Quality Improvement

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   Hollie Shaner-McRae, DNP, RN, FAAN  
   Annie Ireland, MSN, RN, AOCN, CENP  
   Fletcher Allen Health Care

QI-2: Nursing Responsibility Doesn’t End at Discharge  
   Stephanie Drown, BSN, MEd  
   Tammy Grom, RN, BSN, OCN, CMSRN, CHPN  
   Champlain Valley Physicians Hospital

QI-3: Exercise?! Can't You See? I Can Barely Breathe! A Dr. Seuss Approach to Establishing a Pulmonary Rehabilitation Program….  
   Elizabeth Ashworth, RRT  
   Champlain Valley Physicians Hospital

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   VA Medical Center

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   Lorelei Camp, RN, MS, ACNP  
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   University of Vermont

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   Vermont Nurses in Partnership

EB-2: Pass the Torch  
   Holly Carter, AAS RN, CMSRN  
   Courtney Shutt, AAS RN ; Emily Doyle, AAS, RN, BS  
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NR-3: Chocolate Treat Preference Mock Study: A Deliciously Easy Approach to Learning... Research  
   Ellen Prior, MS, BSN, RN  
   Dartmouth-Hitchcock Medical Center

NR-4: Debriefing Tools in Simulation: How to Meet the Standards  
   Dawn Finney, MSN, CMSRN, PCCN  
   Champlain Valley Physicians Hospital  
   Clinton Community College
NDNQI RN SURVEY: PRACTICE ENVIRONMENT SCALE (PES)
GRID HIGHLIGHTS OPPORTUNITIES FOR IMPROVEMENT

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Purpose: The issue: Presentation of complex data in easily understandable format Goal: Easily understandable visual presentation to identify areas of strength and opportunities for improvement

Rationale & Significance: The Clinical Practice Environment is linked to staff satisfaction & patient outcomes. The PES scale provides data assessing staff perceptions of the work environment. Easily understandable data for busy nurse leaders facilitates comprehension of data measures & increases translation into action.

Description of Methodology: The innovation is a visual graph made w/Excel, featuring the PES domains. Color coding is used to enhance the understanding of the results. For example, green shading is used to highlight results that fall at or above the median for academic medical centers; red shading is used to highlight results that fall below the median. Color adds visual appeal and affords an ‘at a glance’ almost instant understanding of the meaning of the data. Viewing the grid from left to right, by PES domain, the shading serves to call out performance. In all presentations to date, the grid has stimulated interest in the dataset and has led to unprecedented interest in the results and how to leverage the findings to drive improvement. This finding has been most pronounced in the outpatient and interventional settings, areas which previously had expressed minimal interest in the results of the RN survey.

Subject Findings: The innovation has stimulated interest & greater use of the NDNQI RN survey results. Nursing leadership have posted the grids in their offices, used the grid to inform future strategy, and used the grid to communicate/collaborate w/Nurse Managers on RN survey findings and action plans.

Conclusions: Implications for Practice suggest that Improved Practice Environments offer myriad benefits for nurses and patients. Facilitating understanding of and application to survey findings to improvement processes has the power to expedite change.

Recommendations for Future Study: Explore and evaluate using a similar grid methodology for other Nursing Sensitive Quality indicators.
Purpose: The purpose of the program is to reinforce discharge instructions, increase patient satisfaction, and decrease readmissions.

Rationale and significance: Literature indicates that post discharge phone calls can be an important quality and service strategy to assure patients understand and follow their discharge instructions, keep medical follow up appointments, get medications filled, and are satisfied with their care. The program allows us to have a better understanding of care provided, areas of opportunity, and to coordinate care and services.

Methodology: The discharge phone call program was created by BSN prepared nurses and nursing leadership. A plan of action, policy, budget, and standardized calling tool were created. The program initially started as a 30 day pilot program on R7, a medical surgical unit, and has since evolved into a budgeted program with 8 bachelor prepared nurses calling on patients from 4 different medical surgical floors. The standardized call tool was revised to fit our needs after further research of other programs. The program is currently looking at online documentation to cut down use of paper, expanding into other areas of the hospital.

Subject findings: The program is ongoing, and HCAHPS results have shown improvements. Patient feedback is positive. We have since identified barriers that patients face post-discharge, and complications and hurdles within the discharge process, such as medications that require pre-authorization, patients without primary care physicians, and patient confusion in regards to medications and discharge instructions. Quality improvement is ongoing due to the beneficial feedback from the program participants.

Conclusion: the program has increased our patient satisfaction scores and has helped to bridge the gap and ease the transition from hospital to home for many patients. There have been many documented positive impacts on post discharge medications regimes, lifestyle behaviors, and overall wellness.

Recommendations for future study: A comparison of the inpatient discharge phone call program to the medical home program in regards to readmission rates and HCAHPS scores and identify areas of opportunities.

A comparison of the CVPH inpatient discharge phone call program to programs at other hospitals to identify areas of opportunities.
EXERCISE?! CAN'T YOU SEE? I CAN BARELY BREATHE!
A DR. SEUSS APPROACH TO ESTABLISHING A PULMONARY
REHABILITATION PROGRAM IN AN UNDERSERVICED AREA

Elizabeth Ashworth, RRT

Purpose of Project: To illustrate how collaboration, social networking, and applying Sam-I-Am thinking can aid in establishing an evidence-based pulmonary rehabilitation service line to meet the needs of a geographically isolated rural area.

Background: Three decades of research and numerous national and international guidelines identify Pulmonary Rehabilitation as the “standard of care” for patients with COPD and other chronic diseases of the lungs (Birnbaum, S Pulmonary rehabilitation: Classic Tune with a new beat, but is anyone listening?. CHEST 2011; 139; 1502). Yet, only 2% of those who qualify have access to a program. Pulmonary rehabilitation is a proven means to reduce hospitalizations. Could we replace the current self-pay, Pulmonary Exercise class of nine with a time-limited, reimbursable program that would open up limited resources to meet the needs of our area? Could we do it here? Could we do it without fear?

