint John, NB



## BACKGROUND

- When implementing a minimally invasive cardiac surgery program, increased surgical times may serve as a deterrent.
- While previous studies have demonstrated that parity in operative times may be achieved between **minimally invasive mitral valve replacement/repair (MIMVR)** and **conventional mitral valve replacement/repair (CMVR)**, these results have been limited to high-volume centres.



## OBJECTIVE

- The purpose of this study was to examine operative efficiency for MIMVR in a low-volume centre.

## DISCLOSURES

I have **not had** an affiliation (financial or otherwise) with a commercial organization that may have a direct or indirect connection to the content of my presentation.

Does your presentation describe the off-label use of a device, product, or drug that is approved for another purpose? **No.**



Cardiovascular  
 Research  
 New Brunswick



**New Brunswick  
 Heart Centre**  
**Centre cardiaque  
 du Nouveau-Brunswick**

## METHODS

### POPULATION

Patients having undergone **non-emergent, isolated MIMVR or CMVR** at the New Brunswick Heart Centre

### TIMELINE

2011–2017

**Eras**

A: 2011–13

B: 2014–15

C: 2016–17

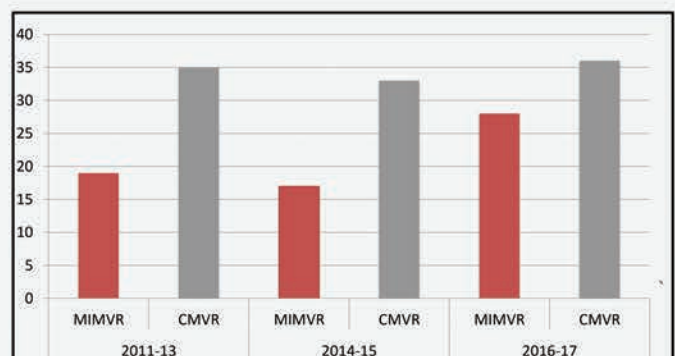
### OUTCOMES

In hospital mortality  
 Atrial Fibrillation  
 Renal failure  
 Length of stay

### OR EFFICIENCY

Cross clamp  
 Cardiopulmonary bypass  
 Skin-to-Skin  
 Total Operative

## RESULTS



- Increasing #'s of MIMVR cases over time
- MIMVR were younger, had fewer comorbidities, were less urgent, more likely to undergo repair
- Experienced less renal failure, shorter LOS
- No difference in-hospital mortality

# ROOM EFFICIENCY FOR MINIMALLY INVASIVE SURGERY AT A LOW-VOLUME CENTRE

## ANALYSIS

Comparisons between MIMVR and CMVR on basis of perioperative characteristics and operative efficiency

## STUDY POPULATION

Overall: n=168  
MIMVR: n=64  
CMVR: n=104

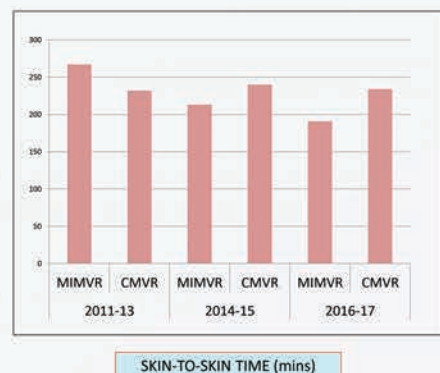
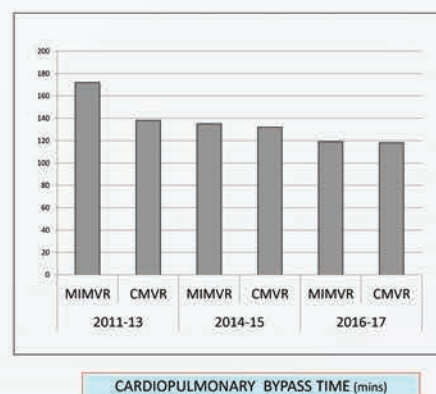
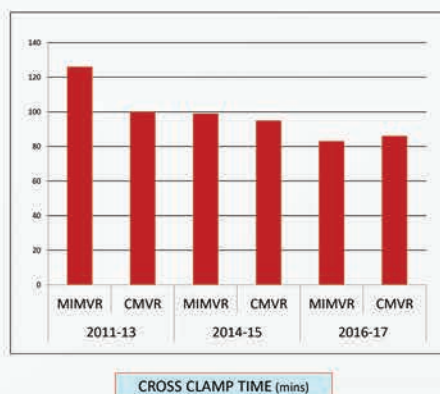
## BASELINE / INTRAOPERATIVE CHARACTERISTICS

