Creating A Tool That Will Measure the Reliability and Validity of A Patient Aggression Assessment Tool (PAAT©) in Acute Care Settings

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ONL Research Day -Research

PROBLEM

- The Bureau of Labor and Statistics found in 2006 that WPV in healthcare settings led all other industries, with 45% of nonfatal assaults leading to loss of work days committed against registered nurses.
- ***Anticipation is the most effective strategy because aggression rarely occurs without warning signs (Strickler, 2013).***
- Studies have been conducted to evaluate the effectiveness of a variety of tools that attempt to predict the potential risk for aggressive behavior in hospitalized patients (Ideker, Todicheeney-Mannes, & Kim, 2011).

PURPOSE/SIGNIFICANCE

- This research study of the Patient Assessment Aggression Tool will include key components from previously tested tools
- To implement and show a prediction of validity and reliability in a hospital setting that will identify patients at risk for aggressive behaviors that may lead to violence in the workplace.

Early Identification

- Hospital patients with a potential of violent or aggressive behaviors will successfully contribute to safety provisions for nurses and other healthcare providers in the healthcare setting.

Reliability & Validity of Tool

- The PAAT© will demonstrate reliability of the key components for assessing patient at risk for aggression, the most crucial stage of early identification before aggression occurs.

REVIEW OF THE LITERATURE

- Various risk assessment tools have been implemented in other healthcare settings and have not been proven to be completely reliable and valid as a risk assessment tool for aggression.
  - Aggression and violence can occur in other areas of the hospital where staff are at increased risk.
  - Violence alone has been described ***as "a process with three behavioral phases: baseline or calm phase, pre-assault or the displaying of verbal and nonverbal behaviors indicating a threat of violence, and assault, when the individual displays out of control verbal and physical behavior"*** (Gallant-Roman, 2008, p. 452).
  - The PAAT© tool was designed to identify this phase of aggression for early prediction.
  - Early identification of hospital patients with a potential of violent or aggressive behaviors will successfully contribute to safety provisions for nurses and other healthcare providers in the healthcare setting

PLAN

- **Goal** - The goal of this project is to create a tool that will demonstrate validity and reliability of the key components for assessing patient at risk for aggression in an acute care setting.
- **Study Design** – Prospective cohort study designed to test validity and reliability
  - **Objective 1**: Create a reliable tool for assessing patient risk for aggression
  - **Objective 2:** Create a specific tool for assessing patient risk for aggression

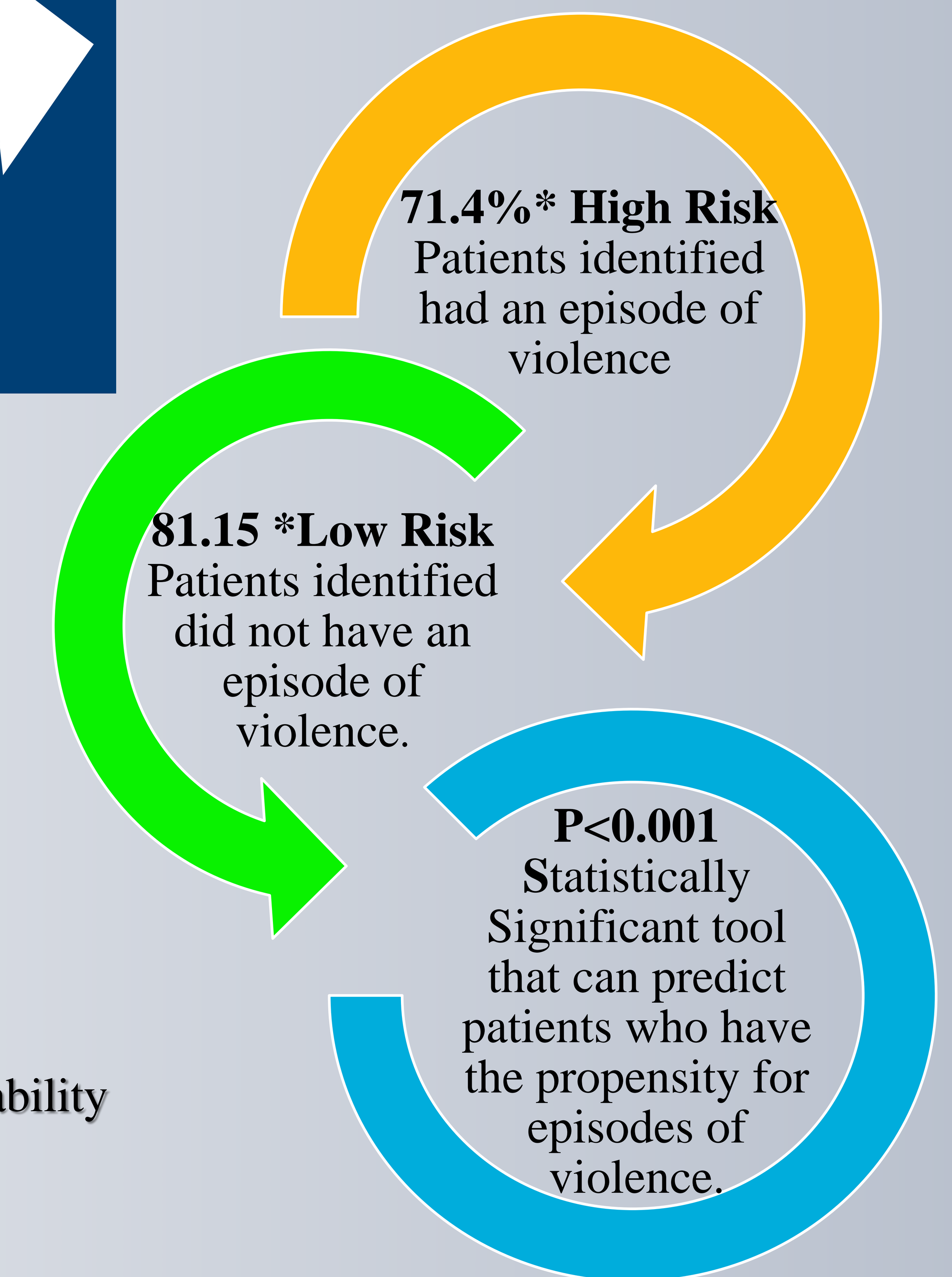
EVALUATION

- Reliability and Validity was completed 12/2017
- Inter-rater reliability testing was completed using the Interclass Coefficient Calculation (ICC) for ten raters each completing a total of 52 observations.
- The SPSS statistic program was utilized for the calculation
- An ICC two way mixed was analyzed with 0.8 being optimal and > 0.9 being excellent with an average measure. Validity testing completed 12/2017 using Mann Whitney U-test to determine the difference in scores between subjects who have a aggressive or violent episode and those who do not, thus establishing specificity of the tool
- Sample size for analysis was 77 with and 175 without for analyses.

CONCLUSION

- At the conclusion of reliability and validity statistical analysis for significance, the PAAT© tool will be implemented into the EMR record as a reliable tool for early identification of patient's at risk for aggression and/or violence in an acute care setting.
- **Next Steps:** Develop interventions and publish tool as a reliable tool for replication into practice.

Validity



Reliability

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RWJBarnabas HEALTH

"Should I stay or should I go now?" Exploring the concept of moral distress in operating room nurses

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Background

- Nursing is a highly charged profession and most specialties are faced with life and death decisions leading to ethical dilemmas which can affect individuals on a day to day basis.
- The research shows that moral distress can impact practice negatively such as contributing to burnout, mental and physical illness as well as premature abandoning of the profession in various nursing specialties.
- Moral distress has never been studied in operating room nurses and since this specialty has to practice in an ever changing challenging environment it is worthy of exploration.

Methodology

Exploratory descriptive; Survey design
Convenience sample (N=98); Operating nurses employed in a hospital system located in the north east; 4 hospitals; response rate 20%

Variable	Conceptual Definition	Operational Definition
Moral Distress	A specific type of moral conflict that occurs when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action (Jameton, 1984)	Moral Distress Scale revised (MDS-R) tool (Hamric, Borchers & Epstein 2012).
Coping	How an individual responds to stress or a threat to self by utilizing problem focused or emotion focused coping (Lazarus & Folkman, 1984)	COPE Inventory (Carver, 1989)
Operating Room Practice	AORN standards	Demographic tool

Results

	Mean	SD
Total MDS-R	44.0	49.00
Total mean frequency MDS-R	16.59	13.24
Total mean level of disturbance	41.59	29.58

Are you considering leaving your position now?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	8	8.2	13.1	13.1
	No	53	54.6	86.9	100.0
	Total	61	62.9	100.0	
Missing	System	36	37.1		
Total		97	100.0		

Correlations

		Total Frequence MD	Total Disturbance	Total MD	Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?	Are you considering leaving your position now?
Total Frequence MD	Pearson Correlation	1	.303*	.888**	.266*	-.208
	Sig. (2-tailed)		.018	.000	.038	.107
	N	61	61	61	61	61
Total Disturbance	Pearson Correlation	.303*	1	.513**	.217	-.050
	Sig. (2-tailed)	.018		.000	.094	.701
	N	61	61	61	61	61
Total MD	Pearson Correlation	.888**	.513**	1	.290*	-.201
	Sig. (2-tailed)	.000	.000		.023	.120
	N	61	61	61	61	61
Have you ever left or considered quitting a clinical position because of your moral distress with the way patient care was handled at your institution?	Pearson Correlation	.266*	.217	.290*	1	-.076
	Sig. (2-tailed)	.038	.094	.023		.559
	N	61	61	61	61	61
Are you considering leaving your position now?	Pearson Correlation	-.208	-.050	-.201	-.076	1
	Sig. (2-tailed)	.107	.701	.120	.559	
	N	61	61	61	61	61

*. Correlation is significant at the 0.05 level (2-tailed).
**. Correlation is significant at the 0.01 level (2-tailed).

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	15.167	8.873		1.709	.095
	Performing a procedure that directly conflicts with moral or religious beliefs	1.278	6.141	.036	.208	.836
	Unreported breaks in aseptic technique	5.536	5.883	.131	.941	.352
	Prisoners	3.323	5.458	.096	.609	.546
	Queer care	2.843	5.462	.084	.521	.605
	Resistance from giving or receiving hand-off	11.642	5.549	.377	2.098	.042
	Gender inequity related to interdisciplinary relationships during a procedure	-2.492	6.866	-.060	-.363	.718
	Feel undue pressure working with technology during a procedure	2.361	5.541	.073	.426	.672

a. Dependent Variable: Total MD

Conclusions

- Denial and religion reported as a common coping mechanism.
- The frequency of the experience of moral distress is predicted by the amount of religious coping reported by the subjects.
- The higher the level of education, the greater the total moral distress.
- OR nurses are leaving positions because of moral distress.

Implications

- Moral Distress is present in OR nurses.
- Coping strategies can be used to help mitigate the negative effects of moral distress.
- The operating room environment impacts the experience of moral distress .
- Education regarding healthy coping mechanisms and the experience of moral distress should be ongoing.
- Moral distress, coping and OR environment are worthy of more study .

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RWJBarnabas HEALTH

Exploring the benefits of a structured hands-on skin and wound care education session with new graduates and their caregiver confidence

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BACKGROUND

- New Graduate Registered Nurses (RNs) enter the work force with minimal academic preparation in the assessment and treatment of pressure ulcers (injuries) and wounds.
- Due to limited clinical exposure it is important for RNs new to practice to have the opportunity to put theory into practice.
- Shadowing in other disciplines is numerous in the literature in initial training programs and minimal in practice settings. This is also true in nursing literature.
- This inadequacy becomes more urgent as reimbursement is connected to the ability to prevent, detect, and manage pressure injuries in the acute care setting .
- To explore the impact that a "hands-on" skin and wound care program would have on a new graduate nurse's care giver confidence level.

METHODOLOGY

- Convenience sample (N=79); New graduate nurses with 0-2 years experience in an acute care hospital located in the North East
- Informed Consent; IRB approved; Nurse can withdraw from project at any time
- Pre-requisites (NDNQI modules; head to toe assessment competency)
- Educational session/informational folders
- Pre-test/survey followed by 8 hour shadowing experience then post-test/survey followed by question/answer session
- Pre and post confidence levels self reported using 0-10 scale (0 being no confidence and 10 being highly confident)

Demographics

N=79	N	Min.	Max.	Mean	Std. Deviation
Pre-Test	79	60.00	94.00	81.5443	7.84431
Post-Test	79	74.00	100.00	89.8987	5.13309
Highest Level of Ed.	79	1.00	4.00	2.3291	.57113
Yrs. Experience	79	1.00	6.00	1.6203	1.01658
Pre-conf Level	79	.00	10.00	5.3544	1.65086
Post-conf Level	79	4.00	10.00	8.0633	1.24645

RESULTS

Pre and Post Test Scores (One-Sample Test[a])

RN Highest Level Of Education		Test Value = 0					
		t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Diploma (1.00)	Pre	17.457	2	.003	80.00000	60.2828	99.7172
	Post	36.472	2	.001	87.66667	77.3244	98.0090
ASN (2.00)	Pre	75.860	47	.000	82.00000	79.8254	84.1746
	Post	109.615	47	.000	90.08333	88.4300	91.7366
BSN (3.00)	Pre	47.836	26	.000	80.85185	77.3776	84.3261
	Post	110.530	26	.000	89.66667	87.9991	91.3342

a. No statistics are computed for one or more split files (MSN (4.00) was only 1)

Pre and Post Confidence Levels (One-Sample Test[a])

RN Highest Level of Education		Test Value = 0					
		t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Diploma (1.00)	Pre-conf	6.047	2	.026	5.33333	1.5388	9.1279
	Post-conf	11.500	2	.007	7.66667	4.7982	10.5351
ASN (2.00)	Pre-conf	20.493	47	.000	5.50000	4.9601	6.0399
	Post-conf	41.974	47	.000	8.08333	7.6959	8.4708
BSN (3.00)	Pre-conf	21.380	26	.000	5.03704	4.5528	5.5213
	Post-conf	38.380	26	.000	8.00000	7.5715	8.4285

a. No statistics are computed for one or more split files (MSN (4.00) was only 1)

CONCLUSIONS

- After completion of the 8 hour experience:
  - 10.2% increase in knowledge overall
  - 50.6% increase in self confidence level in regards to pressure ulcers (injuries) and wounds
- Results were found to be statistically significant
- Incidental findings: ASN prepared nurses had higher pre and post test scores compared to BSN prepared and Diploma prepared nurses that participated in this study
  - ASN pre-test mean 82 and post test mean 90.1
  - BSN pre-test mean 80.9 and post test mean 89.7
  - Diploma pre-test mean 80 and post test 87.7
- No significant difference noted in confidence levels

IMPLICATIONS

- Lack of knowledge received expressed by New Grads re: pressure injuries, wounds, ostomies, Nurse Sensitive Indicators, etc. calls for the need for further curriculum and experiences while in nursing school
- Shadowing/rounding produces more aware and confident nurses
- Increased knowledge can contribute to improved assessment skills and improved documentation skills thus reducing the risk of missed present on admission skin issues

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What is the intent to leave of newly hired new graduate Registered Nurses in a long term care setting between 90 days and 180 days after hire?
What is the intent to leave of newly hired experienced Registered Nurses in a long term care setting between 90 days and 180 days after hire?
What is the intent to leave of newly hired new graduate Licensed Practical Nurses in a long term care setting between 90 days and 180 days after hire?
What is the intent to leave of newly hired experienced Licensed Practical Nurses in a long term care setting between 90 days and 180 days after hire?
What factors relate to nurses intent to leave in a long term care setting between 90 days and 180 days after hire?

Examining Anticipated Turnover of Newly Hired Nurses in a Long Term Care Setting

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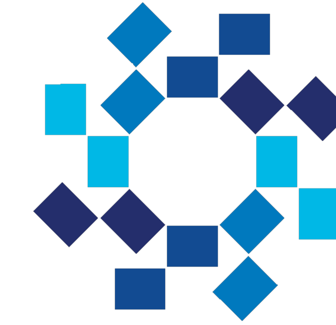


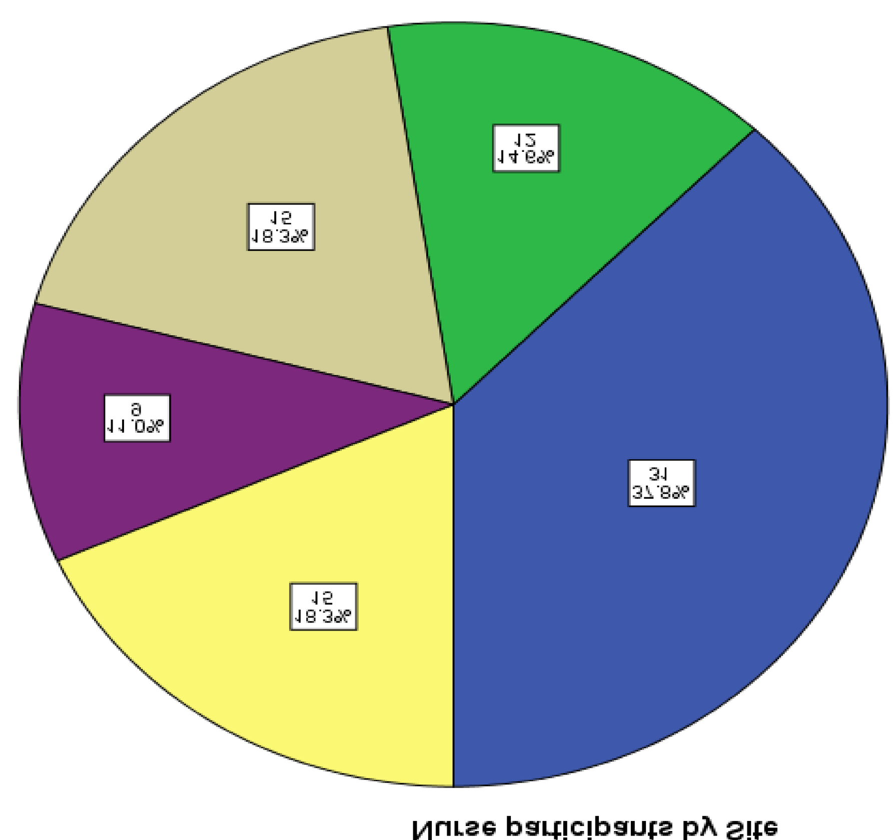
ABSTRACT

•**Aim**: The impetus of this study was to learn which factors are most impactful on newly hired nurses' plans to leave their positions.
•**Design**: Descriptive.
•**Method:** Survey methods and demographic correlations were utilized in a 12 month study at five LTC facilities. Hinshaw and Atwood's (1984) Anticipated Turnover Scale (ATS) was indexed in 82 nurses' perceptions of the possibility of voluntarily terminating present positions within 90-180 days of hire. Four cohort groups of newly hired nurses were examined: new graduate RNs, experienced RNs, new graduate LPNs, experienced LPNs.
•**Conclusion**: While all new graduate nurses are at risk, this study identified that new graduate RNs with no dependents are most likely to anticipate leaving their positions within 90-180 days of hire.

Purpose

An aging workforce and high turnover in LTC demand improved retention strategies. Nurse turnover is significantly related to both patient and corporate outcomes. Anticipated turnover, and early component of the process of leaving, is a good predictor of decision to leave. By studying this and other demographic factors of LTC nurses, the research described addresses this with a study of newly hired nurses after 90-180 days of hire. The aim of this study was to identify actions within the purview of leadership which may stave off the loss of newly hired nurses.

