Poster Presentation Abstracts

EBP & Nursing Research: It's the Right Thing to Do!
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An Exploration of Registered Nurses' Intentions to Leave the Profession

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The United States is in the midst of a shortage of registered nurses, which is predicted to worsen over the next ten years. This prediction is based on the increasing number of individuals that will require healthcare services, the number of registered nurses who plan to retire, a shortage of nursing faculty, and increased ability to treat complex conditions (Schuman, 2003). Further complicating the shortage is the number of nurses who have intentions to leave the profession. Previous research has primarily focused on job satisfaction and has not included the perceptions of the registered nurse. The purpose of this qualitative study was to explore the perceptions of female registered nurses who have serious intentions to leave the profession of nursing. This study utilized a basic interpretive qualitative design that was informed by the theoretical framework of feminist poststructuralism. The research plan was approved by the Pennsylvania State University IRB and The York College IRB. Semi-structured interviews were conducted with eleven female registered nurses. Five major themes emerged from the data: feelings of duty and obligation; the power distribution in the hierarchy; growing incongruity between working conditions and patient care; interpersonal communication; and shifting perspectives on work and self. Factors related to the work environment were found to have more of an influence on the decision to leave nursing than individual characteristics. Based on the findings of this study, suggestions are offered for workplace and nursing education in an effort to influence recruitment, practice, and retention in a profession that is already experiencing a shortage of workers. Additionally, feminist frameworks have not been extensively used to study issues related to human resource development (Bierema, Tisdell, Johnson-Bailey, & Gedro, 2002), and this study supports the poststructural notion that social structures do affect identity development in respect to career decisions and work experiences.

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Balancing Academia and Clinical for Tenure Seeking Nursing Faculty

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Background: Currently there is a dire need for increased nursing faculty. Students require faculty who can relate to the reality of practice and can keep up with current practice trends. In order for this occur, many faculty have a difficult time balancing bedside practice and academia. This study examined the experience of six nursing faculty who currently practice while actively seeking tenure or within two years after seeking tenure.

Practice question: What is the experience of faculty who currently practice at the bedside and currently are working toward a tenured position?

Design / Setting: A hermeneutic phenomenologic research method as proposed by van Manen was used.

Findings: Four themes were identified. First, reasons for working as a practitioner validated a teaching philosophy rooted in practice. Second, these academicians believe that current practice informs their teaching and gives them more credibility in the classroom with their students. Third, the value placed on practicing depended largely on the tenure requirements of the teaching institution and the benefit of the clinical practice to the school. Fourth, techniques of balancing the art of survival were shared by the participants.

Conclusions: The process of tenure is a stressful time for faculty and even more stressful when the faculty felt that their clinical practice was only recognized or valued when it was of benefit to the institution. Clinical practice increases credibility to students as faculty use clinical exemplars of evidence based practice. Clinical practice was noted to detract from the tenure portfolio and may have even been seen to have been detrimental. This stressful situation is compounded when faculty members have teaching philosophies rooted in experiential learning and strive to stay current in practice as a way to maintain certifications and inform the classroom teaching.

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Crew Resource Management for Trauma Resuscitation

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Introduction: Crew Resource Management (CRM) techniques have been successfully utilized in the airline industry to improve safety through improved communication among team members. Most recently in healthcare, these techniques have been incorporated successfully in the operating room. York Hospital developed a CRM program tailored toward trauma activations as a means of improving team interaction, communication and patient safety.

Purpose: To develop and implement a successful trauma-focused CRM program.

Methods: An initial survey of multidisciplinary team personnel (n=160) was obtained to identify perceptions of team performance, level of leadership identified, communication between various team members and perceived willingness to voice safety concerns. Additionally, a trained observer evaluated trauma activations (n=25) using a Communication and Teamwork Skills (CATS) assessment tool to identify specific behaviors of team communication. These initial projects identified significant problems in team communication and leadership which had the potential to negatively impact patient safety.

Utilizing these results, the CRM program was developed and provided to all members of the trauma activation team (n=324). The program contained four modules: Why CRM, Shared Mental Models and Handoffs, Effective Team Communication and Leadership and Performance Improvement. Educational offerings were held numerous times over a three month period, with classes including a multidisciplinary group of personnel.

Results:

Three months after CRM training, a post-implementation survey (n=118) was distributed and the CATS observations (n=38) were repeated. The post-implementation survey demonstrated statistically significant improvement in team leadership, communication and willingness of the staff to speak up for patient safety concerns. Post-implementation observations demonstrated a significant improvement in team communication behaviors.

Conclusions/implications: CRM techniques can be successfully implemented in the TRA setting as a patient safety program unique to this venue. After a brief period of implementation, improvements were noted. CRM compliments ATLS® and ATCN® by improving communication between all participants in trauma resuscitations.

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Does providing nurses with education regarding pain management improve their knowledge, change behavioral biases and improve patient pain management satisfaction?

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Background: Pain is a major reason individuals seek medical care. It is well documented that poorly managed acute pain in hospitalized patients is associated with increased healthcare costs, longer lengths of stay and decreased patient satisfaction. Nurses maintain a 24-hour-a-day relationship with patients and are in the best position to provide effective pain assessment and management. Nurses' beliefs, attitudes, and a lack of pain management knowledge may hinder their ability to provide satisfactory pain management to their patients therefore impacting patient satisfaction. Our organization has documented patient satisfaction scores below the national mean regarding pain management. These scores influenced further inquiry as to why we are not meeting patients' pain management expectations.

Practice Question: Does providing nurses with education regarding pain management improve their knowledge, change behavioral biases and improve patient pain management satisfaction?

EBP Model: The Johns Hopkins Nursing Evidence-Based Practice Model (JHNEBP) was used as the framework for this project.

Synthesis of evidence: PubMed and Cinhal databases were searched, 20 articles were reviewed and 17 were utilized in the Overall Evidence Summation: Three quasi-experimental studies; 10 non-experimental studies; and four expert opinion. All studies were of good quality based on the JHNEBP model.

Practice Recommendations: Recommendations based on the overall summary of evidence suggest the following: nurses should be provided with education about pain assessment and management at orientation and ongoing; education should focus on identified needs; and patients should be educated about their role, rights, and responsibilities regarding pain management.

Practice changes planned: The multidisciplinary team will implement a multifaceted educational approach for nurses and patients. Change in nurses' knowledge will be measured using McCaffery and Ferrell's Nurses' Knowledge and Attitude Survey as a research project. Patient satisfaction with pain management will be measured through patient surveys.

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Does Risk Assessment Scoring Tool for Dysphagia (RASTD) aid in the identification of hospitalized patients at risk for dysphagia?

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Background: In the adult population, the most common form of hospital acquired pneumonia is aspiration pneumonia. Currently all patients that are a suspected stroke are screened for dysphagia on admission. Rarely is any other patient population screened and there is not a consistent process for screening all patients at risk for dysphagia. In 2010, a group involving staff nurses, nutrition, patient safety and speech, were pulled together to complete an evidence based project.

Practice Question: 'What is the best way to decrease the incidence of aspiration pneumonia in hospitalized patients?'