Method: The Respiratory Care Department was asked to establish the new program. A staff questionnaire pinpointed therapists with an interest in the project. Isolated by location from national seminars the FAHC Pulmonary rehabilitation team was engaged in discussions about basic program framework via email and phone, resulting in an invitation to come to class. Eight weeks later two therapists emerged with valuable insight in how to tailor the exercise program to each individual. We could do it here, or there. Sam-I-Am persistence was utilized to convert the self-pay group of nine from hostile to receptive recipients of the new time-limited program. We found flexibility aided us in convincing the short-of-breath that real exercise can be fun. Try, try it you will see! The first class was a mix of the old clients with new members. We found the biggest obstacles were created by the smallest things. Like Sam-I-Am we could be most anywhere. We can get you from your car; we can try it with a group. Try it, try it you will see Ex-er-cise can be a breeze. In a group or all alone, this could work.

Findings: Feedback from the first group was positive. Their input has led us to provide curbside pick-up and expand class times to accommodate our clients’ needs. The original group’s fear over leaving the hospital grounds to exercise has led to the support of a new pulmonary rehabilitation maintenance program at the PARC Wellness Center. Staffs rotating through the program have found it to be a positive experience resulting in renewed career enthusiasm. The ability to accept new patients has resulted in 42 referrals in 6 months versus 11 last year.

Conclusions: Support from an established program was essential to our success. Positive feedback and renewed interest in the program by our 4 local Pulmonologists has led to a growth in referrals. Staff flexibility in meeting patient needs and physician requests has led to support from all partners in this community program.

Recommendations for Further Study: As the program becomes established we plan to pay-it-forward to fellow hospitals in our service area. We will track obstacles to attendance as we look to establish alternative means to provide the program to our more rural areas via telemedicine or Skype.

We will try it here or there, in your house, or on your boat. We will try it with pursed lips. We will even wiggle hips, breathing in and slowly out. Lifting arms and stepping out. Try it, try it you will see exercise can be a breeze.
UP THE CREEK: IMPROVING PARTICIPATION IN FECAL OCCULT BLOOD TESTING

Christine Rovinski-Wagner, ARNP, MSN

Purpose of Study: To increase the completion percentage of colorectal cancer screenings for Veteran patients ages 51-75 from 81% on March 7, 2011 to 85% by September 30, 2011.

Rationale and Significance: Low Veteran patient compliance with (FBOT), creates a major barrier to an effective colorectal cancer screening (CRC) program. The positive impact of CRC screening on the reduction of mortality due to CRC cancer is well-documented. WRJ VAMC uses a combination of screening approaches individually based on patient assessment, but relies heavily on annual FBOT. FOBT is non-invasive and less inexpensive than other acceptable approaches, e.g., colonoscopy. While the screening can be life-saving, the task is unpleasant and, for many Veteran patients, confusing. An envelope kit with complex written instructions, test cards, specimen collection sticks, collection tissue, gloves, and mailer is given to patients. Instructional approach and content can vary among providers.

Description of Methodology: The Colorectal Cancer Screening Improvement Team was formally chartered in March, 2011. Within three months of initiating the Project Charter, as outcomes were plummeting, it was clear the team lacked depth and breadth and needed to use other elements of improvement work. Implemented changes included team expansion, increased leadership participation, more detailed flow mapping, Ishikawa Fishbone diagramming, a creativity challenge, and a substantial review of the literature.

Two flow maps were created. The current process (March, 2011) revealed three opportunities for potential improvement. First, patient engagement in CRC screening relied on provider instructions. Second, patients would not receive the FOBT envelope unless he or she checked out at the clinic desk after the PCP appointment. Third, there was no identified follow-up action after the Clinical Champion sorted and routed the outstanding FOBT order list to providers. These became focal points for the Improvement Team. The future/ideal map (June, 2011) was developed subsequent to the Ishikawa Fishbone diagram, creativity challenge sessions, and the review of the literature.

Subject Findings: The 5 months of measurement prior to the improvement team’s charter and implementation of VA-TAMMCS had a variable pattern. The 3 months following demonstrated a steady decline below desired target. The Ishikawa Fishbone diagram was used by the team to re-examine the CRC screening process. As a result, the team was able to identify three critical elements: the CRC Clinical Champion had discontinued the practice of targeted follow-up, the improvement team was not fully appropriate in its composition, and clinical staff had strong negative perceptions about their ability to influence patient completion of the FOBT. Review of the literature and guided discussions about research articles found helped guide identification of potential tests-of-change.

Conclusion: The team was slow in gaining momentum. Clinical members were reluctant to ask peers to implement tests-of-change, feeling any requests would be derisively greeted as burdensome with no added value. After three months of disappointing results, the team read and discussed a number of articles found in a review of the literature, and agreed to complete a creativity challenge. Specifically, the team sought to identify alternative ways to engage Veteran patients in the CRC screening process. While selecting tests-of-change, team members were cognizant of maximizing staff skills and scopes of practice while minimizing staff perception of added work burden. Compliance in CRC screening has met or exceeded desired target for one year.

Recommendation for Future Study: Future study might focus on the effect of consistent clinical educator, identification of elements in a standard patient teaching tool that result in improved patient understanding of content when individualized to patient learning style, and what educational elements patients value when faced with having to complete an unpleasant health screening.
DEVELOPMENT OF A PROTOCOL FOR MANAGING SOLID ORGAN INJURIES IN PEDIATRIC TRAUMA PATIENTS

Lorelei Camp, RN, MS, ACNP
Jennifer Gratton, RN, BSN

Purpose: The purpose of this quality improvement project was to develop a protocol to manage solid organ injuries (spleen, liver and kidney) in pediatric patients based on current evidence based practice and guidelines. The existing protocol was developed in 2009 to manage patients at any age. The goal was to update the current protocol based on current pediatric guidelines and develop a consistent approach in the management of pediatric trauma patients in our academic medical center.

Rationale: Blunt abdominal trauma occurs in 10 to 15% of injured children, with injury to the spleen occurring most frequently. The non-operative management of these patients has been standard of care since the mid-1980’s. The American Pediatric Surgical Association has developed evidence based clinical practice guidelines for the hemodynamically stable child. The adult literature varies on the amount of time a patient needs to remain hospitalized as well as the amount of time for activity restriction once discharged home. As evidence based guidelines exist for the pediatric population it was determined that two protocols (one for children and one for adults) needed to be developed to reflect current practice.

