2021 Nursing Research & EBP Conference

Dissemination and Implementation: Nurses as Influencers

November 4th, 2021 | 8:00am-4:00pm EST || November 5th, 2021 | 12:00pm-4:00pm EST

Virtual via Zoom

Session 1: Thursday, November 4th, 2021

8:30am **Welcome**
Angeli Mae Lagasca, MA, BSN, RN, CCRN
Clinical Program Manager
Primary Nurse Planner
Continuing Nursing Education
Northwell Health

8:35am **Nursing Research and EBP at Northwell Health**
Lily Thomas, PhD, RN, FAAN
Vice President, System Nursing Research
Institute for Nursing
Northwell Health

8:55am **Opening Remarks**
Maureen T. White, MBA, RN, NEA-BC, FNAP, FAAN
EVP-Chief Nurse Executive
Northwell Health

9:15am **Opening Keynote: Vision for National Institute for Nursing Research Nursing Science**
Shannon N. Zenk, PhD, MPH, RN, FAAN
Director, National Institute for Nursing Research

10:30am **Break**

10:45am **Morning Plenary Session: Spring to Success with Implementation Science**
Kathleen Stevens, RN, BS, EdD, ANEF, FAAN
Berneice Castella Endowed Distinguished Professor in Aging Research
University of Texas Health San Antonio

11:30am **Lunch**

12:15pm **Afternoon Plenary Session: Implementation Science Frameworks for Healthcare Settings**
Laura Damschroder, MS, MPH
Research Scientist, Veterans Association
Ann Arbor Center for Clinical Management Research

1:20pm **Evaluating the Efficacy of a Mindfulness Mobile App for Stress Reduction in Nurses**
Myrta Rabinowitz, PhD, RN-BC, NC-BC
Clinical Program Manager
Institute for Nursing
Northwell Health

2:00pm **Break**

2:10pm **An Inquiry into the Lived Experience of Tele-ICU Nurses' Practice**
Annie George, PhD, RN, NEA-BC, NPD-BC, CCRN-K
Assistant Director of Nursing
Lenox Hill Hospital
Northwell Health

2:45pm **EBP Panel: Developing Influencers through EBP Fellowship**
Ani Jacob, DNP, RN, NPD-BC
Nurse Scientist
Institute for Nursing
Northwell Health
pH testing for NG tube placement verification
Michiko Sato, BSN, RN-BC
Rooming in for NAS infants
Karen Conrad MSN, RNC-NIC, CBC
Interactive vs. passive patient education
Terrial Buhner BSN, RN
Music therapy for agitated patients
Tasha Wiltberger BSN, RN

3:45pm **Closing Remarks**
Lily Thomas, PhD, RN, FAAN

4:00pm ***Session with Northwell Health Talent Acquisition***
Ellen Lorenz, RN, BSN
Program Director, Nursing Fellowships & Recruiting
****Partner Exhibition*

Session 2: Friday, November 5th, 2021

11:00am ***The Role of Nurses in Shaping the Future of Healthcare***
Adele Webb, PhD, RN, FNAP, FAAN
Executive Dean of Healthcare Initiatives
Strategic Education, Inc.
****Sponsor Exhibition*
****Capella University designates this activity for 1.0 ANCC contact hour.*

12:00pm **Welcome**
12:15am **Virtual Poster Showcase**
4:00pm **Closing Remarks**

There's Still Time to Register!

Scan or click the QR Code below to save your seat at Northwell Health's 2021 Nursing Research & EBP Virtual Conference

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Disclosures:
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Joint Accreditation Statement:
In support of improving patient care, Northwell Health is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Credit Designations:
Nurses: Northwell Health designates this activity for 6.0 Session 1/3.75 Session 2/9.75 Total ANCC contact hours.
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Click for Session 1 Agenda

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12:00pm **Welcome**
Angeli Mae Lagasca, MA, BSN, RN, CCRN
Continuing Nursing Education, Northwell Health

12:15pm **RN Perception of a Staff-Driven Professional Development Program**
Christine Fardellone, DNP, RN
Research Nurse, North Shore University Hospital

12:30pm **Development and Validation of the Authentic Leadership Questionnaire for Nurse Leaders (ANLQ-NL)**
Marie Giordano-Mulligan, PhD, RN, CNOR, NEA-BC
Chief Nurse Executive, VP for Nursing
Mather Hospital

12:45pm **Supporting Families through First Episode Psychosis**
Susan Fitzgerald, DNP, RN, NE-BC
Senior Manager, Patient Care
Zucker Hillside Hospital

1:00pm **Implementation of a Nursing Emotional Intelligence Program to Improve Patient Satisfaction**
Deepti Nair, DNP, RN, PMH-BC, CNE
Clinical Professional Development Educator
Zucker Hillside Hospital

1:10pm **Recognizing a Life and Reducing Staff Stress with "The Pause"**
Jessica Svoboda, BSN, RN
Assistant Manager, Patient Care Services
South Shore University Hospital

1:20pm **Enrollment in a Tobacco Dependence Treatment Program during the COVID-19 Pandemic**
Patricia Folan, DNP, RN
Clinical Program Director
North Shore University Hospital

1:30pm **Changing Stigmatic Perceptions on Mental Illness and Substance Abuse among Public Library Staff: A Nursing-Library Initiative**
Denise Driscoll, RN-BC, CARN, PMHCNS-BC, NPP
Assistant VP for Behavioral Health, Mather Hospital
Lilly Mathew, PhD, RN
Nurse Researcher/Statistician, Mather Hospital

1:40pm **Dynamic Appraisal of Situational Aggression (DASA): An Integrative Review**
Doreen Gallagher, DNP, RN, PMH-BC
Clinical Professional Development Educator
Phelps Memorial Hospital

1:50pm **Preventing Pressure Injuries in the Pediatric Intensive Care Unit**
Maria Marchelos, MSN, RN, CCRN-K, NEA-BC
Manager, Patient Care Services
Cohen Children's Medical Center
Lincy Philip, MSN, RN, CPN
Clincal Professional Development Educator
Cohen Children's Medical Center

2:00pm **Break**

2:10pm **Improve the Knowledge Level of Clinical Nurses: Development of an Extravasation Management Protocol**
Neethu Gopinadh, MSN, RN, OCN, VA-BC
Clinical Professional Development Educator
Phelps Memorial Hospital

2:20pm **Individual Characteristics and Shared Decision-Making for Stroke Prevention in Atrial Fibrillation**
Patricia Nadraus, PhD, RN, CCRN
Nurse Scientist, South Shore University Hospital

2:35pm **Decreasing Non-Productive Wait Time in Hodgkin's Lymphoma Ambulatory Chemotherapy Visits**
Donna Newman-Beck, MSN, RN, CPN
Research Nurse, Cohen Children's Medical Center

2:45pm **A Multidisciplinary Approach to Implementation of Preventative Strategies While Maintaining a Safe Environment for Pediatric Patients with Cancers and Blood Disorders During the Covid-19 Pandemic**
Donna Newman-Beck, MSN, RN, CPN
Research Nurse, Cohen Children's Medical Center

3:00pm **Health Literacy focusing on Clinician Education AHRQ's Health Literacy Universal Precautions Toolkit**
Susan Murphy, MSN, RN, CCRN
RN, South Shore University Hospital

3:15pm **Evaluation of Depression Screening Tools for the Older Adult**
Catalina Chistol, BSN, RN
RN, Phelps Memorial Hospital

3:30pm **A Quantitative Analysis of Newly Practicing Nurses' Perceived Self-Efficacy, Assertiveness and Interprofessional Collaboration**
Janice Baglietto, PhD, RN, CCRN-K
Clinical Professional Development Educator
South Shore University Hospital

3:45pm **Closing Remarks**

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Development and Validation of the Authentic Leadership Questionnaire for Nurse Leaders (ANLQ-NL)

Mather Hospital – Northwell Health
Email: mmulligan5@northwell.edu

Marie Giordano-Mulligan PhD, MS, RN; Judith Moran-Peters, DNSc, RN; Sarah Eckardt, MS

Research Question / Problem

- The health care environment is experiencing reformation that is unprecedented and intense.
- The continued COVID-19 crisis underscored the need for Authentic Nurse Leadership (ANL), which promotes Healthy Work Environments (HWE).
- Development of an instrument—the Authentic Nurse Leader Questionnaire (ANLQ)—that identified clinical nurses' perceptions of ANL attributes in 2017 facilitated research linking ANL with HWE.
- However, lack of an instrument to measure ANL from the perspective of nurse leaders was identified as a gap.
- Thus, the **purpose** of this study was to develop and validate an ANL instrument for nurse leaders which will facilitate further research aimed at identifying the relationship between ANL and HWE.

Background Information

- Authentic leaders have self-transcending values, higher levels of compassion, and altruistic attributes which prepares them to be positive role models (George 2003; Gardner 2005).
- **Transparency**, an attribute of authentic leadership, encompasses personal integrity, relationship integrity and shared decision-making, which can lead to positive follower outcomes, such as: engagement, job satisfaction and workplace well-being (Van Iddekinge, Taylor, & Edison 2005). Authentic leaders with relational integrity are open, honest and connect with others by sharing personal experiences.
- **Caring**, an attribute of authentic leadership, is a concept congruent with the core values of the Nursing profession.
- Caring authentic nurse leaders positively shape nurses' job satisfaction, engagement, trust and ultimately how they provide patient care (Bishop 2013; Pipe 2008; Wade, Osgood, Avino, Bucher et al., 2008)
- Research has determined that Authentic Nurse Leadership (ANL) and Healthy Work Environments (HWE) improve nurse engagement and patient outcomes.
- Until recently, research linking ANL and HWE was limited due to lack of measurement tools.
- Development of a valid and reliable ANL Questionnaire (ANLQ) provided the means to conduct research linking ANL and HWE. (Giordano-Mulligan 2017; Giordano-Mulligan & Eckardt 2019)
- The ANLQ was first used in a correlational, descriptive study that identified a positive relationship between ANL and HWE. (Raso, Fitzpatrick & Masick 2019).
- A second study by Raso and associates (2020) focused on determining if a positive relationship between ANL and HWE would be upheld during the COVID-19 pandemic. Findings supported ANL as an essential standard of HWE.