EBP Model: Johns Hopkins Nursing Evidence Based Practice Model

Synthesis of evidence
- ❖ Randomized Control Trials – 0 articles
- ❖ Quasi-Experimental – 0 articles
- ❖ Non-Experimental – 5 articles
  - o Standardized formal dysphagia screening of high risk patients decreases the incidence of aspiration.
- ❖ Opinion of nationally recognized experts based on scientific evidence – 2 articles
  - o High risk patients should be screened and then referred when appropriate. Some high risk conditions should be referred directly.
- ❖ Opinion of nationally recognized experts based on experiential evidence – 6 articles

Practice Recommendations:
1. The evidence suggests that high risk patients should be screened routinely and then referred when appropriate.
2. Education and training for nurses on the dysphagia tool, pathophysiology of dysphagia and the importance of oral care is key.
3. Recommendations should be made in collaboration with a multidisciplinary group.

Practice changes planned/made: A tool was developed, Risk Assessment Scoring Tool for Dysphagia (RASTD), which would determine the high risk patients. Based on diagnoses and patient history a quick assessment could be made by the Registered Nurse (RN). If the score was 8 or greater this would prompt the RN to make the patient NPO (nothing by mouth) and to get a Speech Language Pathology (SLP) consult. If score was 0-3, the nurse could continue with the diet prescribed by the physician. If score was 4-7, that would prompt the nurse to complete the RN dysphagia screen. The tool was created and piloted as a PI process in 3 units. 108 patients were needed for statistical significance. 113 were obtained.

Results: Of those 19 patients that scored 8 or greater on the RASTD, 14 or 73.7% had dysphagia when assessed during the SLP consult. 59 patients had scores that led to the RN dysphagia screen. Only 13 (22.03%) of those patients failed the initial screen. Only 5 of the 13 (38.5%) had dysphagia present when assessed during the SLP consult.

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Does the use of sequential compression devices on surgical outpatients decrease the risk of venous thromboemoblism?

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Background: Venous thromboembolism (VTE) is a complication of surgery that occurs in 600,000 patients in the United States each year and results in 100,000 deaths. VTE prophylaxis is a topic of concern for health care professionals because more procedures are being performed in an outpatient setting and on patients with a higher level of acuity. One of the most preventable causes of hospital death is VTE. In order to prevent VTE, the recommended practice by the Association of Perioperative Registered Nurses (AORN) is to have an organizational-wide policy that addresses the care of perioperative patients. Due to no standardization or policies in place identifying patients who qualify for sequential compression devices (SCD's) and/or TED stockings is not consistent.

Practice Question: Does the use of sequential compression devices on surgical outpatients decrease the risk of venous thromboemoblism?

EBP Model: Johns Hopkins Nursing Evidence-based Practice Model (JHNEBP)

Synthesis of Evidence: A total of sixty-three articles were found on CINAL and Pub Med, with seven articles relating to the topic. The following are the levels of evidence for these six articles; one - 3 A, two - 3 B's and three - 4 A's.

Practice Recommendations: The development of a protocol addressing the care of outpatient perioperative patients. Implementation of a standard of care policy with collaboration from physicians, anesthesia and nursing. This policy would include indications/contraindications for the use of SCD's and TED stockings. Nursing would review history and physical data from both patient and their chart during the pre-operative interview to assess the patients risk for VTE.

Practice changes planned/made: A checklist is currently being developed in conjunction with anesthesia and surgeons based on patient's history, length and type of surgery. Policy and procedure changes are currently being under taken.

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Finding a pain assessment tool for the nonverbal and cognitively impaired child

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Background
Pediatrics department currently uses CHEOPS (Children's Hospital of Eastern Ontario pain scale) to assess pain in nonverbal children. The scale has 6 parameters and scores range from 4 (no pain) to 13 (severe pain). CHEOPS scores did not fit into the standard 0-10 pain scale and a computer adjusted score did not accurately reflect the child's pain.
A valid and reliable observational pain assessment tool is also needed for cognitively impaired children.
Practice Question
Will the FLACC pain assessment tool (Face, Legs, Activity, Cry, Consolability) meet the Pediatric department's need for a reliable and valid 0-10 pain scale for nonverbal children and cognitively impaired children?
EBP model
The Johns Hopkins Nursing Evidence-based Model is used to rate the strength of the evidence.
Synthesis of Evidence
Ten articles found FLACC to be a reliable and valid pain assessment tool for cognitively impaired children, nonverbal infants and children, and nonverbal adults in intensive care. The scale can be individualized for cognitively impaired patients. FLACC pain scale is already part of Wellspan's electronic record.
Practice Recommendations
The pediatric department decided to utilize the FLACC observational pain scale to assess pain in infant and young children and cognitively impaired patients.
Practice changes made
After the pediatric staff completed the competency in May 2011, FLACC has been used to assess pain for nonverbal and cognitively impaired patients on Pediatrics. An individualized FLACC is used for cognitively impaired children.
Accurate pain assessments are documented in the electronic record.

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Have Nurse Residency Programs Met Outcomes?

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Background

The nursing shortage has intensified employer desire for new graduates to readily transition from novice to advanced beginner. However, the realities have been that in today's acute hospital care environments, the graduate nurse lacks confidence, suffers job stress, and experiences role conflict. Employers have been dissatisfied with the lack of nurse graduate preparedness and have noted high turnover rates within the first year of employment, with turnover costs ranging from $50,000 to $145,000 (Bratt, 2009). To address these concerns, nurse residency programs have been initiated by many hospital systems with the goals of increasing nurse graduate skill confidence and competency, as well as employment retention.

Practice Question and EBP Model

The practice question asks whether nurse residency programs have resulted in the achievement of the stated employer outcomes. The Johns Hopkins EBP model (Newhouse et al., 2007) was used to examine evidence related to the practice question. Evidence was examined in peer reviewed articles that included the phrases 'nurse residency' and / or 'retention of nurse graduates' in the title, discussed measurable outcomes, and were published between 2001-2011. A total of seven articles met the criteria for review, with the majority in Levels III to V.

Synthesis of Evidence

Findings indicated use of nurse residency programs: 1) decreased nurse graduate turnover in the first year of employment from rates as high as 75% to as low as 4.3%.; 2) retention of nurse graduates increased the number of nurses and decreased costs previously related to new nurse turnover (based on an annual nurse salary); 3) nurse managers and preceptors of nurse graduates noted increased confidence and competency in nursing skill sets and in job satisfaction. The findings seem to indicate that while nurse residency programs are expensive to administer, the results appear to be worth the costs.

Implications for Practice

Recommendations regarding nurse residency programs include partnering with academia to strengthen resource management, involving all stakeholders , first evaluating current turnover and recruitment / orientation program costs, using periodic measures of program effectiveness, using preceptors and mentors, and providing practice-based experiences.

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How do we manage safe bariatric patient handling and transfers in an acute care setting?

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Background: Bariatric patient admissions have significantly increased in the last year. Bariatric is defined as a patient with a BMI > 30 or weight > 300 lb. Random audits depict 30% of the patients as bariatric. Significant numbers of pieces of equipment are being damaged due to a lack of awareness of weight restrictions. Employee injuries including musculoskeletal back, neck and arm injuries are resulting in lost or modified work days.   Patients express statements of humiliation and embarrassment especially during the transferring process.