Methodology: Review of data from 1/1/09 to 12/31/11 was undertaken utilizing the Trauma Registry (NTRACS, version 4.2) at a Level I Trauma Center, Fletcher Allen Health Care. Patients with isolated solid organ injuries were divided into adult (ages > or = to 14) and pediatric (<14 years) and analyzed as to Grade of injury (per AAST grading) as identified in the chart, which organ, necessity of OR, and delayed rupture, LOS and ICU days. After data was collected, the two pediatric surgeons, Program Manager and Case Manager reviewed findings, the APSA guidelines and developed a protocol.

Findings: 19 patients were identified, with two patients having combined injuries, thus 21 injuries. No operative cases were identified and no adverse outcomes took place. However, when comparing the old protocol to the new protocol 19 PICU days would have been saved. Hospital days remained even between the 2 protocols, as presently patients are being discharged one day earlier then the new protocol. Adjustments to the practice guidelines for pediatric patients were made by the surgeons based on their knowledge of the transport/travel times to any hospital.

Conclusions: Evidence based practice guidelines assist practitioners in identifying current evidence based practice, however, for them to be effective, they must also be incorporated and communicated as the new standard into the specific practice venue. In our rural environment with long transport times, delay to care could have life-threatening consequences. Based on review of the data at our Level 1 ACS Trauma Center and review of published guidelines, our group was able to develop a protocol that reflects current practice, while adapting it for application to a rural environment.
DEVELOPMENT OF AN INTERACTIVE “WHEEL OF CHANGE MAGNET”
AS A MOTIVATOR FOR SUSTAINABLE, HEALTHY LIFESTYLE CHANGES

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Purpose of Study: Small lifestyle changes can make a significant positive impact on an individual's long-term overall health. The purpose of this project is to develop a tool that will encourage adults to make small, sustainable lifestyle changes in the areas of nutrition, physical activity, and stress management.

Rationale and Significance: Stress, inactivity, and poor nutrition are well-characterized risk factors for many chronic diseases such as coronary heart disease, stroke, high blood pressure, type II diabetes, and cancer. The cost of treating diseases related to poor health practices is especially taxing on small communities such as those in Lamoille County (LC). Targeting behavior changes that can directly improve the health of the members within a community will benefit the community as a whole. We believe that providing a tool that encourages a sustained improvement in the areas of nutrition, physical activity, and stress management may help prevent diseases long term.

Description of Methodology: Copley Hospital Community Health & Wellness (CHCHW) serves the people of LC by providing a variety of health and wellness opportunities. In accordance with several of the national Healthy People 2020 objectives, CHCHW has teamed with University of Vermont graduate nursing students to encourage adults to make small lifestyle changes toward improved overall health. Specifically, we have created a tool based on the Stages of Change Model that is interactive and goal-centered. Three versions of the tool exist, and each focuses on one aspect of healthy living: nutrition, physical activity, and stress management. The interactive content is in the form of a “Wheel of Change Magnet” tool. Each week, the client will turn the “Wheel of Change” on the tool and be encouraged to make a small lifestyle change. The magnets will be distributed by the CHCHW to individuals at venues including health screenings, workplace wellness programs, and flu shot clinics.

Prototypes of the tool were presented to health care professionals, students and community members working and residing in the greater LC area. Participants were asked to complete a five question survey rating their experience with the tool and provide suggestions for improvement.

Subject Findings: The tool and a survey were presented to 50 participants following a brief introduction of the project and the project goals. All surveys were returned and results were tallied. The majority of participants (96.0%, 48) wished to improve their health in at least one of the three target areas; of these, 97.9% found the tool easy to read and user-friendly. Of participants who aspired to improve their health, 95.8% believed that the tool would be useful in motivating an individual to continue with healthy lifestyle habits. If available, 79.2% reported that they would use the tool. Suggestions for improving the format and content of the tool were received and implemented for the end product.

Conclusions: Motivation to make lifestyle changes in the areas of nutrition, physical activity, and stress management often fades. Based on preliminary data, the interactive motivational “Wheel of Change Magnet” tool will help people who are ready to sustain their commitment to healthy lifestyle changes by providing ongoing support. Positive lifestyle changes will improve the health of individuals and subsequently benefit the entire LC community.

Recommendation for Future Study: We recommend that two groups of LC adults be followed over time to compare a control group to an intervention group using the “Wheel of Change Magnet.” We predict that the group using the tool would exhibit healthy lifestyle changes for a longer period of time than the control group.
INCREASING EMPLOYEE ENGAGEMENT THROUGH TRANSFORMATIONAL LEADERSHIP

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Purpose of Study: Leaders have often had the misconception that "it's their vision that matters, and if it's their vision then they have to create it." (Kouzes & Posner, 2007, p. 117). However, this mindset can lead to disengaged employees, low motivation, and a decreased sense of morale. To mitigate these outcomes, transformational leadership is key.

Rational and Significance: In 2005 this unit demonstrated very poor employee engagement, satisfaction, and morale. Our specialty certification rate was 6%, and our employee satisfaction score was 31%. Being unhappy with the environment, staff was choosing to leave. RN turnover was at an astounding 34%, 90% of which were new graduates. This turnover, along with a high utilization of agency staff, accounted for hundreds of thousands of dollars, which equated to a non-sustainable situation. After 18 months of unsuccessful strategies we realized that the issues were not ours to solve. Rather, it was our responsibility to empower staff and give them the tools necessary to generate solutions. We needed to change our thinking from “leader’s wishes” to “team solutions”. Transformational leadership as well as appreciative inquiry could help achieve this. However they, like many soft skills, must be learned and developed.

Description of Methodology: Using Beacon and Magnet criteria to direct our goals, books such as The Leadership Challenge by Kouzes & Posner, Hardwiring Excellence by Quint Studer, and Appreciative Inquiry Handbook; For Leaders of Change by Cooperrider, Whitney, & Stavros served as leadership resources. Additionally, leaders were given formal instruction through the Vermont Organization of Nurse Leaders. The ANA Code of Conduct and AACN Healthy Work Environment Initiative were used to help solidify behaviors. Staff was asked to sign the "Commitment to my Co-Worker" by Marie Manthy. With a solid foundation in place a ‘Solution Box’ was established, which allowed staff to see that we truly valued their ideas, opinions, and teamwork. Additionally it allowed staff to develop collaboration and communication skills while promoting positive solution-based critical thinking and accountability by incorporating the 5-D’s of appreciative inquiry: Define the change, discover best practices, dream the solution, design the vision, and deliver the change.