Table 1: Nurse Participants by Site



?earning Objective

т•The participant will be able to describe significant demographic characteristics which impact newly hired LTC nurses' anticipation to leave their positions within 90-180 days of hire.

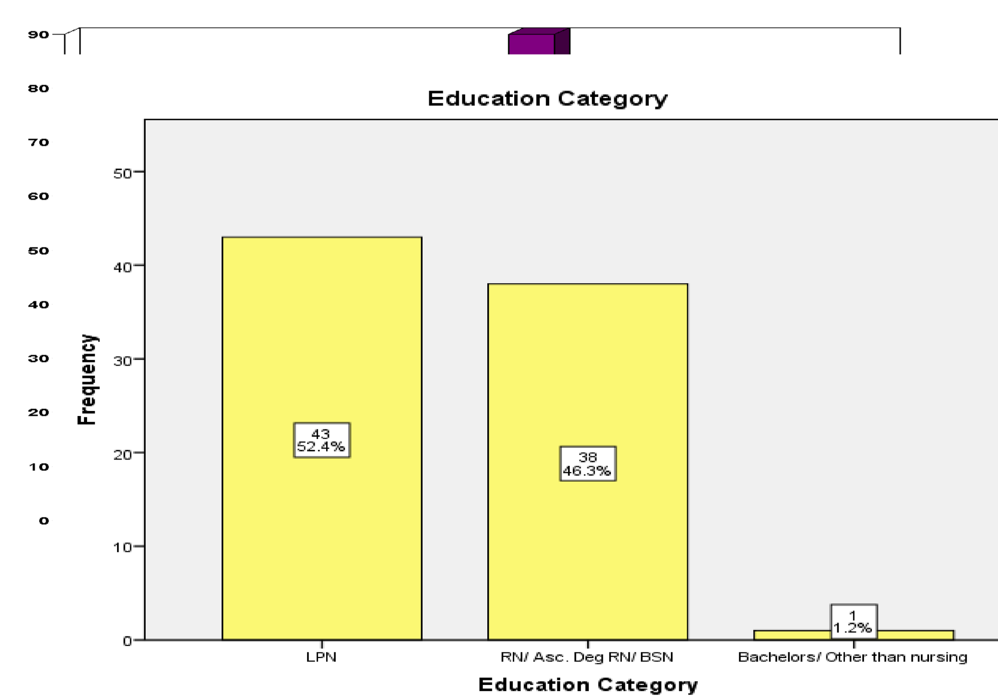
Methods

•A descriptive study using survey methods and demographic correlations was conducted over a 12 month period. Hinshaw and Atwood's (1984) Anticipated Turnover Scale (ATS) was utilized to index the employee's perception or opinion of the possibility of voluntarily terminating his or her present job. Demographic questions regarding age, experience (a new graduate has less than one year of experience), income, education and facility were included. 82 nurses from five LTC facilities were divided into four cohort groups: new graduate RNs, experienced RNs, new graduate LPNs, experienced LPNs. Measures of central tendency and dispersion, means and standard deviations of the items and reliability statistics were obtained.

Results

•An ATS score of 3.5 or over indicates readiness to leave. For nurses without children compared to nurses with children, t-test is significant at 0.05 level (p-value = 0.04). Of the 82 participants the mean score was 3.18 for those with no children compared to the mean score of 2.6 for nurses with children. Though the group with responsibility for over 20 patients scored slightly higher they were not statistically different than the group who care for between 11-20 patients (p = 0.385). Hours worked per week, nurses' workloads and participation in the Preceptor Program were not statistically significantly related to ATS scores. Overall there was a higher mean ATS score from RNs (3.13) as compared to LPNs (2.58). The t-test was significant at less than the 0.05 level (p = 0.038). New graduates' total mean score was 3.14. Experienced nurses' total mean score was 2.56. Though there was a difference in ATS among the five facilities the analysis of variance (ANOVA) was not significant at 0.05. Facility E had the lowest total mean score of 2.26 and Facility D had the highest total mean score 3.38.

Table 2: Frequency by Education Chart Title



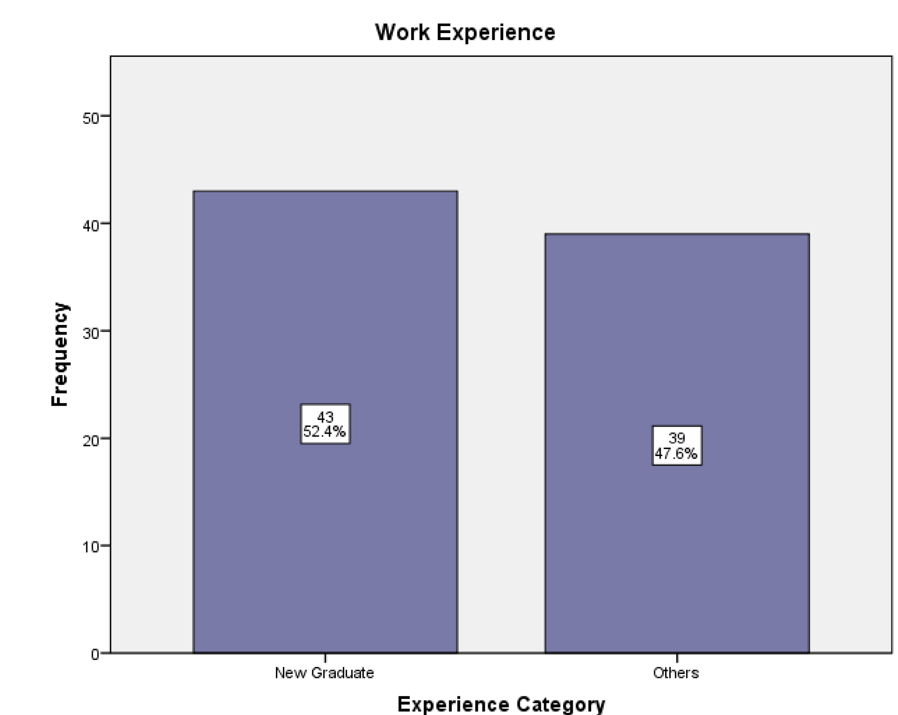
Conclusion

•Previous studies (Hayes et al., 2005; Cowden and Cummings, 2012) related intent to leave to young, newly qualified highly educated nurses but did not identify the lack of dependents as a factor. When education and experience are examined together all new graduates are at risk. This study identified that new graduate RNs with no dependents are most likely to anticipate leaving their LTC position within 90-180 days of hire. Nurses from five LTC facilities were studied with the hopes that facility differences may lead to interventions at the most problematical sites. Facility E, which had the lowest ATS scores overall, had the highest participation in the Preceptor Program and is the only facility utilizing the 12 hour shift pattern for staffing.

Implications

•It would be optimal for nurse leaders to target nurses with high anticipation to leave early on. Younger well-educated nurses respond to reward based climates (Anderson et al, 2004), heightened promotional opportunities (Brewer et al, 2009) and preferred work hours (Aiken et al, 2003). Improved organizational commitment, collaboration, and work group cohesion (Tourangeau and Cranley, 2006) may delay the decision to leave. Offering RN Residency, conference sponsorship, participation in strategic teams, and self-scheduling may optimize retention. During the on-boarding process pre-job shadowing with peer based interviewing and coaching to improve employee/position fit are options. Evaluation of the adequacy of Preceptor preparation and support is suggested. Replication of this study at other LTC facilities may be beneficial as would gathering a larger sample size. Further investigation of the differences between Facility E and the other facilities which had higher ATS scores may guide leaders. A review of the financial impact of nurse turnover in LTC would demonstrate the benefits of nurse retention to corporate management.

Table 3: Frequency by Work Experience



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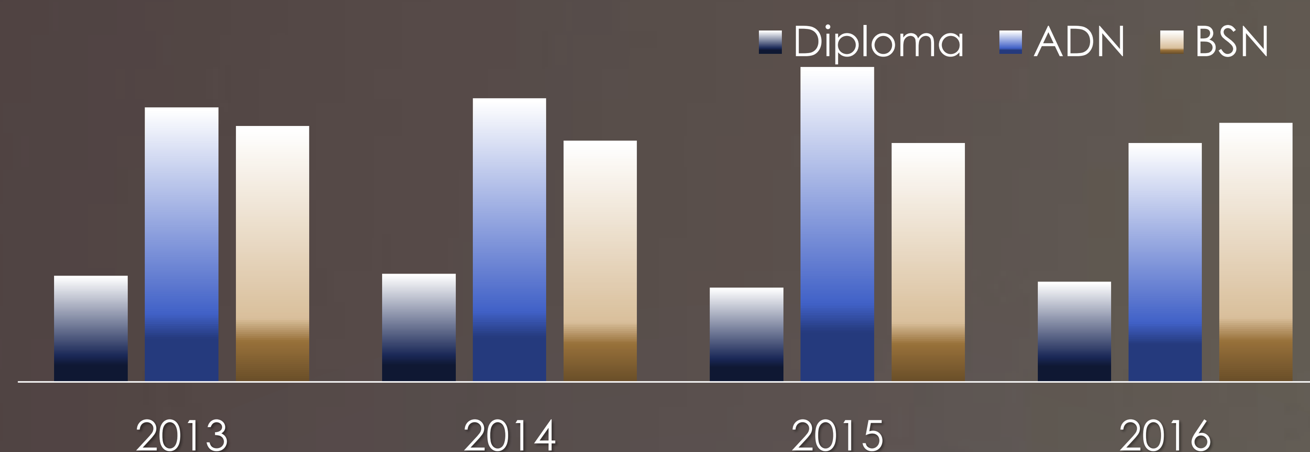
The New Jersey Collaborating Center for Nursing: The Registered Nurse Workforce

The New Jersey Collaborating Center for Nursing (NJCCN) was created through state legislation in 2002 from the work begun by Colleagues in Caring Collaborative. The NJCCN was established to address issues of supply and demand of the nursing workforce, including education, recruitment, retention, and utilization of adequately prepared nursing personnel.

Supply – Educational Capacity

Based on 2016 survey data, New Jersey RN nursing schools cumulatively have 55 pre-licensure programs and 39 post-licensure programs.



Pre-Licensure Graduation Trend 2013-2016 (highlights in graph above)	2013	2014	2015	2016
Diploma	513	523	457	484
ADN Generic	1012	1015	1002	883
ADN Bridge (LPN-RN)	317	357	522	355
BSN Generic	753	667	788	869
BSN Accelerated	486	500	368	384
MSN Pre-Licensure	20	15	24	32

Post-Licensure Graduation Trend 2013-2016	2013	2014	2015	2016
RN – BSN	693	926	1068	1063
MSN	642	634	601	616
DNP	65	59	93	88
PhD	17	26	14	7

About Us

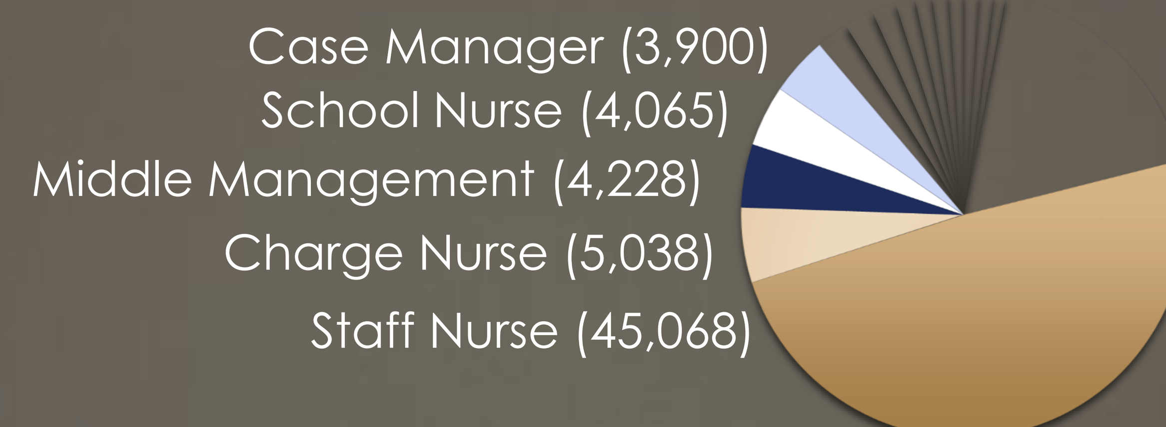
The NJCCN is governed by a 17-member board, appointed by the President of the Senate, the Speaker of the General Assembly, and the Governor with representatives from the following organizations:

- NJSNA
- ONL-NJ
- NJLN
- NJHA
- NJ Council of Teaching Hospitals
- Home Care & Hospice Association of NJ
- Consumers of Health
- LPN Association of NJ
- Council of Baccalaureate & Higher Degree Programs in Nursing
- Council of Associate Degree Programs
- Association of Diploma Schools of Professional Nursing
- LPN Education Council

Supply – RN Workforce

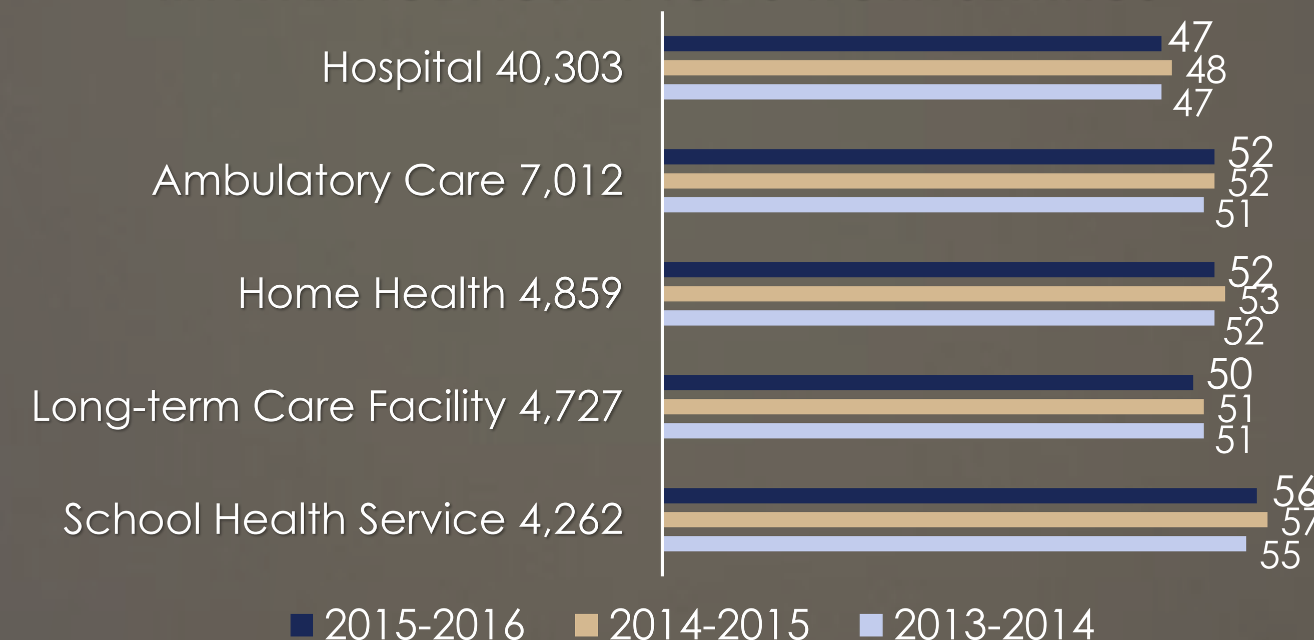
From 2016-2017, there were about 120,000 RN license renewals. 96,113 RNs completed the survey. The mean age of RNs in NJ is 51 years. Of these respondents, 90% (n = 86,639) were female, and 64% (n = 61,562) were of Caucasian ethnicity.

Top 5 Nursing Positions



52% of the NJ Nursing Workforce has a BSN
*Based on 2014-2015 Data

RN AVERAGE AGE BY TOP 5 WORK SETTINGS



Data Sources

RN Supply data is obtained from:

1. RN Workforce Supply data, which comprises responses from the NJ Board of Nursing License Renewal Survey
2. Educational Capacity data, which comprises responses from the NJCCN's annual survey of nursing education programs.

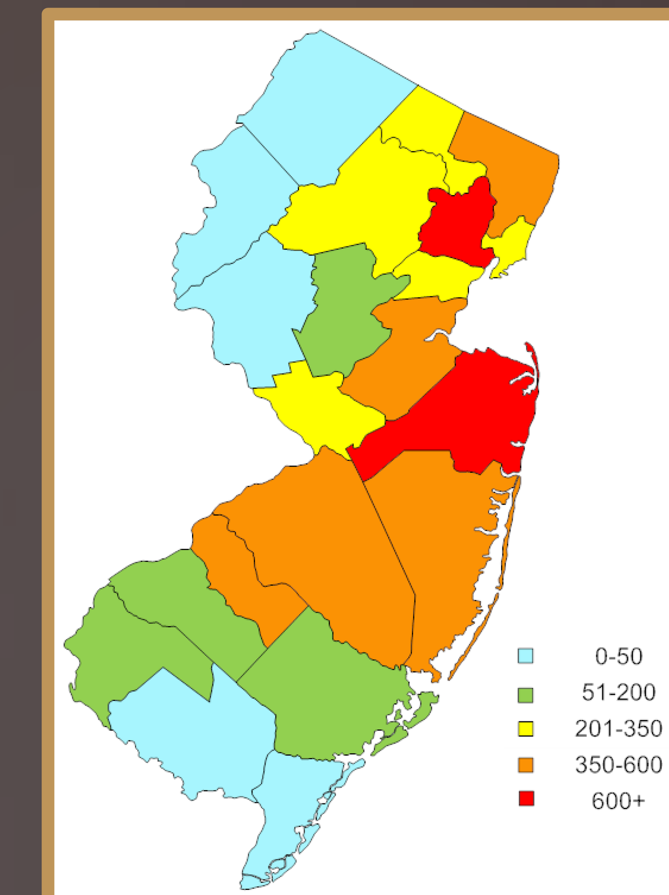
RN Demand data is obtained through data mining of online job postings by Burning Glass Technologies.

Demand

RN Supply and Demand Projections

In 2016, Essex and Monmouth Counties had the most job postings. Most (63%) of postings were for generic RN positions. The top 5 specific RN positions were:

1. Nurse Manager
2. Intensive Care
3. Operating Room
4. Case Manager
5. Home Health



	Number Employed 2016	Increase Employed 2015-2016	Projected Change 2016-2026	Mean Salary Advertised	Mean Salary Actual
RNs	79,400	1%	13.2%	$83,289	$80,580
LPNs	16,360	6%	14.6%	$59,794	$53,740
NPs	3,840	4%	28.2%	$89,447	$115,230

Source: Burning Glass Technologies, Bureau of Labor Statistics

Future Directions

2017-2018 Strategic Plan

Action-oriented approaches using data to direct the Center's work:

- Standardizing APN practice in acute care settings
- Evaluation of current hospital-based residency programs and need for a standardized state-wide program in collaboration with the Leadership Council of ONL-NJ
- Supply and Demand Projections
- School Nurse Leadership in communities
- LPN supply and demand

For more information www.njccn.org or follow us on Facebook (New Jersey Collaborating Center for Nursing) and Twitter (@NJ_CCN)

An initiative to promote sleep and rest in Cardio-Vascular Intensive Care Unit through Quiet Time: A Pilot Study

Helen Richards, BSN; Faith Atte, Phd, RN; Eliza Pacis, MSN, RN; Corinne Topoleski, BSN, RN; Lauralynn Grim, RN.
Deborah Heart and Lung Center

Background

- Lack of adequate sleep has been associated with physiological and psychological dysfunctions that may affect the healing process of a patient in the Cardio-Vascular Intensive Care Unit (CVICU). Review of the literature identified the use of quiet time (QT), which involves noise and light reduction, patient comfort improvement and clustering of patient care activities, as interventions that enhance and promote sleep. Yet little evidence exists about the efficacy of such interventions in CVICU.