Practice question: How do we manage safe bariatric patient handling and transfers in an acute care setting?

EBP Model: Johns Hopkins Nursing Process for Evidence Based Practice

Evidence: Using a systematic review of research and VHA directives on safe patient handling, we were able to formulate bariatric patient management guidelines. A literature review was conducted utilizing key terms such as bariatric, obesity and safe patient handling. Data bases included CINAHL and PubMed. A total of twenty articles were relevant to this topic. The majority of articles were IV/B with one article III/A.

Practice Recommendations:
- Train staff on all bariatric equipment and safe transfer techniques.
- Develop an assessment tool to aid staff in identifying appropriate lifting aides.
- Develop multidisciplinary initiatives utilizing recommendations from the Bariatric Task Force.

Outcomes:
- Staff will be able to identify appropriate equipment and transfer techniques by completion of Healthstream test scoring greater than 80%.
- EMR (electronic medical record) documentation will reflect use of transfer devices and level of assistance.
- Housewide inservicing of transfer techniques to ensure patient and caregiver safety.

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Implementing Bedside Change of Shift Report to Promote Confidence in Caregivers and Encourage Family Involvement

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Practice Question:
Will bedside change of shift report improve staff and patient satisfaction on the maternity unit?

Background:
Change of shift report is a handoff in which information is shared from an offgoing to an oncoming caregiver. Joint Commission (JC) has identified handoffs as a critical time for communication and has identified communication failure as a root cause in more than 70% of sentinel events. Traditionally the change of shift report on the maternity unit has consisted of a report taped by the offgoing caregivers which the oncoming shift listens to in the staff lounge. The information relayed varies with each caregiver, with no standardized format for communication. This type of report allows for no exchange of information between caregivers nor does it elicit patient or family input. National Patient Safety Goals seek improvement in both staff communication and patient involvement in care. Bedside reporting provides not only the additional dimensions of verbal exchange with patients and caregivers, but also the opportunity to visualize the assigned patients. These added dimensions of communication may enhance both patient safety and satisfaction. A multitude of data suggests that nursing staff also report an increased level of satisfaction with the implementation of bedside reporting. Still, there is resistance among nursing staff to changing the method of reporting. Increased time required for bedside reporting and concerns about confidentiality are frequently cited as reasons not to adopt bedside reporting. In practice, the implementation of bedside reporting has been shown to decrease reporting time. Patient preference in terms of participation in bedside reporting is always to be honored. Here, too, research has shown that patient satisfaction and feelings of safety are enhanced with bedside reporting.

EBP Model:
Johns Hopkins Nursing Evidence-based Practice Model

Key terms:
Change of shift report/ hand-off, bedside report, communication safety, patient-centered care, family-centered care, TCAB, white boards

Evidence:
AHRQ, Bio Med Central, CINAHL, National Guideline Clearinghouse, Nursing Center, OJIN
A total of 28 articles were reviewed for strength and quality of evidence. Ten articles were selected as follows: Level one: no articles; level two: no articles; level three: six articles; level four: four articles; level five: no articles.

Practice recommendations:
Implement bedside change of shift reporting incorporating the SBAR format in the EMR and the bedside white boards with patient generated goals. Monitor Press Ganey score results for evidence of change in patient experience of care. Collect pre-and post-implementation surveys from staff to measure level of satisfaction with the handoff process.

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Initiating Early Enteral Nutrition in the Adult Critically Ill Medical Patient on a Ventilator

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Background: Early energy deficit is strongly correlated with infectious complications and organ failures in surgical and medical ICU patients on a ventilator. Adequate nutrition is a vital component in the recovery of any given critical illness; however the initiation of enteral nutrition is often delayed.

Practice Question: What is the optimum time frame for initiating tube feedings on adult medical patients on a ventilator in the ICU?

EBP Model: Johns Hopkins Nursing Evidence-based Practice Model (JHNEBP)

Synthesis of Evidence: Seventy-three articles were obtained during four separate literature searches using Cinahl and PubMed. Forty-one articles were reviewed for content, type, and quality of evidence using the JHNEBP model. Nine articles were randomized control trials, one article was quasi-experimental, eight articles were non-experimental, and two articles were literature reviews. The remaining 21 articles were discarded due to lack of relevance or low quality.

Practice Recommendations: The patient should be hemodynamically stable prior to initiating tube feeding. Enteral feedings should be started within 48 hours of admission. When the patient is malnourished enteral feeding should be initiated within 24 hours. A post-pyloric tube should be considered if an enteral feeding goal is not reached within 72 hours. An early bowel regimen and/or prokinetic agents also should be considered. Better compliance has been demonstrated with an enteral feeding regimen as a protocol.

Practice changes planned/made: An interdisciplinary team has been established to review these recommendations. An algorithm is being developed for the appropriate initiation and maintenance of tube feeding in the critically ill patient on a ventilator.

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Models of Clinical Decision-making Used by BS Nursing Students

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Nursing educators must prepare novice nurses to provide care for acutely ill patients in highly technical environments. Skillful clinical decision-making using multiple modes of thinking is critical to providing safe, effective nursing care (Benner et al., 2010). To effectively plan, implement and evaluate the educational experiences used to prepare baccalaureate (BSN) nursing students for clinical decision-making, it is necessary to understand how nursing students make clinical decisions. However, a review of the literature revealed no reports of research in this regard.

The purpose of this study was to describe models of clinical decision-making (MCD) used by BSN students. The information processing (Newel & Simon, 1972) and cognitive continuum theories (Hamm, 1988; Hammond, 1978) provided the theoretical framework.

A descriptive cross-sectional design was used to assess the MCD of sophomore (pre-clinical experiences) and senior (post-clinical experiences) BSN students. IRB approval for 'exempt review' was obtained from the study institution (a private college). Data was collected anonymously on-line using a demographic survey and the Nurse Decision Making Instrument (NDMI), which measures the use of models of decision-making along a continuum from analysis to intuitive modes within the context of the nursing process (Lauri & Salantera, 2002).

Findings indicated 85.7% of beginning nursing students used an intuitive MCD, while senior students used both intuitive (44.4%) and intuitive-analytical (55.6%) MCD. These results suggest an increase in the use of 'multiple ways of thinking' occurs as the students move through the nursing curriculum.

Use of the theoretical framework was supported for explaining development of clinical decision-making in BSN students. Students should be introduced to different cognitive processing models as they move through the nursing curriculum. The results will be useful in planning and designing educational experiences related to clinical decision-making.

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Nurse Preceptors' Perception of Benefits, Risks, Support and Role Commitment

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Purpose: To determine role satisfaction for nurse preceptors in a community, teaching hospital.

Hypothesis/Statement of the Problem: The nurse preceptor is an essential role in an organization. Nurse preceptors require additional skills and support to provide care, teach, and guide novice nurses. Nursing is inherently stressful and this role requires additional skill, time, and effort.

Background: The nurse preceptor is essential for nurse recruitment and retention and serves as clinician, teacher, and guide for the novice (Benner, 2001).

Methods: This descriptive, correlational study received IRB approval. Nurses who completed the RN preceptor education were invited to participate in the study via the hospitals electronic mail system. 100 nurses completed the study questionnaires and a demographic sheet and space for anecdotal comments were included.