Subject Findings: To date, 150 solutions that increase both staff and patient satisfaction have been generated using the ‘Solution Box’. Working collaboratively staff has identified many patient needs and have implemented such interventions as sleep masks, low level lighting, ear plugs and general noise reduction protocols leading to increased patient satisfaction scores. Additionally staff has recognized their own needs and has implemented process improvements for safer work environments and continuing education opportunities. Currently our unit is at the 99th percentile nationally for specialty certification with 71% of all eligible staff being certified. Where we once had a high use of agency staff and nurse turnover, we now have zero use of agency and no controllable turnover since quarter 3 2009. According to the 2010 Great Places to Work survey our unit scored a 94% in the criteria “Taking everything into account this is a great place to work”.

Conclusions: By incorporating transformational leadership and appreciative inquiry into our daily practice we have been able to increase employee engagement and create a climate of trust where staff is strengthened by choices, and morale and motivation are high. Communication and collaboration are routinely used to solve issues, which has increased staff’s confidence, competence, and accountability. Staff is proud to be a part of their unit’s development and future.

Recommendation for Future Study: By using techniques described above and incorporating new innovations, leadership is challenged to maintain employee engagement, which is paramount for meeting the increasing demands of healthcare.
DECREASING CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION
(CLABSI) RATES BY STANDARDIZING NURSING PRACTICE OF
CENTRAL LINE USE, CARE AND MAINTENANCE

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Kelly Cueman Sargent, BSN, RN, OCN, Kristen Gray, BSN, RN, OCN, Julie Hart, BSN, RN, OCN,
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Purpose of Study: The purpose of this study was to eliminate CLABSIs and save healthcare dollars by standardizing the use, care and maintenance of central lines through the reeducation of nursing staff.

Rationale and Significance: A CLABSI in an oncology patient can be deadly considering their immunocompromised state. In fact, the national mortality rate linked to CLABSIs is estimated between 10-30%. From June 2011 to January 2012, the inpatient hematology/oncology unit at Fletcher Allen Health Care (FAHC) had a CLABSI rate of 5.86 infections per 1,000 patient line days. Additionally, the Centers for Medicare & Medicaid Services stopped reimbursing hospitals for nosocomial infections such as CLABSIs. In 2009, the cost of CLABSI per case at FAHC was estimated to be $71,165. The reeducation of the nursing staff in regards to central line standards of care will have a significant impact on adult oncology patients’ quality of life and on health care dollars.

Description of Methodology: The authors, including five staff nurses, the Nurse Educator, the Nurse Manager and the Assistant Nurse Manager, met with an Infection Control Specialist to further understand the definition of a CLABSI and criteria used by FAHC. Then, an in depth review of the policy NGP0009: Central Line Care and Maintenance and the data related to CLABSIs for the unit was conducted. The authors created a 31 question multiple choice test to identify the knowledge deficits regarding central line standards of care. This test was mandatory for all staff nurses and was completed anonymously through an online survey. An educational blitz was then designed to address the identified knowledge deficits; it was a two-part series.

The first part of the series focused on obtaining lab specimens and the general care and maintenance of central lines. Specifically, this included proper use of needleless connectors, IV tubing and flushing techniques. Both parts of the series involved using simulation with a task trainer that had two types of central lines installed.

The authors evaluated competence by administering a post-test and requiring return demonstration of proper central line techniques. The post-test was identical to the pre-test and was individually graded. The trainer reviewed the test with the staff nurse and discussed any incorrect answers. The educational series was mandatory and replaced the annual competency required by FAHC.

Subject Findings: The pre-test identified the following knowledge deficits: identification of various types of central lines, heparin flush use and lab drawing procedures including blood cultures. There was a 16.9% increase in staff knowledge and competence regarding central line standards of care following the educational series. In addition, from June 2012 to August 2012, the rate of CLABSIs on the unit decreased from 5.86 CLABSIs per 1000 patient days to 4.85 CLABSIs per 1000 patient days. Further data is pending.

One of the largest knowledge deficits identified in the pre-test was related to the proper use of heparin flushes. As a result, the policy was reviewed in depth by nurses and physicians. It was determined that the unit would be exempt from the frequent use of heparin flushes. The policy was then changed to reflect this.

Conclusion: There was an introduction of an antimicrobial disk at the central line insertion site that paralleled the educational series. This implementation has been continued hospital wide and could be considered a contributing factor to the results. Regardless, the increase in staff knowledge decreased the rate of CLABSIs on the unit as hypothesized. The authors expect elimination of CLABSI rates with continued educational reinforcement and with the projected change to the CDC guidelines of CLABSIs.

Recommendation for Future Study: Through the findings of this educational program the authors identified the following recommendations: 1) Hospital wide education including outpatient areas that routinely care for patients with central lines; 2) Annual competence in the care and maintenance of central lines including drawing labs and dressing changes; 3) Random audits to assess staff compliance; 4) Central line super user group to assist in educating staff.
CREATION OF A CHECKLIST TO FACILITATE COMMUNICATION BETWEEN F.A.C.T. AND MEDICAL CONTROL DURING F.A.C.T. PEDIATRIC PATIENT TRANSPORTS

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**Purpose of Study:** To design and implement a FACT pediatric transport checklist for the FACT team and medical control to use as a communication tool during transports.

**Rationale and Significance:** At the time the project began, no checklist existed between the FACT team and Medical Control for pediatric patient transports. The failure rate for medical control to receive report and ETA notification from FACT is >1:100. In addition, the PEWS (Pediatric Early Warning System) protocol, now fully implemented on Baird 5, was not in use during FACT transports. Creation of a checklist to facilitate communication en route and including the PEWS score will standardize the transfer of information, and improve the quality of care delivered throughout the transport and transfer.

**Description of Methodology:** During the months of May and early June, a core group, including FACT team members, medical control and quality team members met to develop a checklist tool to use en route, by both FACT and medical control. A survey tool was developed and transport team members, including FACT EMTs and RNs, respiratory therapists, medical control physicians and Baird 5 and PICU nurses were surveyed about their current experience with communication around FACT pediatric transports. Following collection of survey data, a one month pilot of the new checklist was carried out beginning in late June to test the ease of use and efficacy of the checklist.

A feedback form was used to assess checklist use by the FACT team. In addition, the team met following the pilot to review the feedback forms and discuss anecdotally the effectiveness of the checklist.