Purpose

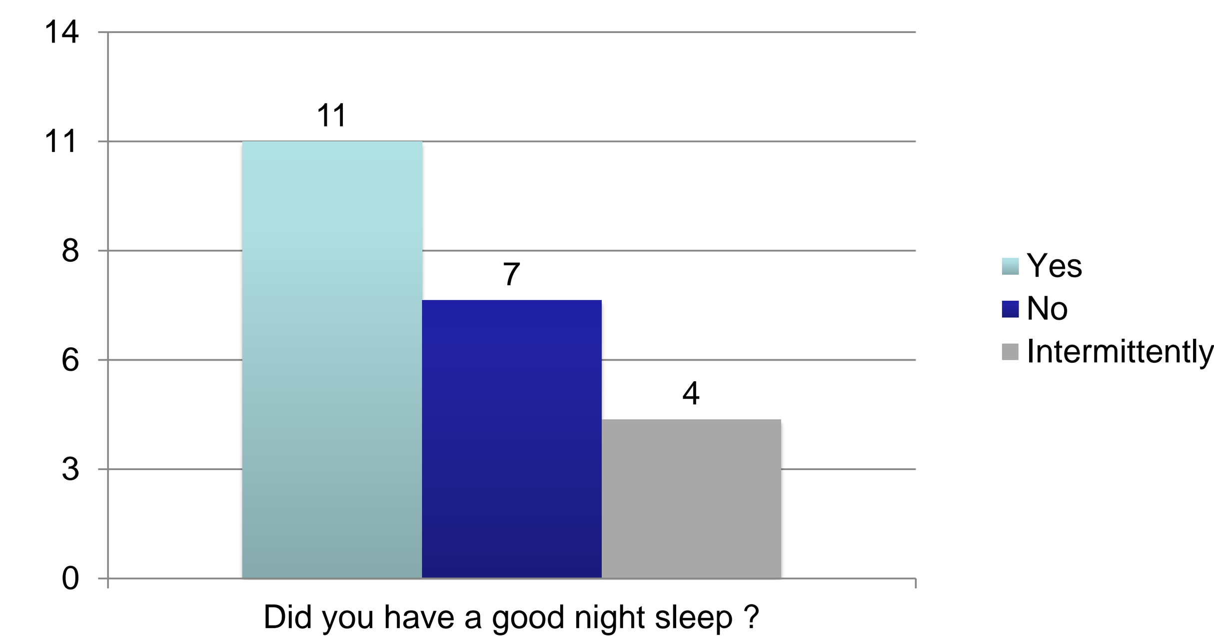
- The purpose of this pilot study was to evaluate the efficacy of QT protocol by reducing external sensory overload often associated with increased quality of sleep and rest among patients.

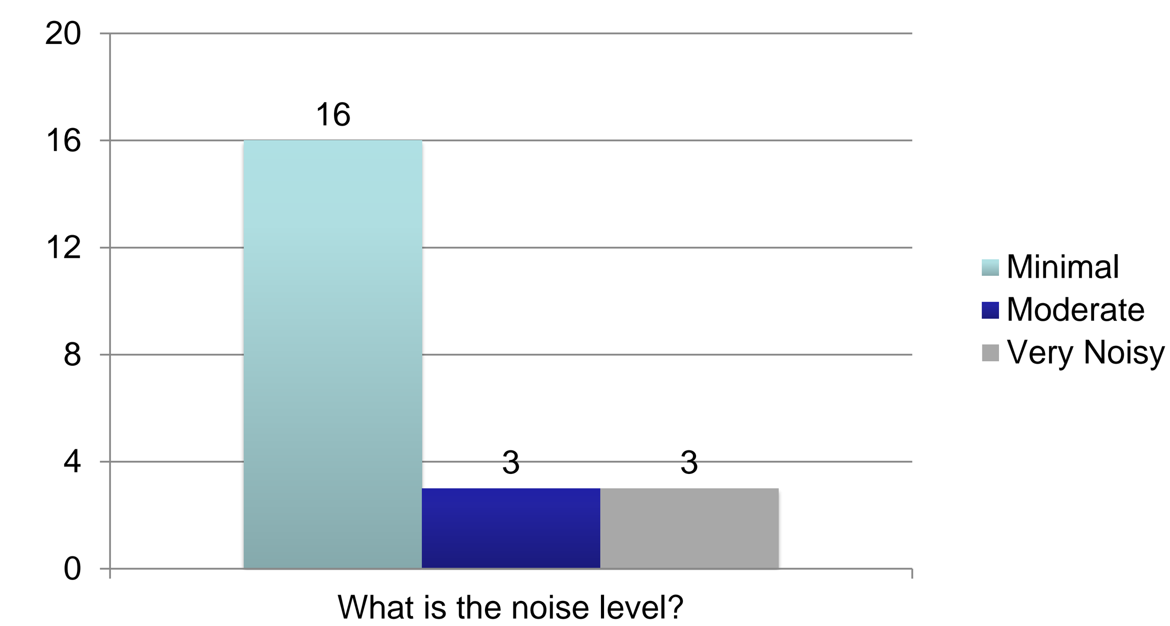
Methods

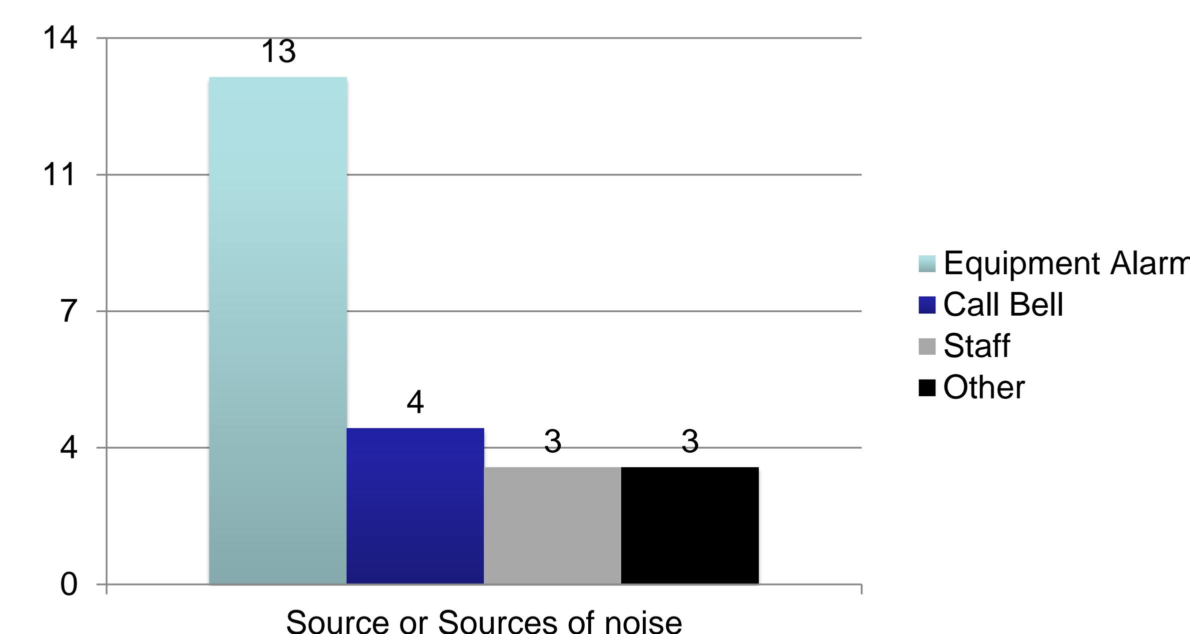
- A survey was conducted in the form of questionnaires utilizing PDCA methodology; 24 patients during regular time (control group) and 22 patients during QT (intervention group). Data were collected on having a good night sleep, the source and level of noise. During QT (2200-0400), lights were dimmed, quiet zone signs were hung, patient's doors were closed and earplugs provided. Staff was required to lower their voices, address monitor alarms and answer call bells immediately. Support staff was to complete supply stocking and errands before and/or after QT.

Results

Before Intervention

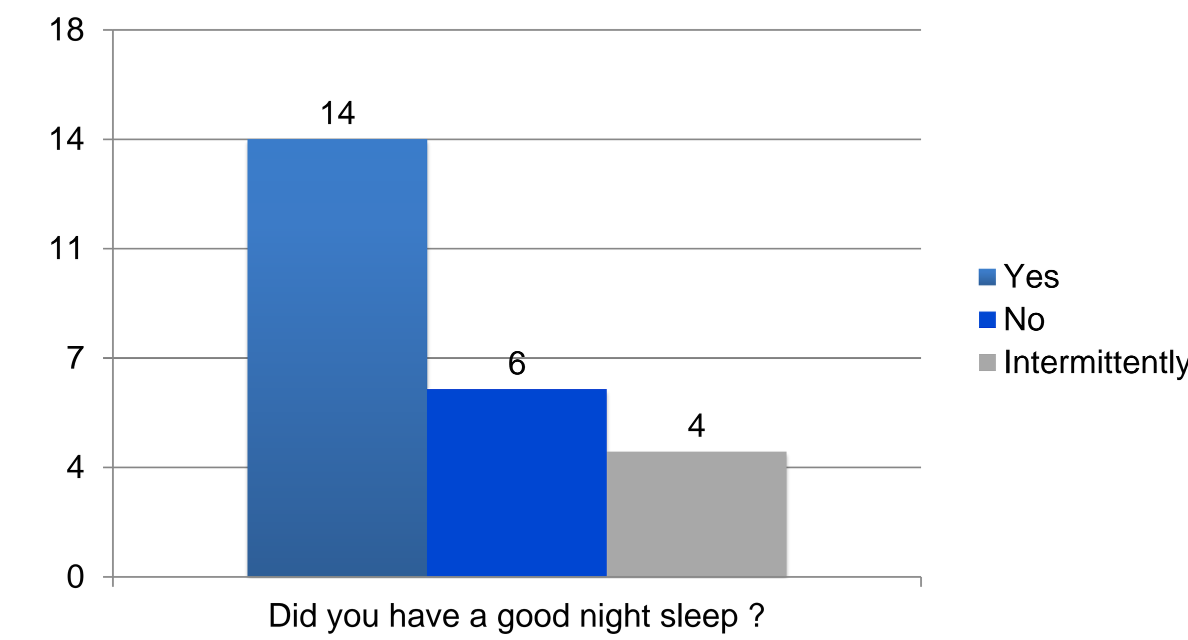


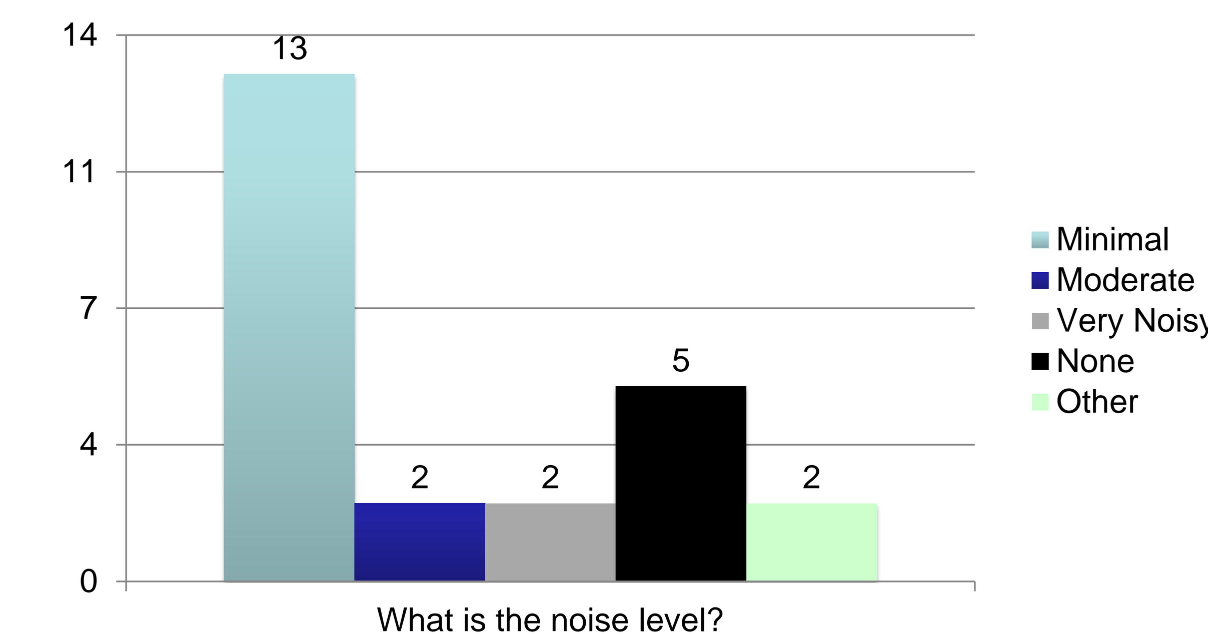


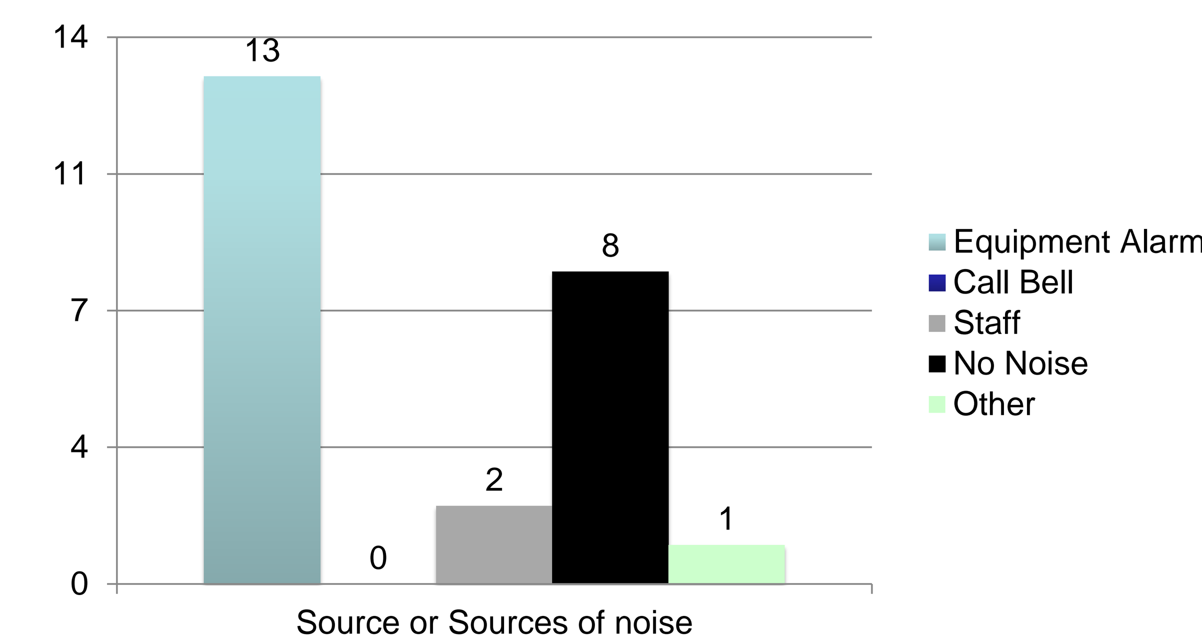


n = 24

After Intervention







n = 22

Conclusion

- Preliminary results demonstrated that (58%) of those in the intervention group experienced an increased good night sleep than those in the control group (50%). There was no difference in the source and level of noise in both groups.
- The study findings that quite time improves the quality of sleep argues for recognizing the importance of implementing interventions designed to enhance sleep in the CVICU.
- Health Care Providers continue to play an integral role in enhancing quiet time in the CVICU which will ultimately improve the healing process of the patients.

References

Freedman N. S., Gazendam J., Levan L., Pack A. L., Schwab R. J. (2001). Abnormal sleep/wake cycles and the effect of environmental noise on sleep disruptions in the intensive care unit. American Journal of Respiratory Critical Care Medicine, 163, 451-457.

Friese R. S. (2008). Sleep and recovery from critical illness and injury: A review of theory, current practice, and future directions. Critical Care Medicine, 36, 697-705. doi:10.1097/CCM.08013E3181643F29

Gardner G., Collins C., Osborne S., Henderson A., Eastwood M. (2009). Creating a therapeutic environment: A non-randomized controlled trial of a quiet time intervention for patients in acute care. International Journal of Nursing Studies, 46, 778-786. doi:10.1016/j.ijnurstu.2008.12.009

Maidl, C. A., Leske, J. S., & Garcia, A. E. (2014). The Influence of "Quiet Time" for Patients in Critical Care. *Clinical Nursing Research*, *23*(5), 544-559. doi:10.1177/1054773813493000

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Administrative Supervisor Leadership Style, Satisfaction, and Educational Needs at Magnet® and non-Magnet Hospitals

Susan H. Weaver, PhD, RN, CRNI, NEA-BC, Amanda Hessels, PhD, MPH, RN, CIC, CPHQ, FAPIC,
Jocelyn Marx, BSN, RN-BC, Katherine Morris, BSN, RN-BC, and Mani Paliwal, MS, MBA

Background

The administrative supervisor, the **nurse leader on the evening, night and weekend shifts**, has responsibility to get the patients, staff and hospital safely through the shift. **Research on this nurse leader is just beginning.**

In a nationwide qualitative study 30 administrative supervisors from 20 states described role responsibilities:

- ✓ Staffing
- ✓ Patient Flow
- ✓ Crisis Management
- ✓ Hospital Representative

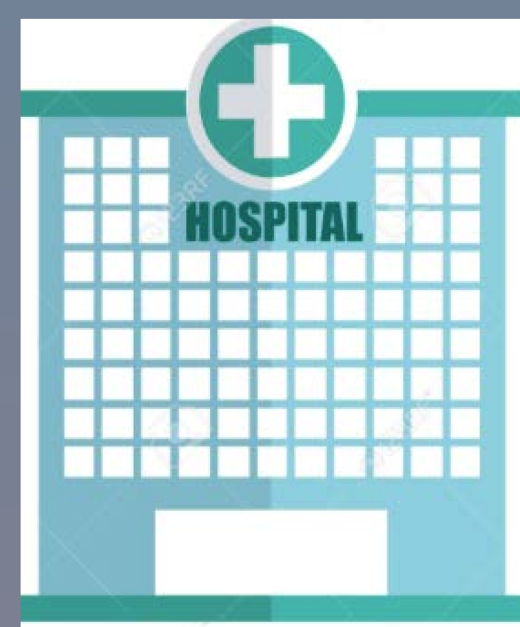
and managerial practices:

- ✓ Establishing Trust
- ✓ Doing Rounds
- ✓ Educating
- ✓ Providing Support

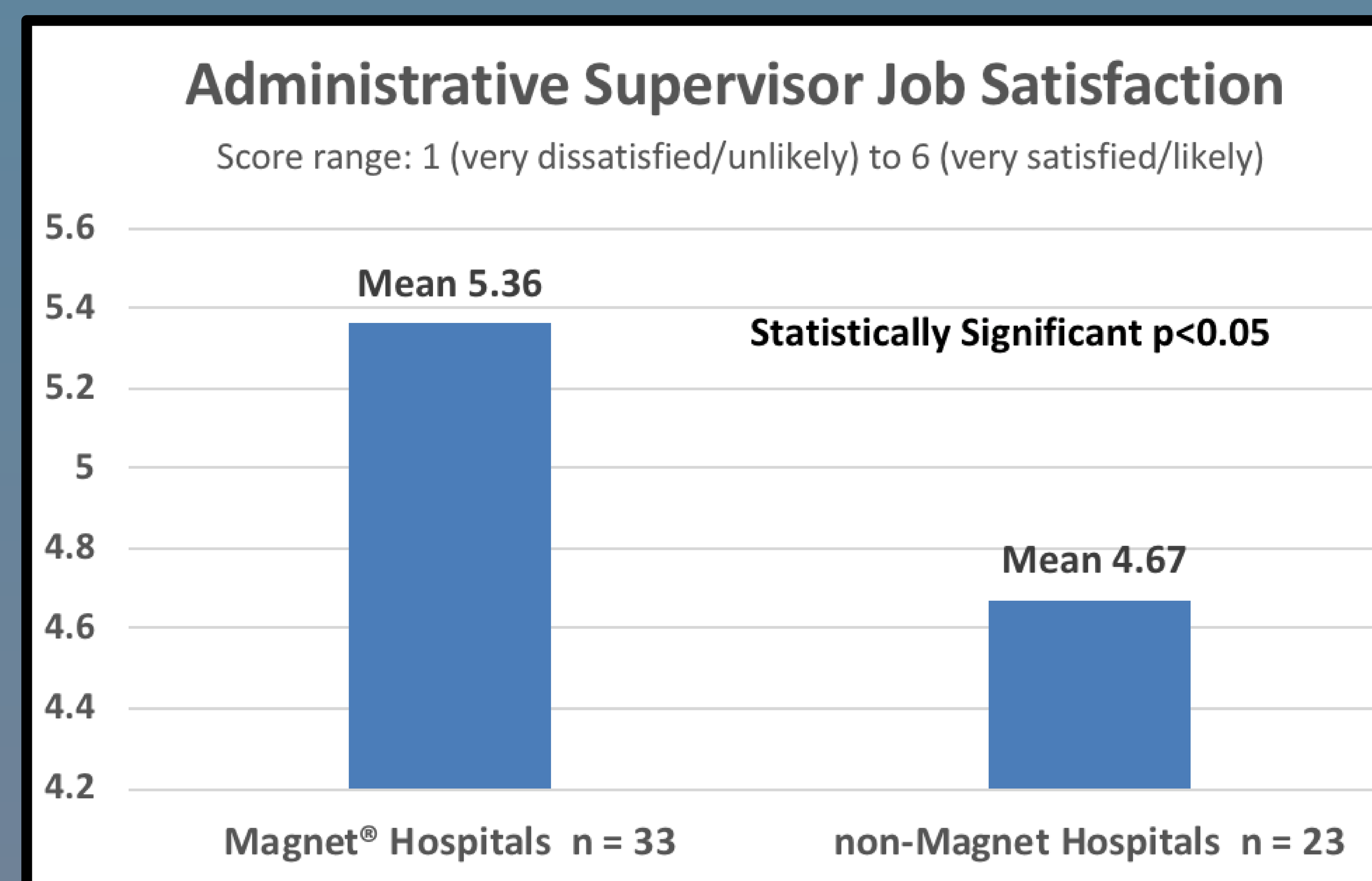
These off-shift safety officers lack role specific education and described a relationship type leadership style.

Results

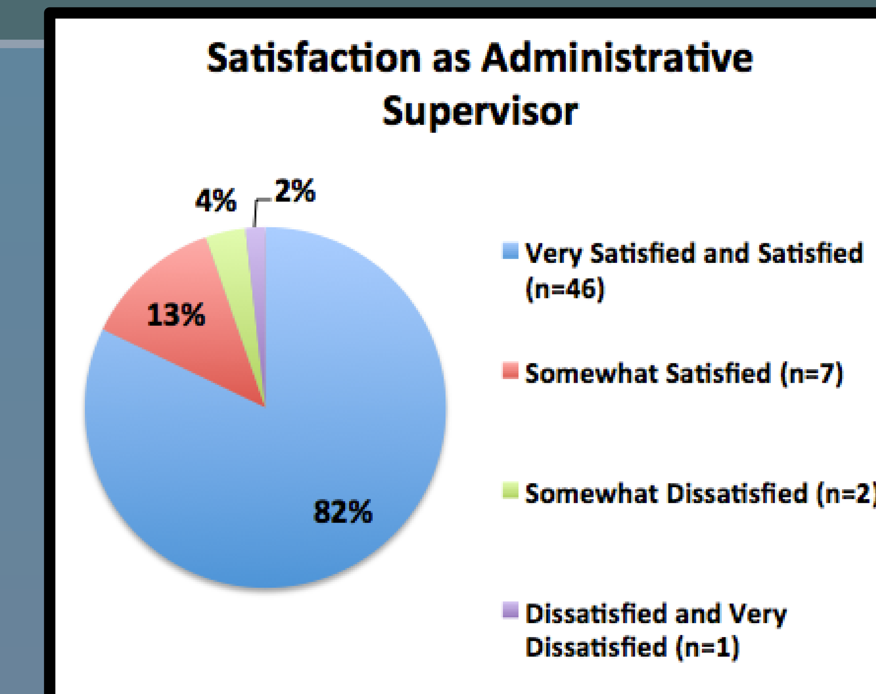
Administrative Supervisors (n=56)	Mean (SD)
Age (years)	53.4 (9)
Years as RN	28.8 (11)
Years in current position	12.5 (11)
Gender	**n**
Male	4 (7)
Female	51 (93)
Highest Nursing Degree	**n**
Diploma or Associate Degree	11 (20)
Baccalaureate Degree	31 (55)
Masters Degree	14 (25)
National Nursing Certification	**n**
Yes	34 (61)

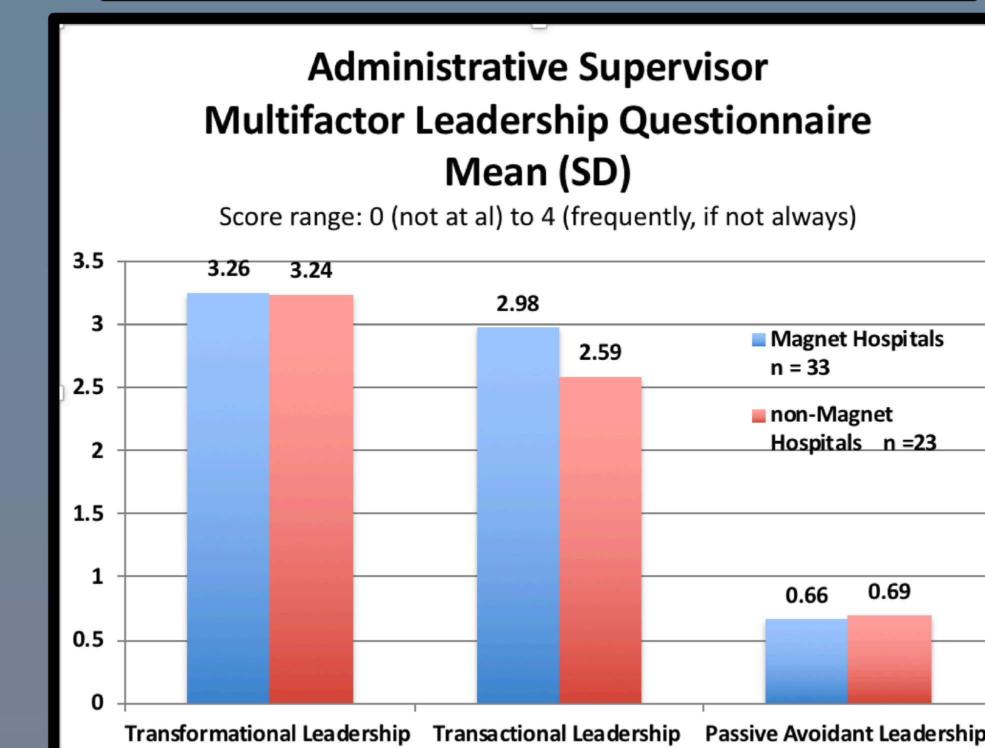


Hospitals n = 28	n (%)
Bed Size	
Small (≤ 149 beds)	4 (14)
Medium (150 - 499 beds)	17 (61)
Large (> 500 beds)	7 (25)
Ownership	**n**
Non-profit	25 (89)
For-profit	3 (11)
ANCC Designation	**n**
Magnet® designation	13 (46)



At Magnet® hospitals supervisors who had higher transformational leadership scores had greater job satisfaction ($r=.481$, $p<.01$). At non-Magnet hospitals supervisors who had higher transactional leaderships scores had been in their position longer ($r=.490$, $p<.05$).





The administrative supervisors reported higher Transformational Leadership, even though 30% revealed they had no formal leadership training.

Methods

In this descriptive correlational study administrative supervisors completed the following surveys prior to the education program:

- **Multifactor Leadership Questionnaire**
- **Job satisfaction**
- **Nurses Assessment of Readiness (NAR) Scale**
- **Questions on the education program, and**
- **Demographic Data.**

These nurse leaders completed the following surveys 3 months later:

- **NAR scale, and**
- **Questions on the education program.**

Ann May Center for Nursing Presents:

Crisis Management for Administrative (Evening/Night) Supervisors

Tuesday, May 2, 2017

8 a.m. to 1:30 p.m.

Meridian Health Village at Jackson
27 South Cooks Bridge Road
Jackson, NJ 08527

Learning Outcome:
At the conclusion of this continuing nursing education activity, participants will be able to discuss the administrative supervisor role in various crisis management situations.

Schedule:

8 a.m. – 8:30 a.m.	Registration
8:30 a.m. – 9 a.m.	What Does the Research Say About the Supervisor Role? Susan Weaver, Ph.D., RN, CRNI, NEA-BC, *Nurse Scientist, Ann May Center for Nursing*
9 a.m. – 10 a.m.	Substance Use Disorder and Nursing Practice Jillian Scott, MSN, RN, *Director of Recovery and Monitoring Program (RAMP) Institute for Nursing, the Foundation of NJSNA*
10:15 a.m. – 11:30 a.m.	"The First Minutes of a Crisis… What Do I Do?" Doug Campbell, *Senior Manager of Risk Management, Jersey Shore University Medical Center* Real-Life Experience of an Evacuation Catherine McCarthy, MSN, RN, FNP, CCRN, *Nurse Administrator, NYU Langone Medical Center*
11:30 a.m. – 12:30 p.m.	Incorporating Mindfulness to Build Self Resilence Sara Scheller, BSN, RN, CPN, CCRN Emma Stafford, MSN, RN, APN Marie Feiter, BSN, RN *Integrative Health & Medicine, Hackensack Meridian Health*
12:30 p.m. – 1:30 p.m.	Lunch and Networking

A *Crisis Management for Administrative Supervisors* program was held and included presentations on the Incident Commander role and a supervisor's real life experience evacuating a hospital. After this Crisis Management Program, the supervisors identified the need for the following role specific education programs:

- **Leadership development**
- **Conflict management**
- **Disaster preparedness training**
- **Legal issues for supervisors**
- **Working with difficult families, and**
- **Crucial conversations.**

Conclusion

If quality and safety are key drivers for organizations, satisfied nurse leaders are needed, on all shifts and at Magnet® and non-Magnet hospitals, that have the skills and competence to move the organization forward.

References available upon request

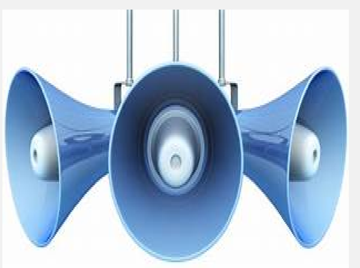
susan.weaver@hackensackmeridian.org

TELLING IT LIKE IT IS:
PLAIN LANGUAGE EMERGENCY ALERTS

Practice Problem

Ask yourself:
Are you running to or from a crisis situation?
Are you certain that you identified the code correctly?

* 40% of healthcare workers self-report code confusion citing dual employment with varied codes.

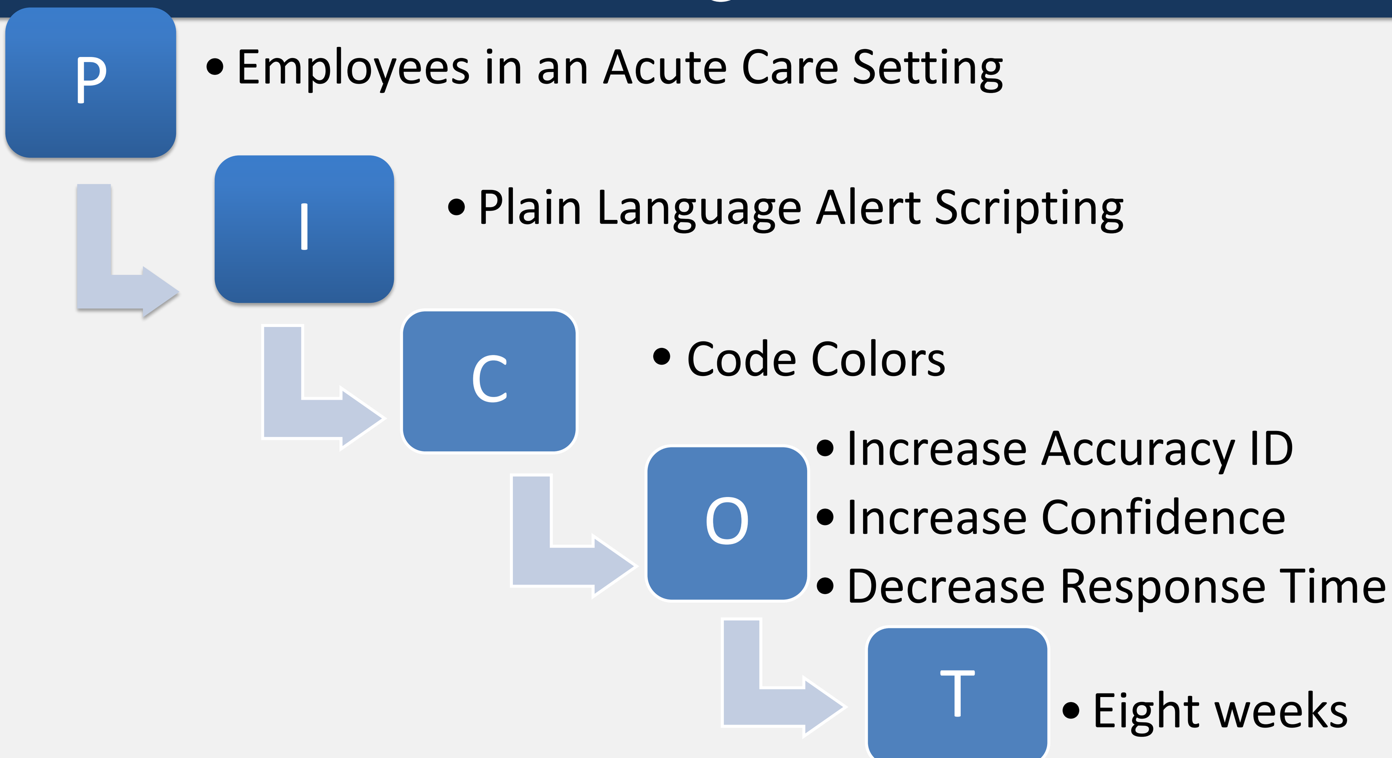


* Before moving to plain language, one state had 80 different color codes in 37 categories with 154 combined meanings.

* Another state had 61 combative patient codes and 47 infant abduction codes.

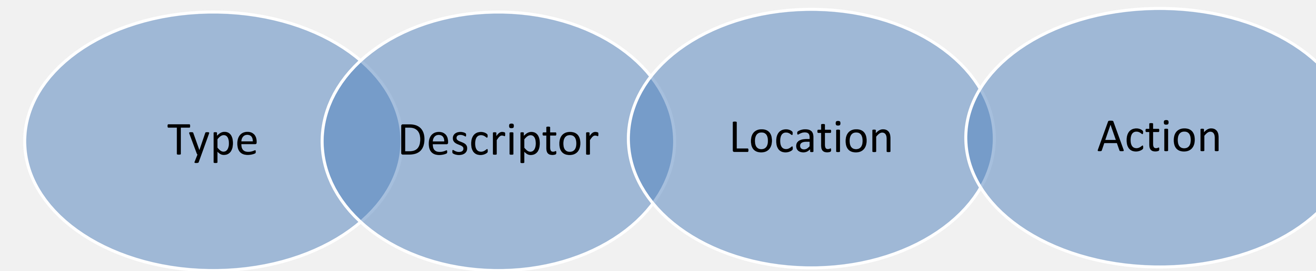
* An active shooter situation was miscoded as a combative patient; the responding RNs were killed (Winger, 2016).

Clinical Question

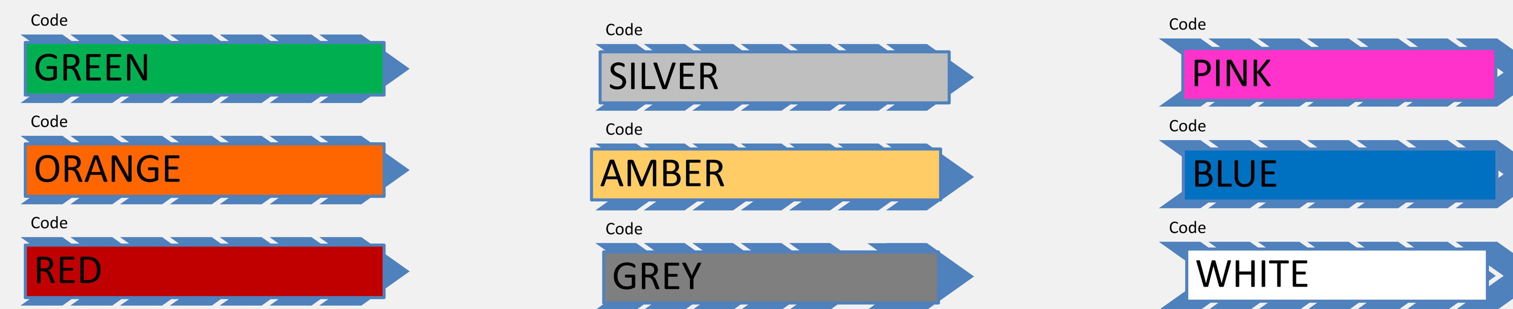


Project Description

Facility color codes were reviewed and categorized. Plain language scripting was formulated and assigned to each code:



versus



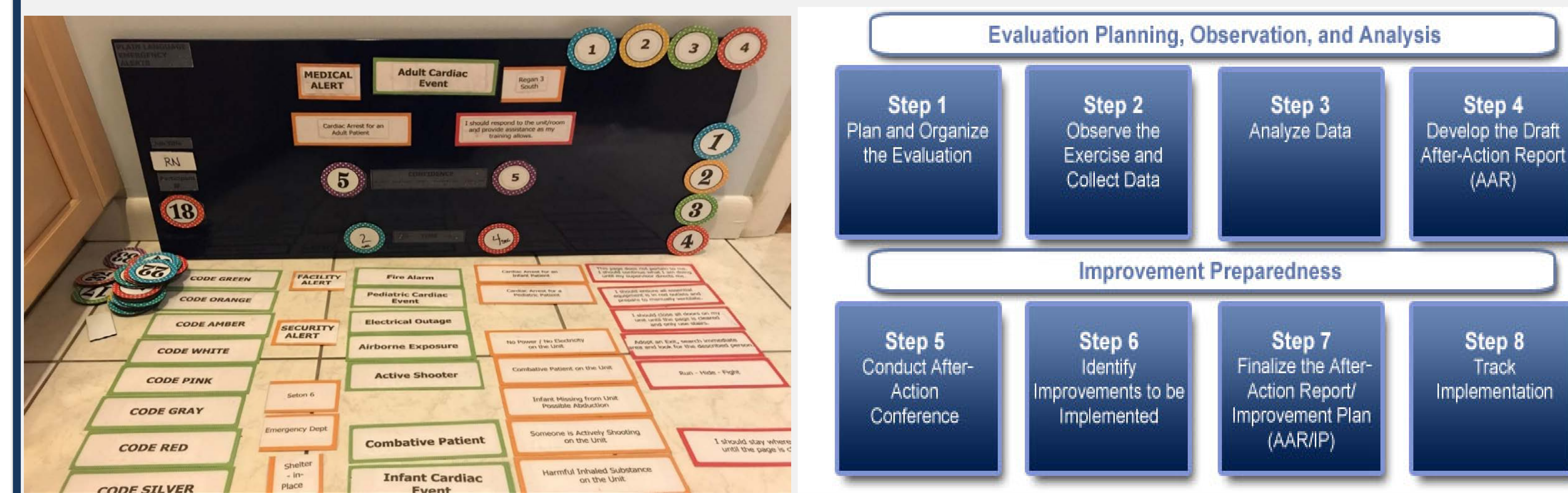
Participants engaged in three, timed table top exercises facilitated by an evaluator and a specially designed board (pictured below). Each exercise drilled one of three different emergency categories:

- Facility Alerts
- Security Alerts
- Medical Alerts

Current facility color codes were evaluated first (pre-data) followed by equivalent plain language codes (post-data). Lastly, each participant self-reported confidence of response accuracy.

