Creating Healthy Work Environments

Building a Healthy Workplace: Best Practices in Clinical and Academic Settings…

17-19 March 2017

JW Marriott

Indianapolis, Indiana, USA

Conference Proceedings Ebook

Sigma Theta Tau International
Honor Society of Nursing®

Sigma Theta Tau International

Creating Healthy Work Environments 2017

Held 17-19 March 2017

Indianapolis, Indiana, USA

Conference Proceedings Abstracts

Sigma Theta Tau International
Honor Society of Nursing®

The Honor Society of Nursing, Sigma Theta Tau International (STTI) is a nonprofit organization whose mission is advancing world health and celebrating nursing excellence in scholarship, leadership, and service. Founded in 1922, STTI has more than 135,000 active members in over 90 countries and territories. Members include practicing nurses, instructors, researchers, policymakers, entrepreneurs, and others. STTI's 530 chapters are located at more than 700 institutions of higher education throughout Armenia, Australia, Botswana, Brazil, Canada, Colombia, England, Ghana, Hong Kong, Japan, Jordan, Kenya, Lebanon, Malawi, Mexico, the Netherlands, Pakistan, Philippines, Portugal, Singapore, South Africa, South Korea, Swaziland, Sweden, Taiwan, Tanzania, Thailand, the United States, and Wales. Learn more at www.nursingsociety.org.

Sigma Theta Tau International
550 West North Street
Indianapolis, IN, USA 46202

To order additional books, buy in bulk, or order for corporate use, contact Nursing Knowledge International at 888.NKI.4YOU (888.654.4968/US and Canada) or +1.317.634.8171 (outside US and Canada).

To request a review copy for course adoption, e-mail solutions@nursingknowledge.org or call 888.NKI.4YOU (888.654.4968/US and Canada) or +1.317.634.8171 (outside US and Canada).

To request author information, or for speaker or other media requests, contact Marketing, Honor Society of Nursing, Sigma Theta Tau International at 888.634.7575 (US and Canada) or +1.317.634.8171 (outside US and Canada).

PDF ISBN: 9781945157523

Glossary

A **plenary session** is a session in which an invited speaker, usually with a significant subject matter, presents their work or viewpoint. All attendees attend these general sessions as they usually begin and end a program of events. Plenary sessions vary in length from one (1) hour to one and a half (1½) hours and can be accompanied by PowerPoint presentations, audio and/or video files and other visual aids.

An **oral presentation** is a brief 15-20 minute individual presentation time moderated by a volunteer. An effective oral presentation should have an introduction, main body and conclusion like a short paper and should utilize visual aids such as a PowerPoint presentation. Oral presentations are divided into different categories based on the program presented. Categories can include: clinical, leadership, scientific, evidence-based practice, or research.

A **poster presentation** is the presentation of research information by an individual or representatives of research teams at a conference with an academic or professional focus. The work is peer-reviewed and presented on a large, usually printed placard, bill or announcement, often illustrated, that is posted to publicize. Exceptions to peer-reviewed posters include Rising Stars student posters and Sigma Theta Tau International's Leadership Institute participant posters.

A **symposium** is a presentation coordinated by an organizer similar to a panel discussion and contains at least three (3) presentations concerning a common topic of interest. Each symposium session is scheduled for 45-75 minutes and allows for questions at the end of the session. Symposia provide an opportunity to present research on one topic, often from multiple perspectives, providing a coherent set of papers for discussion.

A **peer-reviewed paper** is simply an individual abstract that has been reviewed by at least three (3) peer-reviewers to determine the eligibility of the submission to be presented during a program. The determination is made by the peer-reviewer answering a series of regarding the substance of the abstract and the materials submitted. Scores from each reviewer are compiled. The average score must be 3.00 on a 5-point Likert scale in order to quality for presentation. Sigma Theta Tau International enforces a blind peer-review process, which means that the reviewers do not see the name or institution of the authors submitting the work. All submissions, with the exception of special sessions and invited posters are peer-reviewed.

An **invited** or **special session** is similar to a symposium in the length of time allotted for presentation, but is not peer-reviewed. These sessions focus on a specific area, but are conducted by individuals invited to present the work.

Introduction

The Honor Society of Nursing, Sigma Theta Tau International (STTI) conducted its 2017 Creating Healthy Work Environments conference from 17 March through 19 March in Indianapolis, Indiana, USA, with the theme of Best Practices in Clinical and Academic Settings . . .

These conference proceedings are a collection of abstracts submitted by the authors and presented at the conference. To promptly disseminate the information and ideas, participants submitted descriptive information and abstracts of 300 words or less. Each oral and poster presentation abstract was peer-reviewed in a double-blind process in which three scholars used specific scoring criteria to judge the abstracts in accordance with the requirements of STTI's Guidelines for Electronic Abstract Submission.

The opinions, advice, and information contained in this publication do not necessarily reflect the views or policies of STTI or its members. The enhanced abstracts provided in these proceedings were taken directly from authors' submissions, without alteration. While all due care was taken in the compilation of these proceedings, STTI does not warrant that the information is free from errors or omission, or accept any liability in relation to the quality, accuracy, and currency of the information.

Format for Citing Papers

Author. (Year). Title of paper. In *Title of conference proceedings* (page numbers). Place of publication: Publisher.

Example:
Smith, C. C. (2015). Nursing Research and Global Impact. In *Engaging Colleagues: Improving Global Health Outcomes: Proceedings of the 25th International Nursing Research Congress* (pp. xxx-xxx). Indianapolis, IN: Sigma Theta Tau International.

Table of Contents

Sigma Theta Tau International Creating Healthy Work Environments 2017 (17-20 March) Abstracts

Plenary Sessions

PLEN 1 - PLENARY SESSION 1: Healthy Work Environments: Discussions From the Bedside to Academia

Beth T. Ulrich, EdD, RN, FACHE, FAAN, USA
Cynthia Clark, PhD, RN, ANEF, FAAN, USA
Dave Hanson, MSN, RN, ACNS-BC, NEA-BC, USA
Connie Barden, MSN, RN, CCRN-K, CCNS, USA
Cynthia A. Oster, PhD, MBA, ANP, ACNS-BC, CNS-BC, USA
Jane Braaten, PhD, MS, RN, USA

Abstract

Dr. Ulrich will lead a distinguished panel of nurses in a discussion about ways to build, develop, and maintain a healthy work environment. This panel includes nurse leaders from both clinical and academic arenas. The discussion will center around the commonalities between each area and ways to combat incivility.

References

None.

Contact

BethUlrich@aol.com

PLEN 2 - PLENARY SESSION 2: Creating Healthy Work Environments: Powered by Civility, Leadership, and Ethical Practice

Cynthia Clark, PhD, RN, ANEF, FAAN, USA

Abstract

Fostering positive, healthy work environments requires authentic leadership, an emphasis on civility and ethical practice, and an unwavering commitment to patient safety. This session highlights the scope and impact of workplace incivility, provides several evidence-based strategies to foster a positive, professional work environment, and details clear pathways for achieving results.

References

None.

Contact

cclark@boisestate.edu

PLEN 3 - PLENARY SESSION 3: Healthy Work Environments II: Discussions About the Profession

Beth T. Ulrich, EdD, RN, FACHE, FAAN, USA
Mary Jo Assi, DNP, RN, FNP-BC, NEA-BC, USA
Connie Barden, MSN, RN, CCRN-K, CCNS, USA
Linda Cassidy, MSN, EdM, RN, CCNS, CCRN-K, USA
Janet Stifter, PhD, RN, CPHQ, USA

Abstract

Dr. Beth Ulrich will lead a second panel of association leaders to discuss how nursing, as a profession, can enhance the working environments of nurses through their professional organizations.

References

None.

Contact

BethUlrich@aol.com

PLEN 4 - PLENARY SESSION 4: From Toxic to Healthy: Breakthrough Strategies for Transforming the Clinical Practice Environment

Dave Hanson, MSN, RN, ACNS-BC, NEA-BC, USA

Abstract

In today's ever-changing healthcare, there is often competing priorities rivaling caregivers' time. In our quest to provide high quality patient-centered care, it's easy to overlook structures and processes supporting care delivery.

References

None.

Contact

Michael.Hanson@providence.org

Special Sessions

A 05 and C 05 - SPECIAL SESSION: Emotional Intelligence: The Linchpin for Healthy Workplace Environments

Cheri Clancy, MSN, MS, RN, NEA-BC, CPXP, USA

Abstract

Open communication is the foundation to building healthy relationships. Open communication not only includes words, it also includes nonverbal communication, such as facial expressions, gestures, eye contact, posture, pitch and tone of voice. The ability to understand and use nonverbal communication, or body language, is dependent on emotional self-awareness as well as the ability to interpret the emotions of others. This phenomenon is known as emotional intelligence (EI). Those with high EI build rapport easily with others because they are sensitive to those around them and respond in a warm, friendly and empathetic ways. Those with a low EI struggle to demonstrate empathy, which makes it difficult to connect with people. Fortunately, EI is a learned behavior and can be improved upon (Goleman, 1995).

Not only is it important to provide education on the how to increase EI, it is also important to provide awareness of the role the brain's circuitry plays in emotions and the body's response. A greater understanding of the emotional and thinking brains provides a deeper level of understanding individual physiological and psychological differences. For example, if a person is exhibiting stress, even the most benign information can be dramatized. This is due to the thalamus forwarding information to the amygdala, or the emotional brain, before sending to the neocortex, or the thinking brain. This results in an emotionally charged reaction because the thinking brain never had the opportunity to initially respond (Goleman, 1995). This knowledge helps to further explain varying unconscious and conscious body gesturing individuals have when communicating with others. These gestures maybe perceived as favorable or unfavorable, depending on the circumstance and the interpretation of others. Understanding the role of the brain and its connection with emotions and the body will help to foster a mindset of curiosity, not certainty when interacting with others.

Emotional intelligence education is vital to the nursing profession because it provides awareness of the behavioral propensities that improve communication and strengthens relationships (Mauno, et al. 2016; Clancy, 2014). Research suggests those with high emotional intelligence state higher job satisfaction (Littlejohn, 2012; Mauno, et al., 2016). Increasing EI in the nursing profession can lead to more effective management and better functioning teams of professionals.

References

Goleman, D. (1995). Emotional Intelligence: Why It Can Matter More Than IQ. New York: Bantam.

Littlejohn, P. (2012). The missing link: Using emotional intelligence to reduce workplace stress and workplace violence in our nursing and other health care professions. Journal of Professional Nursing, 28(6), 360-368. doi: http://dx.doi.org/10.1016/j.profnurs.2012.04.006

Mauno S., Ruokolainen M., Kinnunen U. & De Bloom J. (2016) Emotional labour and work engagement among nurses: examining perceived compassion, leadership and work ethic as stress buffers. Journal of Advanced Nursing 72(5), 1169–1181. doi: 10.1111/jan.12906

Contact

cac927@me.com

B 05 - SPECIAL SESSION: Establish Your Own Healthy Work Environment: Don’t Recreate the Wheel – Build on Existing Efforts!

Kimberly Thompson, MLS, USA

Abstract

Initiate. Search. Create. Share.

Creating healthy work environments takes effort. That effort benefits from existing guidance. Existing guidance may be found in scholarly repositories and subscription-based databases. Locating and retrieving relevant items within a repository or database can be challenging if you don't have the correct search strategy, your plan is not complete, or you are lacking the necessary tools in your information literacy tool belt. This session will give you the basic tools and tips to craft a search strategy and successfully search STTI’s Virginia Henderson Global Nursing e-Repository (the “Henderson Repository”) for on-target items. These basic search techniques may be utilized in other databases to retrieve relevant results.

This session will answer the following questions. What databases should I use? Should I use a basic or advanced search? What are search limiters or filters and how (or why) should I use them? What is the difference between keywords and subject headings? How will subject headings help my search? What is full-text searching? Is it ever appropriate to use Google?

Once you have created your own plans and policies for a healthy work environment within your organization, you will want to share that information with others while taking credit for your work and retaining copyright. Don’t lose control over your own work. You will also learn the benefits of open-access dissemination through the Henderson Repository. What are you waiting for? Experience dynamic dissemination with the Henderson Repository through its built-in global usage statistics and ability to track and collate online conversations and activity surrounding your work. Almetric allows authors to engage in online discussions surrounding their work.

This session assumes that you already have your topic and question (e.g., What have other hospitals, universities, organizations, and/or nurses done to create healthy work environments?) and are ready to begin searching resources for target materials.

References

Information literacy competency standards for nursing. (2014). *College & Research Libraries News*, *75*(1), 34-41.

Deal, E. (2015). Teaching Information Literacy and Library Skills to Online Nursing Students: A Selected Annotated Bibliography. *Codex (2150-086X)*, *3*(4), 33-54.

Contact

kimberly@stti.org

C 03 and H 03 - SPECIAL SESSION: The Relational Nurse Champion Program™

Cheryl Dellasega, BSN, MS, PhD, PhD, CRNP, USA

Abstract

Nurses connect with patients, each other, and members of the care team to promote the best health possible. These connections and relationships can be positive as well as negative influences on the work environment. For example, it is known that nurses who fail to complete orientation often do so because of the emotional climate rather than work demands (Garrett & McDaniel, 2001).

Research on interventions which help nurses create a quality work environment is in its infancy. One intervention that has had a positive impact is Mindfulness Based Stress Reduction (MBSR), which has been found to decrease stress, burnout, and anxiety while simultaneously improving focus, mood, and empathy (Smith, 2014). As such, MBSR has the opportunity to positively impact nurses' daily practice and improve patient outcomes, but logistics often prevent nurses from participating in the training, which is time intensive.

Relational Aggression (RA) is the use of negative behaviors to aggress against another person within a relationship. Unlike Horizontal or Lateral Violence, RA can occur from nurse to nurse, physician to nurse, unit secretary to nurse, and so on (Dellasega, 2009). It is often a measure of the toxicity of a work environment; where RA is high, so is toxicity (Dellasega & Volpe, 2014).

Previous foundational work with nurses on the subject of RA has shown promise in changing attitudes and beliefs in the short term using an eclectic theoretical model (Dellasega, 2012; Dellasega & Volpe, 2014). A series of eight hour workshops presented to nurses in various hospital settings received positive evaluations and change in knowledge, but the long-term impact has not been studied.

Building on this work, the Relational Nurse Champion Program (Nurse Champions) will create a resource uses the principles of Educate, Relate, Integrate (Dellasega, 2004). The program will be pilot tested in February, 2017 at a large academic medical center.

Selected nurses will be chosen to receive an eight-hour educational program which involves: 1) Education about communication, relationship building and relational aggression in the nursing environment, 2) Relation of the new information to the current work environment, and 3) Integration of objectives for change and a plan of action to meet the specific needs of an individual nurse or unit.