Feedback gathered from the forms and anecdotal information from meetings led to a checklist revision for the medical control group which is currently being tested.

**Subject Findings:** The feedback forms provided mixed results. Positive feedback included feeling like the checklist provided a way to organize information and ensure that all pertinent data was included. Negative feedback included feeling like it was busy work that slowed the workflow and didn’t improve patient care. One individual noted that, especially for intubated or critically ill children, the checklist was valuable as a way to catch information that might otherwise be missed. There were mixed feelings about whether the checklist enhanced the practice for stable transports.

Information gathered at the team meeting: FACT team members thought the pilot went smoothly and there seemed to be few if any concerns with the checklist. It was noted that the checklist did not change the workflow of the FACT team. The only exception to this was in recording and reporting the PEWS score, which had been incorporated without trouble. Concerns were expressed about the experience of the Baird 5 nurses when FACT arrives with a patient on the floor. An example was given where FACT arrived and the Baird 5 nurse had not yet received report from the outside hospital.

The medical control physician representative stated that it was useful to have a tool that put Med Control and FACT on the same page in terms of patient status and interventions. It was noted that because the Med Control physician is receiving patient information, it would be helpful to modify the checklist to provide space for them to write on it. It was also noted that the nurse on the receiving unit (PICU or Baird 5), while not directly involved in the patient transfer, is also a recipient of information, both from the outside hospital as well as from FACT/Med Control on arrival to Fletcher Allen. It was agreed that the medical control checklist would be modified to include space to write notes. A second pilot using this checklist was begun in September and is ongoing. In addition, the checklist was modified to include a prompt to call the floor charge nurse, give an update and cue them to call the OSH for report if it was not already received.

**Conclusions:** The use of the checklist improved the experience of FACT and med control team members in facilitating FACT pediatric patient transports. Nurses on receiving units have continued to express dissatisfaction with the handoff process. Incorporation of the PEWS score into the checklist provides a way to track pertinent patient data and outcomes over time.

**Recommendation for Future Study:** The effects of medical control using the newly modified checklist with space to take notes still needs to be studied as the pilot is ongoing. A current process modification is in place to enhance communication between medical control and the receiving unit charge nurse to provide pertinent patient information prior to arrival on the floor, and to include a prompt to the nurse to call the OSH for report is also ongoing. Feedback is currently being solicited from the charge nurses on the floor using a feedback form similar to that used by FACT. In addition, the FACT team has also expressed an interest in being able to write on the checklist, which will be accomplished in a future modification.
**ENDOSCOPY PATIENT EDUCATION WEBSITE: DOES IT IMPROVE COLONOSCOPY PREPAREDNESS?**

Dorothy Perron, RN

**Purpose of Study:** The purpose of the study is to understand the effectiveness of web based colonoscopy preparation materials as it relates to both patient satisfaction and compliance with colonoscopy preparation instructions.

**Rationale and Significance:** Colonoscopy preparedness is essential to ensuring a successful colonoscopy exam. The preparation involves patients understanding the specific steps involved relating to ingestion of colon cleansing medication, dietary restriction and fluid intake. Inadequate cleansing of the colon leads to cancellation of procedures, suboptimal exams and inconvenience and expense for the patient.

This project is a preliminary trial of using online instructional materials to better inform and prepare patients for colonoscopy exams.

**Description of Methodology:** Research and review of other academic medical centers web based patient colonoscopy preparation sites was conducted. A literature review on patient instructional website effectiveness followed. The team partnered with Fletcher Allen Information Services to design and activate a web based learning resource for colonoscopy preparation for patients which went live in spring 2011. The web address was then featured in the Welcome to Endoscopy brochure available distributed to area provider offices in VT. Outreach and education to provider offices was conducted in person prior to go live. The project is being evaluated through two metrics: a) the number of colonoscopy preparation website hits and b) patient survey results [convenience sample n=200] of patients scheduled by Fletcher Allen providers.

**Subject Findings:** Preliminary results are currently being evaluated and will be completed by November 2012.

**Conclusions:** To be determined based on results of final patient surveys and calculation of # of web hits

**Recommendations for Future Study:** Future studies need to take into consideration understanding up front the timeline/process for booking patients for exams to ensure the sequencing of getting the materials out and surveying the patients are coordinated to prevent delays in study methodology. Future studies would benefit from baseline evaluation of the study population demographics (age, access to and use of computers) to ensure accurate measurement. Periodically follow up communications with provider offices to ensure understanding of and compliance with educational material delivery to patients.
Purpose: To update an application form with the use of ‘evidence-based’ competency statements as an essential part of the performance validation.

Rationale and Significance: The forms used for RN and LPN re-entry licensure were last approved on 7-28-09. In review of the forms by the VT Nurse Education Committee; questions arose regarding the form directions, specific content, institutional responsibilities, recordkeeping, absence of (or variation in) available experiences, lack of clarity pertaining to expectations, and what the evidence base for the selected skills might be.

The Executive Director of the Board of Nursing identified frequent questions and discrepancies as to whether applicants had met the expectations. Out of the 75 rows on the performance checklist, only 5 items clearly delineated an expectation specific to assessment, analysis or planning. The other items comprised a list of tasks, anatomy and procedures; with little or no clarification of what RN or LPN practice looked like in relation to the item. According to the form directions, there was no provision made for times when a specific task was not available during a precepted experience.

Methodology: The re-entry forms were revised to incorporate what has been learned from the evidence-based, statewide, Vermont internship project.

Findings: Significant changes were required in both directions and competency statements. The original form identified expectations that were based on the ‘medical model’ of healthcare education and practice, rather than a nursing model. The competency items were stated in a manner that did not clearly communicate the expected performance.

Utilization of the VNIP competency statements entailed using the Competence Outcomes and Performance Assessment (COPA) model as well as wording each statement with an action verb that clearly identifies the expected performance in clinical language. COPA is a theoretical framework that provides a strong foundation for practice expectations within the full continuum of care.

Conclusions: The form for re-entry licensure is intended to solicit evidence that validates the individual’s capability to provide safe and effective care as a healthcare practitioner. Using theory, concepts, expert experience and data collection improves the communication of performance expectations and validation. Clarifying form directions improves consistency and accurate completion of the document. This, in turn, eases the processing of the applications.