Results: Ninety-seven percent of nurses reported high personal satisfaction and self-efficacy. Eighty-eight percent reported satisfaction with current preparation methods. Nurse managers were viewed as supportive sixty-six percent of the time. No correlation was found for length of service, clinical experience or education. Age was a significant factor with an increase in satisfaction correlating with an increase in age. Content analysis of anecdotal comments (n=36) revealed that the nurse manager was the most significant influence in the areas of role recognition, work allocation, and structural support. Additional education and ongoing support (n=10) was identified especially for nursing students and graduate nurses.

Outcome: Initial preceptor education is adequate, but ongoing support is not. An engaged triad consisting of the preceptor, nurse manager, and nurse educator is essential for success.

Policy Implications: Preceptor programs should be well defined and include both initial and ongoing education.   Nurse managers are key to role satisfaction. Educators provide essential support throughout especially for students and graduate nurses. Engaged, positive nurse preceptors may hold the key to successful recruitment and retention programs.

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Open Visitation in Medical Surgical Units

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Background: The hospital-wide visitation policy is interpreted and applied inconsistently from unit to unit. This has led to patient and visitor confusion and dissatisfaction, especially when patients are transferred from unit to unit. Nurses report concerns with visitation for safety and security reasons as well as interruption of patient care.

Practice question: Which visitation policy, open or structured, best promotes patient safety and rest as well as patient, family and nurse satisfaction in medical-surgical units?

EBP model: The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model was used to appraise the evidence.

Synthesis of evidence: Thirty-seven articles were reviewed. Twenty-six articles were of good quality based on the JHNEBP model and used for this project. There were no randomized control trials or quasi-experimental studies. Six articles were non-experimental or qualitative, two articles were opinion of nationally recognized experts based on scientific evidence, and seven articles were the opinion of nationally recognized experts based on experiential evidence.

Practice recommendations: Visitation should be individualized for each patient. Patients should identify a key spokesperson and other visitors including length of visits and frequency. This visitation plan should be developed with the patient on admission and communicated to the healthcare team. Patient-designated caretakers/family members should participate in patient care and be present for physician rounding if desired by patient. Patient and family should be provided with education about the unit and visitation policy. The healthcare team will need education to manage a more open visitation policy including communication skills and emotional needs of families, addressing disruptive behavior and unsafe practices, and universal compliance with the visitation policy.

Practice changes planned: A multidisciplinary team has been identified to create a universal open visitation policy for medical-surgical units that addresses safety and patient, family, and nurse satisfaction.

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Patient and Nurse Satisfaction Improves by Bedside Handover at Hanover Hospital

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Background – As patients become more knowledgeable consumers of healthcare, they understand that they have certain rights and desire more education and knowledge than ever before. The change-of shift nursing report often involves only nurse-to-nurse communication, occurs far away from the patient's bedside, and includes little or no patient participation. When report is given away from the bedside, the opportunity to visualize the patient and include both patient and family in an exchange of information and care planning is lost. Bedside handover, on the other hand, includes the patient/family, allows the opportunity to discuss their daily plan of care, and encourages confidence and trust in the nursing staff.
Practice question – Will implementation of bedside reporting improve both patient and nurse satisfaction?
EBP model – The John Hopkins model of evidence based practice was used for this project.
Synthesis of evidence – A literature review was conducted using search terms such as patient satisfaction, bedside reporting, handover, nurse satisfaction, shift-to-shift report, and hand-off communication. Numerous articles obtained reported positive outcomes of patient and nurse satisfaction after implementation of bedside reporting. Evidence based practice has proven that effective bedside reporting has improved patient and nurse satisfaction. Literature further reveals resistance to change was encountered with bedside shift reporting. It is important to have a plan of action developed before implementing a change.
Practice recommendations/Practice changes planned – We seek to improve patient and nurse satisfaction by improving communication between patients and nurses. Guided by the success of others, and using methods demonstrated successful at similar acute care settings, we plan to implement bedside shift reporting on our medical surgical unit as a starting point. We will evaluate our plan by tracking patient and nurse satisfaction through nurse surveys and specific HCAP questions.

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PATIENTS' EXPECTATIONS AND SATISFACTION WITH NURSING CARE, AND THEIR NURSES' AWARENESS OF THEIR EXPECTATIONS

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1. Introduction. Patient satisfaction with nursing care has become increasingly important to health care providers in recent years. Patients' expectations for their care have long been identified as a critical factor in patient satisfaction but researchers have typically operationalized expectations as the level of care patients imagined
they would receive in the ideal hospital setting.
2. Purpose. This study operationalized patients' expectations as the care they anticipated receiving during their present hospitalization from their actual nurses. Healthcare providers' understanding of patients' expectations has also been identified as an important factor in patient satisfaction but again, it was operationalized as providers' understanding of the patients' ideal, not the expectations of their own patients regarding their actual care. This study operationalized this variable as nurses' ability to assess their actual patients' expectations.
3. Methods. A descriptive correlational mixed-method research design was used to examine the relationships between two predictor variables (patients' expectations before hospitalization of the nursing care they anticipated receiving, and nurses' assessments of patients' expectations of care) and the outcome variable (patient satisfaction with nursing care). This study modified the existing Patient Satisfaction with Nursing Care Quality Questionnaire (PSNCQQ) to create the needed questionnaires. The study was conducted at an academic medical center located in central Pennsylvania. In each dyad, the nurse was the nurse who cared for the patient.
4 .Results. The study found no relationships between the variables except for a moderate relationship between patients' expectations and satisfaction.
5. Conclusions/Implications. A significant outcome of this study was the development of a measure that allows patients to rate their expectations for nursing care and another measure that allowed nurses to give their assessment of patients' expectations.

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Peer Coaching During Nursing Orientation: Will Utilizing a Coaching Process Improve Staff Satisfaction and Performance Expectations.

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Background
Our telemetry department has been trying to restructure and standardize its orientation process. Time management and organizational skills have been identified as issues among newly hired RNs. The nurses verbalized that they felt they were simply left to figure things out on their own.
Coaching has been used for decades in a variety of arenas with positive benefits. Coaching has been found to improve quality, productivity, performance, teamwork, communication, job satisfaction and decrease anxiety and stress.

Practice Question
Does implementing a coaching process during orientation for newly hired RNs, lead to meeting or exceeding performance expectations in the areas of work intensity, achievement, and relationships compared to the current orientation process?

EBP Model
Johns Hopkins Nursing Evidence Based Practice Model

Recommendations
Include coaching as part of the precepting process:
- Educate preceptors on the coaching process and how to write SMART goals for nursing orientation.
- Establish a standard orientation timeline with regular intervals for evaluation between the coach, coachee, and manager.

Synthesis of Evidence
Little was found on coaching in nursing. Forty-two articles were retrieved via CINAHL and Pub Med. Twenty two articles were applicable. The levels of evidence were:
- 1 II/B
- 2 III/A
- 7 III/B
- 4 V/A
- 8 V/B

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Prenatal Breastfeeding Education Program in the Outpatient Clinic

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Introduction
Pregnant women need to hear about the ease and normalcy of breastfeeding several times before they can comfortably decide whether breastfeeding is the right choice for them. Despite wide-spread breastfeeding encouragement, clinic mothers do not typically breastfeed.