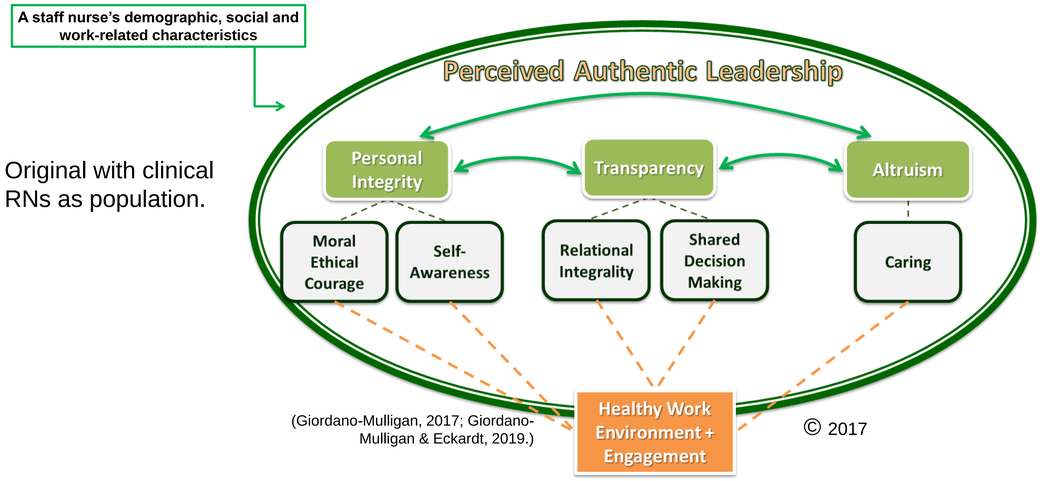
Significance

This research provides scientific evidence that closes the gap in previous knowledge regarding: 1) Nurse leaders' perceptions of ANL attributes; and 2) Relationships between ANL and HWE.

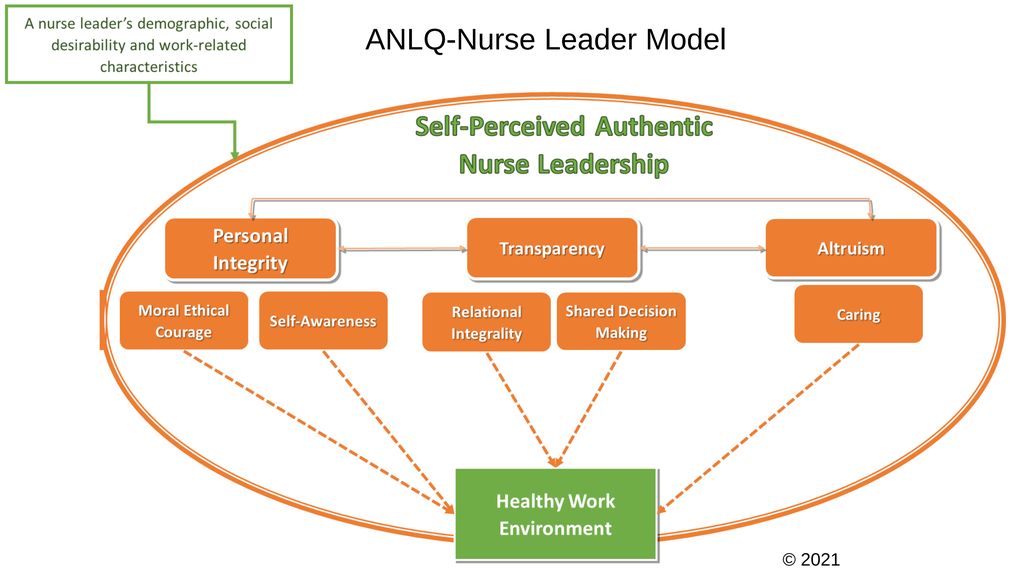
Theoretical Framework

The **conceptual framework** that guided this study was developed based on critical review of literature, authentic leadership theory (George, 2003; Avolio, et al., 2004) and the concept of caring (Ray, Turkel, & Marino, 2002; Boykin & Schoenhofer, 2013). Subsequently, research (Giordano-Mulligan, 2017) developed the ANL model.

Authentic Nurse Leadership Conceptual Framework



ANLQ-Nurse Leader Model



Methods

The study used a non-experimental, correlational design to compare the ANLQ - Nurse Leader instrument (ANLQ-NL) with Healthy Work Environment (HWE), as measured by the Areas of Work Life Survey (AWS). The Marlowe-Crown Index of Social Desirability (SDI) measured nurse leaders' tendency to produce socially desirable responses.

The sample consisted of 207 nurse leaders. Demographic characteristics were identified.

Expert Panel

- ANLQ-NL: 29 items, 5 subscales
- Content validity analysis determined no questions were below the CVI benchmark (S-CVI: Self-Awareness = 0.96; Moral Ethical Courage = 0.96; Relational Integrality = 0.97; Shared Decision Making = 0.97, Caring = 0.97).

Reliability and Validity

- Cronbach's alpha for reliability tested the ANLQ-NL as a full scale, as well as the subscales.
- Exploratory Factor Analysis (EFA) tested validity of the ANLQ-NL.

Results

To accurately identify validity and reliability of the tool, it was anticipated that about six to ten subjects per the items on the tool would be needed in the sample.
Sample:
n=207 (~7 subjects per item.)

Demographic	Range	Mean	Std. Deviation
Age:	42	50.45	11.32
Years practicing as a registered nurse:	48	24.75	12.57
Years in current registered nurse position:	39	7.73	8.39
Years practicing as a registered nurse at current hospital	50	15.49	11.47

Findings demonstrate validity and reliability of the ANLQ-Nurse Leader (ANLQ-NL).

- ANLQ-NL is highly reliable (Cronbach's alpha = 0.91).
- Majority of constructs of AWS (r=0.230, p<.05), SDI (r=0.424, p<.05) and ANLQ-NL were significantly correlated.

Exploratory Factor Analysis (EFA):

- Analysis of the 29 item ANLQ-NL was performed on data from 188 completed questionnaires.
- Principle Axis Factoring with promax rotation was used to analyze factors that presented with initial eigenvalues >1. After identifying the loadings in the 8 factors of the initial EFA and how they compared to the theoretical model, an EFA with a 5-order structure was tested and found to be valid.
  - The rotated factor loading matrix supported the theoretical item structures. Some overlap was identified and correlated with the findings of the initial study of the ANLQ (Mulligan-Giordano, 2016).
  - The domain of **Transparency** (shared decision-making and relational integrality) indicated cross-loading. Aligns with **ANL Conceptual Model**.
  - **Caring/Altruism** loaded as the first factor.

Relationships:

- AWS Workload and Control weakest correlations to ANLQ-NL.
- ANLQ-NL MEC indicated fewer strong correlations than other measures except for SDM which had only 1 significant correlation to the AWS Community subscale.
- MEC indicated the lowest significant correlation to the Social Desirability Index (SDI).

Limitations

- Majority of the demographic sample survey respondents were female (89%).
- Nurse Leaders are a small population within the typically large sample of clinical RNs.
- Difficulty in recruitment to reach a proper sample size for our reliability and validity testing of the tool (emails were used for the recruitment method at multiple Northwell sites.)
- Responses from one health system may limit generalizability of findings.
- Hawthorne Effect despite anonymity of participation in study.

Implications for Practice

- ANLQ-NL is a valid and reliable instrument to measure Authentic Nurse Leadership (ANL) among nurse leaders.
- ANLQ-NL (based on the ANL Conceptual Framework) was statistically supported by exploratory factor analysis (EFA).
- Study findings will facilitate "360 degree" assessment of nurses' performance.
- ANLQ-NL and ANL Conceptual Framework (both statistically significant) can be used with confidence as a Nursing Leadership Career Framework that supports development of Healthy Work Environment (HWE).
- Further research is needed using diverse nurse populations for continued validation of the ANLQ, ANLQ-NL and ANL Conceptual Framework.

Supporting Families through First Episode Psychosis

Susan Fitzgerald, DNP, RN, NE-BC

Zucker Hillside Hospital
Northwell Health℠

Research Question

Do psychoeducational support groups impact stress and self-efficacy on family caregivers, when provided shortly after the diagnosis of First Episode Psychosis?

Background

- Approximately 100,000 adolescents and young adults in the US experience Fist Episode Psychosis (FEP) each year (National Institute of Mental Health [NIMH], 2015).
- FEP significantly impacts families, leaving them stressed and alone with little support or understanding of the disease.
- The theoretical framework of the research is based on Roy's Adaptation Model.

Significance

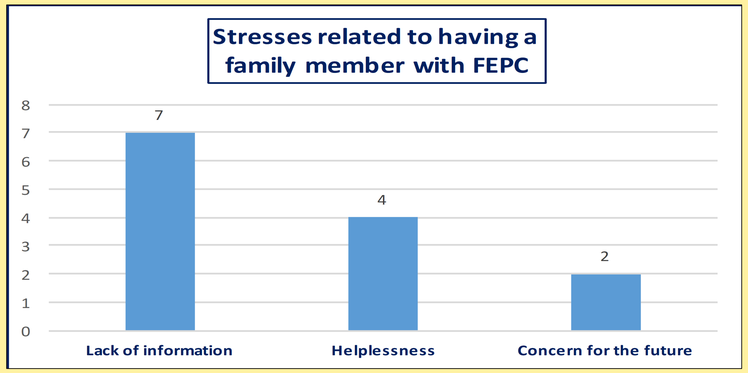
Psychoeducational support groups provide education, resources, and support from other families. Venting Concerns and participating in constructive discussion within the safety of the group, are a means if reducing stress and burden in families. (Gleeson et al. , 1999)

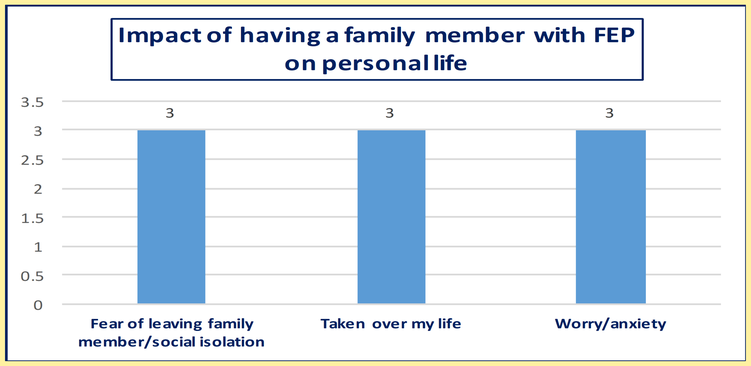
Methods

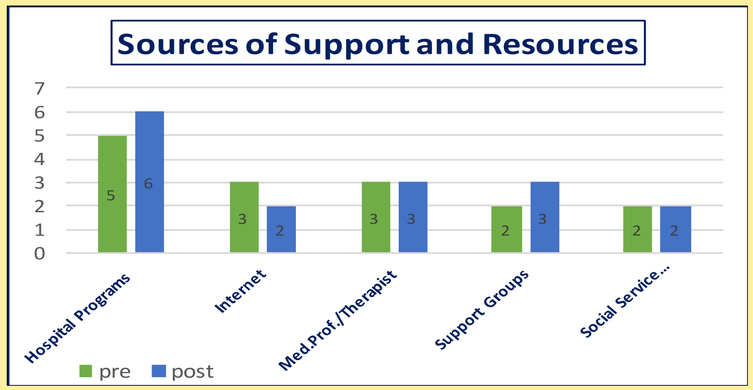
- **Design**: Quasi experimental
- **Recruitment**: FEP Programs in Northwell Health
- **Intervention**: A psychoeducational support group series lasting 6 hours
- **Measures**: General Health Questionnaire – 12 (GHQ-12) (to assess stress) and Self -Efficacy Scale for People with Mentally Ill Relatives (to assess self-efficacy). Both were administered before and after the support group series.
- **Qualitative data**: Open ended questions about the caregivers' individual experiences and needs were collected at the end of the support group
- **Data Analysis**: A two tailed paired t-test for quantitative data and qualitative descriptive technique for qualitative data

Results

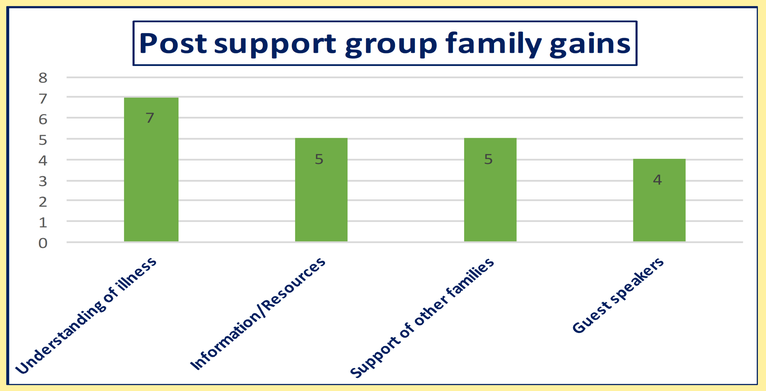
- Four psychoeducational support group series were conducted.
- A total of n=15 subjects completed the study.
- GHQ- 12 scores of dimension one, which assesses anxiety and depression, decreased significantly.
- Qualitative themes included an increased understanding of FEP, availability of information, resources regarding the illness, and finding support from other families.