Recommendations: Only utilization of the revised form will identify any remaining ‘system failures’ within the application. It would be beneficial to maintain records of form completion and any discrepancies, errors or barriers related to either the tool or process.

These forms should be reviewed at least every three years to ensure that they are current, describe current nursing practice, and clearly explain the process for both completion and meeting the re-entry requirements.
**Purpose of Study:** The purpose of this initiative is to improve the effectiveness of communication through the implementation of a bedside handoff of care during shift change. This is a crucial time where important communication amongst the nurses and patient could be compromised. This is an opportunity to include the patient in real time exchange of information.

**Rationale and Significance:** Many benefits can come from reporting at the bedside during change of shift. Benefits include nurse accountability, responsibility and teamwork. Bedside handoff of care gives the oncoming nurse and patient a “real-time” opportunity to ask questions about the patient’s plan of care while in the hospital, to foster the best possible outcome during that time.

As part of The Joint Commission safety goals, bedside reporting meets at least 3 requirements; identification process of the patient, improving communication among caregivers, and encouraging the patient and families to become involved with the patient’s plan of care and safety strategies. By allowing the patient to become more actively involved with their care it gives them a sense of empowerment. Additionally, the patient is another source of information when it comes to their diagnosis and treatment process. While being present at the bedside during handoff of care many potential complications can be avoided and adverse outcomes can be caught at an earlier time, in return improving patient safety. Being present in the patient’s room during shift change gives the outgoing and oncoming nurse the most up to date evaluation of the patient and environment.

Challenges that may be encountered during bedside handoff of care reporting have been brought forward, such as confidentiality in semiprivate rooms. There will be times when certain information should be given prior to entering the patient’s room. This further protects the patient and their medical information.

**Description of Methodology:** The implementation of a practice change on a medical surgical unit will requires planning, staff involvement, enforcement, and follow-up. On our medical surgical unit’s a committee made of managers and staff nurses supply guidance after engaged meetings. On our specific unit a team educates all staff involved, addresses concerns and guides nurses who fall into old habits. Education is provided to patients on admission to reinforce the concept of bedside reporting. To ease the transition provide clipboards and pens are provided to staff.

The report process itself takes roughly 5-7 minutes per patient. A brief history and any confidential or private information is discussed outside the room. Both outgoing and incoming nurses enter and introduce new staff. Privacy is respected and the patient’s wishes are considered as to who should remain in room if visitors are present. A brief survey of the patient and environment which includes identity, overall well-being, and IV sites/ drips or equipment involved in patient care is completed. A one page uniform report sheet/handoff of care tool is utilized per The Joint Commission recommendation. Report is given in a SBAR format. When finished the nurse gives time or opportunity for questions and concerns from the patient.

After practicing bedside reporting for a set amount of time, a follow up with all staff is done to help reinforce the concept and allow for evaluation of methodology or effectiveness.

**Subject Findings:** After the implementation of the Bedside reporting we have observed the nursing staff in action with approximately 50-60% compliance of the methodology. Our handoff of care process has a success rate of 95-98% utilizing the one page tool recommended by The Joint Commission. The nurses who are practicing the bedside methods state that they have been done on time on most days. Some nurses also report that their patient’s seem satisfied and enjoy being a part of their plan of care. Some apprehension has been noted from some staff. They state fear of breaking confidentiality rules related to our patient population in semi-private rooms. Another concern nurses have is a fear of speaking in front of the patient using the SBAR method.

**Conclusions:** Bedside Reporting for RN handoff of care is an important concept that is considered to improve patient safety. Having a more reliable, safe, and interactive way to change caregivers is an excellent goal to provide quality care to patients. This method in studies and literature reviewed had an overall positive outcome for patients and it helped to improve their perception of RN’s organizational and professional skills.

It is too early in our process to determine improved outcomes of this method. A way to determine positive results is an improvement in Press Ganey scores that measure patient satisfaction in relation to patient care.

**Recommendation for Future Study:** In a follow-up of the implementation of this new report method, it is recommended to do a follow up compliance percentage using a more exact study. When follow up calls are made to our discharged patients, we could include a question regarding satisfaction with the bedside reporting.
INTEGRATING PSYCHIATRIC MENTAL HEALTH CONCEPTS WITH PRACTICE VIA FILM

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**Purpose:** To use popular film media as a teaching strategy to enhance clinical experience, clarify misconceptions of mental illness and reinforce mental health nursing concepts.

**Rationale and Significance:** Film helps us to bring real-life experiences into the classroom environment and provides an experiential learning opportunity for our students. Clinical placements for psychiatric nursing are often limited and misconceptions regarding mental illness are rampant and often determined by popular media. Carefully chosen depiction of mental health issues in the classroom can increase students’ comfort in the clinical setting.

**Methodology:** Most students are familiar with the film “One Flew Over the Cuckoo’s Nest” and come to my course with an emotional response to its depiction of insanity. Students compare the clinical environment of a local acute care hospital to that provided by Nurse Ratchett, focusing on the concepts of therapeutic milieu and patient rights. A two minute clip of Geraldo Rivera’s documentary “Willowbrook” illustrates for students how far we as a nation have come in caring for those with mental retardation and illustrates patient safety issues, nurses’ political power and the concept of “whistleblower.” “The Soloist” illustrates the right to refuse treatment and the concepts of autonomy and social justice. DSM diagnoses can also be depicted, an example of which is using “Boys Don’t Cry” to illustrate Gender Identity Disorder.

**Findings:** Student survey response to the use of media clips has been overwhelmingly positive, with all 41 students surveyed finding the method of concept delivery equally or more effective than traditional lecture/powerpoint presentations in meeting learning objectives. Ninety percent responded that media helped prepare them for the clinical setting and one hundred percent agreed that media clips exposed them to real-life situations with which they were not familiar.

**Conclusion:** A pedagogical strategy that incorporates carefully chosen popular film is a way to expose students to human conditions that their clinical experiences may not provide, reinforces psychiatric concepts and increases student comfort when working with the mentally ill. Students respond favorably to this strategy and an informal comparison of HESI standardized test scores found no significant difference in performance between students using this technique and those taught with traditional methods. The use of film media is an innovative, safe, cost effective method of introducing nursing students to psychiatric concepts prior to, or in conjunction with, their clinical rotations.