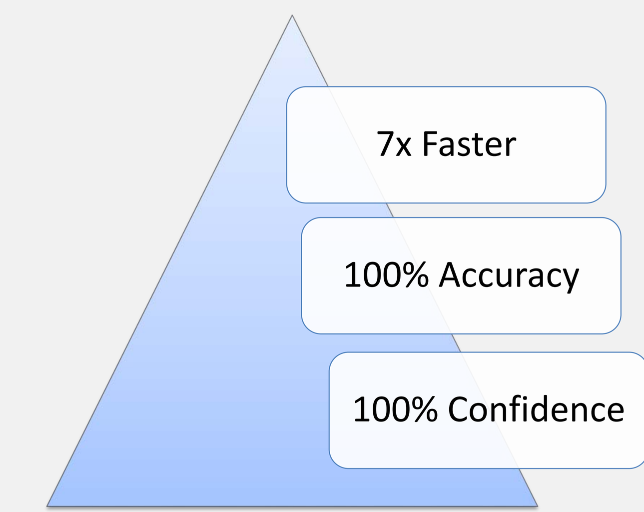
Project Evaluation

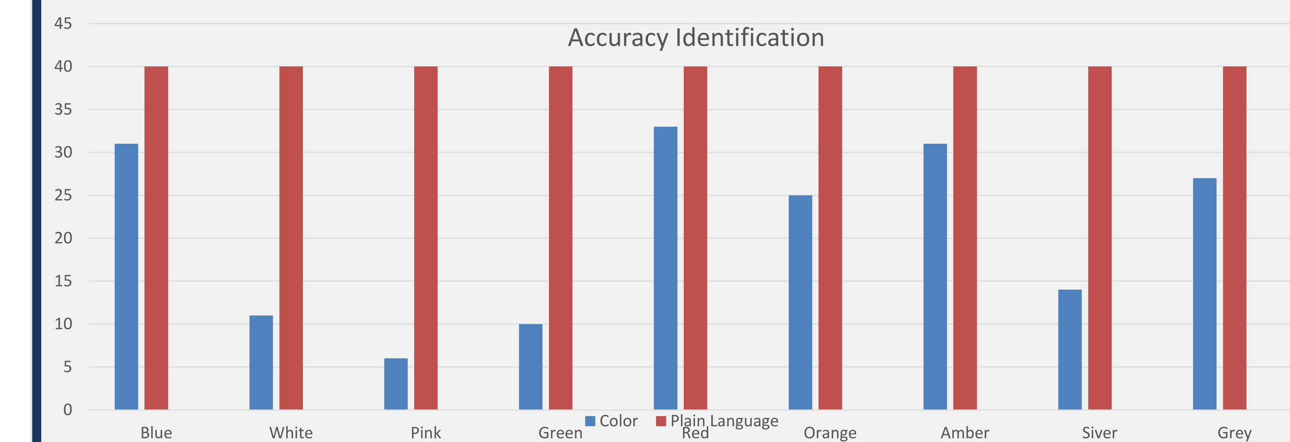
* Homeland Security Exercise and Evaluation Program Tool (HSEEP)
* Table Top Drill Data Collection Board

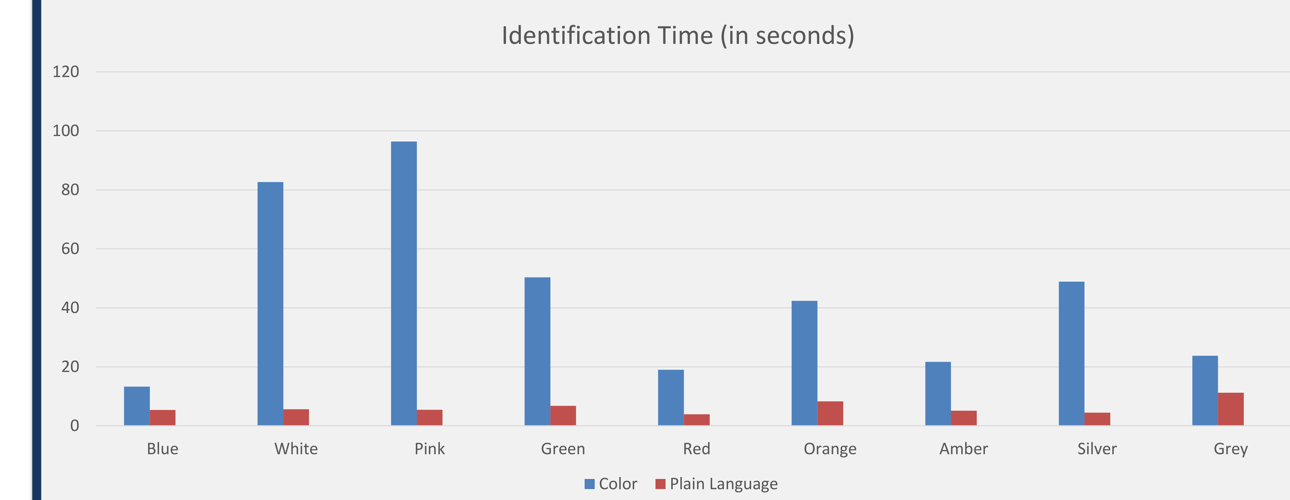


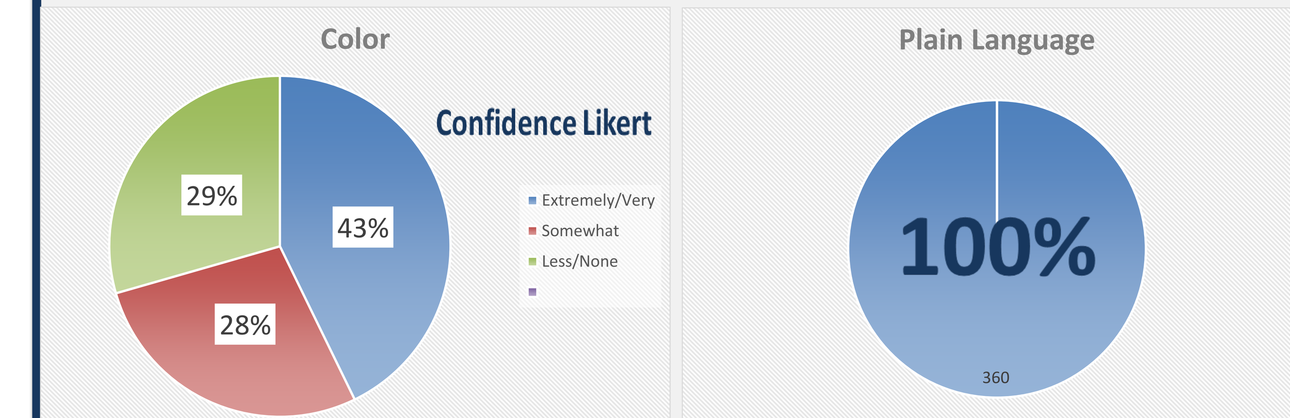
Conclusions

Plain Language vs. Color









Implications

- Healthcare Facilities must carefully consider scripting that informs their employee and community populations without inciting panic.
- Healthcare Leadership has an ethical obligation to ensure verbal facility communications are aligned with the Plain Language Laws, ensuring the safety of employees, patients, visitors, and outside responding agencies.

References

Winger, J. (2016). ENA position statement: Plain language emergency alerts. *Emergency Nursing Journal, 43*(5), 451-456.

Researcher: Stephanie Herr, MSN, RN
Stephanie.HerrEDrn@gmail.com

How a Discharge Care Bundle Reduced Hospital Readmissions in Patients with Acute Exacerbation of COPD

Moira E. Kendra DNP; Cornelia Gilpin, MSN, RN; Nowai Keleekai-Brapoh, PhD, RN; Laura Labrozzi, MSN, RN, CMSRN; Tina Maund, MS, RN , CPHQ;
Federico Cerrone MD; Mary Farrell, BSN, RN, CCRN; & Chirag V. Shah MD MSc

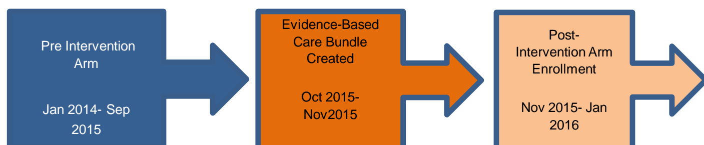
ATLANTIC HEALTH SYSTEM

Introduction

The Centers for Medicare and Medicaid Services limit payments to hospitals with high readmission rates for patients admitted with acute exacerbation of chronic obstructive pulmonary disease (AECOPD). COPD remains the third most common cause of readmission among Medicare beneficiaries occurring in 60% of patients within one year of hospital discharge. Decreasing readmissions in this patient population improves patient health and decreases healthcare utilization of resources. We hypothesize that a COPD care bundle delivered by a multidisciplinary health care team will reduce readmission rates for AECOPD.

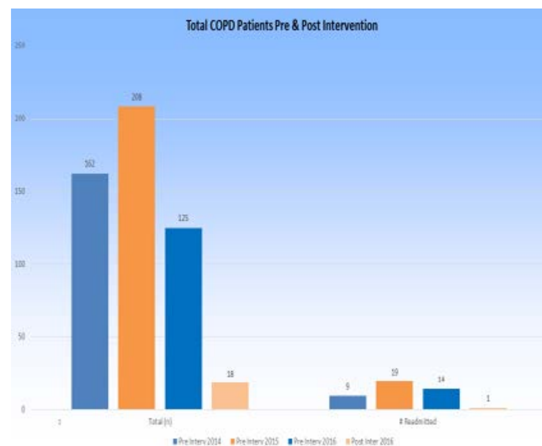
Methods

- Prospective cohort design with pre and post intervention arms for patients admitted to Overlook Medical Center with AECOPD

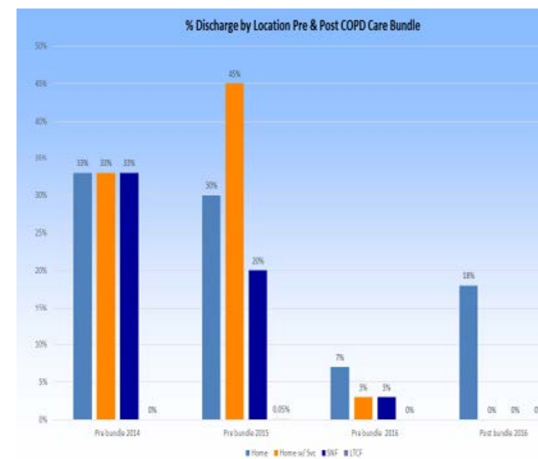


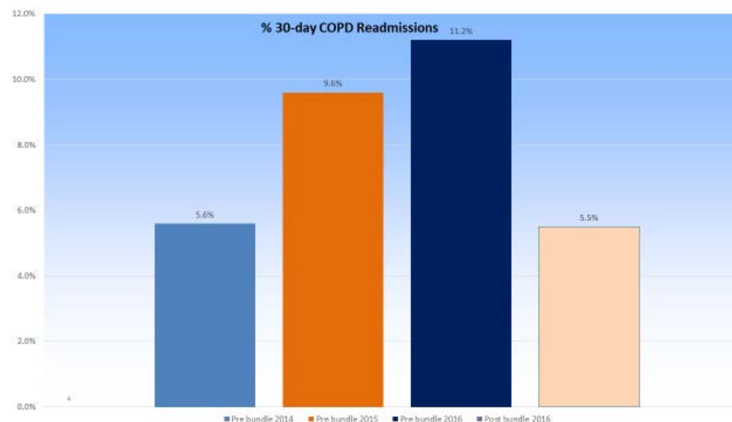
- Evidence-Based Care Bundle:
  - Implemented October 2015- January 2016
  - Patient education on COPD by healthcare providers during hospitalization
  - Completion of an individualized self-management COPD action plan for use after discharge
  - Timely outpatient office visit with a pulmonologist within 7 days of discharge
- Primary outcome: a reduction in 30-day readmission rates

Results



Results





Conclusion

Implementation of a discharge care bundle in patients admitted with AECOPD significantly and consistently reduced 30-day readmission rates in our patient population. The results from this study demonstrate that a multidisciplinary discharge program can improve patient outcomes and should be considered in all hospitals.

References

1. Centers for Medicare and Medicaid Services. Readmission Reduction Program. Available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html. Accessed January 25, 2018.

2. Centers for Disease Control and Prevention. Chronic Obstructive Pulmonary Disease (COPD). Available at: https://www.cdc.gov/copd/index.html. Accessed January 25, 2018

3. Jencks SF, Williams MV, Coleman EA. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *N Engl J Med.* 2009;360(4):1418–1428.

4. Mannino DM, Thomashow B. Reducing COPD Readmissions: Great Promise but Big Problems. *CHEST*. 2015;147(5):1199-1200.

Atlantic Health System
Overlook Medical Center

Incorporating Various Educational Strategies to Improve Nursing Satisfaction

Danielle Hilliard, RN, MSN, APN, CPNP, CCRN-K, Marybeth Gartland, RN, MSN, CCRN, CBC

Maire Andreen, RN, BSN, Angela Brathovde,RN, MSN, BBC, HNB-BC, Joe Cagliostro, RN, MSN, RN-BC, Lynn Clemons, RN, BSN, MSN, RN-BC, Diane Donner, RN, BSN, CWCN, Taquana Holley, RN, BSN, Olga Lopez, RN, BSN, CNOR, Pat Marcelle, RN, MSN, CCRN-K, Wendy Reich, RN, MSN-Ed, RNC-OB, C-EFM, CBC , JeanStraker-Darbeau, RN, MSN, DNP, CEN, Alma Tanchanco, RN, BSN

Background

- Monmouth Medical Center is bed hospital
  - –8 educators cover ICU, Med/Surg, Mother/Baby, Labor &Delivery, Pediatrics, NICU, OR
  - –4 Rapid Response nurses cover education including coverage nights and weekends
- Nurse Educators wear many hats
  - –Change Agents
  - –Leaders
  - –Researchers
  - –Consultants
  - –Mentors
  - –Educator

- Nurses Educators are tasked with bringing evidence-based practice to the bedside
  - –Increase quality of care
  - –Improve patient outcomes
- 4 generations of staff working in hospital with different learning styles/preferences
  - –Veterans
  - –Baby Boomers
  - –Generation X
  - –Millennials
- Generation Z is starting to enter the workforce
- Nurse educators needed to incorporate different tactics to engage all generations of nurses

Objectives

- Create a learning environment that uses a variety of educational modalities to foster learning across the generations
- Maintain organizations priorities and goals
  - High Nursing Satisfaction- NDNQI data
  - Improve Quality and Outcomes
  - Improve Retention
- Utilize Adult Learning Theory
- Tailor education to meet the needs of the staff- consulting the yearly Needs Assessment
- Create Clinical Entry into Practice Programs for new graduates
- Make Education Fun!!!!