Purpose
The study goal was to increase the breastfeeding initiation rate among the clinic population. The intent was to increase the total number of clinic mothers breastfeeding at delivery following several points of contact throughout their prenatal care.

Method
This was a quasi-experimental research study conducted at a 100-bed community hospital's outpatient clinic. Consent was obtained and educational handouts were given at enrollment and throughout each prenatal visit. An International Board Certified Lactation Consultant (IBCLC) spoke to mothers every Friday for one year. Each contact was recorded. The data was used to determine the effectiveness and frequency of contact with mothers resulting in a decision to breastfeed at delivery. Mothers' feeding choice was noted following delivery of her newborn.

Results
Breastfeeding rates were 55% with a total of 123 clinic deliveries for 2010-2011 year. Following the educational program intervention, (based on 43 weeks of data), 51 % chose to breastfeed with 90 clinic mothers delivering.

Conclusion
Mothers report deciding to breastfeed very early in their pregnancy or before pregnancy diagnosis. Limited exposure to successful breastfeeding experiences and a lack of education leads these mothers to formula feed their newborns. Prenatal education must start in the pre-conception phase of a woman's life to have a positive impact on breastfeeding at delivery. The presence of the lactation consultant did not increase breastfeeding initiation rates as intended. Limitations of this study are sample size due to scheduling options, missed opportunities, and data collection not yet complete. Implications for future research involve mandatory time with the lactation consultant at the confirmation of pregnancy visit for each clinic mother.

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Providing perinatal palliative care: How comfortable and confident are clinicians?

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Introduction: Expectant parents dream for a healthy baby. When families are given an unanticipated poor fetal diagnosis, clinicians have a critical role and ethical obligation to deliver appropriate services to these couples. This research reports on clinician confidence and comfort in providing palliative care services to expectant families.

Purpose: This study measured the differences in perceptions of physicians and advance practice nurses, their reported comfort in providing and referring patients to perinatal palliative care (PPC) and their confidence in delivering such care.

Design: A cross sectional survey design using the Perinatal Palliative Care Perceptions and Barriers Scale ©

Procedure: A survey was administered using Qualtrics, a Web-based tool. Recruitment was completed via email invitation and list serves.

Sample: Physicians (n = 66), advance practice nurses (n = 146), and other clinicians (n = 90)

Measures and Analysis: T-test and Mann-Whitney U were used to examine differences in clinician perspectives, comfort and confidence in delivering PPC. Hierarchical multiple regression was used to test the hypothesis that clinician perceptions, barriers to PPC, years in clinician practice, referral comfort and personal comfort and case history explain variation in confidence.

Results: Physicians and nurses have fundamentally similar perspectives but report significant differences in their comfort with providing and referring patients to PPC and their confidence in delivering such care. A significant regression equation with an overall R^2 of .56 explained variation in confidence.

Conclusion: Palliative care involves physicians and nurses making unique and positively synergistic contributions to the care of families expecting a baby with a life-limiting diagnosis. Clinicians share ethical perspectives regarding PPC and are positioned to collaboratively develop PPC programs. Barriers to PPC delivery exist and clinicians can benefit from interventions aimed at modifying practice environments. Supportive interventions and educational initiatives may increase clinician comfort and confidence with palliative care delivery.

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Recognition and Treatment of Depression in Cardiac Inpatients

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Background
Members of the Cardiovascular Serviceline (CVSL) Patient/Family Advisory Council (PFAC) reported they were unprepared to manage their feelings of depression once discharged. Currently, there is no formal process to screen, educate, or follow up patients for depression following a cardiac event.

Practice question
What are the best practices for identifying patients at risk for and treating depression in patients who have been hospitalized for a cardiac event?

EBP Model
Johns Hopkins Nursing Evidence Based Practice Model

Synthesis of evidence
The databases Pub Med, CINAHL, and Google Scholar were searched using keywords "depression" and "cardiac" and "screen*" yielding 1182 articles. Titles and abstracts were then screened for relevance to our question, leaving 43 for further review. Of these, eighteen articles related to the question were selected for appraisal by the CVSL EBP Forum. Fourteen were graded A or B quality and used in the final research summary.

Practice Recommendations
All levels of evidence recommend routine screening to identify depression in cardiac patients, however:
no evidence shows that routine screening programs improve outcomes
a formal followup plan needs to accompany screening.
The PHQ-2 and PHQ-9 are the most recommended depression screening tools for cardiac patients.
Those who perform screening must be educated regarding the tool and referral process.
Screening should be done on the stepdown unit.
Potential risks from screening include labelling, overtreatment, and overuse of scarce resources.
Pharmacologic and nonpharmacologic therapies should be used to treat depression.
Further research is needed regarding the benefits of screening, screening tools, and when to screen.

Practice changes planned
Based on the limited evidence, the Forum determined more information is needed before implementing any recommendations, including:
Other institutions' depression screening/treatment programs.
Current pertinent clinical trials.
Patients' attitudes toward depression screening.

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The Effects brown bag on medication safety

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Background: Medication safety is a growing concern for healthcare organizations and patients. There are 1.5 million preventable adverse drug events each year in the United States. This costs the healthcare systems $3.5 billion annually. Fragmentation of the healthcare system creates inaccurate medication lists. Our Outpatient Clinic participated in a health literacy collaborative with focus on teach back and brown bag (medication bottles to appointments).

Practice Question: Is medication reconciliation improved if patients bring their medication bottles ("brown bag") to their appointments?

EBP Model: John Hopkins Nursing Evidence-based Practice Model (JHNEBP)

Synthesis of Evidence: A total 32 articles from CINAHL and PubMEd were identified only 16 articles were relevant. The level of evidence is as follows: Level 1=0, Level 11/A=1,Level III/B=3,Level IIV,A=2,Level V/A=3, Level V/B=1.

Practice Recommendations: Medications reconciliation occurs at each visit. Educate staff and patients regarding "brown bag" and "teach back" methods.

Practice changes planned/made: Educate residents, nurses, and registration staff. Mail a postcard to patients 1 week prior to appointment encouraging brown bag. Data is documented regarding compliance and discrepancies when found.

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Treating Vitamin D Deficiency to Increase Statin Tolerability

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Introduction:
HMG-CoA reductase inhibitors (statins) are often used in the treatment of hyperlipidemia. Adherence to statin therapy may be difficult for some patients because of the development of statin-induced mylagias. Treatment of vitamin D deficiency may be an effective means of reducing myalgias in patients being treated with statins.

Purpose:
The purpose of the this study was to determine whether treating vitamin D deficiency increased patients' tolerability of statin medications in a cholesterol management program designed and managed by a nurse practitioner.

Methods:
With IRB exemption, patients with statin-induced myalgias who were evaluated in the Wellspan Cholesterol Management Program between May 2009 and May 2010 had a vitamin D level measured. If the vitamin D level was = 33, the patient received vitamin D supplementation to level above 40. Once the vitamin D level was above 40, the patient was advised to restart statin therapy.