Results



Implications for Practice

- Video conferencing groups should be explored as an option to increase flexibility for families. Also, families may be better able to process information and gain psychoeducational support when the crisis stage of the FEP diagnosis has passed.

References

Fact Sheet: First Episode Psychosis. Facts about Psychosis.(2015, August). Retrieved from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode- psychosis.shtml

Gleeson, J., Jackson, H. J., Stavely, H., & Burnett, P. (1999). Family intervention in early psychosis. *The recognition and management of early psychosis: A preventive approach*, 376-406.

Implementation of a Nursing Emotional Intelligence Program to Improve Patient Satisfaction

Deepti Nair, DNP, RN, PMH-BC, CNE

Northwell Health

Zucker Hillside Hospital
Northwell Health

Background/Significance

- Patient satisfaction is an essential determinant in quality healthcare.
- **Patient dissatisfaction:**
  - poor attitudes towards clinical care
  - decreased treatment adherence
  - negatively impact financial revenue
- Patients evaluate nursing care.
- **Patient-centered care:**
  - nursing communication skills
  - provision of information
  - patient education

PICO(T): For registered nurses working on an inpatient adult psychiatric unit, will the implementation of an emotional intelligence (EI) training, compared to no intervention, improve patient satisfaction in nursing care?

Evidence Synthesis

- Nurses with higher levels of EI influenced higher patient satisfaction rates.
- Nursing EI scores improved after EI trainings were provided.

Recommendations/Strength & Evidence Quality

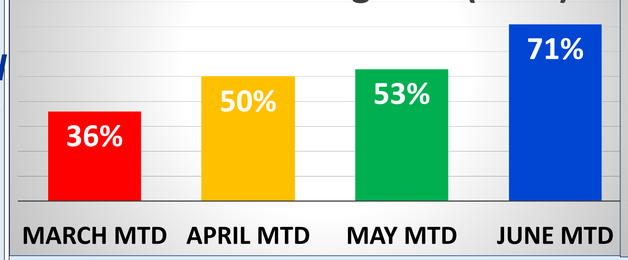
- Level I systematic review, 3 Level III quasi-experimental studies
- High quality, strength of evidence supported the recommendation of implementing education to nurses on developing EI skills to improve patient satisfaction.

Implementation

- **Participants:** 17 nurses working on an inpatient psychiatric unit
- **Timeframe:** 10 weeks
- **Measurement tools:**
  - Pre/post intervention Press Ganey patient satisfaction scores in nursing care
  - Pre/post EI scores using the Emotional Intelligence Appraisal (EIA)
- **Interventions:**
  - 2-hour virtual training
  - 4 weekly 30-minute online modules
  - 4 weekly journal clubs

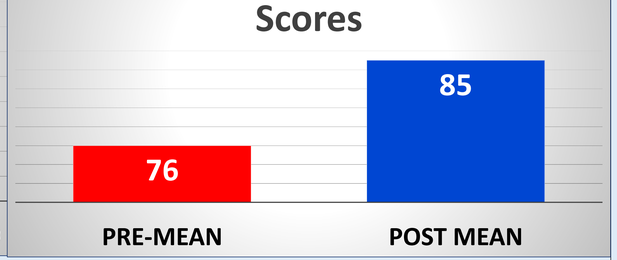
Outcomes/Evaluation

Pre/Post Mean Press Ganey Scores in Nursing Care (2021)

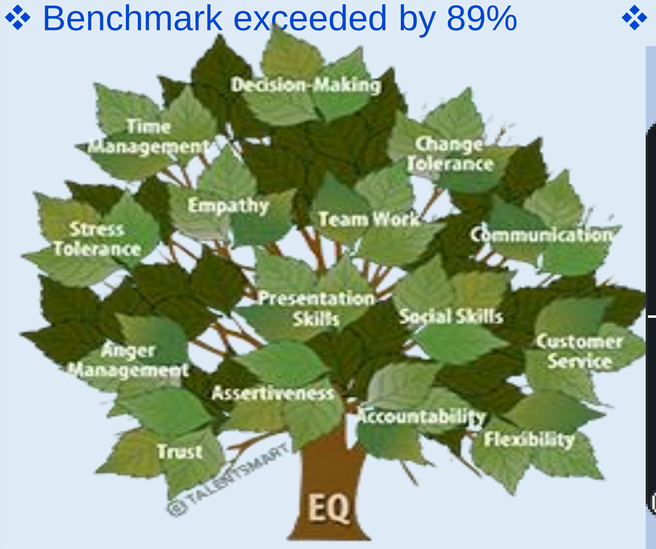


❖ 97% increase patient satisfaction
❖ Benchmark exceeded by 89%

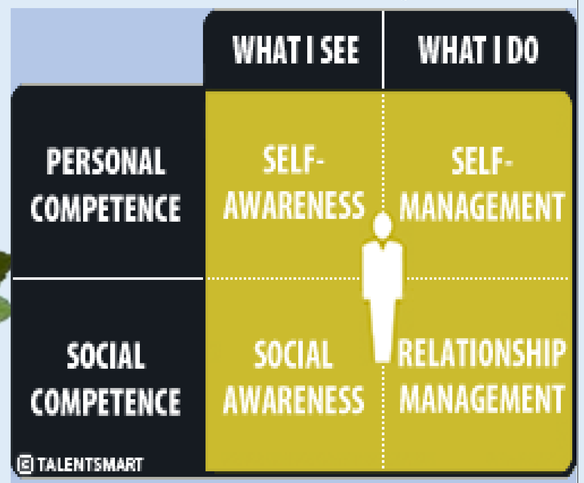
Pre/Post Mean Nursing Emotional Intelligence Scores



❖ 12% increase nursing EI scores
❖ Benchmark exceeded by 2%



Emotional intelligence is the foundation for critical skills.



Emotional intelligence is made up of four core skills.

Implications

- EI trainings support the patient experience tied to value-based purchasing.
- Financial benefits to healthcare organizations and improved healthcare outcomes.
- Staff educational programs should be developed to improve patient satisfaction.
- EI trainings should be incorporated for all current nurses and new hires.
- Training expansion to the interprofessional team can make a greater impact on patient satisfaction.

QR code link to MindTools EI Quiz

References:

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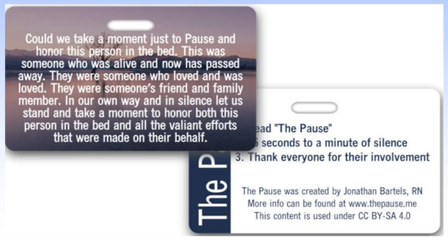
Recognizing a Life and Reducing Staff Stress with "The Pause"

EBP for Practice Change

A. Sagendorf MSN,RN, J. Svoboda BSN, RN, S. Cota MS, RN

South Shore University Hospital
Northwell Health



Introduction/Background

- Stressful incidents in the ED can be profound (Healy & Tyrell, 2011) and repeated exposure to death and grief may lead to occupational stress (Frey et al., 2018; Kapoor et al., 2018) and ultimately burnout (Frey et al., 2018).
- Long term occupational stress has been shown to lead to burnout (Potter, 2006).
- After a devastating loss, South Shore University Hospital Emergency Department joined together to change the repetitious cycle of stress, emotional exhaustion, burnout, and compassion fatigue associated with patient expirations.
- "Pause" has a psychologic background and has been defined as "suspension of goal-oriented activity and temporary disengagement from habitual behaviors (Brach, 2014; Kapoor et al., 2018). It also provides an opportunity to provide humanistic care and reflective practice (Ducar & Cunningham, 2019).
- The Pause occurs after a patient death and provides the care team members a few seconds of silence to honor a patient while honoring the efforts of the healthcare team. The Pause is a form of self-care and evidence suggests it may improve teamwork, support and connectedness (Cunningham & Ducar, 2019).
- Prior research:
  - Kapoor and Colleagues (2018) (Level VI)
    - 18 Bed ICU where 70 Pause Ritual were performed (n=34 clinicians). Findings: Pause brought closure and helped them overcome feelings of disappointment, grief, distress and failure, increased a sense of "team effort", staff felt more appreciated and improved their professional satisfaction. 85% of participants said The Pause should be a "Universal Phenomenon and 70% reported the practice helped their bodies *handle stressful situations*
  - Cunningham & Ducar (2019)(Level VI)
    - Qualitative Study-Theme emergence: Implementation of the pause allowed staff to support each other, assisted in developing a culture of teamwork and community, provides a culture of caring by supporting staff in times of grief & loss and provide respect for the patients
    - The Pause helps reduce caregiver stress

Significance

- In patient death, staff can express feelings of discouragement, disconnection, and compassion fatigue (Frey et al., 2018), Therefore, in an effort to decrease staff stress and provide humanistic care, our unit implemented "The Pause"
- In 2019, the ED at SSUH reported a 52% of workforce responded unfavorably to the question: "*the amount of job stress I feel is reasonable*".

PICO

Will the implementation of "The Pause" after death in the ED decrease reported staff stress compared to previously reported stress?

Location and Appraisal and Quality of the Evidence

- Literature review through PubMed, keywords "The Pause", "Stress in Death", "Sacred Pause"
- Two research studies (Level VI).