After training, the Nurse Champions will work on his/her unit to complete integration of the action plan. Each month, a group meeting of unit Nurse Champions will be held with Dr. Dellasega to discuss the achievement (or lack thereof) of the established objectives. Modification or establishment of new objectives will be accomplished as needed, along with brainstorming on relationship-building and communication activities that can be implemented on individual units to improve the worklife climate.

Nurse satisfaction and the nursing quality of worklife will be measured before and three months after implementation of the intervention. Two-three diverse units of the hospital will participate in the three-month pilot study. Preliminary results of our formative evaluation will be shared.

It is our belief that improving the quality of relationships within the nursing unit will enhance both individual and group wellbeing and job satisfaction. Upon completion of the pilot study we plan to expand the program to other units in the hospital for a more robust analysis of impact.

References

Dellasega, C. (2009). Bullying among nurses. American Journal of Nursing, 109 (1), 52-58.

Dellasega, C. (2011). When nurses hurt nurses. Indianapolis: STTI.

Dellasega, C. & Volpe, R. (2014). Toxic nursing. Indianapolis: STTI.

Garrett, D. K. & McDaniel, A. M. (2001). A new look at nurse burnout: The effects of environmental uncertainty and social climate. The Journal of Nursing Administration, 31(2), 91-96.

Smith, S. A. (2014). Mindfulness-based stress reduction: An intervention to enhance the effectiveness of nurses' coping with work-related stress. International Journal of Nursing Knowledge, 25(2), 119-130.

Contact

cdellasega@aol.com

C 05 - SPECIAL SESSION: AACN Standards for Healthy Work Environments: After More Than a Decade, Where Are We Now?

Connie Barden, MSN, RN, CCRN-K, CCNS, USA
Linda Cassidy, MSN, EdM, RN, CCNS, CCRN-K, USA

Abstract

The healthcare system in the United States is under scrutiny due to escalating medical costs and widely recognized opportunities for improvement in the quality of care delivery and patient outcomes. Suboptimal systemic conditions, inherent within the work environment in hospitals, have been identified as playing an important role in the quality of care and adverse outcomes for patients/families, nurses, and all members of the health care team. A direct link is evident among the health of the work environment, the quality of care provided in the work unit, and patient outcomes. Nurses who work in poor, unhealthy work environments clearly report a lower quality of patient care than those who work in a positive work environment (Aiken, Sloane, Clarke, et al., 2011b; Bai, 2015; Coetzee, Klopper, Ellis and Aiken, 2013; Djukic, Kovner, Brewer, Fatehi, and Cline, 2013; Lake et al., 2016). Specifically, mortality rates, hospital acquired infections, medication errors and other adverse conditions have been shown to be higher in hospitals with unhealthy work environments (Cho, Chin, Kim, and Hong, 2015; Flynn, Liang, Dickson, Xie, and Suh, 2012; Kelly, Kutney-Lee, McHugh, Sloane, and Aiken, 2014; Bulman, 2016; Kelly, Kutney-Lee, Lake, and Aiken, 2013). Furthermore, research demonstrates that quick solutions such as simply pouring dollars into additional staffing resources without addressing the health of the work environment are ineffective (Aiken, et al., 2011a). Equally concerning, unhealthy work environments contribute to nurse and healthcare team burnout, dissatisfaction, stress, and increased job turnover (Aiken et al., 2011b; Koy, Yunibhand, Angsuroch, and Fisher, 2015). Despite this knowledge, there continues to be minimal improvement in the health of hospital work environments, and sadly in some instances, there is evidence of decline (Aiken et al., 2011; Ulrich, Lavendero, Woods and Early, 2014).

In 2001, recognizing the impact that unhealthy work environments play in healthcare, the American Association of Critical-Care Nurses (AACN) committed to boldly raising awareness through open dialogue and addressing key factors imperative for healthy work environments. As a result of this work, AACN released the AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence in 2005. This seminal document provides a framework for creating an environment that fosters optimal outcomes and excellence in patient care. The AACN healthy work environment (HWE) standards have been cited as an important blueprint that organizations and nurses can use to foster a workplace that promotes optimal patient outcomes and nurse satisfaction (Garon, 2012; Naybeck-Beebe, et al. 2013; Palese, Dante, Tonzar, and Balbone, 2014; Rochefort and Clarke, 2010; Van Bogaert, et al., 2014).

Six relationship-based standards are essential for a healthy work environment. These standards are skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership. Skilled communication emphasizes the importance of nurse proficiency in communication. True collaboration stresses the nurse's determination in seeking out and encouraging partnering relationships. Effective decision making describes the importance of the involvement of nurses at all levels of the organization in the decision-making process. Appropriate staffing delineates the effective matching of patient and family needs with the knowledge, skills and abilities of the nurse. Meaningful recognition emphasizes nurses and other healthcare team members being recognized and recognizing others for the value they bring to the organization. The sixth standard, authentic leadership, stresses the importance of nurse leaders authentically role-modeling the behaviors inherent in a healthy work environment. Authentic leadership is considered the force that binds the other standards and it thrives in a positive organizational culture (Shirey, 2009). The six standards are non-hierarchical, are not mutually exclusive, and all must be present to help ensure a healthy work environment (AACN, 2016).

This presentation is focused on the six AACN healthy work environment standards and key evidence that has emerged in the decade since the 1st edition of the standards - now reflected in the 2ndedition, released in 2016. In addition, perspectives of acute and critical care nurses surrounding the health of the hospital work environment and barriers to optimal nursing practice will be presented. This contrast of the

ideal (HWE standards) and the reality (barriers to practice) will provide the forum for a robust and thought-provoking session based on evidence.

References

Aiken, L.H., Cimiotti, J.P., Sloane, D.M., Smith, H.L., Flynn, L., & Neff, K.F. (2011a). Effects of nurse staffing and nurse education on patient deaths in hospitals with different work environments. Medical Care, 49(12), 1047-1053.

Aiken, L.H., Sloane, D.M., Clarke, S., Poghosyan, L., Cho, E., You, L.,…Aungsuroch. (2011b). Importance of work environments on hospital outcomes in nine countries. International Journal for Quality in Health Care, 23(4), 357-364.

American Association of Critical-Care Nurses [AACN]. (2016). AACN Standards for establishing and sustaining healthy work environments: A journey to excellence, (2nd ed.). Aliso Viejo, CA: American Association of Critical-Care Nurses.

Bai, J. (2015) Does job satisfaction mediate the relationship between work environment and care quality? British Association of Critical Care Nurses, 21(1), 18-27.

Buhlman, N. (2016). How nurses' work environment influences key performance indicators. American Nurse Today,11(3),54-56.

Cho, E., Chin, D. L., Kim, S., & Hong, O. (2015). The relationships of nurse staffing level and work environment with patient adverse events. Journal of Nursing Scholarship, 48(1), 74-82.

Cho, E., Sloane, D.M., Kim, E., Kim, S., Choi, M.,…& Aiken, L.H. (2014). Effects of nurse staffing, work environments, and education on patient mortality: An observational study. International Journal of Nursing Studies,52, 535-542.

Coetzee, S.K., Klopper, H.C., Ellis, S.M., & Aiken, L.H. (2013). A tale of two systems—Nurse practice environment, well being, perceived quality of care and patient safety in private and public sectors of South Africa: A questionnaire survey. International Journal of Nursing Studies, 50, 162-173.

Djukic, M., Kovner, C.T., Brewer, C.S., Fatehi, F.K. & Cline, D.D. (2013). Work environment factors other than staffing associated with nurses' ratings of patient care quality. Health Care Management Review,38(2), 105-114.

Flynn, L., Liang, Y., Dickson, G.L., Xie, M., & Suh, D, (2012). Nurses' practice environments, error interception practices, and inpatient medication errors. Journal of Nursing Scholarship,44(2), 180-186.

Kelly, D.M., Kutney-Lee, A., McHugh, M.D., Sloane, D.M., & Aiken, L.H. (2014). Impact of critical care nursing on 30-day mortality of mechanically ventilated older adults. Critical Care Medicine,42(5),1189-1095.

Kelly, D., Kutney-Lee, A., Lake, E.T., & Aiken, L.H. (2013). The critical care work environment and nurse-reported health-care associated infections. American Journal of Critical Care, 22(6), 482-488.

Garon M. (2012). Speaking up, being heard: registered nurses' perceptions of workplace communication. Journal of Nursing Management, 20, 361-371.

Koy, V., Yunibhand, J., Angsuroch, Y., & Fisher, M. L. (2015). Relationship between nursing care quality, nurse staffing, nurse job satisfaction, nurse practice environment, and burnout: Literature review. International Journal of Research in Medical Sciences, 3(8), 1825-1831.

Lake, E.T., Hallowell, S.G., Kutney-Lee, A., Hatfield, L.A., Del Guidice, M., Boxer, B.A.,…Aiken, L.H. (2016). Higher quality of care and patient safety associated with better NICU work environments. Journal of Nursing Care Quality, 31(1), 23-32.

McHugh, M.D., Rochman, M.F., Sloane, D.M., Berg, R.A., Mancini, M.E., Nadkarni, V.M.,…Aiken, L.H., & American Heart Association's Get With the Guidelines-Resuscitation Investigators. (2016). Better nurse staffing and nurse work environments associated with increased survival of in-hospital cardiac arrest patients. Medical Care,54(1), 74-80.

Naybeck-Beebe, A.M., Forsythe T., Funari, T., Mayfield, M., Thoms Jr, W., Smith, K.K., Bradstreet, H., & Scott, P. (2013). Using evidence-based leadership initiatives to create a healthy work environment. Dimensions of Critical-Care Nursing, 32(4),166-173.

Palese, A., Dante, A., Tonzar, L., Balboni, B. (2014). The N2N instrument to evaluate healthy work environments: an Italian validation. International Archives Occupational Environmental Health,87, 217-218

Rochefort, C.M. & Clarke, S.P. (2010). Nurses' work environments, care rationing, job outcomes, and quality of care on neonatal units. Journal of Advanced Nursing, 66(10), 2213-2224.

Van Bogaert, P., Timmermans, O., Weeks, S.M., van Heusden, D., Wouters, K., & Franck, E. (2014). Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse

reported job outcomes, and quality of care, and patient adverse outcomes—A cross-sectional survey. International Journal of Nursing Studies, 51, 1123-1134.

Ulrich, B.T., Lavandero, R., Woods, D., & Early, S. (2014). Critical care nurse work environments 2013: A status report. Critical Care Nurse, 34(4), 64-79.

Contact

connie.barden@aacn.org
linda.cassidy@aacn.org

D 03 and K 04 - SPECIAL SESSION: Research Abstracts, Proposals, and Grant Writing: Basics From Start to Finish

Lois S. Marshall, PhD, RN, USA

Abstract

This presentation will provide the novice researcher the basics to write a research abstract, proposal, and/or grant for submission. This session will enable participants to gain a basic understanding of the steps of the abstract/proposal/grant writing process in order to enable them to put forth a submission in the future. Participants will be able to interact with some past recipients of STTI small research grants who will provide practical information on the writing, submission, and follow-up process.

References

None.

Contact

lsm4556@aol.com

D 05 - SPECIAL SESSION: Create a Healthy Work Environment with Meaningful Recognition

Kay Clevenger, MSN, RN, USA

Abstract

According to the American Association of Critical-Care Nurses Healthy Work Environment Standards, “Nurses must be recognized and must recognize others for the value each brings to the work of the organization.” This session will describe the importance of meaningful recognition in employee motivation, and how it is central to morale and job satisfaction. A real-world example of a Preceptor Academy Award Program will be described, along with the international DAISY recognition program, and multiple ideas for recognition.

References

None.

Contact

kay@stti.org

Pre-Conference Sessions

PC01 - Fostering Healthy Work Environments: Building Trust, High Performing Teams, and a Conflict-Capable Workforce (Part I)

Cynthia Clark, PhD, RN, ANEF, FAAN, USA

Abstract

Fostering healthy work environments is an imperative for all nurses in all settings. Nurses are ethically obligated to promote positive work environments by cultivating interpersonal and organizational trust, improving communication, and building high-performing, conflict-capable teams. This interactive session highlights elements of a healthy work environment, provides attendees the opportunity to assess their workplace health and civility acumen, and describes a variety of evidence-based strategies to build trust, promote teamwork, and effectively address conflicted situations.

References

None.

Contact

cindy.clark@atitesting.com

PC02 - The Art and Science of Marketing Yourself

Lois S. Marshall, PhD, RN, USA

Abstract

As a new or seasoned nursing professional, marketing oneself is often a daunting undertaking. From preparing a resume or CV to developing and maintaining a portfolio, to preparing for an interview of various types, marketing yourself is both an art and a science. This presentation will provide you with specific guidance and tips to creating a masterful resume/CV. Preparing for an interview in today's diverse marketplace will be detailed, with specific recommendations for success.

References

None.

Contact

lsm4556@aol.com

PC03 - Cognitive Rehearsal and Scripting: Strategies to Address Workplace Incivility and Conflicted Encounters (Part II)

Cynthia Clark, PhD, RN, ANEF, FAAN, USA

Abstract

The capacity to successfully manage conflict is an imperative for all nurses especially since the delivery of safe patient care depends on the ability to implement these vital skills. This interactive session describes several common conflicts that exist in health care and provides the participants with an opportunity to apply a variety of evidence-based models for framing conflicted conversations and to learn and practice specific 'scripts' to address conflict in a variety of situations.

References

None.

Contact

cindy.clark@atitesting.com

PC04 - Maximizing Your Career Potential: Opportunities on Your Career Path

Lois S. Marshall, PhD, RN, USA

Abstract

The nursing profession lends itself to endless possibilities. Nurses can take many paths on their career journey, from traditional roles in clinical practice, education, research and administration, to roles that many would consider "outside the box." from entrepreneur to author to global practitioner and so much more. This presentation will focus on all of these endless possibilities and how to build your career trajectory to meet your present and future goals.

References

None.