Results:
Fifty eight patients had their vitamin D level assessed. Thirteen patients had vitamin D levels above 33 and continued to receive usual care. Forty five patients had a vitamin D level = 33. Of the 45 patients for whom treatment was recommended, 7 patients were lost to follow up and 4 patients refused a retrial of statin therapy. The remaining 34 patients were recommended to restart statin therapy.

Of the 34 patients who re-initiated statin therapy, 27 (79%, $P < .001$) were able to tolerate the medication without myalgias. Seven (21%, $P < .001$) still experienced myalgias with re-initiation of statin therapy.

Conclusions:
Patients with vitamin D deficiency showed an increase in tolerability with statins after their vitamin D level rose above 40. Therefore, the maintenance of vitamin D sufficiency in statin-treated patients to avoid myalgia-related non-compliance (and ultimately discontinuation) is a clinical intervention that can improve treatment efficacy and patient outcomes.

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What are best practices to prevent falls with injury in the hospitalized patient?

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BACKGROUND
Falls are a physical, emotional, cognitive and financial stressor on our patients and can cause permanent disability or even death. Falls are an emotional and physical stressor on staff causing possible injury and job burn out. Additionally, falls are a major financial impact on our institution, causing budget implications both unit and system-wide.

PRACTICE QUESTION
What are best practices to prevent falls with injury in the hospitalized patient?

EBP MODEL
The John Hopkins Nursing Evidence-Based Practice Model was used as the framework for this project.

SYNTHESIS OF EVIDENCE
Twenty-eight articles were included in the individual evidence summary. Seven level-I studies were found with 5 rating "A" and 2 rating "B". Four quasi-experimental studies were found rating a "B". Five level-III studies were reviewed with 2 rating "A" and 3 rating "B". Seven level-IV articles were included with 2 rating "A" and 5 rating "B". Lastly, five articles were categorized as level-V and were quality improvement case studies.

PRACTICE RECOMMENDATIONS
Evaluate the current Schmid risk tool for the use of high-risk medications (benzodiazepines, diuretics, newly started medications and prn's) entered as individual entries. Include the use of the EXIT Strategy or 4 P's in purposeful two hour rounding. Introduce the acronym ABCS, educate staff and use personal devices such as gait belts and hip protectors, especially in those with a high-risk ABCS score. And collaborate with the Fall Task Team to create a post-fall bundle to standardize fall prevention interventions with clearly defined steps and techniques, implemented for every at risk patient.

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What are the benefits of Kangaroo Care for a NICU baby after being dressed?

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Background
Multiple studies have shown the physiologic, neurophysiologic and growth and
development effects from Kangaroo Care for term and preterm infants. Kangaroo Care is defined as
holding a diaper clad infant bare chest to bare chest, ventral surface to ventral surface.
While Kangaroo Care is an integral part of Developmental Care for neonatal intensive care infants, the
frequency drastically decreases after the infant is dressed. When an infant is changed from skin-temp
(undressed except for diaper) in an isolette to fully dressed with a set temp or when removed from a
isolette, dressed and placed in a bassinet, parents may view their preemie as "healthier" and
subsequently not engage in Kangaroo Care.
Practice question:
What are the benefits of Kangaroo Care for a NICU baby after being dressed?
Model:
The EBP team utilized the Johns Hopkins Nursing Evidenced Based Practice (JHNEBP) Model to guide
this project.
Synthesis of evidence:
Using the key words: Kangaroo Care, premature infant, skin-to-skin, thermoregulation, and late preterm
infant – a literature search was done using PubMed, CINAHL, Medline, and Google Scholar. Eight
articles most closely addressed the practice question and were of quality based on the JHNEBP Model.
The evidence strength included 5 experimental studies, 1 non-experimental study, 1 national guideline
and 1 expert opinion. The articles gave recommendations and benefits for Kangaroo Care, in general, for
premature and term infants. None of the articles gave recommendations specifically for continuing
Kangaroo Care when an infant is dressed and out of heat.
Practice recommendations:
While the evidence failed to answer the practice question, the overall benefits of Kangaroo Care are
thoroughly supported in the literature. The EBP team will re-educate the NICU staff to support and
encourage parents to provide Kangaroo Care after an infant is dressed.

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Oral Presentation Abstracts

EBP & Nursing Research: It's the Right Thing to Do!
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Faculty and Student Attitudes Toward Attendance Policies in Baccalaureate Nursing Programs

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Introduction: This study originated from a nursing faculty discussion on student and classroom issues. During this discussion, different opinions regarding mandatory classroom attendance policies were evident. The investigators believe that if a student registers for a class, he/she has an obligation to come to class and participate in the discussion and learn from one another as well as from the faculty member. In nursing today, collaboration is imperative and the classroom environment is a starting point for building teamwork. Unfortunately, there is limited literature that addresses the importance of attendance and its correlation to learning in nursing education.

Purpose: To achieve a greater understanding of nursing faculty and students perceptions of attendance policies in baccalaureate nursing classrooms and if attendance has an impact on student learning in nursing courses.

Methods: Correlational analysis. A stratified random sample of 65 CCNE accredited baccalaureate nursing program deans were emailed a description of the study. If interest was expressed, instructions were sent to invite their students and faculty to participate by emailing them each a welcome letter and the survey monkey link.

Results: There were 591 nursing student responses and 91 faculty responses from 14 (22%) schools across the United States. Student responses suggest that 57% believe there should be an attendance policy in nursing courses and 66% of faculty felt the same. Study results also suggest that students valued class time as 64% of students only missed class due to illness. Only 12% did not find class time valuable. The majority of faculty (62%) felt that students who do not attend class are exhibiting unprofessional behaviors. A greater majority (79%) of faculty believe that students who do not attend class are less successful in the clinical learning environment than students who do regularly attend class.

Conclusions/ Implications: There is a great deal of variability in student and faculty beliefs regarding mandatory classroom attendance policies. Understanding faculty and student viewpoints regarding attendance policies has implications for nurse educators as they facilitate learning for a cohort of diverse students. This promotes understanding in a classroom environment where there is teamwork and mutual respect, while at the same time not compromising the learning outcomes and safe patient care.

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The Effect of Listening to Music on Post-operative Pain & Patient Satisfaction in the Adult Orthopedic Patient

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INTRODUCTION: Pain is a common occurrence after orthopedic surgery. Patients need additional resources to manage their pain. Successful pain management needs to include non-pharmacological techniques and adjunctive therapies. Listening to music is one option that nurses can offer patients that is easy to use, cost effective and does not require a physician's order. This method has been studied and found to be effective in patients with chronic pain, but there are limited studies in the orthopedic population.

PURPOSE: The purpose of this study was to assess if listening to music has a positive effect on patient pain scores and satisfaction in the post-operative period following orthopedic surgery.

METHODS: This is a descriptive and comparative study utilizing pre-post pain score assessment and satisfaction surveys. Approval for the study was obtained from Wellspan Health IRB (expedited review) and signed consents for all participants were obtained. Any patient who met the inclusion criteria was invited to participate. Patients listened to music as an adjunct to pain management using portable CD players. All patients used the same type of music which was selected based on a literature review. Patients recorded the pre-post pain scores on log sheets. A satisfaction survey was completed at discharge.