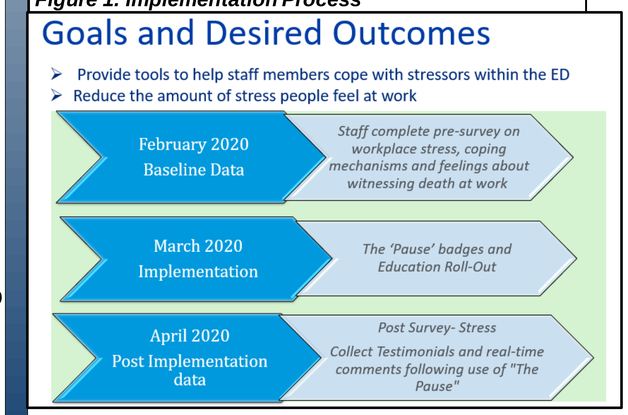
Synthesis of the Evidence and Recommendations

Ways to cope and reflection are important for staff especially in loss, death and trauma (Rettig et al., 2020). There is evidence to support implementing "*The Pause*" to assist staff in handling stress, bringing closure during a distressing time (Kapoor et al., 2018) while supporting teamwork and community and providing a culture of caring (Ducar & Cunningham, 2019).

Implementation Process

This project was implemented as part of the Healthy Work Environment Challenge.
In March 2020 education and badges with "the Pause" narratives were rolled-out.

Figure 1. Implementation Process



Outcomes/Evaluation

Workforce Engagement Survey Response
(2019 vs. 2020)

- Demonstrated a 33% decrease in those who responded unfavorably to "the amount of job stress I feel is reasonable"
  (52% in 2019 vs. 19%, in 2020).
- Testimonial Statements from Staff Nurses regarding "*The Pause*

Figure 2. Measurable Outcomes Post Implementation

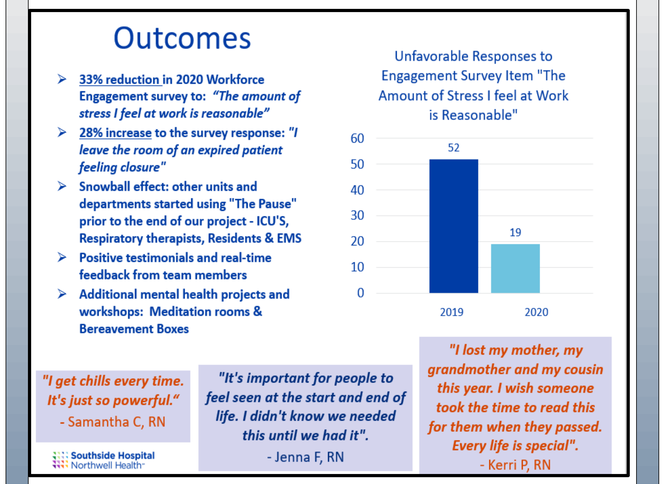
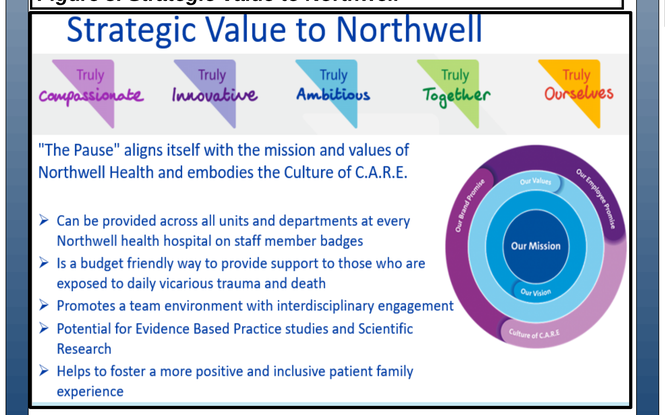


Figure 3. Strategic Value to Northwell



Implications for Practice

Education & Practice
The Pause should be part of Nursing Curriculum and Practice as it is consistent with the 2015 ANA Code of Ethics as described as: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person and the nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth (ANA, 2015)

Research
Implementation of The Pause is consistent with patient-centered care and clinical self-reflection, which can promote healing. This is an area underexplored, providing a robust area for future research.

Organizational Goals
"The Pause" is consistent with the ANCC 's Magnet Recognition Program, which recognizes the implementation of knowledge, innovation and compassion to persons (ANCC, 2020). "The Pause" can provide support and reduce staff stress levels while being consistent with providing dignity and respect to patients and families.

Future Research:
Cunningham & Ducar (2019) recommend rigorous study to better understand its impact on caregivers and patients.
Concepts: Compassion fatigue, Burnout, Patient and Family Centered Outcomes (Family experience witnessing the Pause), Stress, Moral Distress

References

SCAN ME

Changing Stigmatic Perceptions on Mental Illness and Substance Abuse among Public Library Staff: A Nursing-Library Initiative

Denise Driscoll RN-BC, CARN, PMHCNS-BC, NPP, Lilly Mathew PhD RN,
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Mather Hospital
Northwell Health

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Background/Significance

Today, 44 million Americans are living with mental illness; Suicide has become the 4th leading cause of death among adults, 3rd among adolescents and children (NAMI, 2019). There are more than 9,000 public library systems across the United States (Library Research Service, 2018). Each year there are 1.5 billion visits to American libraries, which exceeds the number of physician office visits by over 50% (Pelezar, Frehill, Williams, & Nielsen, 2019).

Many homeless individuals utilize public libraries frequently for entertainment and use the internet (Kelleher, 2012). Public librarians surveyed have expressed their interest in learning more about serious mental illness so that they can effectively interact with users who have them (Pressley, 2017).

PICOT Question

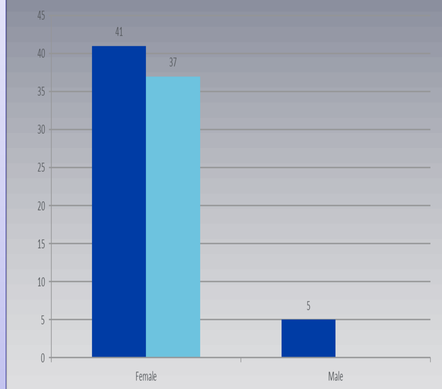
Do Public Library Staff after a 3 week educational session on mental illness and substance abuse have any change in stigmatic perceptions?

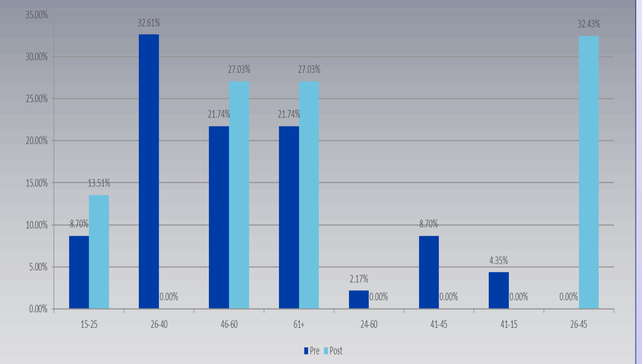
Evidence Synthesis

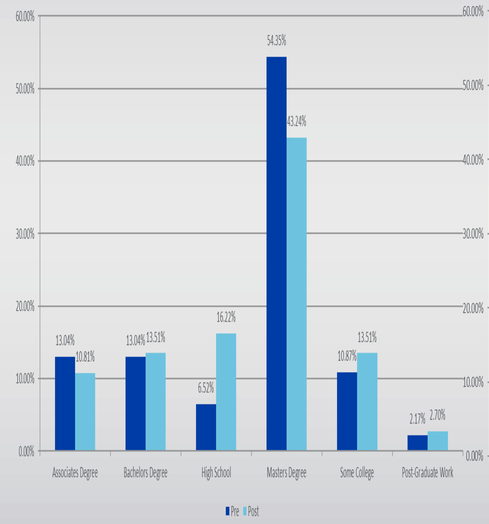
"Community conversations" has proven to be an effective strategy in inducing a change in social values for empowerment (Cao, Huis, Jemaneh, & Lensink, 2017) and to address mental health stigmas among ethnic minority populations (Knifton et al., 2010). This project is innovative as it addresses stigmatic perceptions among Public Library staff.

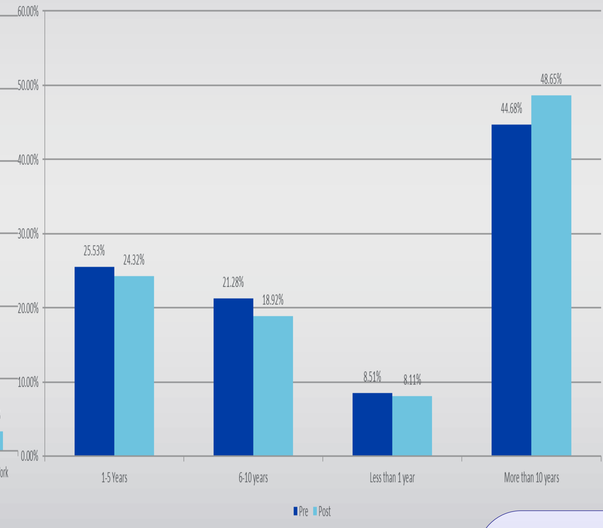
Project Evaluation

Evaluation questionnaire designed included demographic variables, years of Service in the library, and common mental health and substance abuse related perceptions









Project Implementation Process

In 2019, a project with New York Library Association (NYLA) Community Change Agents, established five teams to identify issues within their communities, and develop an action plan to create sustainable change. Through an assessment process called "community conversations", Librarians identified a need to understand how to serve patrons with stigmatized health conditions, particularly mental illness and substance abuse better.

On Long Island, the team was led by a psychiatric advanced practice nurse and the director of a local library. The project included partnering with three mental health and substance abuse agencies to provide education to the Library staff.

Project Outcomes/ Implications

A total of N=37 Librarians attended the educational sessions and completed pre & post questionnaire. There was a statistically significant difference in the scores for stigmatic perceptions "*commonality of substance abuse*" pre (M= 3.10, SD= 1.35) and post (M= 3.78, SD= 1.61); t(81)= -2.07, p = .04 and "*embarrassed to disclose mental illness*" (M=3.80, SD= 1.43) and post (M= 4.47, SD= 1.66); t(79)= 1.94, p = .05.

Library staff education through partnerships with the health sector like nursing is beneficial not only to address stigmas but also to help them manage patrons with mental illness and substance abuse effectively.

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Enrollment in a Tobacco Dependence Treatment Program during the COVID-19 Pandemic

Presenters

Patricia Folan DNP, RN, Christine Fardellone DNP, RN, Raisa Abramova FNP-BC, Andrea Spatarella DNP, FNP-BC

Research Question/Problem

During the pandemic, COVID 19 mortality rates were higher in those who smoke. Smokers reported relapse to tobacco use during the pandemic and/or an increase in the number of cigarettes smoked. Individuals reported working from home, with more opportunity to smoke without restriction, as one reason for increased use, as well as increased stress, anxiety, boredom, and isolation.

Background Information

Tobacco use is the leading cause of preventable disease, disability, and death in the US. Motivation to quit is an important factor in the quit process. A report from NCI, indicated that monthly calls to the state quitlines decreased during the first four quarters of the pandemic when compared to the previous year. During the same time period cigarette sales increased. During the pandemic, without smoke-free restrictions at home, smokers increased use.