Strategies

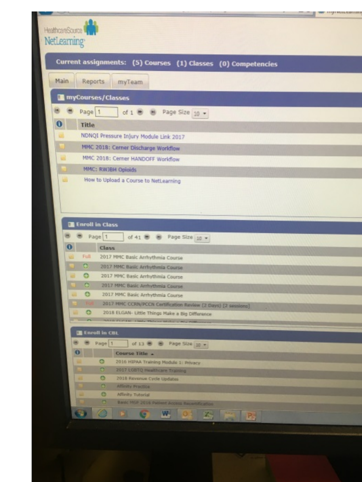
Interactive Games

Simulation

Learning Lab - Video Library

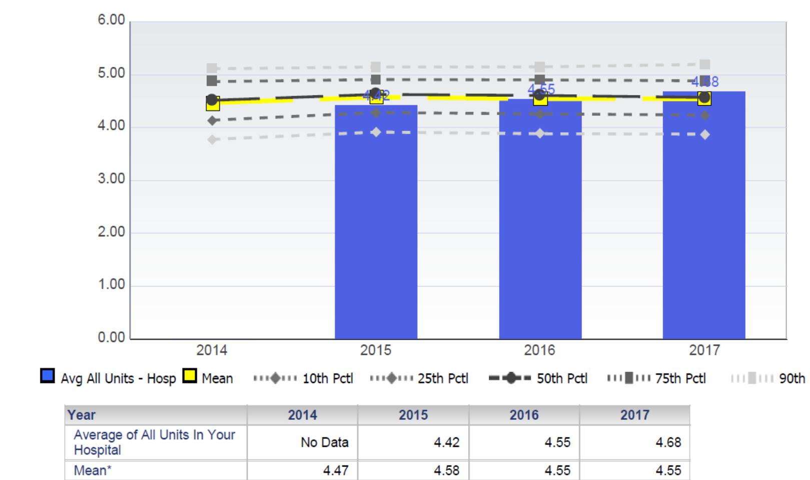
Traditional Classroom Learning

Computer Based Learning



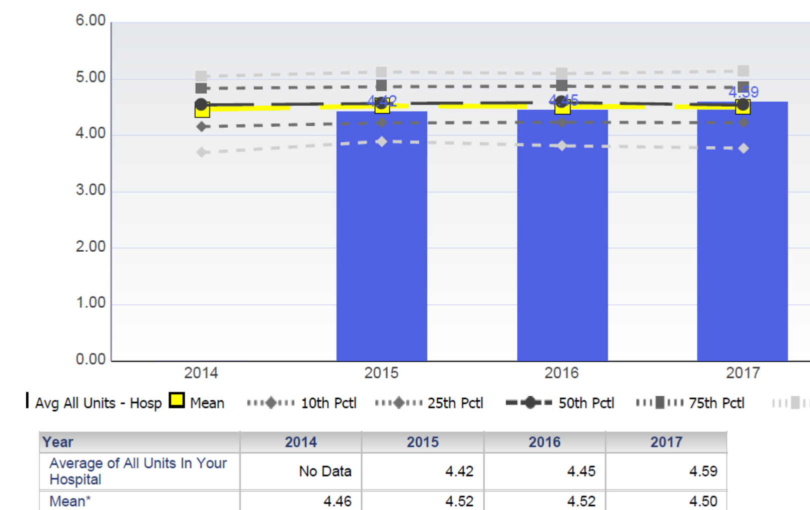
Results

Professional Development Opportunity



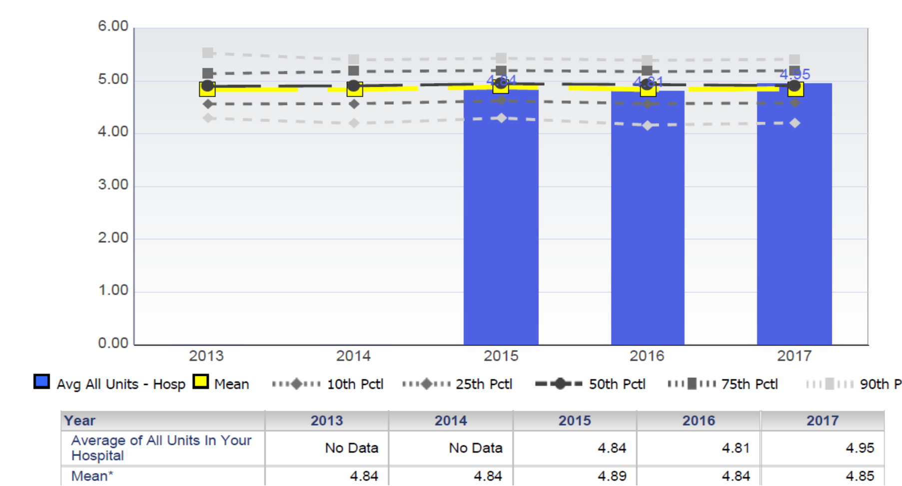
Year	2014	2015	2016	2017
Average of All Units In Your Hospital	No Data	4.42	4.55	4.68
Mean*	4.47	4.58	4.55	4.55

Professional Development Access



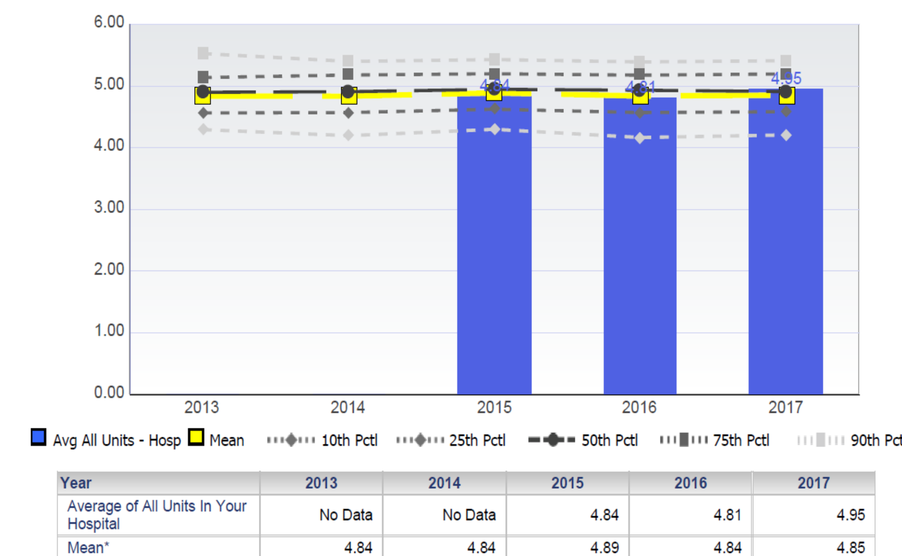
Year	2014	2015	2016	2017
Average of All Units In Your Hospital	No Data	4.42	4.45	4.59
Mean*	4.46	4.52	4.52	4.50

RNs have access to regular In-Service Programs



Year	2013	2014	2015	2016	2017
Average of All Units In Your Hospital	No Data	No Data	4.84	4.81	4.95
Mean*	4.84	4.84	4.89	4.84	4.85

RNs have access to continuing education



Year	2013	2014	2015	2016	2017
Average of All Units In Your Hospital	No Data	No Data	4.84	4.81	4.95
Mean*	4.84	4.84	4.89	4.84	4.85

Future Implications

Generation Z- starting to graduate from higher education and will be entering the workforce

- Born in 1995 or after
- Differ from millennials
- Use their smartphones on average 15.4 hours week – watch less TV than baby boomers and Generation X
- Raised in high-tech, hyper-connected, on-demand culture
- Like short bursts of information
- Learn by observation, visual experiences and practice instead of reading and by listening to classroom presentations
- Believe education leads to success
- Value group work and collaboration

Veterans and Baby Boomers are leaving/retiring from the workforce

Changes in healthcare trends

- Shift to outpatient settings- will this effect how education is given

Use of teleconferencing- can nurses attend class from home using webinar technology?

Demands for nursing in NJ and other states will be increasing

- If the current level of health care is maintained, seven states are projected to have a shortage of RNs in 2030, with four of these states having a deficit of 10,000 or more FTEs, including California (44,500 FTEs), Texas (15,900 FTEs), **New Jersey (11,400 FTEs)** and South Carolina (10,400 FTEs).

Continue to incorporate different teaching methodologies

- Flipped classroom
- Hybrid learning modules- combination of both outside of class learning experiences with instructor-led classroom education
- Escape rooms/ solving puzzles

Let us never consider ourselves finished nurses…..
We must be learning all of our lives.
~Florence Nightingale

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RWJBarnabas HEALTH

Monmouth Medical Center | RWJBarnabas HEALTH

Enhancing the Management of the Behavioral Health Hold Patient in the Emergency Department

Quality Improvement

Jennifer Clendining, BSN, RN, CEN, CPEN; Constance M. Bowen, DNP, RN, APN-C, CCNS, CCRN, CEN, CPEN

Purpose

The purpose of this project was to enhance the continuity of care for the Behavioral Health (BH) hold patient in the Emergency Department (ED), through the use of strategies to improve nursing handoff communication and knowledge of home medication administration.

Background

Nationally, patients with mental health complaints account for 7% to 10% of ED visits. Psychiatric patients experience longer treatment times in the ED compared to non psychiatric patients, regardless of acuity level. Patients who present with behavioral health-related signs and symptoms are more likely to experience longer lengths of stay in the ED and may not receive the same level of assessment and care as patients presenting with "medical" concerns.

The management of the BH hold patient in our ED was inconsistent. Report was given using the SBAR as per the current policy; however, essential information for this population was not always communicated. This information includes, but is not limited to the following: history of violence, history of substance abuse and last use, flight risk, past psychiatric history, and compliance with prescribed medication prior to arrival.

The practices for the administration of the BH hold patient's home medications for medical and psychiatric conditions, while in the ED, were inconsistent. There was no process for tracking the medications that need to be given or when they should be administered. This could lead to inconsistent medication administration while the patient is on hold in the ED.

Significance

BH hold patients are typically in our ED for up to 72 hours. This presents unique challenges for nurses to effectively manage their care. It can also increase the risk for adverse events for the patient and ED staff. A process for a more detailed report that included BH aspects of patient care and home medication administration for the BH hold patient needed to be implemented. The ED Practice Committee recognized the need to improve nursing communication in order to enhance the management of this population in the ED.

Strategy and Implementation

The ED practice committee revised the current SBAR handoff communication form to include information related to the BH hold population, such as past/present psychiatric conditions, substance abuse and violence. A BH Hold Home Medication Administration worksheet was developed to assist with increasing the nurses' knowledge regarding home medications and administration times.

A survey was used to assess the nurses' perceptions regarding the effectiveness of the information received during report to care for the BH hold patient and their home medications. The voluntary and anonymous survey was conducted pre-implementation of the new forms and process, and 3, 6 and 9 months post-implementation.

BEHAVIORAL HEALTH HOLD NURSING REPORT

S (Situation)

B (Background)

A (Assessment)

R (Recommendation)

SBAR

Rx

THIS IS NOT A MEDICATION ADMINISTRATION RECORD

BEHAVIORAL HEALTH ED HOLD
HOME DAILY MEDICATION WORKSHEET

Patient Sticker

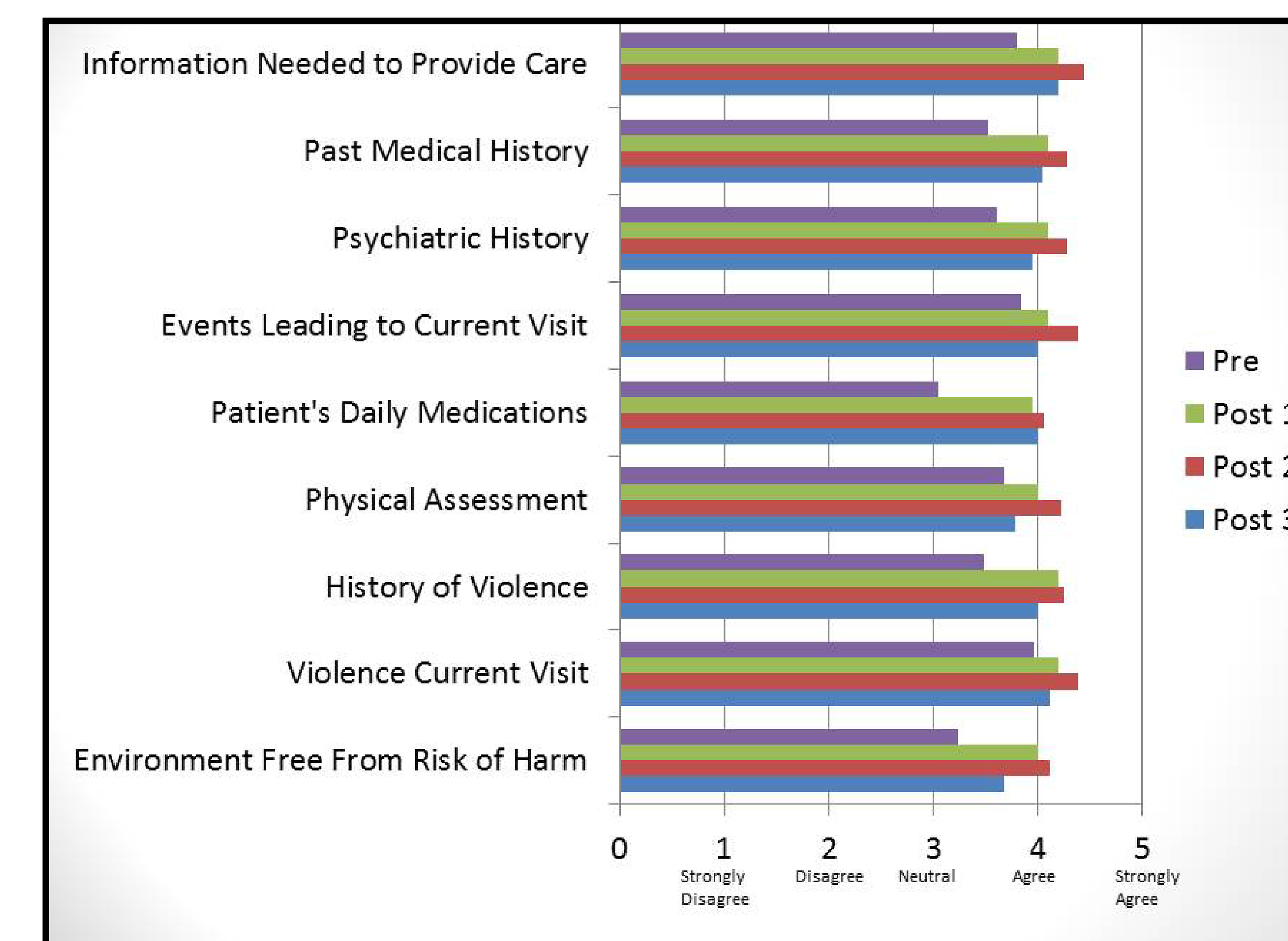
Allergies

Instructions for Use:

THIS DOCUMENT IS NOT PART OF THE PERMANENT RECORD

Results

Improvements in the nurses' perception regarding the effectiveness of receiving the information they need to provide care for the BH hold patient during reports was demonstrated. Nurses also reported sufficient knowledge regarding their patients' home medication administration. The overall project data demonstrated improvement.



Implications for Practice

Our project shows that although there are no firm solutions to the problem of BH holds in the ED, it is possible to implement a uniform process to enhance the management and continuity of care for the BH hold patients in the ED.

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Acknowledgements

This project was a coordinated effort by the entire ED Practice Committee. Additional members: Kaitlin, Buono, BSN, RN, CEN; Pam Hood, BSN, RN; Stephanie Maxwell, BS, RN, CEN; Ian McComas, BSN, RN, CEN; David Pierce, BSN, RN, CEN.

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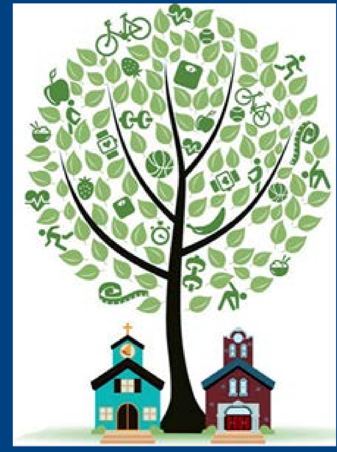


Faith Community Health Needs Assessment

Mary Rich DNP, MAS, RN, NE-BC, CCRN

Thomas Edison State University

Research Category

Significance

Community-based interventions are essential for improving chronic self-disease management and population health outcomes. Under the Affordable Care Act, all nonprofit hospitals are required to complete a Community Health Needs Assessment (CHNA) every three years. The previous CHNA did not include feedback from faith-based community leaders or individual residents at the neighborhood level.

Purpose

The purpose of this research study was to determine the self-reported chronic conditions, needs, interests, and social barriers of adults in faith-based organizations and compare the findings to the previously conducted CHNA.

Population

The target population included adults 18 years and older who attended one of four participating churches in three northern New Jersey counties.

Participant characteristics:

- Female 67%
- Male 33%
- Married 57%
- White 71%
- African American 27%
- Hispanic Origin 9%
- English Language 95%
- Age 55-74 years 58%
- Health insurance coverage 96%

Method

A cross-sectional, non-experimental research design with a nonrandom convenience sampling was utilized to develop and administer a 26-item Faith Community Health Needs Assessment.

Phase One: Qualitative Focus Group Sessions

- Structured seven-question focus group protocol
- Included 39 participants from five faith communities
- Transcription analysis guided survey revisions
- Survey period: June - August 2017

Phase Two: Quantitative Survey Analysis

- Administered the single page survey in the English language to adults attending a worship service
- 159 surveys completed: 141 paper and 18 online
- Responses entered into Qualtrics database
- Survey period: October - December 2017

Results and Discussion

Self-reported chronic health conditions	Faith community # 1	Faith community # 2	Faith community # 3	Faith community # 4	Aggregate results
Chronic conditions	% (*n*)	% (*n*)	% (*n*)	% (*n*)	% (*n*)
Arthritis	35% (6)	45% (14)	25% (7)	36% (25)	36% (52)
Cancer		16% (5)		9% (6)	8% (11)
Diabetes	53% (9)	10% (3)	18% (5)	7% (5)	15% (22)
Hypertension	53% (9)	32% (10)	43% (12)	30% (21)	36% (52)
Mental health conditions	6% (1)	6% (2)		14% (10)	9% (13)
Overweight	53% (9)	39% (12)	29% (8)	27% (19)	33% (48)
Respiratory conditions	6% (1)	3% (1)	4% (1)	7% (5)	5% (8)
Substance use disorders		6% (2)		7% (5)	5% (7)
None	6% (1)	23% (7)	21% (6)	21% (15)	20% (29)
Other:	12% (2)	19% (6)	11% (3)	23% (16)	18% (27)

Note . % = percentage. *n* = number of respondents. Green highlight = top three conditions.

- Arthritis was a new finding not identified in the previously conducted CHNA.

Results and Discussion

- Eighty percent of the participants reported currently having at least one chronic condition.
- Twenty-eight respondents **(22%)** provide unpaid caregiver assistance to a family member or friend.
- Eighty-two respondents **(56%)** would consult nurses for screenings or health education programs if available after services.
- Seventy-seven respondents **(58%)** would participate in support groups.
- Eighty-four respondents **(68%)** would prefer to attend a support group at their church.

Social Determinants of Health: In the last 12 months

$	7% of respondents could not see a doctor because of costs.
	4% of respondents skipped their medications to save money.
	6% of respondents went without health care because they did not have a way to get there.
	9% of respondents ate less than they felt they should because there was not enough money for food.
	4% of respondents had problems getting child care, making it difficult for them to work or study.
	10% of respondents needed help reading basic health information.

Top five health programs most likely to attend:

1. Healthy Eating
2. Aging Well
3. Dealing with Stress
4. Exercise
5. Caregiver Support

These findings provide congregation specific data useful for developing targeted interventions and aligning system resources to improve population health in partnership with faith-based organizations.

UNIVERSITY HOSPITAL
Newark, New Jersey

RN PROCESS IMPROVEMENT: BARCODE MEDICATION ADMINISTRATION

Prepared by Marthe Leveille, MSN, RN, CPHQ

BACKGROUND

Medication errors have become a top priority for hospitals. The Institute of Medicine (2000) stated "each year an estimated 7,000 deaths are linked to medication errors" (ME). ME can occur at every step of the process from ordering to administration. More than 30% of preventable ME occur at the point of administration (Leapes, Bates, Cullen, Laird et al, 1995). Barcoding Medication Administration is the system proven to help in reducing ME by verifying the 7Rs: Right medication, right patient, right time, right strength, right route, right documentation, right administration (Smeulers, Verweij, Maaskant, De Boer, Krediet, Van Dijkum, Vermeulen, 2015). To ensure patient safety and reduce medication errors our institution, a Level 1 Trauma and Academic Medical Center, implemented barcode medication administration (BCMA) in all nursing units.

Purpose

The purpose of this presentation is to demonstrate the methodology used to improve BCMA compliance and medication safety measures.

Significance

The significance of this presentation is to describe how a Nurse led process improvement resulted in achieving >95% compliance with Barcode Medication Administration and used the electronic tools to identify errors caught by BCMA.

LITERATURE REVIEW

- Voshall et al (2013) reported that 34% of all medication errors in hospitals occur in the administrative phase of the medication process
- Poon, Keohane, Yoon, et al (2010) reported that BCMA contributed to a 41.1% reduction in nontiming errors and a 50.8% reduction in potential adverse drug events due to such errors.
- Sakowski & Ketchel (2013) reported that a harmful drug error cost an institution $3100 to $7400.
- Nationally 2 of every 100 admissions experienced a preventable adverse drug event, resulting in increased hospital costs of $4,700 per admission (Kohn, Corrigan & Donaldson, 2000)

THEORITICAL FRAMEWORK

Patricia Benner's five stages of clinical competence "From Novice to Expert" provided the framework for the change in culture, attitude and practice.