RESULTS: Data analysis was completed by the scientific support staff of the Emig Research Center. There was a statistically significant decrease in the pain scores of the patients who listened to the music. Satisfaction surveys also indicated that patient were satisfied with their pain control and that they would recommend the use of the music therapy to others.

CONCLUSIONS: The information gained through this study can lead to an enhancement in the standard of care for patients in the post-operative period by offering another method to manage pain which is easy to use, safe and easily incorporated into nursing care. Due to the limited sample size of this study, further research is recommended to verify these results.

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The Nurse as Scholar: Promoting Evidence-Based Practice Among Direct Care Nurses

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Background: Engaging direct care nurses in research and evidence-based nursing practice (EBNP) is challenging due to their lack of knowledge about research and EBNP processes and insufficient time for learning and project development. The authors aimed to find strategies to help nurses learn the steps for EBNP and research and promote the best evidence to improve patient outcomes.

Practice Question: What strategies educate and engage direct care nurses in EBNP?

EBP Model: The Iowa Model for Evidence-Based Nursing to Promote Quality Care was the framework.

Synthesis of Evidence: 9 articles contributed ideas for structure, curriculum, and evaluation. of programs which varied widely in participants served, length, content, and implementation format. Evaluation data were scant.

Practice Recommendations: Structured education programs incorporating mentorship, didactic instruction, and time to develop an EBNP project seemed most successful in bringing about desired learning and translation of evidence to practice.

Practice Changes Made: The authors proposed an Evidence-Based Nursing Practice (EBNP) Fellowship Program for direct care nurses to hospital administrators; they provided financial support. The Research and Education Council assisted the Director of Nursing Research to develop a curriculum, marketing materials, and an application process.

Results: In 2010, 17 Fellows participated in 12 days of didactic instruction and additional independent work, assisted by MSN-prepared mentors, over an 8-month period. 15 Fellows participated in the 2011 program. Program evaluation included baseline and end-of-program data on nurses' perceptions of their knowledge, attitudes, practices and competencies in research and EBNP and peer feedback on oral and poster presentations of individual projects. Very positive program outcomes were obtained. The presentation will elaborate on the program curriculum, evaluation results and topics that Fellows pursued to bring innovative nursing practice to patients, families, and colleagues in various practice arenas.

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The Experience of Perinatal Loss and Bereavement in Black Adolescents

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Introduction:
Perinatal loss is a stressful event, particularly during the turbulent years of late adolescence. Black adolescent females experience perinatal loss at higher rates than any other racial group, yet there is scant scientific literature to describe their perinatal bereavement experience.

Purpose:
The purpose of this qualitative study was to build an understanding of the experience of perinatal bereavement in Black adolescents after recent perinatal loss.

Methods:
This study used grounded theory methods to prospectively explore the experience of perinatal bereavement in eight Black adolescent females with recent perinatal loss. After IRB approval, participants were recruited from urban hospitals and interviewed at three points in time throughout the first 12 weeks of bereavement. Constant comparative analysis and theoretical sampling were used to develop a disclosive theory.

Results:
The resulting theory, "Enduring to gain new perspective", discloses the main theoretical categories of the perinatal bereavement experience: Life before pregnancy; Reacting to the pregnancy (sub-categories: accepting and attaching); Living through the loss event (sub-categories: emotional response and physical response); Seeking and receiving support; Maintaining relationship; Searching for meaning; and Gaining new perspective. The core concept was "Enduring the Loss".

Conclusions/Implications:
This research uniquely contributes to extant bereavement theory by giving voice to a group which had previously been excluded from qualitative exploration of perinatal bereavement. The data reveal rich detailed accounts of devastating perinatal loss with ensuing bereavement experiences lived out through the major transitions of late adolescence. Black adolescents experience perinatal bereavement in the context of the meaning of the loss and in social interaction with others. Traditional methods of perinatal bereavement support must be retooled to address the cultural and developmental needs of this population. Nursing interventions must be targeted at critical points in the experience and include support by immediate family and women of similar cultural and experiential background.

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Do men belong in sexual assault nursing?

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Introduction
Of the 2.6 million registered nurses in the United States, approximately 6% are men. While men have become more widely accepted in the nursing profession, men seldom venture into a few specialties—particularly Sexual Assault Nurse Examiners (SANE).

Purpose
The purpose of this mixed-methodology study was to evaluate female SANEs attitudes towards male nurses in the SANE specialty.

Methods
A survey tool was developed, piloted, and distributed by electronic mail using the International Association of Forensic Nurses' database (n=6,393). Data was collected electronically using an anonymous survey, with both quantitative and qualitative questions, over four week period in 2010. Seven hundred and twenty eight SANEs participated, including four males.

Results
A majority of female SANEs (84%) would welcome males onto their SANE Teams. Furthermore, 71% indicated that males can provide the same level of care for victims of violence as females. Qualitative data was analyzed using Van Kaams Method, resulting in two major themes and multiple sub themes. These themes focused on the perceived needs of sexual assault patients and the ability of males to care for female victims. Of the four males who completed the survey, only one reported his services were declined based on his gender.

Conclusion
It was concluded thata majority offemale SANEs support males in the specialty. Furthermore, while female patients may be reluctant to have a male examine them; they can have a positive experience with a male caregiver that is kind, compassionate, and knowledgeable. As the need for SANEs increase, programs should not exclude male nurses from recruiting efforts.

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Student Poster Presentation Abstracts

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Best Practices to Withhold or Withdraw Treatment in the ICU

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Admission to the Intensive Care Unit is stressful, but when the decision to withhold or withdraw care arises, strain and uncertainty are placed not only on the patient and family members, but also on healthcare staff. Answering the question "What are the best practices for withholding and withdrawing care for patients in the ICU" creates an ethical and moral dilemma. This becomes problematic as there are no universally established protocols regarding withholding or withdrawing care in the ICU. Classifying care as futile can also be seen as unethical or unclear as these areas are also not clearly defined. Parameters need to be established and adopted for ICU wards to help navigate what can often be a taxing situation for all involved. Using the Johns Hopkins Nursing Evidence Based Practice Model, nine sources of evidence ranked Levels III – V were reviewed. The evidence found provided recommendations for providing optimal levels of care to the patient while keeping the family in consideration and also taking into account the impact on healthcare personnel. While evidence resulting from studies or trials in withdrawing or withholding patient care is not directly available, practice recommendations are made. The goals of these recommendations aim to provide healthcare staff with more training and education regarding end-of-life care, maintaining open communication with the physicians, with a very strong emphasis placed upon involving and educating family members in decision-making throughout the entire end-of-life care process.

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Discovering an Acuity Tool: Stage 1 Post-Anesthesia Care Unit

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Background: Staffing in the stage I PACU can become inadequate with the introduction of patients that require more intensive care. Increasingly, surgical patients have more co-morbidities, making them more complex to care for, especially when recovering from anesthesia. The health complexities of these patients require more attention from nurses, making the nurses less available to care for other patients. High nurse patient ratios can lead to decreased quality of care and decreased patient safety. The current practices for Stage I PACU follow ASPAN guidelines. The Stage I PACU patients are monitored until they can safely be transferred to a less intensively monitored unit. This system is less than adequate when patient acuity is high. Thus, there is a need for an acuity tool to guide PACU nurse staffing.