Contact

lsm4556@aol.com

Oral Presentations

A 01 - Academia's Role in Creating Healthy Work Environments

Bringing Back Field Day: An Innovative Approach to Cultivating Healthy Work Environments

Sara K. Kaylor, EdD, RN, CNE, USA
Paige Johnson, PhD, RN, USA

Abstract

A positive workplace culture is perhaps one of the most dynamic factors thought to be integral to an organization's success, as it has potential to significantly boost employee commitment, engagement, and job satisfaction (Burchell & Robin, 2011). One aspect that plays into the health of organizational culture is "social capital," which refers to the thought that social networking and interpersonal relationships create value and resources for individuals and organizations (DiCicco-Bloom et al., 2007; Read, 2013). Formulated by American education scholar L. J. Hanifan (1916), "social capital" is defined as "goodwill, fellowship, mutual sympathy and social intercourse among a group of individuals and families who make up a social unit" (p. 130). He proposed that placing time and attention towards investing in social capital by getting people to socialize and work together made life worthwhile to people in their everyday lives (Hanifan, 1916; Read, 2013). Subsequent classical work on the concept of social capital adds that it has capacity to boost productivity outcomes that may otherwise be unachievable (Coleman, 1988); in nursing, this relates to stronger outcomes for nurses, patients and health care organizations through improved communication, teamwork, staff retention, and patient safety (Read, 2013). If positive working relationships contribute so strongly to thriving, professional environments, perhaps then leaders of change in academia and health care can foster positive, healthy workplace environments through intentional activities directed towards investment in their organization's social capital.

The purpose of this presentation is to summarize how the implementation of a "Faculty-Staff Field Day" event was used as an innovative approach to cultivating a healthy academic-based work environment. A brief discussion on the planning, implementation, and feedback evaluation of the Field Day event will be offered, as well as "tried-and-true" recommendations for future implementation. Specific activities used for this event will also be shared, as they were intentionally planned to promote physical activity, an increased sense of community, and enhanced collegial relationships among faculty and staff participants.

References

Burchell, M., & Robin, J. (2011). *The great workplace: how to build it, how to keep it, and why it matters.* San Francisco, CA: Jossey-Bass.

Coleman, J. S. (1988). Social capital in the creation of human capital. *American Journal of Sociology, 94,* S95-S120.

DiCicco-Bloom, B., Frederickson, K., O'Malley, D., Shaw, E., Crossan, J. C., & Looney, J. A. (2007). Developing a model of social capital: relationships in primary care. *Advances in Nursing Science, 30*(3), E13-E24. doi:10.1097/01.ANS.0000286626.07634.78

Hanifan, L. J. (1916). The rural community school center. *Annals of the American Academy of Political and Social Science, 67,* 130-138. doi:10.1177/000271621606700118

Read, E. A. (2013). Workplace social capital in nursing: An evolutionary concept analysis. *Journal of Advanced Nursing, 70*(5), 997-1007. doi:10.1111/jan.12251

Contact

skkaylor@ua.edu

A 01 - Academia's Role in Creating Healthy Work Environments

Today's Nursing Student as Tomorrow's Nurse: The Role of Academia in Shaping Healthy Work Environments

Kristi L. Frisbee, DNP, RN, USA
Susan Luparell, PhD, RN, CNE, ANEF, USA

Abstract

In a seminal study of nursing faculty nationwide, Lashley and deMeneses (2001) identified that uncivil behavior by nursing students was an unfortunately common occurrence, with almost all faculty respondents reporting students who were inattentive, unprepared, late, or inappropriately talkative in class. Of concern was the large percentage of respondents who reported experience with students who yelled or verbally abused peers in the classroom (65.8%) or clinical setting (46.3%), as well as the nearly one in four who reported uninvited, objectionable physical contact by a student. Subsequent research ensued and further demonstrated the prevalence of student incivility[1] and its impact[2,3].

As discussions on the topic continue to become more widespread, a common concern voiced by nursing faculty is that poorly behaving students may go on to be poorly behaving licensed nurses. Although the medical profession has established a link between post-licensure disciplinary action and unprofessional behavior during medical school, internship, or residency[4-6], no empirical nursing literature could be identified that addressed this potential link.

In an effort to fill this gap, we conducted a cross-sectional, descriptive study of a national sample of nurse faculty (n = 1869) to explore their attitudes and beliefs about student incivility in nursing programs, including how it should be managed and the major challenges faced when attempting managing it. Additionally, we explored educators' personal knowledge regarding poorly behaving students and subsequent behavior as licensed nurses. Data have been compiled and results will be reported.

Over one in three (37%) faculty reported personal knowledge of a former poorly behaving student who subsequently went on to demonstrate poor behavior in the workplace. Additionally, 55% reported that at least two students graduated from their nursing program in the previous academic year whom they thought should not have graduated based on unprofessional or uncivil behavior. Lastly, faculty reported multiple challenges to effectively addressing poor behavior in students.

The findings from this study, which will be presented in more detail, are both alarming and highly relevant to the health care environment, as they suggest a possible link between pre- and post-licensure behavior in nursing. Suggestions for ongoing conversation and additional research will be provided.

References

Reference cited in abstract:

1. Clark, C., & Springer, P. (2007). Incivility in nursing education: A descriptive study on definitions and prevalence. *Journal of Nursing Education, 46*(1), 7-14.
2. Luparell, S. (2004). Faculty encounters with uncivil nursing students: an overview. *Journal of Professional Nursing, 20*(1), 59-67.
3. Luparell, S. (2007). The effects of student incivility on nursing faculty. *Journal of Nursing Education*, *46*(1), 15-19.
4. Papadakis, M., Hodgson, C., Teherani, A., & Kohatsu, N. (2004). Unprofessional behavior in medical school is associated with subsequent disciplinary action by a state medical board. *Academic Medicine, 79*(3), 244-249.
5. Papadakis, M., Teherani, A., Banach, M., Knettler, T., Rattner, S., Stern, D., Veloski, J., Hodgson, C. (2005). Disciplinary action by medical boards and prior behavior in medical school. *New England Journal of Medicine, 353*(25), 2673-2682.
6. Papadakis, M., Arnold, G., Blank, L., Holmboe, E., & Lipner, R. (2008). Performance during internal medicine residency training and subsequent disciplinary action by state licensing boards. *Annals of Internal Medicine, 148*(11), 869.

Additional references informing our work:

American Nurses' Association. (2015). Code of ethics for nurses with interpretive statements. Washington, DC: American Nurses Publishing.

Docherty, A., & Dieckmann, N. (2015). Is there evidence of failing to fail in our schools of nursing? *Nursing Education Perspectives*, *36*(4), 226-231 226p. doi: 10.5480/14-1485

Kerber, C., Woith, W., Jenkins, S., & Astroth, K. S. (2015). Perceptions of new nurses concerning incivility in the workplace. *Journal of Continuing Education in Nursing*, (11), 522-527.

Lachman, V. (2015). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *Urologic Nursing*, *35*(1), 39-42.

LaDuke, R. D. (2013). Academic dishonesty today, unethical practices tomorrow? *Journal of Professional Nursing*, *29*(6), 402-406. doi: http://dx.doi.org/10.1016/j.profnurs.2012.10.009

Lux, K., Hutcheson, J., & Peden, A. (2014). Ending disruptive behavior: Staff nurse recommendations to nurse educators. *Nurse Education in Practice*, *14*(1), 37-42. doi: http://dx.doi.org/10.1016/j.nepr.2013.06.014

Contact

kfrisbee@pittstate.edu

A 02 - Career Transitions

Successful DNP Transition: Nurse Practitioner to Academician

Lisa B. Robinson, DNP, RN, CCRN, CNE, NP-C, USA

Abstract

The last decade has seen increasing numbers of nurse practitioners completing DNP programs, leaving clinical practice, and entering academia. These providers have been experts in clinical practice and may expect the transition to the role of nurse educator to be seamless. A knowledge deficit related to the tripartite role of teaching, scholarship, and service impact the successful transition of nurses to the roles of nurse educators. The purpose of this presentation is to explore the support and development needed for a successful transition of a DNP to the role of nurse educator.

Several important considerations for a nurses' academic appointment relate to the environment of the institution. New nurse educators may initially be focused on the role of teaching in the classroom or clinical setting. While this is an integral part of the role, the expectations extend far beyond the classroom. Institutional requirements for promotion and tenure are important to explore. The basic criteria for promotion and tenure are established by the institution and may vary within the individual department.

Advising of students may be managed at the department level. Some larger institutions employ advisors to guide students through the curriculum, while other institutions rely on faculty to be accessible to students for advisement. Service to the community may extend from the department or institutional promotion and tenure guidelines. Opportunities for service may include involvement with nursing organizations at the local and national level or service to the community at large.

Facilitating the successful transition from practice to educator requires support of the DNP and assistance with developing into the education role. Mentoring of new faculty members is pivotal. Knowing the level and degree of mentoring offered to new faculty is very important. Mentors can keep new faculty abreast the coming expectations, such as yearly review for tenure processes, committee expectations, and the development of a research program. The specific of matching new educators with expert faculty with an understanding of the expectations is essential. A method to monitor the mentoring relationship can ensure a successful partnership.

New educators who are nurse practitioners will need to continue to practice to maintain their nurse practitioner certification. Depending on which agency the nurse practitioner is certified through, a specific requirement of the number of practice hours required to maintain certification exists. Certification of nurse practitioners can be advantageous for the institution. Developing a method to allow time for faculty clinical practice is common. Many institutions allow faculty members to dedicate one day per week to clinical practice.

Institutions and administrators should support the development of clinical DNP's assuming faculty positions. The development of a plan by the institution and by the new faculty member provides the essential elements for the transition. While the challenges may vary, the results of a successful transition are essential to nursing education.

References

Chism, L. A. (2013). *The doctor of nursing practice A guidebook for role development and professional issues* (2nd ed.). Burlington, MA: Jones & Bartlett.

Zaccagnini, M. E., & White, K. W. (2011). *The doctor of nursing practice essentials A new model for advanced practice nursing*. Sudbury, MA: Jones & Bartlett.

Contact

lisarobinsonnp@gmail.com

A 02 - Career Transitions

The Forgotten Ones' Improving the Onboarding of Clinical Staff in the Ambulatory Care Setting

Jennifer L. Densmore, MSN, RN, CNL, AGPRNP, PDS, USA
Rebecca Deal, MSN, RN, USA

Abstract

Introduction/Background: All too often, the ambulatory care setting is a forgotten area that does not get nearly the attention that the inpatient setting receives when it comes to onboarding new employees, even though this care setting exists as the patient's medical home and where patients flow through at a much greater volume than the inpatient setting. While newly hired inpatient nurses and clinical staff receive ample time to train in their new positions, outpatient clinical staff do not always receive the attention they need to ensure patient safety and quality are being met when they are first hired into a healthcare organization, even though they are interacting with patients, administering medications and procedures, and are depended on by both providers and the patient to ensure that they are competent in the care they give to this population of patients. Many patient injuries and incidents have occurred for the simple lack of support and training these clinical staff members receive upon hiring. The outpatient ambulatory setting employs medical assistants, registered nurses and licensed practical nurses, and although they have been through an educational program, outpatient medical offices have lofty expectations that they have covered every detail in their training. Because of the lack of attention that these staff members receive from the medical offices upon employment, patients are often at risk for injury, turnover of staff is high, and medical offices suffer.

Description of Project: A robust, comprehensive onboarding program was created for the outpatient clinical staff including simulation, extensive preceptorship and competency completion to ensure patient safety and quality is met before the new employee even steps into their new role independently.

Outcomes: New employees feel supported and satisfied with their orientation experience, patient safety is elevated, quality is being taught at the front end.

Implications for Global Health Nursing: The outpatient setting across the world can benefit from increasing onboarding and training of new clinical staff to ensure patient safety and quality are being met in this arena.

References

Garrett Jr, J. H. (2015). A Review of the CDC Recommendations for Prevention of HAIs in Outpatient Settings. *AORN Journal*, *101*(5), 519-528. doi:10.1016/j.aorn.2015.02.007

Kelly, M. A., Berragan, E., Husebø, S. E., & Orr, F. (2016). Simulation in Nursing Education-International Perspectives and Contemporary Scope of Practice. *Journal Of Nursing Scholarship*, *48*(3), 312-321 10p. doi:10.1111/jnu.12208

Sittner, B. J. (2015). INACSL Standards of Best Practice for Simulation: Past, Present, and Future. *Nursing Education Perspectives*, *36*(5), 294-298 5p. doi:10.5480/15-1670

Contact

jenniferrn2001@aol.com

A 03 - Collaborations to Enhance Professional Development

Collaboration Between Academia and Practice on Service Excellence and Core Measures

Crystal Joy Wilkinson, DNP, RN, CNS-CH, CPHQ, USA
Elizabeth H. Boyd, MSN, BS, RN, RNC-MSN, USA

Abstract

Texas Tech University Health Sciences Center in partnership with 23 facilities associated with Seton Healthcare Family and St. David's Healthcare, the Healthcare Workforce Alliance of Central Texas, Austin Community College, Texas State University, University of Texas at Austin and Concordia University will identify and then, reduce or eliminate practice gaps for new graduates in the areas of patient perception of customer service and the Centers for Medicare and Medicaid Services (CMS) clinical quality measures. The health sciences center will develop and test a competency assessment tool specifically designed to identify gaps in these areas, and curriculum will be developed and implemented to reduce or eliminate those gaps.

Nursing shortages, fiscal restraints, complex healthcare organizations and regulations, increasing patient acuity and the explosion of knowledge and technology have increased the need for nursing graduates to arrive in the work setting with the ability to move quickly into practice. Nursing residency programs were designed to facilitate the complex process that prepares new graduate nurses for practice, taking the novice nurse from a beginner to more competent provider. Nursing residency programs last anywhere from six weeks to six months and are estimated to cost around $65,000. Historically there has been a gap between nursing schools and hospitals on how well prepared graduate nurses are when they reach this critical juncture. Due to recent changes in Medicare and Medicaid reimbursement nurse residency programs have an increased focus on two particular areas: 1) Competency in service excellence; and 2) the nurse's role in compliance with clinical quality measures. Healthcare organizations feel these topics are not adequately addressed in nursing programs but could be included integrated into competency-based curriculum and would align well with patient-centered care and evidence-based practice content. Collaboration between nursing schools and hospitals on these priority topics could help close these gaps and speed transition to practice, saving time and money.

Approach: The aim of this project is to identify gaps in customer service skills and core quality measures in new graduates and nursing residents and develop and implement an assessment tool specifically designed to measure competency in these two high priority areas. Currently a tool that addresses these topics does not exist. This project involved extensive collaboration between the participating nursing schools, two major hospital systems and their education and management staff. Focus groups involving administrators and educators with varying years of experience were conducted to identify key concepts and constructs related to the study competencies. The individuals and organizations participating helped to define gaps, define competencies and provide perspectives on the new graduate and nursing residency experience. The data was used in the assessment tool and curriculum development. The curriculum was designed and implemented by the participating nursing programs and offered to programs across the state of Texas. The goal of the project is to increase competency in the new graduates and new hires in the two topic areas. The objective was to reduce the time and cost of ensuring competency for the study topics in the residency program. Consultation on use of the tool and the process will be provided through onsite visits or a web-based tool kit to increase spread and sustainability of the project.