| CHARACTERISTICS                   | MIMVR   | CMVR    | P-VALUE |
|-----------------------------------|---------|---------|---------|
| MEAN AGE (years)                  | 62 ± 15 | 66 ± 12 | 0.04    |
| FEMALE, %                         | 42.2%   | 57.7%   | 0.07    |
| DYSLIPIDEMIA, %                   | 32.8%   | 46.2%   | 0.11    |
| CHF, %                            | 35.9%   | 58.7%   | 0.007   |
| ATRIAL FIBRILLATION, %            | 34.4%   | 48.1%   | 0.11    |
| NYHA CLASS IV, %                  | 17.2%   | 41.3%   | 0.002   |
| PRIOR CARDIAC SURGERY, %          | 4.7%    | 23.1%   | 0.003   |
| URGENT STATUS, %                  | 12.5%   | 35.6%   | 0.002   |
| MV REPAIR (vs. MV REPLACEMENT), % | 65.1%   | 29.1%   | <0.0001 |

## POST-OPERATIVE OUTCOMES

| CHARACTERISTICS         | MIMVR    | CMVR      | P-VALUE |
|-------------------------|----------|-----------|---------|
| MORTALITY, %            | 0.0%     | 3.9%      | 0.30    |
| RENAL FAILURE, %        | 1.6%     | 16.5%     | 0.006   |
| ATRIAL FIBRILLATION, %  | 48.4%    | 63.1%     | 0.09    |
| MEDIAN LOS (days) (IQR) | 5 (5, 7) | 7 (5, 10) | 0.002   |

## OPERATIVE EFFICIENCY



- MIMVR operative times were significantly longer at onset of study
- By 2014-2015, MIMVR operative times were comparable to CMVR

## CONCLUSION

Improved operative efficiency may be achieved for MIS MVR in a low-volume centre. Surgical experience of the team, along with comparable learning opportunities between centres, are necessary for positively affecting "organizational learning effects". These factors are important in influencing the "learning curve" for a centre. Further study is required to determine the factors underlying this improvement so that organizational learning strategies may be developed to help further improve OR team performance and decrease OR times.

## BACKGROUND

- ❖ Perioperative nursing is one of the largest specialty nursing groups in Canada
- ❖ There is a continual and detrimental shortage of skilled nurses to provide specialized care in the operating room (OR) setting
- ❖ Undergraduate programs are well situated to expose students to this practice environment
- ❖ Advantages to the student, to the patient, to the School of Nursing, and to the employing agency can result from an undergraduate practice experience in the perioperative setting

## OBJECTIVE

- ❖ To outline the process and outcomes of an undergraduate perioperative clinical experience

## PROCESS

- ❖ Students spend time in Daycare Surgery (DCS)- Pre-op assessments and patient care, informed consent process, post-op assessments, pain control, patient teaching, relational practice, discharge
- ❖ Operating room (OR)- Develop understanding of circulating and scrub role, principles of asepsis, scrub-in, assist with transport, reporting, monitoring and relational practice
- ❖ Post-Anesthesia Recovery (PAR)-take report, post-operative assessments, medication administration, enhanced understanding of airway management, ECG practice, documentation, discharge criteria



OU

- ❖ Advantages include;
  - ❖ Student – Enhanced clinical decision-making, prioritization, collaboration and communication, multidisciplinary teamwork, physiology, patient-centered relational practice
  - ❖ Patient- Enhanced quality of care, reduced anxiety, increased education, more time available for patient care
  - ❖ School- Valuable surgical experience for students, provides student feedback
  - ❖ Hospital- Recruitment of new graduates



# Through an Innovative Undergraduate Program

Julie Cinel, RN MSN  
Thompson Rivers University School of Nursing



## OUTCOMES

competency in clinical  
prioritization, critical thinking,  
communication,  
teamwork, anatomy and  
patient-centered care and advocacy,  
quality of care, decreased  
education opportunity due to  
for patient interaction  
logical placement option for  
students with transferable skills  
and retention potential



## EVALUATION

- ❖ Course Evaluation- N=41
  - ❖ The course was a valuable experience for me- 98% agreed or strongly agreed
  - ❖ The course challenged me to do my best work- 97% agreed or strongly agreed
  - ❖ The course experience increased my appreciation for the subject matter- 97% agreed or strongly agreed

## CONCLUSION

- ❖ Undergraduate Schools of Nursing can provide quality education in perioperative environment
- ❖ Student feedback:
  - ❖ *"After working in the OR I definitely know that I want to come work in the OR in the future."*
  - ❖ *"I was able to practice many nursing skills including IV push medications, client assessments, bladder scanning, catheterization, mechanical ventilation (bagging) and removing IV's. I am very grateful I had the opportunity to employ these skills into my practice"*

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