Evidence Based Practice Question: Does the use of a reliable and valid acuity tool for Stage 1 PACU patients increase patient satisfaction, safety, and nurse satisfaction?

EBP Model: The Johns Hopkins EBP Model was used to explore this PICO question in collaboration with staff nurses from York Hospital.

Synthesis of Evidence: Increases in RN staffing may result in earlier detection of patient complications and improved satisfaction. The addition of overflow ICU patients greatly increases the workload of the PACU nurses and increases nurse-patient ratios. Surgical sequencing can affect PACU staffing and the hourly number of patients in the PACU. Policies and procedures should recognize all of the variables associated with the PACU. Current ASPAN standards are based on expert opinions with little evidence to support them. Decreased staff levels lead to decreased quality of care. PACU staffing is different from staffing in other units, which makes it difficult to create nursing schedules. Research on patient acuity does not provide enough evidence to create an acuity tool.

Practice Recommendations: More research must be performed before developing a valid acuity tool

Does New Graduate Participation in a Nurse Residency Program Result in Improved Outcomes?

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Graduating nursing school involves a daunting plethora of tasks, but surviving the monumental first year as a new nurse is even more challenging. Years before the computerized licensing exam, nurses entered the field with a provisional license closely mentored by a seasoned nurse for several months. Today, upon completion of the National Council Licensure Examination (NCLEX), it is possible for an individual to enter the nursing field as a licensed professional, ready to provide care for patients whose needs may exceed one's knowledge and capabilities acquired during nursing school. This realization resonates with a graduate nurse, causing feelings of incompetency and thus a poor transition into the nursing profession. This outcome has prompted the question, "Would new graduate participation in a nurse residency program result in improved outcomes, including increased retention, decreased attrition, and the increased likelihood of successful transition into the RN role?" Following the Johns Hopkins Nursing Evidence Based Practice (JHNEBP) Model, seven studies from evidence levels II, III and V were critiqued. Overall, the evidence supports the need for nurse residency programs stretching over the first year as a graduate nurse.

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Do More Med Errors Occur in 12 Hour Shifts vs. 8 Hour Shifts?

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Background: Nurses work shifts vary between both 8 hr and 12hr shifts. Medication errors occur regardless of the number of consecutive hours a nurse works. There is little information about how working longer than 12 hours affects patient care & med errors. The purpose of this project was to determine if more medication errors occur during a 12 hr shift compared to an 8hr shift. Review of the evidence showed working longer hours is related to a lower quality of care with higher incidence of errors.

Practice Question: Do More Med Errors Occur in 12 Hour Shifts vs. 8 Hour Shifts?

EBP Model: The Johns Hopkins EBP Model was used to explore this PICO question in collaboration with staff nurses from York Hospital.

Synthesis of Evidence: Medical errors are significantly higher when nurses work more than 12 consecutive hours, work beyond their scheduled shift times, work more than 40 hrs a week, or obtain insufficient sleep prior to their shift of work. Both errors and near errors are more likely to occur after 12 hrs or more. Nurses who work in inconsistent shifts are drowsier, have difficulty concentrating, feel more uncomfortable, confused, depressed, angry, fatigued, and anxious. The likelihood of errors working12.5 hrs or more was 3X more likely than those working 8 hr shifts. 12hr shifts had better planning, organization, & satisfaction in patient care. Errors increased in nurses 24years old or less, less than 4yrs nursing experience, working more than 8hr per day, and in surgical or intensive care patients.

Practice Recommendations: It is recommended to recreate a pertinent study to gain more information on medication errors in 8 and 12hr shifts. More research studies need to be done in order to implement changes in practice, as well as see the approximate rate and causes of errors that occur on 12 hr shifts.

In hospitalized post-partum women, does rooming-in and non-separation compared to mother-baby separation result in improved mother-baby dyad outcomes?

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Background: At York Hospital, it has been the practice to allow mothers to send their newborns to the nursery for extended periods, at any time, resulting in mothers being less prepared to care for their infants at discharge. Due to shortened hospital stays, there is less time for patient teaching so it has become imperative that mothers are encouraged to spend their time bonding with and caring for their newborns, better preparing them for discharge. The purpose of this project was to explore whether or not rooming-in/non-separation results in improved mother-baby dyad outcomes as compared to mother baby separation in hospitalized post-partum women.

Practice Question: In hospitalized post-partum women, does rooming-in and non-separation compared to mother-baby separation result in improved mother-baby dyad outcomes?

EBP Model: The Johns Hopkins EBP Model was used to explore this PICO question in collaboration with staff nurses from York Hospital.

Synthesis of Evidence: Skin to skin contact decreases the amount the baby cries and helps babies maintain optimal body temperature. Mothers' perceptions were positive in "not separating from baby at birth". Encouraging a period after birth during which there is close contact between mother and infant may induce a long term positive effect on mother-infant interaction. Mothers who roomed-in with their infants stated that they got a better quality of sleep as opposed to when the infants slept in the nursery. Mothers' discharge teaching is important in assisting mothers with coping and caring for self and newborn. Mothers feel ready for discharge when feeling physically capable, knowledgeable, and competent in their abilities. Rooming-in assists a mother in achieving these goals. Early mother-infant contact may reduce maternal inadequacy.

Practice Recommendations: Rooming in and non-separation were most beneficial to the mother-baby dyad in the hospitalized post-partum patient and vital to the successful discharge of the patient. Recommendations include: Begin discharge teaching at birth, encouraging mom with coping and caring for her baby to enhance her knowledge and confidence in her abilities. Avoid frequent interruptions during the night and allow mothers to receive restorative sleep. Educate mothers and staff of benefits of non-separation. Encourage early bonding to ensure healthy development.

What Practices are Most Effective for Prevention and/or Management of Acute Delirium in the ICU?

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The practice question for this project was 'What Practices are Most Effective for Prevention and/or Management of Acute Delirium in the ICU'. Delirium is the abrupt change in a patient's sensation, perception, alertness, orientation, and cognitive thinking. Delirium in an ICU setting exists whether it is due to the use of psychotic medications and sedations or as a result of environmental factors. Consequences faced by those with delirium include placement on mechanical ventilators and decreased performance in spontaneous breathing trials (SBT) which lead to prolonged hospital stays. The prolongation of the hospital stay then results in a statistical increase in the risk for delirium (Grover, 2011). That is why prevention and management of delirium in an ICU setting is necessary. According to the literature more than two-thirds of patients in the ICU with delirium go undiagnosed (Dubois, 2001). Furthermore, the literature contains discussion of interventions that use one or more scales for measurement, such as the NEECHAM confusion scale. Overall, thirty-five sources of evidence (Levels I-V) were reviewed using the Johns Hopkins Nursing Evidence Based Practice (JHNEBP) Model. The evidence identifies the prevalence and the importance of diagnosing and treating delirium in an ICU setting; this will ultimately prevent harm to the patient and facilitate a returning to the patient's original state of mind. It is the recommendation from the evidence reviewed that the 'ABCDE' model of care should be instituted for ultimate prevention and management of ICU delirium.