Theoretical Framework

The theoretical framework of the Tobacco Dependence Treatment Program is based on Pender's Health Promotion Model. Education regarding risks of smoking and COVID-19 may promote improved health care outcomes .

Significance

Educating healthcare providers and the community about the impact of COVID 19 on smokers and offering a virtual tobacco cessation program may motivate patients to quit, increase cessation rates, and decrease the more severe consequences of COVID 19 infection.

Methods

A health system tobacco cessation program was offered remotely with individual telephone or telehealth sessions and weekly virtual support groups. Referrals to the program came from physician practices via the EHR system or by self-referral. Data was collected on the number of enrollments and quit status.

Patient Testimonials

Those who participated in Tobacco Dependence Treatment during the COVID-19 Pandemic expressed messages that help them remain abstinent.

"I have several health conditions that put me at risk for getting really sick if I get COVID 19. The one thing I can do to help myself is quit smoking." (Male, age 58)

"During the pandemic, I have suffered personal loss and increased stress. I know smoking will only make things worse. The smoking cessation support group is helping me avoid relapse and remain healthy." (Female, age 50)

"Since working remotely, I started smoking 2 packs per day instead of 1 pack per day. I need to quit smoking all together!" (Male, age 25)

Results

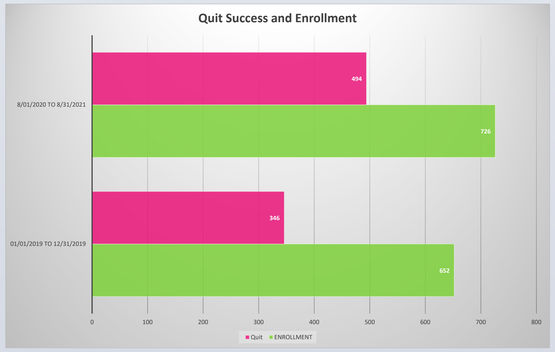
There was a significant increase in program enrollments and quit rates during the pandemic compared to the previous year.

The Chi Square Test of Association was used to evaluate the variables of Enrollment and Quit Success.

Statistical significance was achieved for both variables.

Enrollment: 726 vs 652, $p = 0.00$.

Quit Success: 494 (68%) vs 346 (53%), $p = 0.00$.



Implications for Practice

The majority of individuals enrolled in the program cited concerns about contracting COVID-19 while smoking and indicated that it was the main reason for their quit attempt. Health care providers who are aware of the dangers associated with smoking and COVID-19 infection, as well as the potential risk of relapse during the pandemic may have been more likely to ask about tobacco use, offer brief counseling, and refer for additional support. The pandemic may have increased the motivation to quit among many tobacco users. Although the quitlines experienced a decrease in calls from tobacco users during the pandemic, our program with assistance of referring practitioners was able to enroll a substantial number of patients for tobacco dependence treatment. In addition, as individuals return to work, continuing tobacco control measures, such as tobacco-free indoor and outdoor environments is important in reducing smoking and encouraging cessation.

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Preventing Pressure Injuries in the Pediatric Intensive Care Unit

Maria Marchelos MSN, RN, CCRN-K, NEA-BC
Lincy Philip MSN, RN, CPN
Emanuel Remilus BSN, RN
Cohen Children's Medical Center

Background/Significance

Critically ill children are at risk of developing hospital acquired pressure injuries (HAPIs). The prevention of HAPIs in this vulnerable population requires a multi-faceted and interdisciplinary approach and pediatric evidence-based protocols. In 2019, the Pediatric Intensive Care Unit (PICU), a 25-bed unit saw an increase in HAPIs, which accounted for the large majority of HAPIs incurred at the hospital.

PICOT Question

Our investigation focused on the PICU to determine how effective pediatric-centered pressure injury prevention (PIP) strategies are compared to standard PIP in decreasing HAPIs during the PICU length of stay.

Evidence Synthesis

Solutions for Patient Safety, an organization comprised of over 145 children's hospitals dedicated to eliminating harm to children, developed a PIP bundle and additional elements to decrease pressure injuries in the pediatric population. Current PIP methodology is adult focused and understanding regarding the diversity of age and skin maturity, ranging from neonates to adolescents needs further exploration.

Evidence-based Recommendations

Recommendations included

- active surveillance to identify and mitigate high-risk situations
- implement and measure compliance with the PIP bundle
- partner with a wound care nurse to optimize PIP strategies
- These recommendations are primarily based on Level 1 evidence. This PIP bundle, focused on the pediatric population, is the first of its kind.

Implementation

Bundle components were implemented through collaboration and education of the PICU team, skin champions, unit leadership, and the wound care nurse. They included:

- Skin assessments every 12 hours
- Device rotation
- Turn and position immobile patients every 2 hours
- Moisture management
- Use of pressure reduction devices

Outcomes

The PICU saw a 61% decrease in HAPIs ≥ Stage 2 with no significant change in the number of those related to medical devices. Additionally, there was an increase in the reporting of Stage I HAPIs which may be linked to the focus on early recognition and collaboration with the interprofessional team to prevent pressure injuries from progressing.

Implications for Practice

Continued efforts are necessary to review and evaluate relevant pediatric PIP clinical practice elements. More work is needed to develop tools to identify pediatric patients at higher risk of pressure injury due to medical devices.

References:

Cohen Children's Medical Center
Northwell Health℠

Improve the Knowledge Level of Clinical Nurses: Development of an Extravasation Management Protocol

Neethu Gopinadh, MSN, RN, OCN, VA-BC™

Background/Significance

- If there is a delay in the recognition and treatment, extravasation of chemotherapy can lead to consequences such as blistering, sloughing, tissue necrosis, and damage to tendons, nerves, and joints.
- An assessment was conducted to assess the knowledge level of clinical nurses on the prevention and management of extravasation.
- The test results revealed a score of 12.5% to 100%.
- Timely management represents a challenge due to the knowledge gap and the time constraints on reading the guidelines/policy.

PICO

- In clinical nurses working in an ambulatory infusion center, does the availability of a protocol improve the knowledge level related to the management of extravasation?

Location and Appraisal of Evidence

- A literature review using the PubMed, UpToDate, and Google Scholar data bases was conducted.
- The guidelines established by the Oncology Nursing Society (ONS, 2019), Quality Oncology Practice Initiative (QOPI) standards established by the American Society of Clinical Oncology (ASCO, 2020), and the institutional policy were reviewed.

Evidence Synthesis

- Evidence from the literature review provide critical information for the prompt management of extravasation.
- According to the QOPI standard 3.10, facilities should have defined extravasation management procedures based on current literature and guidelines (ASCO, 2020).

Strength and Quality of Evidence

- There was no evidence of randomized controlled trials (RCTs) conducted in humans.
- Even though deficiencies were found in several guideline quality domains, the practice recommendations were strong.

Recommendations for Practice

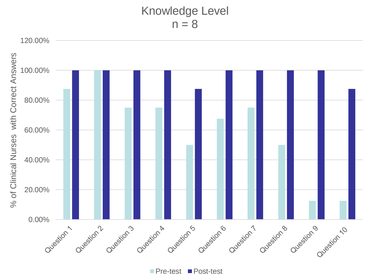
- The quick availability of a protocol and an extravasation kit is critical for units where chemotherapy is administered.

Implementation Process

- Education of the clinical nurses
- Consultation with the oncology pharmacists for expert opinion
- Development of the protocol
- Making a readily available extravasation kit and protocol for quick reference

Outcome

- A post-test was conducted to evaluate the knowledge level
- Improved knowledge level of clinical nurses with a score of 87.5% to 100%.



Protocol

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Implications for practice

- Clinical protocols support healthcare professionals to perform procedures based on the best available evidence.
- The standardization of nursing practice using protocols is essential to improve patient safety and patient outcomes.
- It is critical to update protocols and evaluate the knowledge level of team members on an ongoing basis.
- Assessment of the knowledge level of clinical nurses will be conducted during annual competency.

References

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Individual Characteristics and Shared Decision-Making for Stroke Prevention in Atrial Fibrillation

Original Research

Patricia Nadraus, PhD, RN, CCRN-K

No disclosures to report

Background

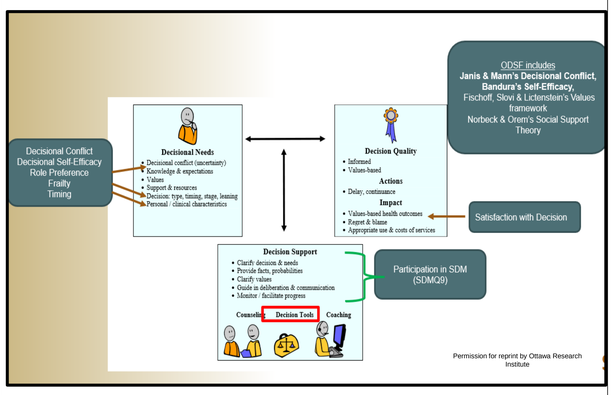
- Afib is the most common type of heart arrhythmia and associated with a fivefold risk of thromboembolic stroke
- 2.7 million and 6.1 million American adults (January et al., 2014), and with the growing elderly population that number is expected to double by 2030 (Colilla et al., 2013).
- Stroke prevention therapy- complex choice (equipoise)
- With the advent of *patient-centered care*, patients are asked and sometimes required to participate in a ***shared decision-making (SDM***) process when considering therapeutic management for thromboembolic stroke prevention in Afib
- Shared Decision-Making
  - "***Meeting of the Expert***" (Tuckett et al., 2018)
  - Expected to ***decrease medical costs*** because of unnecessary treatments (Veroff et al., 2013).