Conclusion: The tools developed and the information obtained from this project will be generalizable to healthcare organizations and schools of nursing across the country. This project is unique in its innovative and cooperative structure and could be used as a model by other organizations seeking to bridge the gap in preparing nurses for practice and for ensuring high quality in evidence-based practice and excellence in customer service.

References

Adamack, M., & Rush, K. L. (2014). Disparities in new graduate transition from multiple stakeholder perspectives. *Nursing Leadership (Toronto, Ont.), 27*(3), 16-28.

Rangachari, P., Bhat, A., & Seol, Y. H. (2011). Using the "customer service framework" to successfully implement patient- and family-centered care. *Quality Management in Health Care, 20*(3), 179-197.

Wilkinson, C. A. (2013). Competency assessment tools for registered nurses: An integrative review. *Journal of Continuing Education in Nursing, 44*(1), 31-37.

Contact

crystal.wilkinson@ttuhsc.edu

A 03 - Collaborations to Enhance Professional Development

Mentoring Approach to Professional Development

Leighsa Sharoff, EdD, RN, NPP, AHN-BC, USA
Judith Aponte, PhD, RN, CDE, CCM, APHN-BC, USA

Abstract

There is a significant decrease in nurse educators in the 21st century. According to AACN's 2012-2013 report on Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing, approximately 79,659 qualified applicants are turned away from U.S. baccalaureate and graduate nursing schools. Reasons for this were due to insufficient number of faculty, clinical sites, classroom space, and clinical preceptors, as well as budget constraints. Almost two-thirds of these nursing schools responding to the survey pointed to faculty shortages as a reason for not accepting all qualified applicants into their programs. This ripple effect leads to a decrease in nurses in the workforce. Unfilled faculty positions, resignations, projected retirements, and the shortage of students being prepared for the faculty role pose a threat to the nursing education workforce. Working with students to encourage them to be active participants in the learning process is beneficial. For example, by encouraging students to revise assignments based on the feedback received can bring about a collaborative experience for both the student and educator. By providing feedback, guidance and encouragement to the student is a way to transfer knowledge. Nurse educators working with students to prepare manuscripts for publications are another process to instill professional behaviors. Bridging the gap between student and educator, developing a collaborative academic working relationship, while instilling the critical elements required for professional and skilled communication imparts significance importance to the nursing profession. These professional development approaches can be applied through mentoring.

Mentoring is an evidenced-based concept and mechanism for professional development that has shown positive outcomes to recruitment and retention, and professional organizational culture. In order to foster a healthy academic learning environment mentoring needs to begin in nursing schools through different types of experiences other than the standard clinical practicums. These experiences can be gained as a research or teaching assistant. Through these roles discussions will be based on the different learning opportunities and experiences (e.g., in developing simulation and genetic scenarios; or as a member of a research team) undergraduate and graduate nursing students have engaged in with nursing faculty. During these experiences students, have gained additional practice and have improved on their communication skills which have enhanced the educational process. It is essential for all current nurse educators to share one's knowledge and pass the torch of educator. Developing a culture of mentoring that begins in the academic setting is essential for academic success, professional growth and career development, potentially fostering new nurses to become mentors themselves in their work environment. As the Institute of Medicine and the Robert Wood Johnson Foundation Report on the Future of Nursing highlight, nurse mentoring plays a crucial role in assisting nurses to develop into the kind of leader who can play a larger part in the development, design and delivery of health care.

References

American Association of Colleges in Nursing (2014). Nursing Shortage. Accessed from: http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage.

American Association of Colleges in Nursing (2014). Nursing Shortage Fact Sheet. Accessed from: http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf.

Burr, S., Stichler, J.F., Poeltler. D. (2011). Establishing a mentoring program. Nurs Womens Health, 15(3), 214-224. PMID: 21672171. doi: 10.1111/j.1751-486X.2011.01636.x.

Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press, 2011. doi:10.17226/12956.

Latham, C.L., Ringl, K., Hogan, M. (2011). Professionalization and retention outcomes of a university-service mentoring program partnership. J Prof Nurs., 27(6), 344-353. PMID: 22142910. doi: 10.1016/j.profnurs.2011.04.015.

Contact

jap@hunter.cuny.edu

A 04 - Developing Professional Communication Skills

Resolving Conflict with Staff, Patients, Families, and Friends and Improve Patient Safety

Terri L. Bogue, MSN, RN, PCNS-BC, USA
Robert L. Bogue, BS, MCSE, MCPD, MCTS, MCITP, USA

Abstract

The complex, high stress, and emotionally laden environment of healthcare frequently leads to conflict. This conflict may contribute to a culture of disrespect, which is a barrier to patient safety and quality of care (Leape, et al., 2012). Patient safety and quality care is dependent on collaborative relationships among healthcare team members, effective communication, and a collaborative work environment (The Joint Commission, 2008). Overall, the Joint Commission has found that communication failures are a "root cause in nearly 70% of reported sentinel events, surpassing other commonly identified issues such as staff orientation and training, patient assessment, and staffing." Many of these communication lapses are the result, or the cause of conflict (Morreim, 2015).

Every healthcare professional encounters disagreement and conflict on a routine basis; this is expected, as conflict is natural and necessary to every organization. Recognizing the frequency of conflict, it is surprising that few nurses have been trained to truly understand the components of conflict or effective methods to resolve it. We are all familiar with conflict, yet reacting to and resolving conflict continues to consume significant time and energy for both the bedside nurse and healthcare leaders. A significant portion of a nurse manager's time is devoted to resolving employee conflicts. Unresolved conflict impacts employee morale and retention, and may ultimately affect the overall well-being of the organization.

Recognizing that conflict is natural and necessary emphasizes the necessity to learn how to improve efficiency in communication and collaboration. This increased efficiency can be supported through an understanding of emotional intelligence, conflict styles, the psychology of decision making, and communication styles. This background knowledge related to conflict enables the nurse to improve their personal conflict resolution skills and develop mentoring skills to better assist employees and co-workers in conflict resolution.

By learning to identify the conditions that create conflict, the specific causes that trigger it, and the techniques for resolving conflict, nurses will be better prepared to negotiate the complex world of healthcare. Success under conditions of high stress, risk, ambiguity, and complexity require effective conflict resolution skills. While it is impossible for nurses to resolve all conflict without the collaboration of the interdisciplinary team, it is their centrality to healthcare that places nurses in the position where they are able to take the lead in these efforts.

Healthcare organizations that support the development of effective conflict resolution and communication skills can transform organizational culture and leadership while improving efficiency, reduce preventable errors and adverse events, and improve staff and patient satisfaction (Rosenstien, Dinklin, & Munro, 2014). Learning to identify conditions that create conflict and techniques to effectively resolve it will impact multiple areas of healthcare, including staff satisfaction and engagement, improved patient outcomes, and patient satisfaction.

References

Leape, L. L., Shore, M. F., Dienstag, J. l., Mayer, R., Edgman-Levitan, S., Meyer, G. S., & Healy, G. B. (2012). Perspective: A Culture of Respect, Part1: The Nature and Causes of Disrespectful Behavior by Physicians. *Academic Medicine*, 845-852.

Morreim, H. (2015). Conflict Resolution in the Clinical Setting: A Story Beyond Bioethics Mediation. *Journal of Law, Medicine & Ethics*, 843-856.

Rosenstien, A. H., Dinklin, S. P., & Munro, J. (2014). Conflict Resolution: Unlocking the Key to Success. *Nursing Management*, 34-39.

Contact

tbogue@thorprojects.com

A 04 - Developing Professional Communication Skills

Helping Nursing Students Develop Professional Values, Morals, and Ethics through Reflective Practices

Elizabeth Ann Fiske, PhD, RN, CNE, PCNS-BC, NNP-BC, USA

Abstract

We want nursing students to be thoughtful, reflective practitioners and we want them to develop professional values, morals and ethics. At the minimum we expect civil, respectful behavior. Nursing programs typically include learning outcomes in the affective domain in their programs and accrediting bodies and professional organizations value this type of learning. Developing classroom activities to foster this type of learning can be difficult; however, a range of reflective, contemplative activities can be used. I will demonstrate and describe some activities used in the classroom.

Contemplative practices have been used for centuries to promote concentration and focus and also to develop a positive, compassionate outlook. Contemplative pedagogical strategies have been incorporated in the classroom as a means to improve attention, develop empathy and search for meaning. Simple contemplative activities can serve as proactive measures to prevent incivility among nursing students as well as to lay a foundation for future practice. These activities can create an environment of openness that in turn promotes understanding and valuing of different perspectives. Examples of how these strategies have been used to enhance learning over the past two years in an undergraduate nursing course will be discussed.

Student learning outcomes were met through purposefully selecting appropriate, relevant activities. A variety of activities used in the course will be described briefly. These activities included meditation, compassion practice, attending and exhibits on campus. Evaluation methods used, types of data collected and student outcomes will be discussed. The session will include discussion of ways to incorporate similar activities in other courses.

Use of meditation in nursing classes is not uncommon. Simply starting class with an exercise that helps students clear their minds of distracting thoughts helps students focus. Students close their eyes and are given prompts to focus on their breathing. They are encouraged to not get caught up in their thoughts and return their focus to their breathing. This practice can be used for five to ten minutes. Students are encouraged to slowly open their eyes. This short practice helps students develop awareness and focus more attentively on class. Quieting in this way can also set the tone for class as a calm, quiet environment.

Helping students see similarities shared by the class members can be a first step toward developing compassion. For this exercise students are asked to work in pairs. Without talking to each other they simply visually focus on each other while contemplating a series of statements read aloud by the instructor. The statements can include thoughts related to individual needs such as the need to feel respected and valued. Statements can also include common feelings all students experience at some point such as disappointments and misunderstandings. The exercise concludes with statements of wishes and hopes such as being healthy or having the strength to accomplish a task or goal. While this practice sounds simple, it can be very powerful.

Contemplative seeing is the practice of beholding something, usually a work of art, and contemplating it. Student impressions and interpretations of abstract visuals will vary and this practice can be a springboard to discuss difficult or controversial topics. Many different media sources can be used for this practice. I will discuss visual exhibits and media presentations that students attended and share their reflections. The goal of this activity was not necessarily to interpret the art work and come to consensus but to foster open dialogue about difficult subjects.

There are several important recommendations for implementing any of these practices. Instructors should develop their own self-awareness through engagement with these practices prior to introducing them in to students. Many of the contemplative practices have religious roots and teachers need an understanding of the origins of each practice. All the activities used in class were purposefully kept secular. Allowing

students to choose whether or not they want to participate is also essential to be respectful of students' individual backgrounds. Faculty also need to be aware that these practices can elicit a variety of responses and appropriate support must be available if needed.

Students found the activities beneficial and the activities helped students achieve learning outcomes. Using a range of activities allowed all students to find at least one reflective practice that they enjoyed and planned to use again in the future. These activities can foster the reflective, professional behavior that we want to see exhibited by nurses.

References

Hensel, D. & Laux, M. (2014). Longitudinal study of stress, self-care, and professional identity among nursing students. *Nurse Educator;* 39(5), 227-231.

Rees, K. (2013). The role of reflective practices in enabling final year nursing students to respond to the distressing emotional challenges of nursing work. *Nurse Education in Practice*, 13, 48-52.

Walker, M. & Mann, R. A. (2016). Exploration of mindfulness in relation to compassion, empathy and refection within nursing education. *Nurse Education Today*, 40, 188-190.

Contact

fiskeea@appstate.edu

B 01 - Distress in the Work Environment

Music Therapy to Reduce Staff Annoyance Related to Construction Specific Noise: A Quality Improvement Project

Kimberly K. Norton, MS, RN, USA

Abstract

Background: Of the 579 hospitals under construction in November of 2015, 163 are renovation projects occurring on campus while patients continue to be seen and treated (Hargrave, 2016). Currently the construction team is in the middle of remodeling the cardiac care unit (CCU) at a local hospital, resulting in the incorporation of construction processes and patterns to the critical care environment. The necessary tasks for construction work require the use of loud, and disturbing tools, which are disruptive to the entire unit and to all those who enter the CCU. The specific aim for this quality improvement project is to decrease the annoyance score of the CCU staff from construction specific noise by 10% before July 30, 2016.

Methods: This unit-based intervention was implemented in a previously 10-bed cardiac care unit that is the workplace environment for not only unit staff, but also for contractors, construction employees, and project managers. The intervention of Native American Celtic Flute music was played at the nurse's station via a Bose speaker from 0800 to 1500 for four days in attempt to desensitize the members of the CCU to the construction noise. A pre- and post-implementation survey designed with the Genlyd instrument, for all CCU staff was used as the assessment of measuring annoyance due to construction noise. The nonparametric test of the Wilcoxon sign rank test was used to determine the significance of the results.

Results: The survey results illustrated a 75% decrease in average annoyance score related to construction noise after the implementation of Native American Celtic Music. This results in a significant ($p< 0.0001$) improvement in self-reported annoyance. The accepted level of significance is $p<0.05$. The music also had an overwhelming effect on the workplace satisfaction for the staff members within the CCU, as well as a decrease in self-reported distraction from the noise.

Conclusion: This quality improvement project has led to the intended results of Native American Celtic Flute music to decrease annoyance and desensitize construction specific noise for the staff in a critical care unit. In conclusion, it is recommended that music be implemented into practice for hospital units to increase staff satisfaction, staff ability to focus and decrease annoyance factors related to construction specific noise.

References

Choiniere D. The effects of hospital noise. Nurs Adm Q 2010;34(4): 327-33.

Darbyshire, J. L., & Young, J. D. (2013). An investigation of sound levels on intensive care units with reference to the WHO guidelines. *Crit Care*, *17*(5), R187.

Good, M. (1995). A comparison of the effects of jaw relaxation and music on postoperative pain. *Nursing research*, *44*(1), 52-57.

Hargrave, M. (2016). *Medical real estate construction pipeline at 97.1 billion-10 insights from revista's US construction report.* Unpublished manuscript.

Jaber S, Bahloul H, Guetin S, Chanques G, Sebbane M, Eledjam JJ. [Effects of music therapy in intensive care unit without sedation in weaning patients versus non-ventilated patients]. *Ann Fr Anesth Reanim.* 2007; 26(1):30-38.

Kardous, C. A., & Shaw, P. B. (2014). Evaluation of smartphone sound measurement applications. *The Journal of the Acoustical Society of America*, *135*(4), EL186-EL192.

Konkani, A., & Oakley, B. (2012). Noise in hospital intensive care units—a critical review of a critical topic. *Journal of critical care*, *27*(5), 522-e1.