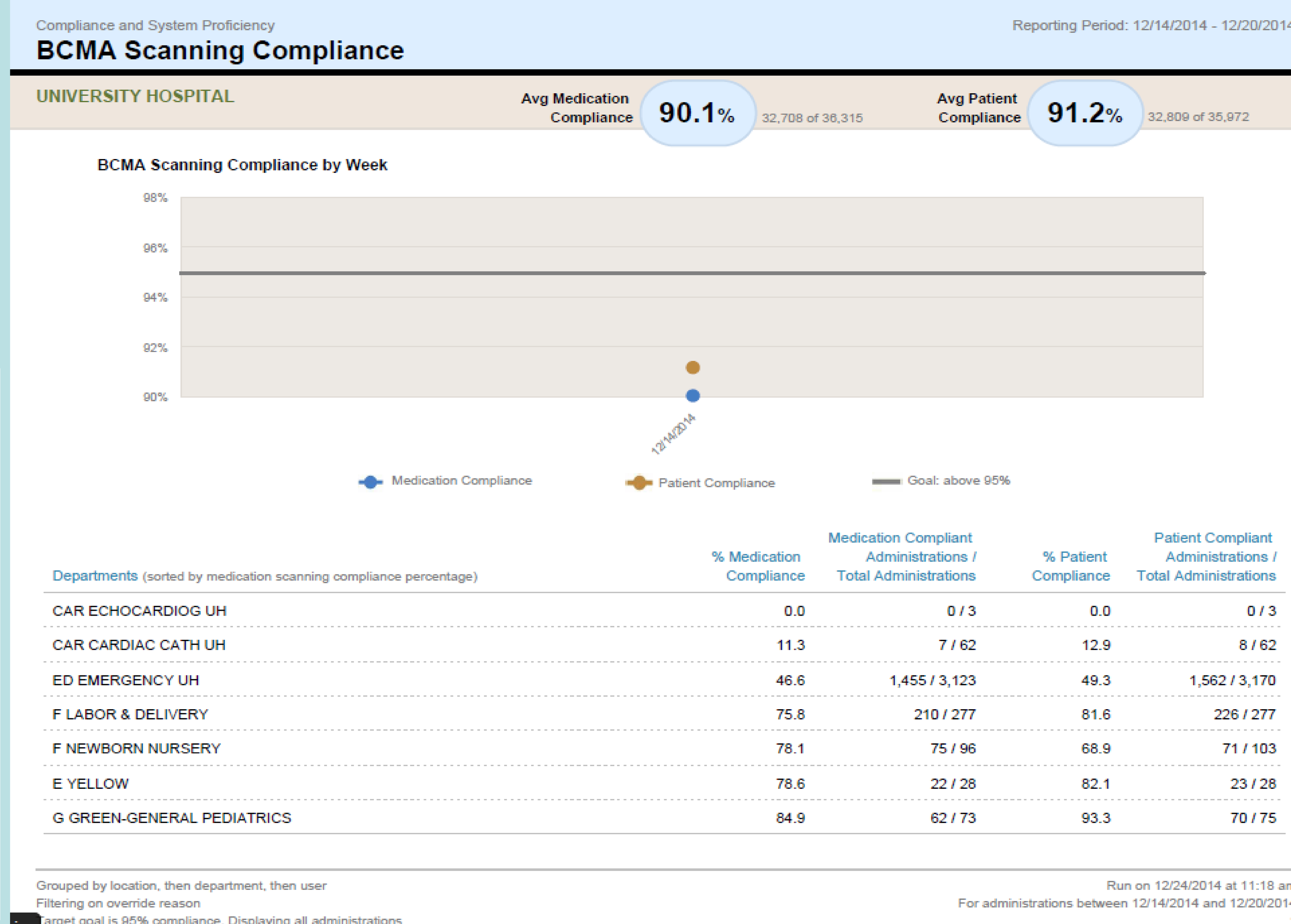
Novice nurses- New graduates or nurses with limited experience with computers were identified and given intensive training in classroom and at the elbow.

Workflows were standardized. Front line nurses contributed to the selection of equipment, workflow designs and implementation plans.

Proficient nurses became members of the Nursing Informatics steering committee (shared governance) and were utilized as "super users".

METHODS

- ❑ An electronic dashboard report that identified name of nurse and medications, date and time of administration and override reason was created. Data was analyzed, shared with leadership and individual nurses and posted on units boards.
- ❑ Proficient nurses were taken out of direct care once a month to participate in reviewing workflows and staff education.
- ❑ A comprehensive process that included re-education, just in time troubleshooting from Information Technology (IT) and weekly monitoring ensued.
- ❑ In 2017, weekly monitoring was initiated. Timely feedback was required from unit leadership and shared with senior leadership.



Compliance and System Proficiency
Reporting Period: 12/14/2014 - 12/20/2014

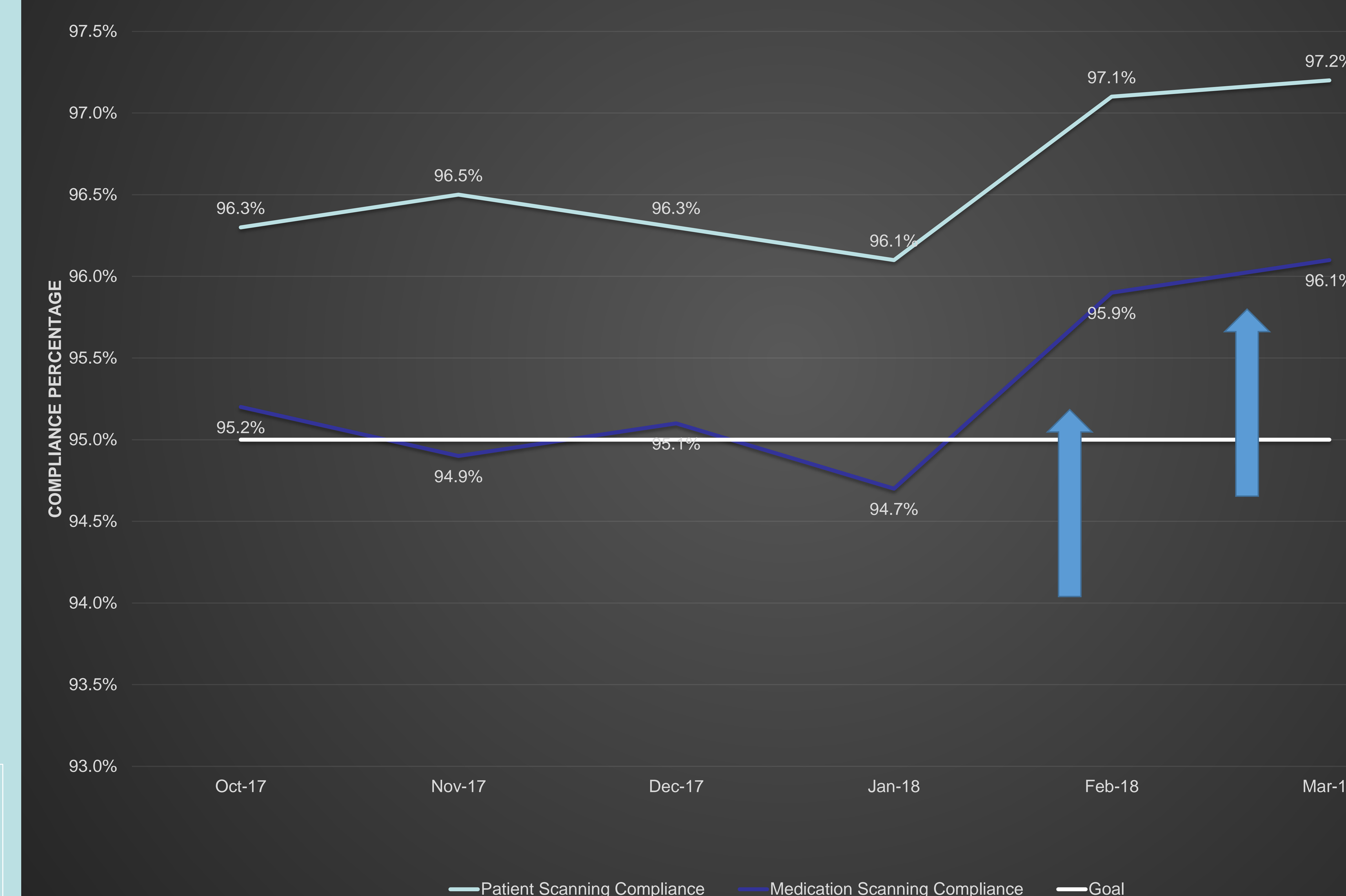
BCMA Scanning Compliance

UNIVERSITY HOSPITAL
Avg Medication Compliance 90.1% 32,708 of 36,315
Avg Patient Compliance 91.2% 32,809 of 35,972

Departments (sorted by medication scanning compliance percentage)	% Medication Compliance	Medication Compliant Administrations / Total Administrations	% Patient Compliance	Patient Compliant Administrations / Total Administrations
CAR ECHOCARDIOG UH	0.0	0 / 3	0.0	0 / 3
CAR CARDIAC CATH UH	11.3	7 / 62	12.9	8 / 62
ED EMERGENCY UH	46.6	1,455 / 3,123	49.3	1,562 / 3,170
F LABOR & DELIVERY	75.8	210 / 277	81.6	226 / 277
F NEWBORN NURSERY	78.1	75 / 96	68.9	71 / 103
E YELLOW	78.6	22 / 28	82.1	23 / 28
G GREEN-GENERAL PEDIATRICS	84.9	62 / 73	93.3	70 / 75

Grouped by location, then department, then user
Filtering on override reason
Target goal is 95% compliance. Displaying all administrations
Run on 12/24/2014 at 11:18 am
For administrations between 12/14/2014 and 12/20/2014
1

RESULTS



OUTCOMES

- ❑ In 2014, initial compliance was 90%. Analysis and Action plan was deployed.
- ❑ Compliance improved to 95% in 2015. A comprehensive process that included re-education, just in time troubleshooting from IT and weekly monitoring was initiated.
- ❑ Compliance improved to 96.4% in 2018.

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inspira HEALTH NETWORK CANCER SERVICES

Assessing Needs of Cancer Caregivers

Authors: Ruth Ann Bishop-Sotak RN, MS, CBCN; Barbie DiMatteo, RN, OCN;
Jennifer Nanni , BA, CIM, CIP; Brittany Raup, BA, CTTS; Charles Sonaliya, MHA; Pam Touchstone, RN, BSN, MBA, CCRP

MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

INTRODUCTION

A diagnosis of cancer not only affects the individual with cancer, but it can profoundly impact the people that are assisting the patient, often a loved one, through the experience. The caregiver and patient can be viewed as "one" leading to the description of cancer as a we-disease or family disease (Ussher, Wong, & Perez, 2010). The experience of being a caregiver to someone going through cancer treatment can have positive effects on both the patient and the caregiver. However, for many caregivers it can be a very challenging time in their lives. Their own physical well-being, ability to fulfill their obligations related to their life stage, psychological health, finances, social life, and possibly their faith may be adversely impacted. Stressors associated with caregiving can affect the overall quality of life for the caregiver and eventually for the patient.

PURPOSE

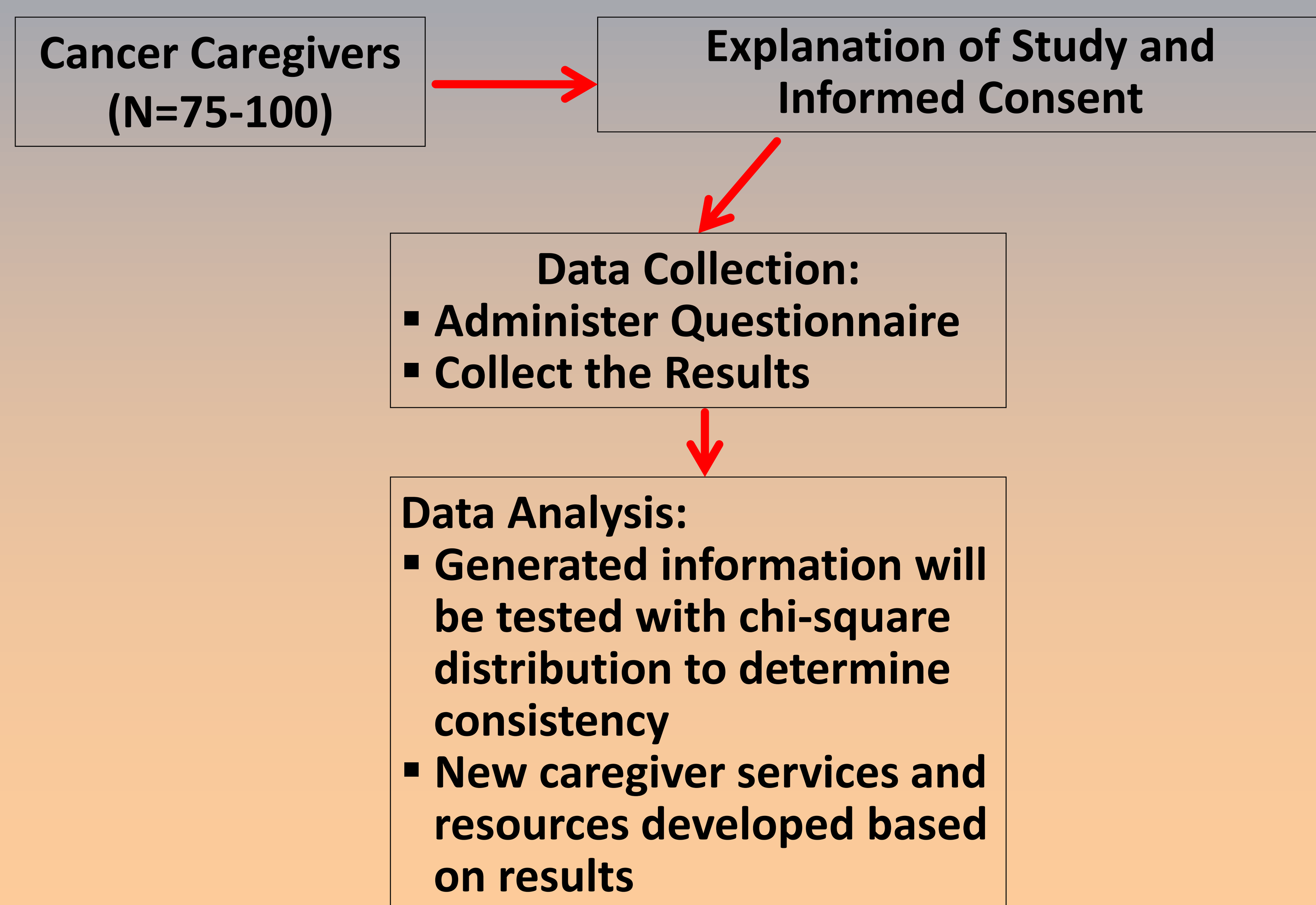
The purpose of this study is to offer a venue for caregivers to provide information to the cancer care team about the effects, both positive and negative, caregiving has on their overall quality of life.

RESEARCH QUESTION/OBJECTIVES

Research Question: How does the cancer caregiver experience impact the five variables of self: Physiological, Psychological, Sociocultural, Developmental, and Spiritual, in the context of the Neuman Systems Model?

Objective: To obtain knowledge about the caregiving experience, and to use this information to develop new services and resources to assist caregivers.

PROCEDURE DIAGRAM



METHODS

Population Sample:

A convenience sample of 135 caregivers who were providing care to cancer patients undergoing treatment at Inspira Health Network participated in the study. A 60 item comprehensive questionnaire, created for this study by members of the Inspira Cancer Caregiver Task Force, was administered to caregivers.

Research Design:

This study used a descriptive, prospective study design and a 60 item questionnaire, developed for this study, to assess the needs of cancer caregivers.

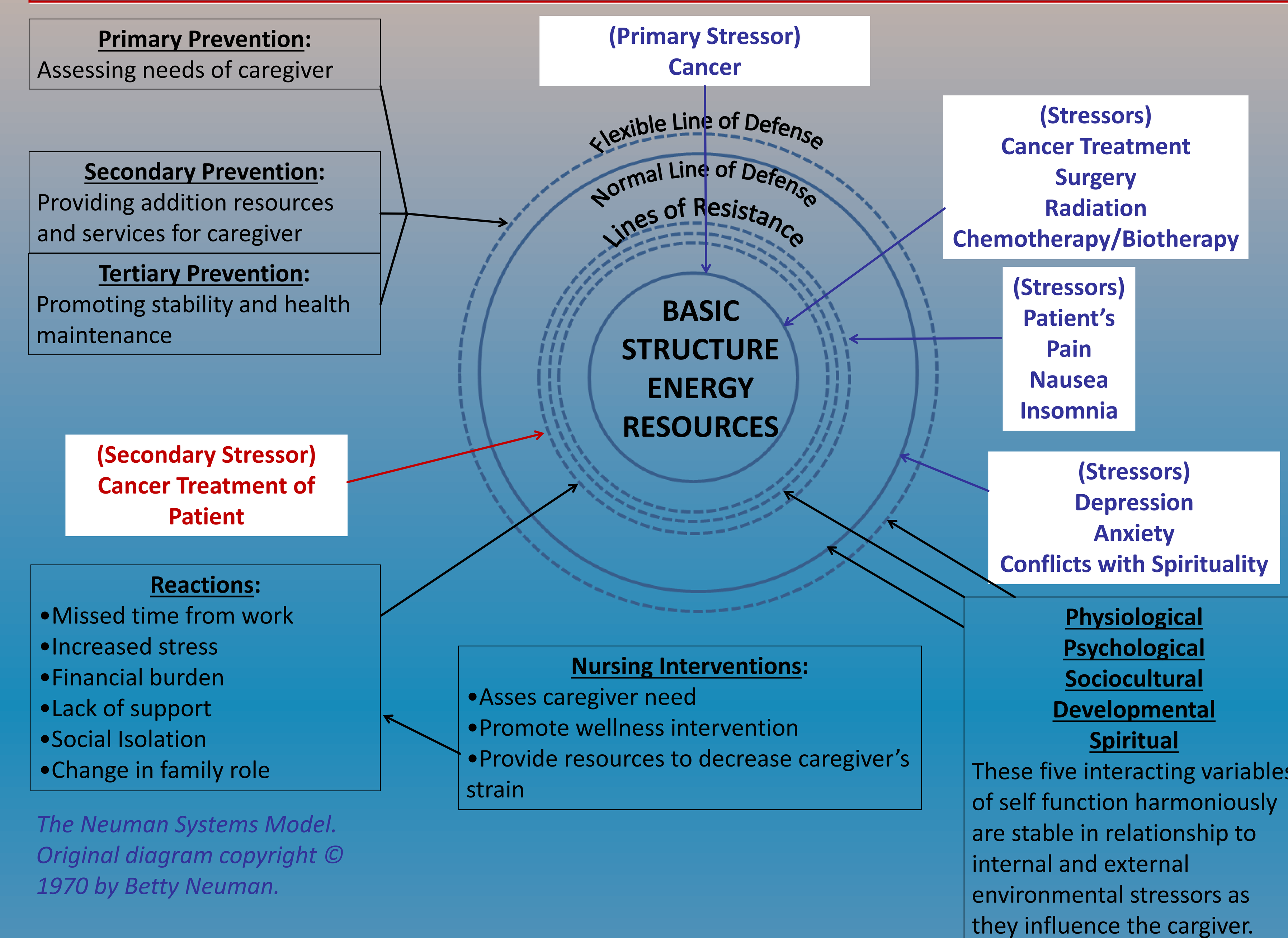
Study Procedures:

Prospective participants were identified by members of the research team and were informed about the study. If interested in participating and met eligibility requirements, caregivers reviewed and signed informed consent. Privately, they completed the questionnaire. Low literacy and Spanish speaking caregivers were also included to participate. Both the informed consent and survey was available in Spanish to fit the needs of the community. This questionnaire took approximately 20 minutes to complete. Participants that completed the survey were given a $10 gift card to Wal-Mart.