Problem/Gaps/Significance

- Despite ethical, legal and society guideline recommendations along with CMS mandates, individual characteristics in relation to shared decision-making have not been explored.
- Gap: Individual Characteristics in individuals with Afib have not been examined in their relationship to perceived participation in SDM
- Significance- SDM used appropriately has the potential to impact decisions and provide an opportunity of cost containment while being ethical and equitable in healthcare

- The purpose of this study was to explore and investigate relationships between demographics, clinical features, decisional self-efficacy, decisional conflict, control preference, and frailty status on perceived participation in SDM in individuals with Afib

Ottawa Decisional Support Framework



Research Questions

Shared Decision-Making	Decisional Conflict	Satisfaction with Decision
• Demographics • Clinical Factors (CHA2DS2-Vasc score) • Decisional Self Efficacy (DSES) • Decisional Conflict (SURE Test) • FRAILTY Status • (FRAIL Scale) • Control Preference (CPS) • Education packet /Decisional Aid	• Demographic • Education packet/Decisional aid • Time since decision	• Shared Decision Making

Methodology

- Cross sectional Quantitative, Convenience sample (Afib.org-HON Certified) evaluate constructs of decisional needs (e.g., individual characteristics) as described by the ODSF- Survey Monkey online
- Inclusion: USA citizen , =/> 18yrs, Afib diagnosed by a HCP, Decision timing(currently deciding or within the last 3 months) decided).
- Power analysis G*Power 145-180 participants
- Data collection: Dec.2019-March 2020. Pairwise deletion on SPSS 26.0
- Instruments with reliability testing (Table 1)

Results

- Participants: N=201- White (97.5%), female (53.7%), between 65 and 74 years old (47.8%), married or partnered (75.6%), and college educated (72.2%)
- Greater participation in SDM reported in participants: 75 years or older (p = .023), men (p = .002), permanent Afib (p = .049), CHA2DS2-VASc score of 3-7 (p = .043), individuals receiving an educational packet/DA from HCP (p < .01)
- Variables of interest and relationship with SDM (Table 2)
- Decisional Conflict- Overall, 76.2% (n = 32) of individuals currently considering a treatment decision (Figure 1)
- Correlation of SDM and Satisfaction with Decision and Predictive Models of SDM and DC (Table 3)

Table 1. Instrument Reliability Testing in this Sample

Instrument Reliability Testing

Instrument	Statistical Findings	Sample	Test
DSES	.952	201	Cronbach's α
SDM-Q-9	.930	181	Cronbach's α
SWD Scale	.915	133	Cronbach's α
SURE test	.808	201	Spearman-Brown Split Half
CPS	.669	192	Spearman-Brown Split Half
FRAIL	.743	185	Spearman-Brown Split Half

Table 2. Variables of Interest and Shared Decision-Making

Variables and Participation in Shared Decision Making

Variable	Statistical Findings	Sample	Test	Findings
DSE	**<.01 28.7% variance**	177	Pearson's Correlation	Strong positive relationship (.536) DSE scores explaining 28.7% of variance
SURE test	**<.01** Effect .09	181	ANOVA	Participants reporting decisional conflict reported lower *M*ean scores on the SDM-Q-9 (51.52 versus 66.46)
CPS	.099	180	ANOVA	Participants reporting a passive role reported greater *M*ean scores on SDM-Q-9 (67.85, Collaborative/Shared 60.14, Active 56.60)
FRAIL	.890	176	ANOVA	Participants reporting Frail Status reported greater Mean scores on the SDM-Q-9 (62.53, Pre-Frail 60.08, Robust 59.66)

Figure 1. Time Since Decision and Decisional Conflict (p < .001)

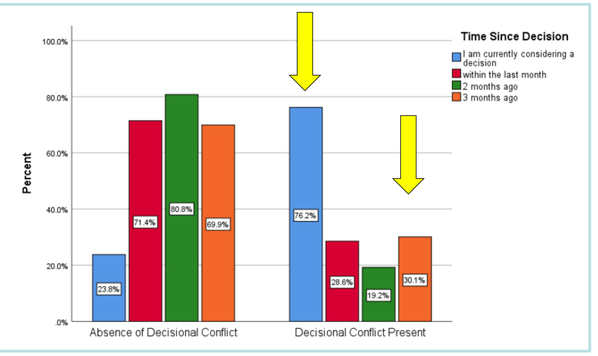


Table 3. SDM and Satisfaction with Decision, Prediction Models- SDM and Decisional Conflict

Outcomes	Statistical Findings	Sample	Test	Findings
Participation in SDM and Satisfaction with Decision	**<.01**	129	Pearson's Correlation	Strong positive relationship (.431) SDM-Q-9 scores and SWD scores explaining **18.5%**
Predication Model				
Shared Decision-Making	**<.01**	181	Logistic Regression	Model: type of Afib [permanent], CHA2DS2-Vasc categorical [3-9], gender [male], age [=/>75], decisional conflict [none reported] and receiving an educational pamphlet/decisional aid by health care provider). **Greater Self Efficacy Scores and Receiving an Education Packet/Decisional Aid most predictive**.
Decisional Conflict	**.003**	155	Logistic Regression	Model: (Female, Non-Partnered, Paroxysmal Afib, and not receiving an Educational Packet/Decisional Aid. **Non-partnered (.022) and not receiving an educational packet/decisional aid (.019)**

Implications for Nursing

- Critical to examine an individual's characteristics influencing participation in shared decision-making.
- Previous studies in SDM focus on use of DA's and Decisional conflict, this study provided insight into clinical characteristics as potential facilitators and barriers to participation in SDM for stroke in Afib.
- The results of this study have broad implications for providing individualized care through the development of comprehensive needs assessment to facilitate patient-centered care.
- Clinicians should evaluate their own perceptions of patient's role in decision making

References

QR Code

SCAN ME

Health Literacy focusing on Clinician Education

AHRQ's Health Literacy Universal Precautions Toolkit

EBP Synthesis of Evidence and Recommendations

Susan Murphy MSN, RN, CCRN, Cheryl Coletti BSN, RN, CVRN & Rachel Haddock, MSN, RN, CVRN

No disclosures to report

Background and Significance

- Improving health literacy (HL) to promote patient safety has been endorsed with guidelines by the American Medical Association and the Joint Commission (Brega, Barnard et al., 2015)
- Healthy People 2030 Health Literacy Goals (3/6 Goals) (U.S. Department of Health and Human Services, 2021). This project will focus on "Organizational Health Literacy"
- Health literacy (HL) is an important predictor of health status. Low HL is associated with an increase death rate (Fabbri et al., 2020; Fan et al., 2021; Bostock & Steptoe, 2019)(Level I, III), lower self-rated health, and higher rates of long-term health conditions (Rowlands et al., 2020)(Level VI)
- Clinicians may lack counseling skills and knowledge about the principles of adult learning and education, especially when educating those with limited HL (Podergajs, 2016)(Level VII)
- With the intention to improve on HCAPS scores and mitigate negative patient narratives at follow up, our unit identified an opportunity to implement the AHRQ' s Health Literacy Universal Precautions Toolkit (AHRQ's-HLUPT) focusing on the organization and raising awareness of clinician training in health literacy

PICO(T)

What is the effect of implementing the AHRQ's Health Literacy Universal Precautions Toolkit focusing on clinicians training in a cardiology unit on HCAPS scores and patient narratives at follow-up compared to baseline data?

Framework

- Health Literate Care Model is based on the health literacy universal precautions, which acknowledges the need for providers to approach all patients with the assumption that they are at risk of not understanding information relevant to maintaining and improving their health
- Lewin's Change Theory
  - Unfreezing-Moving-Freezing

Goals- SMART goals

- Increase HCAP Scores
  Specific: Communication with Nurses, Communication about Medicines, Discharge Information and Care Transition
- Decrease negative/concerning patient follow up narratives (48hr/30day)
- Potential Readmission assessment (currently reviewing unit readmission rates-report pending)

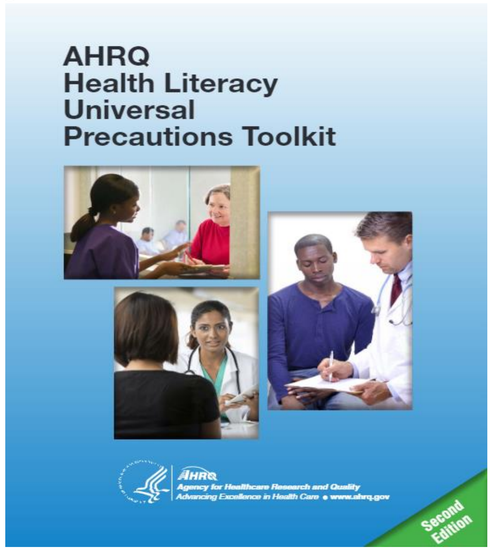
Location & Appraisal of Evidence

Using the IFN EBP Algorithm guided our review of the literature and assisted with synthesizing the evidence and evaluating Quality & Strength. Fourteen articles were reviewed along with the AHRQ's Health Literacy Universal Precaution Toolkit 2nd Edition. Level of Evidence I-VII Search Engines utilized include PubMed (Health Literacy", *" Health Literate Care Model", "Health Literacy Universal Precautions Toolkit", "Health Literacy in Cardiology")* Web Of Science ("Health Literacy Patient Satisfaction") Joanna Briggs Institute ("health literacy educating clinicians")

Evidence Synthesis
Strength and Quality of Evidence

- There is strong evidence in the literature to support developing appropriate educational materials, assessment of health literacy in patients, provide HCP with education on HL using the AHRQ's Toolkit (e.g., awareness, assessment tools, effects on outcomes)(Brega, Barnard et al.,2015), and involve all healthcare workers in using the teach-back method to maximize patient's understanding of disease state, treatment, care, and prevention of complications (Brega, Freedman et al., 2015; Ha Dinh et al., 2016; Karliner et al., 2012)(Level VII, I, IV respectively)
- Staff must be educated to recognize limited health literacy (Maniaci et al., 2008)(Level IV).
- To improve HL, staff need to review their current mode of communication and information resources they provide to patients to ensure patients have adequate understanding (Kilonzo et al., 2011 (Level VII) and pay attention to how information is being presented to patients (Dunn& Conard, 2018).
- Organizational Health Literacy has been demonstrated to be associated with patient satisfaction (Hayran & Özer, 2018)

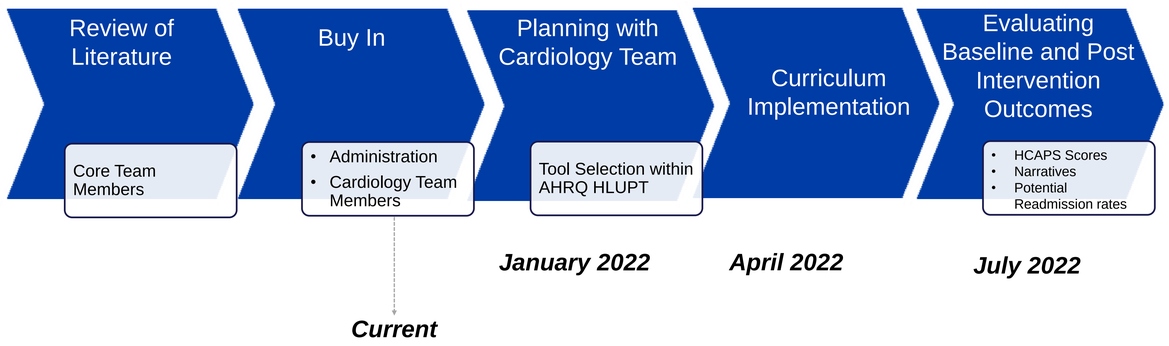
Figure 1. AHRQ's HLUPT



Recommendation for Practice

- Perform a Unit and Individual self-assessment in Health Literacy
- Create a Unit based- Health Literacy Improvement Plan
- Raise awareness on effects of limited health literacy in patients
- Educate staff on Teach-Back Methodology and importance of utilizing Teach-Back in practice
- Evaluate current patient education and instructional materials

Project Tentative Timeline Methodology



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SCAN ME

Evidence Based Practice: Evaluation of Depression screening tools for the Older Adult

Catalina Chistol, BSN, RN, Daniella Gavilanes, BSN, RN, & Meaghan McKiernan, BSN, RN
(Phelps Hospital, Northwell Health Nurse Residency Program)

BACKGROUND

As an age-friendly organization, we screen all patients ≥ 65 for the 4Ms (What Matters Most, Medication, Mentation and Mobility). We use the Confusion Assessment Method (CAM) and suicide risk assessment for mental health but identified a gap in detection of depression. Depression exists in 10-12% of hospitalized older adults. Contrary to the belief that depression is a normal part of aging, depression is often reversible with prompt recognition & early treatment, of which nurses can play a vital role. Left untreated, depression can result in physiological, cognitive, functional and social impairment.