**Recommendations:** Future formalized study is indicated to determine impact of this technique on clinical and NCLEX performance. The use of media to reinforce concepts may also be used by in-service educators seeking to expose audience to clinical situations not readily available.
BENEFITS OF CHLORHEXIDINE GLUCONATE (CHG) BATHING IN THE ICU

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Purpose of Study: To evaluate whether daily bathing with 2% Chlorhexidine Gluconate (CHG) Cloths in the Medical and Surgical Intensive Care Unit (MICU/SICU) decrease the prevalence of Vancomycin-Resistant Enterococcus (VRE) and Methicillin-Resistant Staphylococcus Aureus (MRSA) infections in the ICU population.


Description of Methodology: The target population included all patients admitted to the 45 Adult ICU beds at Fletcher Allen Health Care, a Level I Academic Medical Center. ICU staff received in-service education through the months of May, June and July 2011, focused on this QI initiative targeted to reduce hospital acquired infections through daily bathing of ICU patients with 2% CHG impregnated cloths. During implementation the education consisted of a bedside demonstration on the bathing procedure, specific techniques, contraindications for use, and documentation required. A careful review for product compatibility was done shortly after implementation, examining the organizations current bathing products and the CHG cloths. Full implementation began on July 1st 2011 and transformed bathing practices, in that all patients, except those for whom contraindications exist, are now bathed once a day with 2% CHG impregnated cloths.

Subject Findings: Implementation challenges included: Feedback from staff varied after the education phase and during the initial implementation. Opposition to use of the CHG cloths consisted of, concern for cleanliness without a soap and water bath, need for a “real” bath, feel of skin, skeptical of the evidence based data, discontented with stopping the use of powder and lotion until compatibility with our products was determined. The incidence of VRE and MRSA infection from July 2010 to May 2011 (PRE CHG bath) and July 2011 to June 2012 (POST CHG bath) was examined. The combined incidence of infection decreased from 1.12/1000 patient days to 0.79/1000 patient days (p = 0.13, MidP exact 2-tail). The reduction varied by type of infection and ICU. A patient day represents a unit of time during which the services of the facility are used by a patient.

Conclusions: There was an overall drop in both MRSA and VRE infections when 2% CHG bathing in the ICU population was instituted. The largest drop was seen in the MICU for VRE infections; data revealed a 65% reduction (p=0.03). Conversely an increase was seen for MRSA infection in the MICU. The combined rate of VRE and MRSA infections in the ICU decreased by 48% and 10% respectively. A rate is a comparison of data to a known standardized quantity to allow for comparison across organizations. Typically infection rates are reported per 1000 patient days. Data suggests a reduction in infection, however a longer evaluation period is required to identify the actual benefit of this intervention.

Recommendation for Future Study: Continue with daily 2% CHG baths on all ICU patients. Monitor for 6 months to a year and re-evaluate. If the data continues to show a reduction, we could look at the possibility of integrating the 2% CHG baths on all general care areas to assist in the reduction of hospital acquired infections.
TO VOID OR NOT TO VOID? A PACU QUESTION
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Purpose: An evidence-based practice team was assembled to evaluate research literature and address the following practice question: Do adult ambulatory GI, GU, OB/GYN, and spinal anesthetic patients have increased urinary retention post discharge if they do not void in PACU?

Rationale or significance: The inability to void in the Post Anesthesia Care Unit can delay discharge and significantly impact patient satisfaction and expense. In addition, it is often in the patients’ best interest to void prior to discharge due to alterations in the voiding response that can be caused by various procedures and/or anesthetic interventions. Research is limited on which patient populations should void prior to discharge from the post anesthesia care unit and are at risk for post-discharge urinary retention. Subsequently, nurses do not have clear guidelines for voiding requirements for patients in the PACU.

Methods: A practiced team consisting of 4 practicing PACU nurses, unit nurse educator, and unit assistant nurse manager was assembled. The John Hopkins Nursing Evidence-Based Practice Model was used to guide this project. A practice question was developed using the question development tool. Literature searches were conducted in CINAHL, PubMed, and Cochrane Review using key words identified by the group. Articles were first evaluated for applicability to patient populations of the project question, and then appraised using the John Hopkins Nursing Evidence Appraisal Tool. Individual nurses were assigned specific articles to review, evaluate, and present to the group. ASPAN (American Society of Perianesthesia Nursing) standards were reviewed as well as 7 experimental studies, 2 quasi-experimental studies, 4 non-experimental studies, 4 practice guidelines, 4 non-experimental, 1 qualitative, and 3 expert opinions/literature reviews.

Findings: Findings indicate that there are many factors that can influence a patient’s risk for post-operative urinary retention. Such factors may include age, gender, anesthetic type, type and/or length of surgery, comorbidities, anesthetic usage, fluid administration, narcotic use, and pain. Additionally, there is great variation surrounding the practice of post-surgical voiding prior to discharging patients from the hospital. Patients can be stratified into low, moderate, or high risk categories and subsequent guidelines applied to their care in the post-anesthesia unit prior to discharge.

Conclusion: Our evidence based practice study was able to identify several research studies surrounding post-operative voiding. However, the studies identified often examined a very specific patient population or factor. Additionally, some of the identified research was conflicting. Due to the wide variability of factors that influence a patient’s risk for post-operative urinary retention, the group recommended that a risk stratification tool be developed. This tool would assist the nurse to determine whether a patient is at low, medium or high risk based on a combination of several factors that influence post-operative urinary retention. Nursing care guidelines can then be developed for patients based on what category the patient is determined to fall into.

Recommendations for future study: Next steps include the development of the risk tool and nursing guidelines, an action plan to include inter-professional collaboration with the surgical and anesthesia teams, education of staff, implementation of the assessment tool, and evaluation of its effectiveness.
THE EVOLVING ROLE OF THE ACUTE CARE NURSE PRACTITIONER IN THE HOSPITAL: A LITERATURE REVIEW

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Purpose: This literature review examines the expanding and evolving role of the Acute Care Nurse Practitioner (ACNP) in the hospital setting over approximately 20 years.

Rationale and Significance: The American Association of Critical-Care Nurses Scope and Standards for the Acute Care Nurse Practitioner 2012 is to be released this fall; and the Advanced Practice Registered Nurse Consensus Model is expected to be fully implemented 2015. Additionally the Affordable Care Act will bring about changes in the healthcare system that may affect the need for ACNPs in the hospital.