McCrum-Gardner, E. (2008). Which is the correct statistical test to use? *British Journal of Oral and Maxillofacial Surgery, 46*, 38. doi:10.1016/j.bjoms.2007.09.002

Morrison, W., Haas, E., Shaffner, D., Garrett, E., & Fackler, J. (2003). Noise, stress, and annoyance in a pediatric intensive care unit. *Critical Care Medicine*, *31*(1), 113-119 7p.

Ryherd EE, Waye KP, Ljungkvist L. Characterizing noise and perceived work environment in a neurological intensive care unit. J Acoust Soc Am 2008;123:747-56.

Supnet, C., Crow, A., Stutzman, S., & Olson, D. (2016). Music as Medicine: The Therapeutic Potential of Music for Acute Stroke Patients. *Critical Care Nurse*, *36*(2), e1-e7.

Squire 2.0 guidelines. (2015). Retrieved from http://www.squire-statement.org/index.cfm?fuseaction=Page.ViewPage&PageID=471

Theories of Florence Nightingale. (2012). Retrieved from http://currentnursing.com/nursing_theory/Florence_Nightingale_theory.html

Thoma, M. V., La Marca, R., Brönnimann, R., Finkel, L., Ehlert, U., & Nater, U. M. (2013). The effect of music on the human stress response. *PloS one*, *8*(8), e70156.

Wiese, C. (2010). *Investigation of patient perception of hospital noise and sound level measurements: Before, during and after renovations of a hospital wing* (Master of Science). Available from Digital Commons @University of Nebraska-Lincoln.

Worker safety series: Protecting yourself from noise in construction. (2011). Retrieved from https://www.osha.gov/Publications/3498noise-in-construction-pocket-guide.pdf

Zborowsky, T. (2014). The legacy of Florence Nightingale's environmental theory: Nursing research focusing on the impact of healthcare environments. Health Environments Research & Design Journal, 7(4), 19–34.

Contact

kimmienorton@gmail.com

B 01 - Distress in the Work Environment

Barriers and Values of Moral Distress Among Critical Care Nurses

Melissa A. Wilson, PhD, MSN, APRN, CCNS-BC, USA

Abstract

Aims. To understand the barriers and values present in civilian and military critical care nurses during moral distress experiences. **Background.** There is a problem plaguing our healthcare organizations that is causing providers to suffer and putting patients at risk. Working in healthcare is often not without moral or ethical encounters that leads to distress (American Association of Critical Care Nurses [AACN], 2008). These situations are such that an increasing frequency or an intense single encounter could result in a painful, psychological alternation named moral distress. Advances in technology and our capabilities to extend life-saving measures are a few examples that have created a healthcare environment rich with the possibility of moral distress. Moral distress is frequently identified by critical care nurses who experience moral conflict while caring for others in an intensive care environment which results in distress (Burston & Tuckett, 2013). When conflict occurs, moral distress may influence actions and behaviors of that individual. Moral distress situations may result in greater rates of burnout and turnover of nurses, poorer patient outcomes, increased healthcare expenses, poor team collaboration and damage to a nurses' self-integrity (Cimiotti, Aiken, Sloane & Wu 2012; Pauly, Varcoe & Storch 2012; Epstein & Hamric 2009; AACN, 2008). The purpose of this work is to examine the barriers in both civilian and military healthcare environments that prevents a nurse to act in a morally comforting manner and the moral values that are present in moral distress experiences. Identification of specific barriers and values within the context of moral distress may lead to crucial interventions that could lessen the effects of moral distress on nurses. **Design.** A series of studies will be presented from both the civilian and military healthcare environments. Two nonexperimental descriptive studies were completed utilizing qualitative interviews with civilian and military critical care nurses who self-report that they have experienced moral distress. **Methods.** Primary interviews were conducted with seven critical care nurses utilizing a semi-structured approach in the civilian sector and 12-15 critical care nurses from the United States Air Force (USAF) critical care air transport teams (CCATT), who are currently being interviewed. Recruitment occurred through a local chapter of a professional critical care nurse organization and the USAF. **Results.** If present, establishment of the phenomenon is first needed in CCAT nurses and then barriers and values present in moral distress experiences will be examined. A list of five barriers and associated values from civilian critical care nurses was generated from the first study completed through a content analysis methodology approach. Future measures will examine similarities and differences in civilian and military experiences of moral distress. **Relevance to clinical practice.** Studying barriers and values present in civilian and military critical care nurses who have experienced moral distress provides direction for targeting interventions to lessen the impact of this detrimental phenomenon in healthcare. **Current efforts.** Efforts are underway to evaluate the presence of moral distress in CCATT nurses in the United States Air Force. CCATT members' roles include stabilizing and managing critically ill patients in the confines of air transport during war and peacetime missions. Often these healthcare members are exposed to unpredictable and extreme patient conditions within the confines of an austere environment (Brewer & Ryan-Wenger, 2009). Research is limited in exploring moral distress within military populations and no data was found related to the CCATT experience. This effort seeks to establish the phenomenon of moral distress among CCATT nurses. If established, follow-up studies will examine barriers and values present in other military healthcare members. Identification of similarities and differences between civilian and military critical care nurses will be examined. Efforts in this research area will build on the wealth of knowledge from moral distress research in the civilian sector. It will create a foundation for moral distress interventions within military nurse populations.

References

American Association of Critical Care Nurses [AACN] (2008). Moral distress public policy position statement. Retrieved from http://www.aacn.org/WD/Practice/Docs/Moral_Distress.pdf

Brewer, T. L. & Ryan-Wenger, N. A. (2009). Critical Care Air Transport Team (CCATT) Nurses' Deployed Experience. *Military Medicine*, *174*(5), 508-514.

Burston, A. S., & Tuckett, A. G. (2013). Moral distress in nursing: Contributing factors, outcomes and interventions. *Nursing Ethics, 20*(3), 312-324. doi: http://dx.doi.org/10.1177/0969733012462049

Cimiotti, J.P., Aiken, L.H., Sloane, D.M., & Wu, E.S. (2012). Nurse staffing, burnout, and health care associated infection. *American Journal of Infection Control, 40*(6), 486-490.

Epstein, E.G. & Hamric, A.B. (2009). Moral distress, moral residue, and the crescendo effect. *Journal of Clinical Ethics, 20*(4), 330-342.

Pauly, B.M., Varcoe, C. & Storch, J. (2012). Framing the issues: moral distress in health care. *HEC Forum, 24*(1), 1-11. doi: 10.1007/s10730-012-9176-y

Contact

melissawilson967@gmail.com

B 02 - Creating a Collaborative Culture

Building a Culture of Ownership in Healthcare: The Invisible Architecture of Ownership, Values, and Attitude

Robert L. Dent, DNP, MBA, RN, NEA-BC, CENP, FACHE, USA
Joe Tye, MBA, VC, USA

Abstract

When we design a new physical facility we hire professional architects and engineers to guide us through the process; we go through multiple iterations from schematic design to final construction blueprints; we have committees giving input on wallpaper design and carpet color. We'll lay out a room with masking tape in the parking lot to make sure that there is a good fit between the new design and the processes and equipment for which that space is being designed.

But when it comes to employee engagement, patient satisfaction, effective communication, and even quality and productivity, the visible architecture of the physical structure is less important than what we call Invisible Architecture. Yet most healthcare organizations do not put nearly as much thought and attention into designing their Invisible Architecture as they do the design of their physical facilities. We wouldn't remodel a patient care floor without a detailed blueprint, but once the remodeling is finished and staff move in, we allow the Invisible Architecture to evolve haphazardly. This is one of the main reasons so many healthcare organizations don't have a consistent overarching culture but rather are a patchwork of cultures that vary by department, shift, census, staffing levels, manager on duty, and other variables.

Invisible Architecture is the soul of an organization the way bricks and mortar are the body of the organization. In recent years, there has been a growing realization that care of the spirit is just as important as, and is essential to, care of the body. In the same way, we should be as deliberate in designing our Invisible Architecture as we are in designing the visible architecture of our buildings.

When a new building goes up it is built in three stages: the foundation is put down, a superstructure is erected upon that foundation, and the interior is finished off. If you have a good designer and a good builder, it's seamless – you don't see where the foundation ends and the superstructure begins and there are no structural gaps between the walls and the carpeting.

This presentation will use a construction metaphor to describe Invisible Architecture. In the metaphor (this construct, if you will) the foundation is *core values*, the superstructure is *organizational culture*, and the interior finish is *workplace attitude*. As with physical design, in great organizations the transitions are seamless. If, for example, one of the foundational values of the organization is integrity, there would be a culture that honors confidentiality and a workplace attitude that is intolerant of gossip and rumor-mongering.

The presentation will be in two parts. Part 1 will describe the Invisible Architecture model, illustrated with examples of values statements, culture codes, and attitude expectations (both best and worst) from healthcare and other industries. Part 2 will shift the focus to the importance of values-based authentic leadership for sustaining a culture of ownership.

References

Tye, J., Dent, R.L. (2017). Blueprinting the invisible. Designing and building a culture of ownership. Sigma Theta Tau International. Book published in March 2017.

Dent, R.L., Tye, J. (2016). Creating a positive culture of ownership. Nurse Leader. May/June 2016.

Contact

bob.dent@midland-memorial.com

B 02 - Creating a Collaborative Culture

Interprofessional Collaborative Partnerships to Create Healthy Environments: Understanding Fetal Alcohol Spectrum Disorders

Ann M. Mitchell, PhD, MS, BS, RN, FAAN, USA
Irene Kane, PhD, RN, CNAA, HFI, USA
Kathryn Puskar, DrPH, MN, FAAN, USA
Holly Hagle, PhD, USA
Dawn Lindsay, PhD, USA

Abstract

The Center for Disease Control and Prevention (CDC) along with Practice Implementation Centers (PICs) and Discipline Specific Workgroups (DSWs) have embarked on an interprofessional collaborative practice project to enhance professional's clinical skill sets for the prevention of Fetal Alcohol Spectrum Disorders (FASDs), by employing the expanded use of alcohol screening and brief intervention. This innovative collaboration entails work from 6 disciplines and numerous national partners.

Maternal prenatal alcohol use is one of the leading preventable causes of birth defects and developmental disabilities (Hartje, Edwards, & Edney, 2015). Children exposed to alcohol during fetal development can suffer a wide array of disorders, from subtle changes in IQ and behaviors to profound intellectual disability, known as fetal alcohol spectrum disorders (FASDs) (Hartje, Edwards, & Edney, 2015). Nurses can play a vital role in the prevention of FASDs by identifying women consuming alcohol which may put them at risk for an alcohol exposed pregnancy through simple and direct screening. Since the adverse effects of prenatal alcohol exposure constitute a continuum of disabilities clinical guidelines for diagnosing FASDs were recently updated (Hoyme, 2016).

This interprofessional collaboration vested in an evidence-based environmental scan supports the enhancement of team-based care of patients to improve population health outcomes (IPE, 2016). The production of diverse resources to support interprofessional collaboration to address alcohol screening and brief intervention through the development of online courses, comprehensive website resources, unique trainings, and the development of champions. Examples of these collaborative tools, which have been developed, will be highlighted for the group in this interactive session. This interprofessional national network and discipline specific working groups is providing evidence-based materials for the clinical work environment for any practicing nurse who advocates a healthy lifestyle environment for their clients. An example of clinical integration into a national organization will be highlighted and discussed with the participants.

References

Hartje, J., Edwards, A., & Edney, C. (2015). Competency I: Foundation. In Regional Training Centers Curriculum Development Team (Ed.), Fetal Alcohol Spectrum Disorders Competency-based Curriculum Development Guide for Medical and Allied Health Education and Practice. Retrieved from www.frfasd.org/Comp_Guide.html. Retrieved from www.frfasd.org/Comp_Guide.html

Hoyme, H. E., Kalberg, W. O., Elliott, A. J., Blankenship, J., Buckley, D., Marais, A. S., ... & Jewett, T. (2016). Updated Clinical Guidelines for Diagnosing Fetal Alcohol Spectrum Disorders. Pediatrics, 138(2), e20154256.

Interprofessional Education Collaborative. (2016). Core competencies for interprofessional collaborative practice: 2016 update. Washington, DC: Interprofessional Education Collaborative.

Contact

irk1@pitt.edu

B 03 - Effective Decision-Making: How Concepts Come Together

Identifying Educational Needs: Training Gap Analysis of United States Air Force Aeromedical Evacuation Technicians/Nurses

Tiffany Losekamp-Roberts, MSN, RN, CNE, CHSE, USA
Julie F. Roseboro, MS, BSN, RN, CCRN, USA

Abstract

INTRODUCTION: The United States Air Force (USAF) is curtailing its medical treatment facilities, thus reducing the number of opportunities for skill attainment and proficiency for flight nurses (FNs) and aeromedical evacuation technicians (AETs). Assignment to outpatient clinics and inpatient units with lower census and acuity creates skills gaps for aeromedical team members. It is critical that FNs and AETs demonstrate clinical expertise on the ground before they can be expected to proficiently care for combat or civilian wounded on an 8- to 12-hour flight in the back of a cargo aircraft within the en route care environment. Opportunities to practice these skills on the ground have been challenging, requiring the USAF to initiate alternative training opportunities.

Current clinical prerequisites for active duty USAF FNs and AETs include a minimum of 2 years clinical experience (1 year inpatient experience is recommended), current Basic Life Support, current Advanced Cardiac Life Support (nurses), current registration in the National Registry of Emergency Medical Technicians (technicians), skilled in Air Force Specialty Code, and core clinical competencies such as patient assessment, blood administration, intravenous therapy, and management of the patient in hypovolemic shock. Clinical competency can be broadly interpreted across the various practice environments. FNs and AETs often attempt to maintain clinical competency in a simulation laboratory due to limited, or absent, opportunities to perform skills in a clinical setting with patients. Simulation has been shown to be an effective training method. Today's healthcare providers often learn high-risk and low-volume procedures in simulated environments, offering the chance to learn and practice in a safe setting (Fairhurst, Strickland, & Madden, 2011). Much like the civilian environment, the USAF is also using simulation for sustainment of skills. However, there is minimal information about the best way to train this unique AE population (O'Connell et al., 2013).

Very little research exists to support simulation decisions in the USAF AE environment (O'Connell et al., 2013). A program of research was developed to provide an evidence base for decision making on education and training initiatives. An assessment of training needs was identified as a foundational study for this new trajectory of research within the USAF. A training gap analysis study was completed; the aims of this study were to (1) describe the clinical experience of active duty (AD) FNs and AETs and (2) identify the clinical education needs of the AD FNs and AETs.