PICO QUESTION

For patients aged 65 years and older, does the use of depression screening tool, compared to no screening tool, improve the identification of patients with depression?

LOCATION AND APPRAISAL OF THE EVIDENCE

We searched CINAHL, PubMed and Google Scholar databases with librarian assistance to obtain 10 articles on depression screening tools.

EVIDENCE SYNTHESIS

We obtained a significant number of high-quality evidence, mainly from systematic reviews, meta-analysis, CPGs & expert opinions.

Last Name and Year of Publication	One sentence summary of what the study is about.	List the findings	Author's conclusions and the bottom-line result(s)?	Do the results answer your question	Level of Evidence
1.Development of a brief Validated Geriatric Depression Screening Tool: The SLU "AM SAD" (Chakkamparabil,2015)	Developing a short depression screening tool with similar sensitivity and specificity as the conventional, more time-consuming tools.	High sensitivity and specificity. High correlation with the conventional tools, MARDS>GDS-15. The AM SAD can be reliably used as a short depression screening tool in patients with a SLUMS score of 20 or higher.	Additional utility to be determined by future studies	Yes	Level III
2. Is the 15-item Geriatric Depression Scale a fair screening tool? A differential item functioning analysis across gender and age.(Chiesi and Primi, 2018)	Longitudinal study (indep variable was age) of 15 item GDS. N= 1305 (542 men/763 women) >60 years old.	Measurement precision of the test was the same across gender and age. GDS-15 works the same in individuals >60, regardless of gender	GDS-15 can be widely used.	Yes	Level IV
3. Which version of the GDS is most useful in medical settings and nursing homes? Diagnostic validity meta-analysis (Mitchell et al.2010)	Comprehensive search of 69 studies; 21 examined comparing versions of GDS (GDS30, GDS 15, GDS4)	Sensitivity/Specificity were: GDS-30: 81.9%/77.7% GDS-15: 84.3%/73.8% GDS-4: 92.5%/77.2%	Short versions often generate substantial false positives. Results- short version recommended in a multistep approach,when applied as an initial screen with repeat assessment of all those who test positive	Yes	Level I
4. Depression in older people in the general hospital: a systematic review of screening instruments (Dennis, Kadri, Coffey, 2012)	Systematic review of 13 screening instruments N=14 studies	The GDS was the most validate instrument at the time (2012)	Best performance was the GDS: cutoff of 5/6 for GDS-15 and 10/11 for GDS-30	Yes	Level I
5. Accuracy of Patient Health Questionnaire-9 (PHQ-9) for screening to detect major depression: individual participant data meta-analysis (Levis, Benedetti, Thombs, 2019)	Accuracy of PHQ9 for screening: meta-analysis	PHQ 9 sensitivity compared with semi structured diagnostic interviews was greater than previous studies.	Cut off score of 10 or greater maximized combined sensitivity and specificity overall and for subgroups	Yes	Level I
6. Accuracy of PHQ2 alone and in combination with PHQ9 for screening to detect major depression (Levis, Ying et al. 2020)	Systematic review and meta-analysis (2000-2015): 100 of 136 eligible studies (N=44,318) Accuracy of scores of PHQ-9 was compared to results from semi-structured clinical interviews by trained professionals	For semi-structured interviews, sensitivity of PHQ-2 scores of 2 or greater followed by PHQ-9 scores of 10 or greater (0.82) was not significantly different than PHQ-9 scores of 10 or greater alone (0.86). Specificity for the combination was significantly but minimally higher (0.87 vs 0.85).	Used individual participant data to assess diagnosis accuracy of PHQ-9 Large sample size Diagnostic accuracy of PHQ-9 was more specific among older adults. *The combination of PHQ-9 was estimated to reduce the number of participants needing to complete the full PHQ-9 by 57%.	Yes	Level I
7. Depression: screening and diagnosis, American Academy of Family Physicians (Maurer, Raymond & Davis, 2018)	Expert content for Continuing Medical Education (CME) compares PHQ-2 and PHQ-9 with GDS and Edinburgh Depression scales	Depression is a major risk factor for suicide in older men. Economic burden of major depressive disorder. Describes risk factors and symptoms of depression for adolescents, pregnant & postpartum women & older persons. Provides valid & reliable screening tools. Provides diagnostic criteria for major depressive disorder	The PHQ-2 can be used in older patients and may have similar effectiveness with greater brevity and ease of use than other instruments. If screening is positive for possible depression, the diagnosis should be confirmed using Diagnostic and Statistical Manual of Mental disorders.	Yes	Level VII
8. Guidelines for Data Collection and submission on Depression Screening and Follow-up indicator (Press Ganey NDNQI, 2020)	Percentage of patients aged 12 years and older should be screened for depression on the date of the encounter using an age-appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter	Standardized depression screening tools should be normalized and validated for the age-appropriate patient population in which they are used. The follow-up plan must be related to a positive depression screening,	We currently compare our nurse sensitive outcomes to the national benchmark (NDNQI). Following implementation of an age-appropriate depression screening tool (GDS is one of the recommended tools), we will use the NDNQI Depression screening tool to compare our findings nationally.	Yes	Level VII
9. Depression in Older Adults: Screening and Referral, Journal of Geriatric Physical therapy (Vieria, Brown & Raue, 2014).	Selected overview of evidence-based approaches for screening of suspected cases of depression in older adults by physical therapists and other non-mental health specialists.	Increasing prevalence of Major depressive disorder (MDD) is consistent with limitations/illness, associated with falls, common after stroke and other conditions that result in functional impairment & activity limitations, participation restrictions & reduced quality of life.	If PHQ-2 screen is positive, complete the remaining 7 questions of the PHQ-9. The GDS-15 scale also reliable and valid: yes-no format. PHQ-2, PHQ-9 and GDS-15 can all be self-reported. Differentiated apathy from depression. "Training in the assessment of depression (TRIAD)" Communicating depression symptoms Facilitating referrals ,Online resources	Yes	Level VII
10. Diagnostic accuracy of various forms of geriatric depression scale for screening of depression among older adults: Systematic review and meta-analysis (Krishnamoorthy, Rajaa, Rechman, 2020)	Systematic Review & Meta Analysis Consisted of 53 studies	Shorter versions of GDS (15 &10) = more efficient & time saving Longer versions of GDS = redundant	Supports the use and effectiveness of the GDS 15 in diagnosing depression in elderly adults. Strength: All versions of GDS (GDS-15, GDS-30, GDS-10, GDS-4) were all reviewed	Yes	Level I

QUALITY OF THE EVIDENCE

The PHQ and GDS scales respectively, consistently demonstrated high sensitivity & specificity when compared to other diagnostic criteria. Each tool has several versions (PHQ-4, PHQ-9, GDS-4, GDS-15) with the shorter version used as a precursor. GDS (yes/no) was preferred to meet the needs of the elderly.

4 ITEM GDS			Score
1. Are you basically satisfied with your life	YES	NO	
2. Do you feel that your life is empty?	YES	NO	
3. Are you afraid that something bad is going to happen to you?	YES	NO	
4. Do you feel happy most of the time?	YES	NO	
Total			

15 ITEM GDS			Score
1. Are you basically satisfied with your life?	YES	NO	
2. Have you dropped many of your activities and interests?	YES	NO	
3. Do you feel that your life is empty?	YES	NO	
4. Do you often get bored?	YES	NO	
5. Are you in good spirits most of the time?	YES	NO	
6. Are you afraid that something bad is going to happen to you?	YES	NO	
7. Do you feel happy most of the time?	YES	NO	
8. Do you often feel helpless?	YES	NO	
9. Do you prefer to stay at home, rather than going out and doing new things?	YES	NO	
10. Do you feel you have more problems with memory than most?	YES	NO	
11. Do you think it is wonderful to be alive now?	YES	NO	
12. Do you feel pretty worthless the way you are now?	YES	NO	
13. Do you feel full of energy?	YES	NO	
14. Do you feel that your situation is hopeless?	YES	NO	
15. Do you think that most people are better off than you are?	YES	NO	
Total			

RECOMMENDATIONS FOR PRACTICE

We presented this EBP to our New Knowledge & Innovation Council, discussed the feasibility of implementation, documentation requirements, interventions for a positive score on the GDS (an in-depth psychological assessment/evaluation for suicide, Social Work referral, staff/patient family education). We presented this EBP to our nurse leaders, who endorsed piloting the GDS on a medical-surgical unit.

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A QUANTITATIVE ANALYSIS OF NEWLY PRACTICING NURSES' PERCEIVED SELF-EFFICACY, ASSERTIVENESS, AND INTERPROFESSIONAL COLLABORATION

Janice Baglietto, PhD RN CCRN-K

Research Questions

1. Is there a statistically significant relationship between a nurse's perceived level of self-efficacy and perceived level of assertiveness?

2. Is there a statistically significant relationship between a nurse's perceived level of assertiveness and perceived level of interprofessional collaboration?

3. Is there a statistically significant relationship between a nurse's perceived level of self-efficacy and perceived level of interprofessional collaboration?.

- Due to Covid-19 one qualitative question was added. What effect, if any, did the Covid-19 pandemic have on your interprofessional collaborative practice?

Review of the Literature

• According to Thibault (2013) todays health professional are unprepared to work in interprofessional teams. Current educational models continue to segregate learning. Delays in exposure delays interprofessional competencies.

•Assertive communication style has been studied in RNs of various cultures (Ibrahim, 2011; Law & Chan, 2015; Mansour & Mattukoyya, 2018).

• Nurses and other healthcare professionals, can feel empowered to speak-up despite identified barriers to communication . (Guttman et al., 2018; Numminen, Repo, & Leino-Kilpi, 2007; O'Daniel & Rosenstein, 2008).

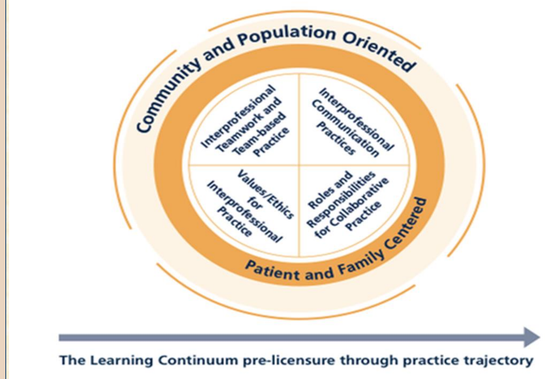
• Self-efficacy and assertiveness have shown a relationship with interprofessional collaboration (Ibrahim, 2011: Yoshinaga, et al., 2018). .