Healthcare takes place in an environment that is changing. Cost effectiveness, high quality care and increased efficiency are some of the challenges faced by the health care delivery team. ACNPs are positioned to meet the challenges in a managed care environment where healthcare systems search for cost-effective strategies while maintaining quality of care. The ACNP can work collaboratively with Physicians to streamline and optimize patient care while minimizing healthcare costs. A practice model suggestive of this type of collaboration could be adapted readily in an acute care hospital setting. understanding how the ACNP role has evolved will lay the groundwork for the role to fulfill this need since little research has been done on this particular type of practice model.

Description of Methodology: Medline and CINAHL were searched using the terms "Acute Care Nurse Practitioner" and "Hospital." Inclusion criteria were: United States-based literature in peer reviewed journals.

Findings: The first ACNP certification exam was in 1995 and literature published around this time focused on describing the role of the ACNP in the hospital: as an expanded nursing role and as performing work traditionally done by physicians. Changes in healthcare institutional structures and a shortage of physicians also influenced the role. Few publications also described hospital specific ACNP roles. The Accreditation Council for Graduate Medical Education implemented work-hour restrictions for resident physicians in 2003. Around this time studies were published examining outcomes of patients managed by ACNP. One study showed similar outcomes between Critical care/Pulmonary Fellow managed patients and Nurse Practitioners/Physician Assistant managed patients. In 2006 The Scope and Standards for the ACNP was published. Literature in 2006-2008 delineates the ACNP role from the Clinical Nurse Specialist and describes an expanded ACNP role beyond the ICU, managing heart failure patients, rapid response team leader, in the operating room, and as a Hospitalist. Greater attention is paid to the holistic care provided by the ACNP, including patient education, patient safety and continuity of care. Over the past couple years some literature continues to compare ACNP-run units to resident-run units but there is greater discussion of the benefit of the ACNP independent of the relationship to residents. Some literature focuses on examining the impact of nurse practitioner-led initiatives such as heart failure support and ACNP processes that lead to patient outcomes.

Conclusion: It is important for ACNPs to know the how the evolving role has been described in literature over time. By understanding the role in context to the historical changes in the health care system ACNPs will be better able to define the role in the future.

Recommendation for Future Study: A comparison of US-based literature to international literature would allow a comparison of how the role of the ACNP is evolving with different sociopolitical influences.

Future studies could also include ACNPs in a collaborative practice with physicians in a hospital setting. Sub-specialty practices may be one identifiable source to validate the important contributions of the ACNP may play in a collaborative practice.
Purpose: To provide an educational opportunity for nurses about conducting and utilizing nursing research. To do this the Shared Governance Nursing Research Council conducted a “mock research study” evaluating preferences for different chocolate treats. In addition, the poster provided education and examples of projects conducted within the organization. Information was also provided about informed consent and the research council. A literature review was conducted about how other councils engaged staff nurses in research. A decision was made to adapt a simulated research study previously conducted by Estes, T, Globig, C., & Selig, P., (2009) to include a chocolate intervention and provide education to the council members and staff nurses locally and regionally. The project was reviewed by the Committee for the Protection of Human Subjects at Dartmouth and determined to be “not human subjects research” and so did not require ethical review.

Rationale & Significance: Education about conducting nursing research, differentiating evidence-based practice, quality improvement and product evaluation as well as resources available for the staff nurse is essential in promoting evidence-based practice at the bedside.

Methodology: A poster containing information about research, the details of the “mock study” and the Nursing Research Council was created and displayed at three times during Nurses Week: outside the cafeteria in the morning; outside an awards reception in the afternoon; and as a traveling display to three affiliating clinics in the southern region of the state. Members of the Nursing Research Council were available at the display to administer the survey, answer questions and discuss research council opportunities. A convenience sample was used. The target audience was nurses, though anyone who stopped by the poster was welcome to participate. Participants randomly selected a chocolate treat from a colorful bag which contained chocolates (gold and purple wrapped). After tasting, participants filled out a survey of 7 questions. Surveys were anonymous. The survey instrument was developed by members of the research council and approved at a council meeting. The survey contained questions asking participants to rate (on a scale of 1 to 5) the qualities of the chocolate, the overall experience of eating the chocolate, and then how often they ate chocolate. In appreciation for completing a survey, participants could select another candy to take or eat later. Participants could also participate in a “gift-basket” raffle.

Findings: There were 212 participants, 116 at the main campus (DH-North) and 96 at the clinics (DH-South). Surveys were compiled by members of the Nursing Research Council. Descriptive data (frequencies and percent) were calculated. Results were shared with the full council with discussion about next steps for expanding the project to include other unit-based councils. A subgroup of the council is in the process of collaborating with the organization’s public affairs department to publish an article for an internal nursing newsletter in order for the nursing community to learn the outcomes.

Conclusions: The benefits of this innovative teaching strategy included education of the individual council members as well as participation in a shared project which in turn enhanced visibility of nursing research in the organization. In addition, the project informed nursing staff (and others) not only about research, evidence-based practice, and quality improvement, but also about the Nursing Research Council and other resources within the organization for staff nurses.

Recommendations for Future Study: This method could be adapted and evaluated by other organizations as a way to promote research and evidence based practice at the bedside.
DEBRIEFING TOOLS IN SIMULATION: HOW TO MEET THE STANDARDS

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Purpose: The purpose of this poster presentation was to review current utilization of debriefing tools within simulation education.

Rationale & Significance: The aim of the literature review was to determine current best practices in simulation education regarding debriefing strategies. Comparing and contrasting the current debriefing tools used in simulation education common themes emerged. The result was a creation of a debriefing tool that would meet the INACSL standard number six within simulation education.

Description of Methodology: A review of current debriefing tools in simulation education was completed using multiple search engines.

Subject Findings: A standardized debriefing tool that was created including themes that would best meet INACSL standards and needs of our learners which are to provide nursing students the skills to provide safe and competent care through reflective practice, critical thinking, connecting didactic and clinical, communication, and interdisciplinary teamwork through simulation education.

Conclusion: In conclusion, the utilization of standardize debriefing tool has the advantage of incorporating the major themes of safety and quality of care within nursing practice can be meet through simulation education and support newly developed standards within simulation practice.

Recommendation for Future Study: Standardizing tools utilized in debriefing using student self-reflection and analysis.