THEORETICAL FRAMEWORK

The stress of Caregiver burden can cause an imbalance in the five dimensions of self: physiological, psychological, sociocultural, developmental and spiritual as described by the Neuman System Model (V5, 2010).

When caregivers experience an imbalance of one or more of the dimensions, it can lead to a decreased ability to effectively interact with their environment to maintain stability, health, and wellness (Neuman & Fawcett, 2010).



The Neuman Systems Model. Original diagram copyright © 1970 by Betty Neuman.

RESULTS

Impact of Caregiving on Caregivers:

72.6%	Reported Emotional Stress (n=98)
70.4 %	Unable to Keep Up with Own Healthcare (n=95)
57.8 %	Less time with Family / Friends (n=78)
50.0 %	Gave up Hobbies / Social Activities (n=67/134)
40.7 %	Less Physical Activity (n=55)
36.3 %	Negative Diet / Eating Habits (n=49)
35.6 %	Inadequate Sleep (n=48)
28.6%	Income Negatively Affected (n=38/133)

Caregiver Tool:

Caregivers requested additional information and guidance as one of their needs. The team put together Inspira's "Caregiver Resource Guide" to provide caregivers with information that assists them in helping our patients and themselves through their cancer journey. The guide is available in English and Spanish as a hard copy and electronically.

DISCUSSION

Significance to Nursing:

Getting through cancer treatment together can bring families closer and strengthen their relationships. The caregiving role is often associated with many rewards, but current research focuses on caregiver strain and burden that can result in poor physical and mental health for the caregiver. Oncology nurses and the cancer care team spend a great deal of time with both the patient and family and are in an ideal position to assess caregivers for increased stress, promote wellness interventions and provide resources to reduce the negative impact of caregiving (Honea et al., 2008).

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The Nursing Supervisor: A Role Requiring Further Exploration

Anne Bertino-Lapinsky, MS, RN; Amy Glasofer, DrNP, RN, NE-BC

Background

- Nursing Supervisors (NSs) are utilized in most acute care organizations
- Little is known regarding the work of the NS[1]
- Few scholarly attempts have been made to define this role, resulting in a gap regarding best practices among NSs.

Purpose

This was a multi-phase study to:

- Explore nature of NS role and what it means to be a NS
- Develop a role delineation questionnaire based on results of exploratory study and existing evidence
- Describe the demographic characteristics of a representative sample of nursing supervisors.
- Describe the work environments and utilization of a representative sample of acute care hospitals employing nursing supervisors.
- Prioritize the work of the nursing supervisor based on of the consequence and frequency of tasks performed.

Methods

Phase 1:

- Sample: 17 NS from community based health system in southern NJ
- Procedures: Completion of open-ended questionnaire regarding what NSs do in their typical work day
- Results: Thematic analysis utilized to generate items on NS Role Delineation Questionnaire

Phase 2

- Sample: 50 NS currently working in New Jersey hospitals
- Procedures:
  - Developed questionnaire based on Phase 1 results and existing evidence, following the American Nurses Credentialing Center model[2]
  - Distributed online questionnaire through New Jersey professional nursing organization

Supervisor Characteristics

Demographic Characteristics

Gender	n(%)	Age	n(%)	Race/Ethnicity	n(%)
Female	44(88)	<25	0(0)	Asian/Pacific Islander	4(8)
Male	6(12)	25-34	3(6)	Black or African American	4(8)
		35-44	9(18)	Hispanic	0(0)
		45-54	12(24)	White/Caucasian	42(84)
		55-64	21(42)		
		>64	5(10)		

Work History

Tenure as US RN Years	n(%)	Tenure as NS Years	n(%)
0-9	4(8)	0-9	21(43)
10-19	9(18)	10-19	15(31)
20-29	9(18)	20-29	13(26)
30-39	18(36)		
40-49	9(18)		
>49	1(2)		

Education/Certification

Highest Degree Earned	n(%)	Specialty Certification	n(%)
Associate/Diploma	9(18)	NE-BC	4 (8.3)
BSN	15(30)	NEA-BC	4 (8.3)
Graduate Nursing	12(24)	CNML	1(2)
BA/BS (non-nursing)	3(6)	Other- clinical	13(27)
MA/MS (non-nursing)	6(12)	Other- non-clinical	6(12.5)
Other	5(10)		

Role/Facility Characteristics

Role Characteristics	n(%)
Report to	
CEO	1 (2)
CNO	14 (28)
Lead Nursing Supervisor	10 (20)
Unit-based Nurse Manager	8 (16)
Other Nurse Leader	16 (32)
Other Non-Nurse Leader	1 (2)
Salary Status	
Exempt (salaried)	18 (36)
Non-exempt (hourly)	32 (64)
Length of Typical Shift	
8 hours	18 (36)
12 hours	25 (50)
Other	7 (14)

Facility Characteristics	n(%)
Nurses Unionized	
Yes	25 (50)
No	25 (50)
Magnet or Pathways to Excellence	
Yes	12 (24.5)
No	37 (75.5)
Number of Beds	
<100	6 (12.2)
100-199	11 (22.5)
200-299	10 (20.4)
300-399	9 (18.4)
400-499	9 (18.4)
>499	4 (8)

NS Work Activities

Most Critical Work Activities of the NS

Rank	Activity
1	Responds to all internal emergencies
2	Activates and directs emergency management during internal/external emergency
3	Allocates and redirects staffing resources to ensure safe patient care
4	Encourages and supports staff to utilize nursing policies and procedures
5	Informs senior leadership of any situations with serious impact on hospital operations
6	Collaborates with staffing resources to obtain coverage for call-outs
7	Responds to all code blues
7	Responds to all code reds
9	Coordinates the organizational response during times of high census
10	Continuously monitors daily operations
11	Monitors facility environment
12	Rounds on nursing units
13	Informs department manager of staff/patient care issues
14	Responds to all Rapid Responses
15	Promptly investigates all patient/visitor occurrences

Conclusions

- NSs in this pilot study consist of a homogeneous sample
- If this is consistent with the general population of NSs, there will be a need to develop the future NS workforce
- NSs have many roles and responsibilities in a worked shift
- Based on the findings of this study, the top priorities include:
  - emergency and code response
  - staffing and census management
  - supporting nursing practice and patient care
  - communication with hospital leadership
- Nurse supervisors are critical to hospital operations, and must be able to adjust their work day according to census, situations, and staffing.
- This study makes a significant contribution to nursing knowledge on the role of the NS in acute care
- Further research is required to validate the findings of this study in a broad sample
- Only then will nurse leaders be able to maximize the role of the NS

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The Lived Experience of Nurses Caring for Patients Who May Benefit from Palliative Care

Alina Bixler, RN, BSN, CHPN, OCN, Staff Nurse at Ocean Medical Center ◆ Susan Inwright, RN, BC, Staff Nurse at Riverview Medical Center
Mentors: Barbara Williams, PhD, APN & Teri Wurmser, PhD, MPH, RN, NEA-BC; Ann May Center for Nursing

Aim/Purpose

To determine the prevalence of, and to understand, the experience of nurses who care for patients on medical-surgical units who may benefit from palliative care but are not receiving it.

Study Design – Mixed Methodology

Part 1: Quantitative Survey

- Conducted to identify the prevalence of nurses who have cared for patients they felt may benefit from palliative care, but palliative care was not on consult.

Part 2: Qualitative; In-Person Interviews

- To understand the experiences of nurses who cared for patients whom they felt may benefit from palliative care.

Research Questions

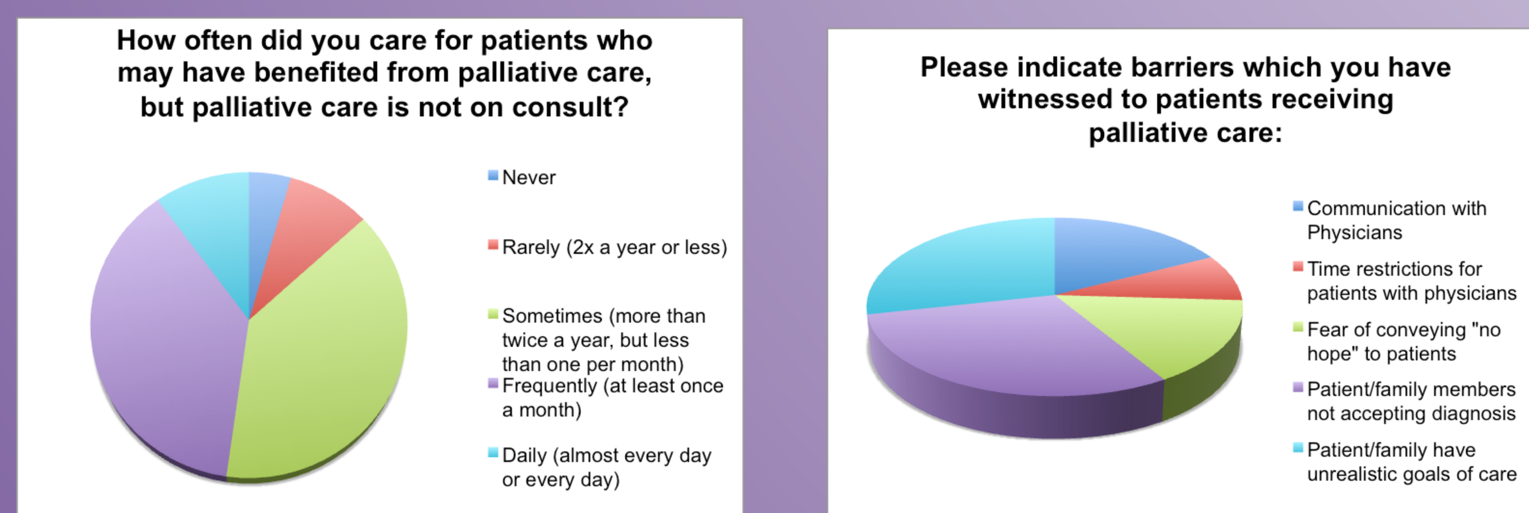
1. What is the prevalence of nurses who care for patients who may benefit from palliative care but are not currently receiving it?
2. What is the lived experience of nurses who care for patients who may benefit from palliative care?

Methods

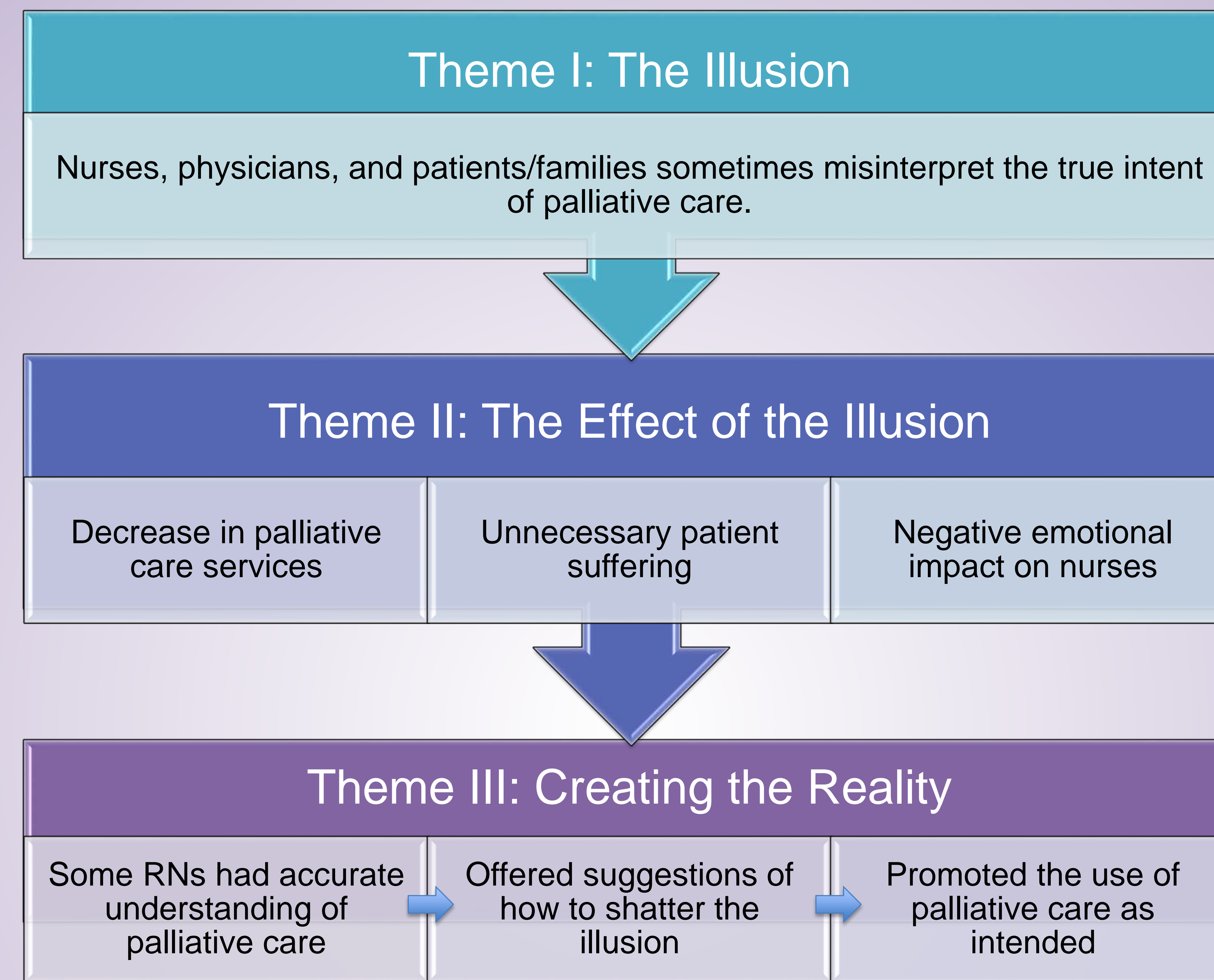
An invitation to participate in a SurveyMonkey© questionnaire was sent electronically to all direct-care nurses who work on medical-surgical floors at Jersey Shore University Medical Center, Riverview Medical Center, and Ocean Medical Center.

Nurses who responded to the survey were invited to participate in in-depth interviews that explore their experiences in caring for patients who may benefit from palliative care. The Colaizzi (1978) method of analysis was used to organize the data into themes.

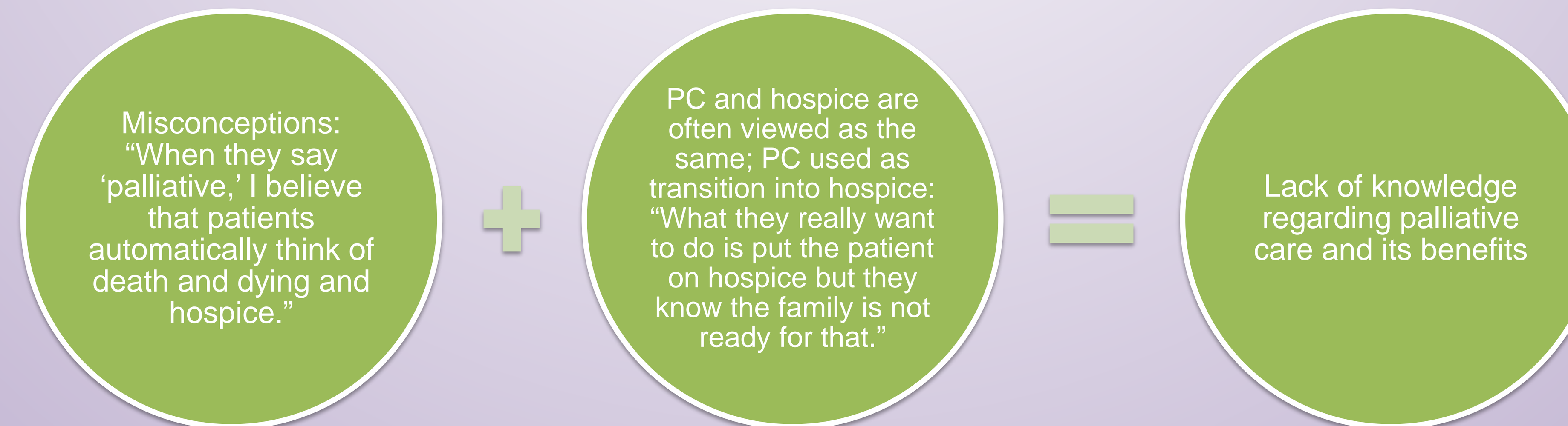
Quantitative Results



Qualitative Results



Theme I: The Illusion



Theme II: The Effect of the Illusion

- "It's frustrating."
- "It makes me feel helpless […] makes me feel like I'm not a good nurse sometimes."
- "I get so mad. I have screamed at doctors on the phone, like, fuming 'Call another rapid response? Just give me a palliative care consult!'"
- "I don't want to go home feeling I couldn't give the care I needed to give. I was so busy, I couldn't take care of […] a need that the patient and family had."
- "I couldn't even function afterwards I was so upset."

Patient Suffering

Impact on Nurses

Families/ Doctors feel "giving up"

"I feel like if there would have been a palliative care consult, we would have not watched that last breath being struggled."

"I don't feel that palliative care is well enough understood for patients and their families to kind of accept palliative care into their lives. I think the misunderstanding has a big negative stigma with it."

Theme III: Creating the Reality

Nurse-driven protocol for when to consult PC team

- "Palliative care should be a nurse-driven protocol, somehow, some way that we can say "come talk to the family" because we're not revealing anything, we're just giving resources."
- "I mean I think nurses should take that initiative and say "hey this palliative care team helps patients with chronic illnesses like yourself…" I think it would be great. I think nurses should drive that. "

Change the name

- "I feel like if they named it 'Management of Chronic Illness', people would be like "YEA! I want that!!"

Greater education resources for RNs, MDs, patients/families re what is PC

- "I have a very limited scope of what goes on in terms of like how people decide to proceed with palliative care, of their options in terms of end of life or treatment."
- "Maybe there needs to be a competency on it so that we are able to accurately explain all that they do to our patients. I think that the physicians also need to be supportive of it."

Introduce PC at time of diagnosis of chronic disease

- "If they get to patients diagnosed with chronic illnesses earlier, I think that they'll have more engaged patients, and [...] they'll be a more integral part of the healthcare system […] kind of [a] preventative care measure."

Conclusions

The study results indicate that health care professionals often misperceive the intended purpose of palliative care, resulting in decreased use of palliative care. This misperception can have deleterious effects on patients as well as the nurses. Based on suggestions from nurses, however, these misperceptions (illusions) can be shattered so that an accurate perception of, and appropriate use of, palliative care becomes the reality.

Implications

1. Practice changes via an increase in palliative care consults
2. Support services for nurses
3. Higher patient satisfaction with health care services
4. Cost savings to institutions related to both the cost of care and better retention of nurses