•Interprofessional courses have shown a significant positive effect on nurses: communication and teamwork; leadership and management; and self-efficacy (Soudagar, Rambod, & Beheshtipour 2015; Watters, et al. 2015).

•Recommendations for timely interprofessional education for all healthcare professionals have been made by AACN (2020) and IPEC (2011,2016)

• No studies were identified showing a relationship among newly practicing nurses' perceived self-efficacy, perceived assertiveness & perceived interprofessional collaboration.

Theoretical Framework



Interprofessional Education Collaborative (IPEC) (2016)

Significance

- The ability to "speak up" is paramount for the RN's success within an interprofessional collaborative practice model (Numminen, Repo, & Leino-Kilpi, 2017).
- Newly practicing nurses must be able to use assertive communication to express feelings, opinions, and beliefs to advocate for their patients, families, communities, and profession (Riley, 2000; Hunt-Slamow, 2007).
- Importance of effective teamwork in healthcare has been recognized as a means to improve patient safety and outcomes (Brock, et al., 2013).

Method

- Quantitative correlational design was used to establish the strength & direction of relationships between/among newly practicing RNs and the research variables.
- A web-based survey was constructed and distributed via email to a national sample of newly practicing RNs (*N*=3,793), obtained with permission from the NSNA.
- Survey included the: *General Self-Efficacy Scale (GSE),Simple Rathus Assertiveness Schedule – Short Form (SRAS-SF) & Interprofessional Collaboration Scale (ICS)* and demographic questions.
- Molloy College IRB approval was obtained.
- Response rate 11% (*N* = 410).
- Analysis included descriptive, correlational, and comparative statistical testing.
- Inferential statistical testing included: *t*-tests, ANOVA, Pearson's product-moment correlation and point-biserial correlation analyses

Results

Self-efficacy and Assertiveness

	Total RN Sample	RNs ≤ 2 yrs.	RNs > 2 yrs.
Pearson r	.408**	.394**	.407**
Sig (2-tailed)	.000	.000	.000
N	400	203	197

** Correlation is significant at the .01 level (2-tailed).

Assertiveness & Interprofessional Collaboration

	Total RN Sample	RNs ≤ 2 yrs.	RNs > 2 yrs.
Pearson r	.111*	.070	.143*
Sig (2-tailed)	.027	.324	.044
N	397	199	198

* Correlation is significant at the .05 level (2-tailed).

Assertiveness & Interprofessional Collaboration with physicians

	Total RN Sample	RNs ≤ 2 yrs.	RNs > 2 yrs.
Pearson r	.131**	.088	.159*
Sig (2-tailed)	.009	.213	.025
N	402	203	199

** Correlation is significant at the .01 level (2-tailed)
* Correlation is significant at the .05 level (2-tailed.)

Self-efficacy & Interprofessional Collaboration

	Total RN Sample	RNs ≤ 2 yrs.	RNs > 2 yrs.
Pearson r	.233**	.245**	.217**
Sig (2-tailed)	.000	.000	.000
N	399	201	198

** Correlation is significant at the .01 level (2-tailed).

Cronbach's alpha: GSE α = .836, SRAS-SF α = .829, and ICS α = .919

Self-efficacy and assertiveness: A statistically significant moderate positive correlation was found in the total RN sample, RNs ≤ 2 yrs., and RNs > 2 yrs.

Assertiveness & interprofessional collaboration: A statistically significant weak positive correlation was found in the total RN sample and the RNs > 2 yrs., but not in the group of RNs with ≤ 2 yrs.

Assertiveness & interprofessional collaboration with physicians: A statistically significant weak positive correlation was noted in the total RN sample and the RNs > 2 yrs., but not in the group of RNs with ≤ 2 yrs.

Self-efficacy & interprofessional collaboration: A statistically significant weak positive correlation was found in the total RN sample, RNs ≤ 2 yrs., and RNs > 2 yrs.

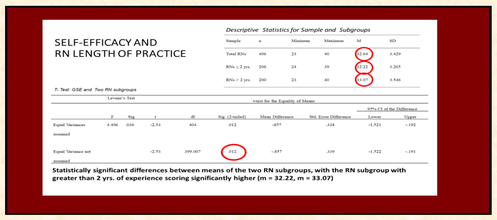
Self-efficacy & length of practice: Statistically significant differences between means of the two RN subgroups, with the RN subgroup with greater than 2 yrs. of experience scoring significantly higher (m = 32.22, m = 33.07).

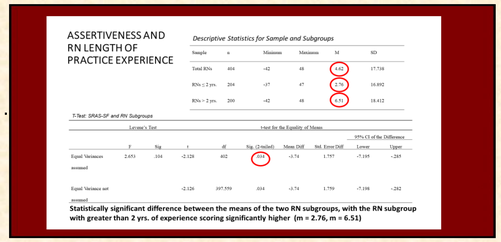
Assertiveness & length of Practice: Statistically significant difference between the means of the two RN subgroups, with the RN subgroup with greater than 2 yrs. of experience scoring significantly higher (m = 2.76, m = 6.51)

Gender: No statistically significant correlations between self-efficacy, assertiveness, and interprofessional collaboration.

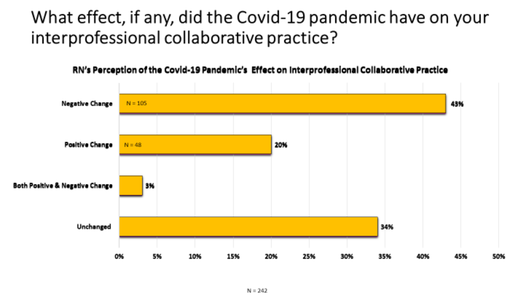
Age: Weak positive statistically significant correlation between self-efficacy and age, and assertiveness and age in the RNs with > 2 yrs. experience. There was no correlation with IPC.

Nursing Degree: No statistically significant differences between self-efficacy, assertiveness, interprofessional collaboration, and degree type were noted.





Results



(R1) "Physicians and tech want to avoid being at the bedside of positive COVID patients…which causes nurses to be at the bedside for more tasks"

(R42) "…the interprofessional collaborative practice was negatively affected due to nurses becoming the primary, if not sole provider to interact with Covid Positive patients…"

(R70) "Worse communication than it was before definitely both with the medical and allied health staff. Multiple disputes unresolved…been to three different hospitals. Same thing."

(R88) "I think in some ways we had to be more collaborative. Doctors, residents, fellows, and attendings, would come into the room to help turn patients, we collaborated more on the timing of all patient care…"

(R105) "Covid-19 made everyone in the hospital have to communicate and work together more than ever due to the craziness of the work environment…"

(R143) "…I feel like it has actually improved relations between different allied health disciplines. More communication and collaboration seem to be happening on behalf of the patients."

Implications for Practice

Administrators and managers in healthcare need to:

- Maintain collegial work environment
  - Safe and free of barriers to communication
- Provide necessary training
  - Adequate orientation programs/time
  - Communication training
  - Manager training
- Administrative policies and processes
  - Reporting procedures for bad outcomes
  - Reporting procedures for unprofessional behaviors
- Recognize and thank
  - Staff need to feel valued

References

SCAN ME

Dynamic Appraisal of Situational Aggression (DASA): An Integrative Review

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MAGNET RECOGNIZED AMERICAN NURSES CREDENTIALING CENTER

PRACTICE PROBLEM

Inpatient psychiatric violence was a globally recognized problem (Edward, Stephenson, Ousey, Lui, Warelow, & Giandinoto, 2016). Violence was both physical and emotional (di Giacomo, Iozzino, Ferrari, Strozza, Large, Nielssen, & de Girolamo, 2020).

Violence toward psychiatric nurses greatly impacted safety and wellness at work (d'Ettore & Pellicani, 2017). The American Psychiatric Nurses Association (APNA) supported an evidence-based approach to violence prevention in best practice (Allen, Mistler, Ray, Batscha, Delaney, Loucks, & Sharp, 2019).

DASA (Ogloff & Daffern, 2006) was a validated quantitative brief screening tool that enabled educated clinicians to predict violence and prevent dangerous patient behavior. This integrative review supported DASA screening to reduce predictable violence in psychiatric inpatient units.

Many psychiatric adult units do not use evidence-based screening to predict, mitigate or reduce inpatient violence.

CLINICAL QUESTION

"In adult psychiatric inpatients, does implementation of DASA screening upon admission and each shift reduce violence like restraints and psychiatric emergency codes?"

METHODOLOGY

- Review protocol: modified PRISMA
- Data bases: CINAHL, Chamberlain University Library, ClinicalKey, Cochrane, Joanna Briggs, Google Scholar, Journal of the American Psychiatric Nurses Association.
- Search terms: "Dynamic Appraisal of Situational Aggression AND inpatient adult psychiatric unit", "DASA", "workplace violence AND psychiatric units", "psychiatric nurses AND workplace violence", "restraints AND adult psychiatric violence".
- Inclusion: DASA was identified screening tool for violence screening in psychiatric adult inpatient setting. Evidence between 2016-2020.
- Exclusion: Any evidence that did not align with the clinical question or DASA as screening tool.
- Themes and Patterns: Focused on evidence that validated DASA as a primary screening tool to predict violence in adult psychiatry.
- Data Analysis: Johns Hopkins Nursing Evidence-Based Practice Summary tool used to appraise the 3 selected systematic reviews, as well as the 12 other sources for a total of 15 sources.

RESULTS

- DASA was a globally recognized quantitative instrument intended to predict and mitigate psychiatric inpatient violence since 2006 (Ogloff & Daffern).
- DASA research validated clinicians' ability to predict and mitigate avoidable violence among adult psychiatric patients using a brief validated quantitative instrument.
- DASA supported reduction of restraints and emergency intramuscular medication administration by predicting risk and allowing for less coercive and dangerous earliest interventions.
- Psychiatric nurses completed the 7 item DASA instrument quickly (2-3 minutes per patient) and easily after education.

IMPLICATIONS

- DASA implementation was feasible, sustainable and reliable.
- DASA implementation was validated to close an important gap in psychiatric practice where no EBP approach related to violence screening and mitigation.
- DASA supports proactive team communication via briefs, huddles.
- DASA empowered psychiatric nurses and other clinicians to predict and mitigate violence risk using a measurable process, even with the most violent adult psychiatric inpatients.
- DASA screening best practice every shift along with timely team communication aimed at avoiding violence in individual patients at risk for acting out due to elevated score.

CONCLUSIONS

DASA did not replace clinical judgement of the expert psychiatric nurse. DASA added a validated evidence-based tool to the kit to keep patients and staff safer. More research is needed to further understand DASA usefulness, and the avoidable traumatic experiences of nurses and patients alike (Lantta, Daffern, Kontio & Valimaki, 2015).

The Covid-19 pandemic delayed robust multi-professional EBP implementation at the original selected site, therefore outcomes are not available at this time.

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