METHODS: The aims of the study were accomplished concurrently through the use of a single paper survey developed by subject matter experts (SMEs). Content validity was developed using the established USAF clinical competencies and SME feedback. Survey questions identified clinical experience and level of comfort performing clinical tasks. A convenience sample of AD FNs and AETs assigned to one of the following AD aeromedical squadrons were invited to participate: Kadena Air Base, Japan; Pope Army Airfield, North Carolina; Ramstein Air Base, Germany; and Scott Air Force Base, Illinois. Over 100 AE clinicians participated in the study (n=102 following statistical exclusions). Since this study was descriptive and exploratory in nature, a power analysis was not conducted. Descriptive statistics were used to analyze results.

RESULTS: Demographics of study participants were similar to a previous skills gap conducted on students attending the FN and AET course (n=198, officer 39%, enlisted 61%, tech training 51%, associate degree 7%, BS degree 36%, MS degree 7%) (De Jong, Dukes, & Dufour, 2014). Specifically, clinicians were half enlisted (50%) and half officers (50%) by rank; approximately half AETs (48%) and half FNs (49%); educated to a variety of levels, from Emergency Medical Technician/Paramedic (33%), Associate Degree Nurse/Associate Degree (9%), Bachelors of Science in Nursing/Bachelors of Science (39%), to Masters of Science in Nursing/Masters of Science (18%); and displayed varying years of patient care experience, from fewer than 3 years (4%), 3 to 5 years (38%), 5 to 10 years (35%), to greater than

10 years (23%). One hundred three participants reported their role and years of patient care experience, while 102 reported military rank and level of education and 100 provided duration in current assignment. This sample is representative of 25% to 33% of each AD aeromedical squadron.

Analysis of clinician comfort, as measured by the developed tool, looked at various healthcare tasks. This revealed 10 key areas where FNs and AETs were less comfortable providing care (on a 5-point scale, 1=least comfortable, 5=most comfortable): managing neonatal patients (2.82), using a ventilator (2.87), treating labor & delivery patients (2.94), managing obstetric patients (3.19) and pediatric patients (3.48), managing a central line (3.49), giving blood components (3.61), managing hematology (3.62) and endocrine disorders (3.74), and treating burn victims (3.80). By comparing collected data to SME ranking of important skills to AE comfort level, several tasks were distinguished as more comfortable to AE clinicians than important to SMEs. Thus, these tasks were well-grasped by clinicians, and training regimens do not require focused intervention at this time. These tasks include monitoring vitals and pulse ox, using restraints, managing nasogastric tubes, and others.

DISCUSSION: The data from this study revealed the typical clinical experience of FNs and AETs in the tasks they were most comfortable with and shed light on the tasks that must be emphasized in future training. This allows effective decision making related to training and competency tasks before clinicians take to the air with their AE squadrons.

The findings from this study will continue to build a foundation for education initiatives and allow for targeted interventions to meet sustainment needs of AD FNs and AETs. Given fiscal constraints, leadership has identified a need to provide an evidence base for educational initiatives. This study begins to provide an evidence base and future direction of skill sustainment training for FNs and AETs.

References

De Jong, M. J., Dukes, S., Dufour, K. (2014). Clinical experience and learning style of Air Force flight nurses and aeromedical evacuation technician students. Presented at the TriService Nursing Research Program Research and Evidence-Based Practice Dissemination Course, San Antonio, TX.

Fairhurst, K., Strickland, A., & Madden, G. (2011). Simulation speak. *Journal of Surgical Education, 68*(5), 382-386. doi:10.1016/j.jsurg.2011.003.003

O'Connell, K. M., De Jong, M. J., Dufour, K., Millwater, T., Dukes, S., Winik, C. (2013). Simulation use in aeromedical evacuation training: research gaps from an integrated review. *Clinical Simulation in Nursing, 66*, 3-15.

Contact

Talosekamp@gmail.com

B 03 - Effective Decision-Making: How Concepts Come Together

Influence of Menopausal Symptoms on Perceived Work Ability Among Women in Ekiti State, Nigeria

Aanuoluwapo Olajubu, MSc, BNSc, RN, RM, RPHN, Nigeria
Adekemi Eunice Olowokere, PhD, MSc, BNsc, HND, RPHN, RM, RN, Nigeria
Deborah Oluwanifemi Amujo, BNSc, RN, Nigeria

Abstract

Background: In recent years, Africa has experienced escalation in women participation in nation building. Women constitute about 45% of the over 50-year old work force in virtually all forms of employment. In the quest to tackle the challenges of an ageing population, employers have sought to retain and increase the number of mature women at work. Over the years, there has been an increased participation of women and the ageing profile of labour market in many industrialized nations. However, while these women are busy taking up paid employments, they have also been transiting through a major period of their lives – the menopause.

Associated with the various perceptions surrounding the menopause, this normal physiological event has been viewed as a syndrome and more recently as a newly discovered deficiency disease. Women experiencing this normal end of reproduction are thought to experience regrets and signs of depression and are also known to present with a broad range of accompanying symptoms. The typical menopausal woman is therefore perceived as growing old, beset with psychosocial complaints, experiencing major physical changes, losing cultural significance and generally being a burden on medical resources.

The concept of work ability was developed in the early 1980s in Finland and was adopted by various European and Asian countries. Work ability may be described as how good the worker is at present, in the near future, and how able is he/she to do his/her work with respect to the work demands, health and mental resources. Decreased work performance in working places and various arms of government affects the productivity and takes its toll on the nation's economy and development. The effect of the stress on the women also decreases life expectancy and increase health challenges among the ageing population.

Perception and knowledge of women about menopause has been studied, however, there is paucity of data on the influence of menopausal symptoms on work ability and the coping strategies employed by women.

This study therefore aimed at investigating the menopausal symptoms experienced by women of menopausal age in Ekiti State, Nigeria and its influence on their perceived work ability. It also explored women's experiences of working through menopausal transition and the influence of menopausal symptoms on perceived work ability

Method: The study employed a descriptive cross-sectional research design. The study was conducted in Ekiti State University Ado Ekiti, among working class women within the age range of 45-60 years who had experienced at least 12 continuous months of amenorrhea. A sample size of 200 was calculated and samples were drawn proportionately from the three units of the University; main campus (150), health center (20) and staff school (30). The lists of all the nurses working in the facilities were collected as the sampling frame, from which the samples were drawn. A semi structured questionnaire adapted from the Greene's climacteric scale and the work ability index was used to assess menopausal symptoms and work ability respectively. The questionnaire was distributed to women aged 45 and above in various section of the institution.

Result: Findings revealed that majority of the women were experiencing one menopausal symptom or the other. Higher percentage experienced headaches, muscle or joint pain, hot flashes, sweating at night, loss of interest in sex and tachycardia, while very few people had symptoms like crying spells and depression. The severity of these symptoms however was high for vasomotor symptoms which includes hot flashes and night sweats. About two-third of the respondents (62%) perceived that they have a moderate work ability, 27% perceived excellent work ability while 11% perceived low work ability. The

Pearson correlation coefficient showed a positive significant relationship between menopausal symptoms and perceived work ability.

Conclusion: The study concluded that menopausal symptoms does not have a negative influence on work ability of the respondents.

References

Abedzadeh-Kalahroudi M., Taebi M, Sadat Z., Saberi F., Karimian Z., (2012) Prevalence and severity of menopausal symptoms and related factors among women 40–60 years in Kashan, Iran, Nursing and midwifery. 1 (2): 88–93.

Alquaiz J., Siddiqui A., Tayel S., Habib F. (2014). Determinants of severity of menopausal symptoms among Saudi women in Riyadh city, Climacteric 17 (1): 71–78.

Whiteley J., DiBonaventura M., J.-S. Wagner, Alvir J., Shah S, (2013) Impact of menopausal symptoms on quality of life, productivity, and economic outcomes, Journal of Women's Health 22 (11) 983–990.

Contact

bolajubu@gmail.com

B 04 - Engaging Nurse Managers

Using a Microscope to Examine Human Caring through the Lens of the Nurse Manager

Katherine Ricossa, MS, BSN, RN, PHN, USA

Abstract

Background: The significance of examining caring among nurse managers corresponds directly with balancing quality of work life. Day to day demands requires nurse mangers to: staff the department (shift by shift); promote quality of care at the bedside; stay in budget; and have direct oversight of frontline staff. This middle management role is demanding with little support is provided by nursing leadership. Because of the imbalance of quality of work life, nurse managers are considered a vulnerable population. The reality is job longevity is non-existent for most due to undue pressures. Nurse Administrators can turn that paradigm around and must have an understanding of the concept of human caring to support nurse managers to be successful in their role.

Purpose: The purpose is to analyze the concept of human caring personally and professionally from the slant of the nurse manager. It is important to uncover and critically evaluate perceptions of human caring among this vulnerable population to gain insight in order to have senior nursing leadership can proceed to provide support to this at risk group.

Method: Rodgers (2000) Evolutionary Method of Concept Analysis was selected to further explore the dynamic concept of human caring. This method utilizes 7 activities: identification of the concept of interest; choosing the setting and sample; collecting and managing the data; analyzing data; identification of an exemplar; interpreting the results; and identify implications.

Results: The literature on caring is prolific. References were non-existent on human caring and nurse managers. References found were mostly older than 10 or more years. A concept map examined four distinguishing features: antecedents, consequences, socio-cultural, and temporal variation. A dichotomy exists between each of the distinguishing features examining contrary viewpoints that could affect how the nurse manager functions at work and home based on each individual circumstance.

Conclusions: The Evolutionary Method provided a formal structure to investigate the concept of human caring by creating a strong foundation for evaluation. The concept map demonstrates a visual depiction to gain insight. This process stimulates new thinking on divergent perspectives to aid nursing administrators to support nurse managers' quality of work life and promote retention in the role.

References

Beck, C. (1991). How students perceive faculty caring: A phenomenological study. *Nurse Educator, 16*(5), 18-22.

Cruz, J.P. (2016). Quality of life and its influence on clinical competence among nurses: A self-reported study. *Journal of Clinical Nursing*.

Mason, V. M., Leslie, G., Clark, K., Lyons, P., Walke, E., Butler, C., & Griffin, M. (2014). Compassion fatigue, moral distress, and work engagement in surgical intensive care Unit trauma nurses. *Dimensions Of Critical Care Nursing*, *33*(4), 215-225 11p. doi:10.1097/DCC.0000000000000056

Rodgers, B.L. & K.A. Knafl. (1994). *Concept development in nursing: Foundations, technique, and applications.* Philadelphia, PA: Saunders.

Watson, J. (2016, July 12). *Science of caring ten caritas processes: Caring science defined.* Watson, Caring Science Institute: International Caritas Consortium. Retrieved from https://www.watsoncaringscience.org/jean-bio/caring-science-theory/10-caritas-processes/

Contact

kathy_ricossa@hotmail.com

B 04 - Engaging Nurse Managers

Compare Nurse Engagement Level with Clinical Ladder Level and Perception of Managerial Support

Mary A. Lang, MSN, RN, RCES, USA

Abstract

Purpose: To identify the work engagement level of nurses at a Midwestern academic medical center and determine whether a clinical ladder tool and perception of managerial support impact this engagement.

Significance-: The study explores factors that impact nurse work engagement, using the globally recognized Utrecht Work Engagement Scale (UWES), which defines engagement by the attributes of vigor, dedication and absorption. In addition, his or her perception of managerial support is correlated for significance with their level of engagement. This perception of managerial support may be an example of authentic leadership, whereby the leader is promoting an honest, positive environment. The nurse is working with a positive mindset and framework. The authors of the UWES described a work engaged individual as a person with a "positive, fulfilling, work-related state of mind…engagement refers to a more persistent and pervasive affective cognitive state".

Therefore, the authentic leader style may foster openness that encourages the individual nurses' self-expression and commitment to improve themselves, as well as a give excellent patient care with vigor, dedication and absorption.

Method: A survey monkey tool was used to collect data. It was sent out through the hospital's email system, to over 1000 nurses at a Midwestern academic medical center. There were three monthly reminders to complete this survey monkey tool. Random selection with inclusion criteria was utilized. The UWES was included, and questions regarding clinical ladder level, years of experience, and certification in nursing, overall commitment to the workplace, and their perception about managerial support, with regard to their clinical ladder achievements was designed. All surveys were confidential and without including names. An incentive was designed to hold a raffle after the completion of the data collection where three nurses would receive a Starbucks gift card. This raffle was collected separate than the survey.

Response rate: Representative sample at this Midwestern academic center to a completed survey monkey was 277 nurses. The majority of respondents (64%) were primarily situated in inpatient service followed by outpatient service (26%). Regarding work area, many respondents reported working in the adult ICU (14%) or medical surgical inpatient area (14%); fewer reported working in ambulatory clinics (10%). Among respondents, most worked during the day from 0700 – 1930 (27%) followed by evenings – nights 1900 – 0730 (21%); a surprising number of individuals worked outside of the normal shift options (i.e., 25% reported "other" hours). Regarding education, the majority of respondents held a BSN (68%) followed by an associate's degree in nursing (18%) and masters in nursing (11%). About 41% of the sample held a nursing certification and more than half of the respondents (51%) were not likely to leave the academic medical center in the next two years.

Analysis: Along with the demographics, the years of experience as a nurse were compared with their level on the clinical ladder system. When compared to individuals in level I, those in level II had significantly more years of experience at the academic medical center (post-hoc $p = .003$), as did those in level III (post-hoc $p < .001$), those in level IV (post-hoc $p < .001$. Similarly compared to individuals in level II, those in level III had significantly more years of experience (post-hoc $p = .001$), as did those in level IV (post-hoc $p < .001$). Lastly, when compared to individuals in level I, those in level II had significantly more years of experience in their present area (post-hoc $p = .002$), as did those in level III (post-hoc $p < .001$), those in level IV (post-hoc $p < .001$).

The UWES item analysis as a function of the clinical ladder showed no differences by ladder in response to the UWES items. Sensitivity analyses were also conducted that collapse ladder levels into smaller units: (1) Levels I and II, (2) III and IV, and there was no significant difference to the UWES items by ladder level.

With regard to perception of managerial support, the Level III or IV respondents who were Very Likely to acknowledge managerial support had a significantly higher vigor score compared to those who were Somewhat Likely to acknowledge managerial support (post-hoc p = .01). Similarly, Level III or IV respondents who were Very Likely to acknowledge managerial support had a significantly higher vigor score compared to those who were Not Likely to acknowledge managerial support (post-hoc p = .02). No other comparisons were significant for vigor. A similar trend was found with dedication and absorption. Finally, Level III or IV respondents with a perception of more managerial support had higher total UWES scores when compared to those who had less support.

Conclusions: Hence, a perception of managerial support was significant for the higher-level experienced clinical ladder nurse, and this showed significance with the level of the nurses' work engagement as defined by the UWES. Furthermore, the clinical ladder level showed no differences by level in response to the UWES items.

Implications-Nurses' perception of managerial support enhances their level of work engagement. Further study needs to be done on the authentic leaders and their honesty and openness being key factors to a higher level of vigor, dedication and absorption in the nurse.

References

Auerbach, D. I. Staiger, D. O. Muench, U. & Buerhaus, P. I. (2013) The nursing workforce in an era of health care reform. *N Engl J Med*., 368(16), 1470-1472.

Kuykendall, J. W. Marshburn, D. M. Wall Poston, C. & Mears, A. (2014). Experienced nurses' level of engagement. *Journal of Nursing Administration, 44*(10), 546-551.

Schaufeli, W. & Bakker, A. (2003). Utrecht Work Engagement Scale. Occupational Health Psychology Unit. Preliminary Manual, Version 1, 1-58.

Contact

maryjlang1@sbcglobal.net

C 01 - Creating a Healthy Work Environment through Mentoring for Novice Nurse Educators

Creating a Healthy Work Environment through Mentoring for Novice Nurse Educators

Pamela R. Cangelosi, PhD, RN, CNE, ANEF, USA
Jeanne M. Sorrell, PhD, RN, FAAN, USA

Abstract

Healthy work environments are essential for the recruitment and retention of nursing faculty internationally. Research has demonstrated that mentoring can help to create an academic environment that fosters healthy inquiry and self-confidence for nurse clinicians transitioning to a nurse educator role (Sorrell & Cangelosi, 2016). A nurse participant in our research study stated, “Please mentor me! Don’t just orient me.” The mentoring process is much more than orientation; it is a critical element in the establishment of a healthy academic environment (Clark, 2015; Eller, Lev, & Feurer, 2014) and a specific catalyst in the global development of novice nurse educators (Morton, 2016). A critical shortage of nursing faculty in the United States and internationally has resulted in denied admission to nursing programs for many qualified nursing student applicants in Canada, China, Australia, and Malaysia (AACN, 2014; Reid, Hinderer, Jarosinski, Mister, & Seldomridge, 2013). Without sufficient clinical nurse educators, the ability to prepare nursing students is jeopardized. To meet this need, many nursing programs are looking to experienced clinicians to assume new roles as educators. These nurses often assume this new role with little formal preparation and find that many of the usual guidelines for clinical practice do not appear relevant to their new role as clinical educators (Gardner, 2014; Sorrell & Cangelosi, 2016). Uncertainty and a lack of self-confidence can lead to disappointment, discontent, and even departure from the academic environment (Cangelosi, 2014). Not only does this create dissatisfaction for nurses themselves, but it increases costs for the institution. This presentation is based on our collaborative research that explored the phenomenon of learning to teach. Themes of “buckle your seatbelt”, “embracing the novice”, and “mentoring in the dark” shed light on the importance of careful mentoring of clinicians who are learning new roles as clinical nurse educators. Through the presentation and discussion of our qualitative research findings, our aim is to discuss characteristics of academic work environments that foster mentoring. Our presentation will address strategies that help to create a healthy academic work environment to assist experienced clinicians in gaining new skills and self-confidence in their ability to teach. By giving voice to the challenges and opportunities embedded in the role of the novice clinical nurse educator, findings and recommendations from this research can assist both new and experienced nurse educators to work collaboratively to implement mentoring programs that help to create a healthy academic work environment.

References

American Association of Colleges of Nursing. (2015). Nursing faculty shortage fact sheet. Retrieved from http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-faculty-shortage

Cangelosi, P.R. (2014). Novice nurse faculty: In search of a mentor. *Nursing Education Perspectives, 35,* 327-329.

Clark, C.M. (2015). The power and potential of positive mentoring. *Nurse Educator, 40,* 109-110.

Eller, L.S., Lev, E.L., & Feurer, A. (2014). Key components of an effective mentoring relationship: A qualitative study. *Nurse Education Today, 34,* 815-820.

Gardner, S.S. (2014). From learning to teach to teaching effectiveness: Nurse educators describe experiences. *Nursing Education Perspectives, 35,* 106-111.

Morton, P.G. (2016). Thriving in an academic career. *Journal of Professional Nursing, 32, 253-254.*

Reid, T.P., Hinderer, K.A., Jarosinski, J.M., Mister, B. J., & Seldomridge, L.A. (2013). Expert clinician to clinical teacher: Developing a faculty academy and mentoring initiative. *Nurse Education in Practice, 13,* 288-293.

Sorrell, J.M., & Cangelosi, P.R. (2016). *Expert clinician to novice nurse educator: Learning from first hand narratives.* New York: Springer.

Contact
pcangelo86@su.edu

C 02 - Exploring Nurses' Feelings on Floating: A Phenomenological Study

Exploring Nurses' Feelings on Floating: A Phenomenological Study

Marie-Paule M. Lafontant, EdD, MSN, RN-BC, USA

Abstract

The purpose of the current study was to explore nurses lived experiences floating in an acute health care facility within a large southern city of the United States. Husserl's transcendental approach assisted in capturing the essence of floating as a lived phenomenon occurring in the nurses' natural work environment. Husserl (1970b/1901) addressed consciousness as the awareness of objects in the outer world translated into meaning. Karasek job demand-control (JDC) was the theoretical framework. The core concept of Karasek's JDC is the effect of stress on workers. JDC encompasses a three-dimensional paradigm (affective strain, work overload, and control). JDC is a bi-dimensional model, which includes the concepts of job demand, job control, and their additive/multiplicative effects. The study data analysis was conducted using the NVivo 10 software and Giorgi's six steps, reflecting Husserl's descriptive transcendental phenomenology. The study purposive sample included eleven full-time staff male and female registered nurses who routinely float to other units. Participants described their feelings on floating during digitally recorded interviews based on three open-ended interview questions aligned with the research questions to address the research purpose. Six themes emerging from the data analysis were (1) workflow process, (2) patients care assignment, (3) work environment, (4) psychological components, (5) sociological factors, and (6) physiological needs. Nurses expressed concerns about their ability to deliver quality/safe patients care in areas different from their home unit. In this study, nurses recognized that they have to float for diverse reasons, a finding different from previous studies. A conclusive evidence from this study was that nurses are reluctant to float but will do so comfortably if there were some measures in place to ease the process. The recommendations included ideas for changes in floating based on the data analyzed from participants' responses. With the predicted nursing shortage, leaders may want to consider reviewing their policy on floating. This initiative may prevent staff dissatisfaction, burnout, and costly turnover and enhance nurses' recruitment and retention in health care organizations.

References

AbuAlRub, R. F., Gharaibeh, H. F., & Bashayreh, A. I. (2012). The relationships between safety climate, teamwork, and intent to stay at work among Jordanian hospital nurses. *Nursing Forum*, *47*(1), 65-75. doi:10.1111/j.1744-6198.2011.00253.x

Aiken, L. H., Sloane, D. M., Bruyneel, L., Van den H. K., Sermeus, W. (2013). Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. *International journal of nursing studies*, *50*(2), 143–153. doi:10.1016/j.ijnurstu.2012.11.009

Balaraman, P., & Kosalram, K. (2013). E –hospital management & hospital information systems-changing trends international. *International Journal of Information Engineering & Electronic Business*, *5*(1), 50-58. doi: 10.5815/ijieeb.2013.01.06

Bates, K. J. (2013). Floating as a reality: Helping nursing staff keep their heads above water. Medsurg Nursing, 22(3), 197-9. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23865282bate

Bergman, P. N., Ahlberg, G., Johansson, G., Stoetzer, U., Åborg, C., Hallsten, L., & Lundberg, I. (2012). Do job demands and job control affect problem-solving? *Work, 42*(2), 195-203. doi: 10.3233/WOR-2012-1340

Creswell, J. W. (2013). *Qualitative inquiry & research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage.

Contact

marielaf@baptisthealth.net

C 03 - Resilience, Compassion Satisfaction, Compassion Fatigue, Depression, Anxiety, Stress in Nurses Working Shift Work in Australia

D 01 - Exploring Interprofessional Teamwork

TeamSTEPPS Training Improves Teamwork

Tina M. Withrow, MSN, RN, CFRN, CEN, EMT-P, NREMT, USA

Abstract

"TeamSTEPPS® is an evidence-based teamwork system aimed at optimizing patient care by improving communication and teamwork skills among health care professionals, including frontline staff. It includes a comprehensive set of ready-to-use materials and a training curriculum to successfully integrate teamwork principles into a variety of settings" (AHRQ, 2016). The hospital identified a requirement for improved teamwork within and between departments. Improved teamwork increases patient satisfaction and quality of care. "It helps you train your staff in teamwork skills and lead a medical teamwork improvement initiative in your organization from initial concept development through to sustainment of positive changes" (AHRQ, 2016). After completion of TeamSTEPPS training, the employees will be able to describe the use of TeamSTEPPS to enhance patient safety, recognize the connection between communication and medical error, define Chain of Command, describe proper utilization of Chain of Command and identify tools and strategies for effective teamwork. Furthermore, they will be able to describe how mutual support affects team processes/outcomes, discuss strategies to enhance communication such as Briefing and Debriefing, demonstrate timely briefing/debriefing and describe the connection between communication and patient safety. "In order to make an improvement, transfer of learning (TOL) must occur. In other words, employees must be able to apply new knowledge and skills to their working practice and environment in order to improve ways of working" (John, 2015, p. 41). TeamSTEPPS has proven to be a valuable learning tool. This week the Emergency Department quality statistics were calculated. Through the quality calculations from previous patient's comments, it has been proven that TeamSTEPPS implementation improved team work between the nurses and doctors. One of the questions asked to former patients is "How do you perceive the teamwork between healthcare providers?" In October and November (after implementation of TeamSTEPPS), the rating on this question improved dramatically. It was exciting for everyone to actually see the proof that TeamSTEPPS works.

References

AHRQ. (2016) Retrieved from http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/index.html

John, V. (2015). A search for learning transfer: does non-mandatory training make a difference? *British Journal of Healthcare Assistants*, *9*(1), 41-47 7p.

Contact

tina.withrow@shhpens.org

D 01 - Exploring Interprofessional Teamwork

Keeping Nurses Safe: Creation of a Safe Patient Handling and Mobility Program

Rebekah Powers, DNP, RN-BC, CMSRN, CSPHA, USA
Christina Ramdeo, MSN, RN, CNOR, CHTS-CP, USA

Abstract

Work related musculoskeletal injuries among nurses are costly. As many as 20% of nurses who leave direct patient care do so because of risks associated with their work (OSHA, n.d.). Safe patient handling and mobility (SPHM) programs can reduce risk to nurses.

SPHM program has become one of the top initiatives for health care facilities to reduce caregiver injuries associated with the high-risk patient handling tasks (American Nurses Association, 2013). Healthcare workers are at risk for musculoskeletal disorders (MSDs) and MSDs are responsible for a significant cost to health care institutions but it negatively impacts quality of care. According to OSHA news release inspections from complaints should include a review of hazards involving MSD related to patient handling (2015).

In the fall of 2011 an interdisciplinary team was formed and charged by the organization to create a SPHM program. A new hospital tower was being built and each room would incorporate a patient ceiling lift and motor. After attending the SPHM National Conference, it was soon realized what was available in the organization was woefully inadequate. A formal infrastructure and enduring program needed to be created. State Law and American Nurses Association SPHM standards were used to guide and ensure all required elements were included. A SPHM interdisciplinary committee was established to help administer the program and continues to participate in the decision-making process. Interdisciplinary team evaluates both inpatient and outpatient units for patient handling needs and challenges, then makes recommendations on the type of equipment needed for the units' unique needs. Nurses and other staff members are involved in equipment trials and evaluation. Formal policies and procedures were written. Education was created and delivered to all staff who move patients.

The effectiveness of the program is measured in reduction of injures and cost of injuries to the organization. Number of staff injuries have been reduced every year and the costs to organization related to those injuries were also reduced. In 2012 the hospital experienced 24 staff injuries related to patient handling, and in 2015 there were 4 reported injuries. Lost time work days were zero in 2015. If an injury does occur it is evaluated for the root cause contributing to incident. The root cause identified is then addressed. An annual report about program is submitted to hospital administration.

References

American Nurses Association (2013). Safe patient handling and mobility: Interprofessional national standards across the care continuum. Nursesbooks.org Silver, Springs MD.

Occupational Safety & Health Administration (nd). Safe Patient Handling. Retrieved from https://www.osha.gov/SLTC/healthcarefacilities/safepatienthandling.html

Contact

rebekah.powers@midland-memorial.com

D 02 - Impacting the Work Environment: From Bedside to Academia

Surviving and Thriving in a "Not-So-Healthy" Academic Work Environment

Teresa M. Stephens, PhD, RN, CNE, USA

Abstract

Nursing faculty experience unique stressors in the academic work environment that can contribute to moral distress, job dissatisfaction, and attrition. For those working in an unhealthy or toxic work environment, the daily stressors experienced are compounded by the added stress of surviving within a perceived uncivil ethos. Resilience is a concept often discussed when exploring work-related stressors and perceived adversity. While efforts to promote healthy work, environments are strongly encouraged and should be emphasized, there is the unfortunate reality of the continued existence of unhealthy academic settings. Nursing faculty working in these settings often struggle with the cumulative effects of these stressors while working through the decision to leave or stay. Many will leave prematurely to escape the current situation before they are able to thoroughly assess more positive opportunities.

The purpose of this interactive presentation is to explore the application of the evidence-based program, RN P.R.E.P. (personal resilience enhancement plan), to assist these faculty members in fostering personal resilience to enhance effective coping, promote career longevity, and reduce the negative effects of working within a “not-so-healthy” work environment while exploring realistic and positive options to meet their professional goals. The concept of resilience will be explored and applied to the challenges often reported by nursing faculty (e.g. moral distress). Attention will be given to selected protective factors and their use as effective coping mechanisms to promote personal growth and well-being. Participants will be guided in the development of a personal strategic plan to increase resilience through self-reflection, environmental assessment, the identification of protective factors to develop and/or enhance, and the creation of specific strategies to actively and confidently move forward in their professional career trajectory. Finally, participants will be encouraged to promote resilience-enhancing strategies within colleagues and student groups to affect change and foster civility and collegiality through role modeling and positive leadership.

References

Candela, L., Gutierrez, A., & Keating, S. (2013). A national survey examining the professional work life of today's nursing faculty. *Nurse Education Today, 13, 853-859.*

Clark, C.M., Olender, L., Kenski, D., & Cardoni, C., (2013). Exploring and addressing faculty-to-faculty incivility: A national perspective and literature review. *Journal of Nursing Education, 52*(4), 211-218.

Gallo, V.J. (2012). Incivility in nursing education: A review of the literature. *Teaching and Learning in Nursing, 7,* 62-66.

Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. *Critical Care Nurse, 31*(2), 92-95.

McDonald, G., Jackson, D., Wilkes, L., & Vickers, M.H. (2013). Personal resilience in nurses and midwives: Effects of a work-based educational intervention. *Contemporary Nurse, 45*(1), 134-143.

Peters, A.B. (2014). Faculty to faculty incivility: Experiences of novice nurse faculty in academia. *Journal of Professional Nursing, 30*(3), 213-227.

Rushton, C.H., Caldwell, M., & Kurtz, M. (2016). Moral distress: A catalyst in building moral resilience. *American Journal of Nursing, 116*(7), 40-49.

Stephens, T.M. (2013). Nursing student resilience: A concept clarification. *Nursing Forum, 48*(2), 125-133.

Stephens, T.M., & Gunther, M.E. (2016). Twitter, millennials, and nursing education research. *Nursing Education Perspectives, 37*(1), 23-28.

Contact

tesestephens@gmail.com

D 02 - Impacting the Work Environment: From Bedside to Academia

Impact of Meaningful Recognition on Nurses'€™ Environment: Comparative Exploration of Leaders' and Staff Nurses' Perception

Usha Koshy Cherian, DNP, RN, CCRN, NEA-BC, USA

Abstract

Purpose: Meaningful Recognition (MR) for job performance, one of the six essential standards of a Healthy Work Environment (HWE), is central to nurses' satisfaction and retention, patient satisfaction and outcomes, and organizational outcomes (AACN, 2005). However, little evidence exists to guide clinical practices related to MR strategies that are most valued by clinical nurses. As a result, nurse managers and other leaders often provide recognition based on assumptions, traditions, and previous experiences, which may or may not be meaningful to their nursing staff members. The purpose of this project was to explore the perception of MR among staff nurses and nurse leaders, compare these perceptions, and identify innovative methods for recognizing nurse's contributions in ways that are valued by the individual, and make recommendations for implementing these methods to the Organizations' Nursing Practice Council.

Design: This DNP project used mixed method approach to explore the perception of MR among a convenience sample of nurse leaders and staff nurses working in the Intensive Care Units (ICU) of a large academic medical center, utilizing a mixed method approach. Twenty-six nurses participated in seven focus group interview (FGI) sessions that were grouped by position, to obtain a cross sectional perspective. Ninety-five nurses participated in the Healthy Work Environment (HWE) survey and Recognition surveys administered via Qualtrics software.

Results: Thematic analysis of the focus group discussion yielded eight themes: what is MR; when to give MR, ways to give MR, who should give MR, who should receive MR, benefits of MR and barriers in providing MR. A lack of awareness about the concept of MR and unavailability of best practices to provide MR were the major reasons cited by staff nurses and nurse leaders for not providing MR. In addition, limited resources, institutional policies and the size and diversity of the nursing workforce were also barriers to providing MR to nurses. Survey results indicated that critical care staff nurses' perception of the current work environment and MR was 'good' based on the AACN's scoring guidelines for HWE survey. The results of the Recognition survey were similar to the focus group discussion theme 'ways to give MR', which confirmed that salary commensurate to performance scheduling flexibility, opportunities for growth, private verbal feedback and written and public recognition were the most meaningful methods of recognition.

Conclusion: The standard of MR should be given equal priority along with other five HWE standards. Nursing leadership needs to focus on developing strategies to provide MR in a consistent and systematic manner, so that every nurse will reap the benefits of MR. The art and science of providing MR should be added to leadership development programs and included as an essential competency for nurse leaders.

References

American Association of Critical-Care Nurses (AACN). (2013). AACN Healthy Work Environment assessment. Retrieved from http://www.aacn.org/wd/hwe/content/aboutassessment.

Aiken, L.H, Sloane, D.M, Clarke, S. (2011). Importance of work environments on hospital outcomes in nine countries. *International Journal of Quality Health Care, 23*(4), 357–364. doi: http://dx.doi.org/10.1093/intqhc/mzr022

Ulrich, B. T., Lavandero, R., Woods, D., & Early, S. (2014). Critical care nurse work environments 2013: A status report. *Critical Care Nurse*, *34*(4), 64–79. doi:10.4037/ccn2014731

Contact

ucherian@unch.unc.edu

D 03 - Implementation and Dissemination of Preceptorships

D 04 - Improvement in Job Satisfaction

Nurse-Led Peer Review Committee Promotes External Recognition of Nurses

Pamela Petto, MEd, BSN, RN, NE-BC, USA
Maggie Finke, BSN, RN, NE-BC, USA
Renee Roberts-Turner, DHA, MSN, RN, NE-BC, CPHQ, USA
Cheryl Reggio, BN-PC, RN, CPON, BMTCN, USA

Abstract

This abstract describes a nurse peer review committee focused on external recognition of nurses. Support for external awards promotes a positive, professional nursing work environment that recognizes nurses directly for autonomous nursing practice. The Nursing Nomination Advisory Committee (NNAC) supports clinical nurses, nurse leaders, and nurse- led collaborative teams who provide evidence of quality improvements targeted toward the advancement of nursing.

Promoting nurses externally is a strategy to highlight an organization's mission, vision, and values. It showcases nursing and organizational performance as it focuses on excellence in the delivery of patient and family-centered care. This innovative program encourages and supports nominations for external awards that recognize and honor individual nurses and nurse-led teams, promotes the image of nurses in the local/regional/national/international communities, and strengthens our organization's brand.

After several years of promoting The Daisy Award for Extraordinary Nurses within our institution, clinical nurses from a shared governance council decided to increase nurse recognition through external awards. The NNAC formed as a peer review process to encourage the submission of nominations for external awards. The NNAC tracks external awards, packages nomination criteria, calls for nominations within the organization, and sets a deadline for nominations to be received by the NNAC in advance of the official deadline. The NNAC peer reviews each nomination to ensure award criteria are met in a clear, succinct, and well-written fashion. When appropriate, nominators are mentored to strengthen submissions to better compete with those from other organizations. This peer review process and mentorship provides structured support to staff who consider writing a nomination and increases confidence in making a successful submission. The NNAC has also gained expertise in evaluating criteria used by external contests, which has contributed to the program's success.

To date, the NNAC has received, peer-reviewed, and promoted a total of 56 nominations for external recognition. Twenty-three registered and advanced practice nurses have been chosen as finalists or awardees, including three nurses honored as ANCC National Magnet Nurse of the Year® - a 41% success rate for nominations submitted from our organization. Current RN satisfaction scores exceed benchmark in 12 out of 14 NDNQI Job Enjoyment and Job Satisfaction Scale-Revised (JSSR) subscales which also includes scores exceeding the benchmark in 4 of out 5 Magnet® domain subscales. We see RN recognition as a contributing factor to an improved work environment and in nurses' perception of high professional status.

The impact of this nurse-led, peer review committee is far-reaching. It recognizes individual nurses, strengthens the brand for our healthcare organization, and promotes the image of nursing in the community. These methods can be applied to any organization to provide meaningful recognition and promote its individual nurses locally, regionally, nationally or internationally.

References

American Association of Critical-Care Nurses. (2005). AACN standards for establishing and sustaining healthy work environments: a journey to excellence. *American Journal of Critical Care*, *14*(3), 187-197.

American Nurses Credentialing Center. (2013). *2014 Magnet® application manual*. Silver Spring, MD: Author.

Barnes, B., Barnes, M., & Sweeney, C. D. (2016). Putting the" Meaning" in Meaningful Recognition of Nurses: The DAISY Award (TM). *Journal of Nursing Administration*.

Lefton, C. (2012). Strengthening the workforce through meaningful recognition. *Nursing Economics*, *30*(6), 331.

Ritter, D. (2011). The relationship between healthy work environments and retention of nurses in a hospital setting. *Journal of nursing management*, *19*(1), 27-32.

Zwickel, K., Koppel, J., Katz, M., Virkstis, K., Rothenberger, S., & Boston-Fleischhauer, C. (2016). Providing Professionally Meaningful Recognition to Enhance Frontline Engagement. *Journal of Nursing Administration*, *46*(7/8), 355-356.

Contact

mfinke@childrensnational.org

D 04 - Improvement in Job Satisfaction

Generating Gratitude in the Workplace to Improve Job Satisfaction

Amy Stegen, MSN, RN, USA
Jamie Wankier, MSN, RN, USA

Abstract

A nursing shortage is looming yet again and has been well documented in the literature. As a result, it is vital that we keep the nursing faculty we have and improve the job satisfaction of those faculty as much as possible. Studies show the cost of replacing an employee ranges from six months' salary to as much as twice their annual salary (Merhar, 2016). Higher education continues to struggle with having adequate funding and cannot afford the cost of turnover. In addition, the nursing shortage decreases the supply of qualified faculty making it imperative that faculty turnover be kept to a minimum. One way to directly improve retention rates is by improving job satisfaction (Derby-Davis, 2014). Research has shown that salary and compensation is only a small part of job satisfaction (Wang & Liesveld, 2015). Gutierrez, Candela, & Carver (2012) demonstrated that perceived organizational support had an impact on the job satisfaction of nursing faculty especially when associated with other factors. It is important to find and explore innovative ways that enhance organizational support to increase job satisfaction and facilitate retention.

One innovative intervention that we utilized to improve job satisfaction and increase collaboration was cultivating an 'attitude of gratitude'. Gratitude is recognized as a positive emotion and is associated with empathy, increased self-esteem, and overall happiness (McCullough, Emmons, & Tsang, 2002). Grateful people have increased coping skills, more positive emotions, and deal with problems in a more direct way (Lin, 2015). Increased gratitude is also positively correlated with improved interactions and greater social support from coworkers (Lin, 2015; McCullough et al., 2002), which we hypothesized would improve job satisfaction.

To assess if our intervention was successful a pre- and post survey of faculty on perceived gratitude levels and job satisfaction was administered prior to the start and at the end of the project. We introduced the theme of 'Attitude of Gratitude' in the opening faculty meeting and continued gratitude discussion at each faculty meeting throughout the year. We provided a book on gratitude and offered optional lunch session gratitude collaboration groups twice each semester. We also established a social media group site related to this topic for people to share and interacted with faculty related to the topic through email, breakroom bulletin board, and mailboxes. Our ultimate goal in introducing gratitude interventions was to create a more collaborative and grateful environment that would ultimately lead to increased job satisfaction for faculty.

References

Derby-Davis, M. J. (2014). Predictors of nursing faculty's job satisfaction and intent to stay in academe. *Journal of Professional Nursing*, *30*(1), 19-25. http://dx.doi.org/10.1016/j.profnurs.2013.04.001

Gutierrez, A. P., Candela, L. L., & Carver, L. (2012). The structural relationships between organizational commitment, global job satisfaction, developmental experiences, work values, organizational support, and person-organization fit among nursing faculty. *Journal of Advanced Nursing*, *68*(7), 1601-1614. http://dx.doi.org/10.1111/j.1365-2648.2012.05990.x

Lin, C. (2015). Impact of gratitude on resource development and emotional well-being. *Social Behavior and Personality*, *43*(3), 493-504. http://dx.doi.org/10.2224/sbp.2015.43.3.493

McCullough, M. E., Emmons, R. A., & Tsang, J. (2002). The grateful disposition: A conceptual and empirical topography. *Journal of Personality and Social Psychology*, *82*(1), 112-127. http://dx.doi.org/10.1037//0022-3514.82.1.112

Merhar, C. (2016). Employee retention - The real cost of losing an employee. Retrieved from https://www.zanebenefits.com/blog/bid/312123/employee-retention-the-real-cost-of-losing-an-employee

Wang, Y., & Liesveld, J. (2015). Exploring job satisfaction of nursing faculty: Theoretical approaches. *Journal of Professional Nursing*, *31*(6), 482-507. http://dx.doi.org/10.1016/j.profnurs.2015.04.010

Contact

amystegen@weber.edu

E 01 - Incivility in Academia

Using Cognitive Rehearsal to Address Nurse-to-Nurse Incivility: Student Perceptions

Jennette S. Logan, DNP, RN, USA
Maija Andrson, DNP, RN, USA
Pamela Stoekel, PhD, RN, USA

Abstract

Incivility is defined by researchers as rude, discourteous, dismissive and belittling behavior which causes physiological and psychological problems for all involved. It may occur on a continuum which ranges from eye rolling to physical stalking or injury. It creates barriers to learning and destroys work relationships. Unfortunately, incivility is so prevalent, it has become the accepted norm in many work environments. Incivility contributes to students leaving the nursing program, clinicians leaving the practice and educators are leaving the class room. Additionally, it contributes to medication errors, poor patient outcomes and satisfaction. Incivility unchecked will contribute to the impending nursing shortage. According to research, incivility costs approximately $12,000 dollars in lost productivity a year. The American Nursing Association as well as the Joint Commission has charged nursing administrators to address incivility and to establish a safe, civil work environment.

Incivility may occur in various forms; It may be descending, ascending or lateral. Horizontal or lateral incivility is also known as nurse to nurse incivility. It is the most commonly reported type of incivility in the nursing profession. Many researchers suggest this phenomenon results because nurses are an oppressed group as illustrated by the Stanley-Martin Model.

According to literature reviews, approximately 86-90 % of all nurses have experienced and or witnessed incivility in the work environment. Ninety percent of the sample in this study reported experiencing incivility in the nursing program while attending clinical or in academic settings. Consequently, there is a need to prepare nursing students with evidenced based strategies to address incivility. Research about incivility in nursing is plentiful, however evidenced based strategies to address the phenomena are scarce.

Evidence supports that cognitive rehearsal is one strategy which provides nurses with a professional and effective means of addressing incivility.

In this qualitative study, 10 senior BSN nursing students were surveyed using six open ended questions following a roleplay using cognitive rehearsal to address incivility. Comparative analysis was used to identify and categorized responses. This study demonstrates the effectiveness of cognitive rehearsal as a strategy to address incivility from a nursing student's perception.

Incivility in nursing is defined by researchers as rude, discourteous, dismissive and belittling behavior which causes physiological and psychological problems for all involved. Nurses and nursing students therefore need an evidenced based strategy to address this phenomenon. Cognitive rehearsal coupled with role play can effectively impact an uncivil environment.

References

Clark, C., Ahten, S. & Macy, R. (2013). Using problem based learning scenarios to prepare nursing students to address incivility. Clinical Simulation in nursing 9, 75- 83.

Griffin, M. & Clark, C. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. The journal of continuing education in nursing. 45(12) 535-542.

Contact

Jlogan3@jhmi.edu

E 01 - Incivility in Academia

Incivility in Nursing Classrooms

Sheri L. Wainscott, MSN, RN, USA
Carie L. Strauch, MSN, RN, USA
Angela D. Martindale, MSN, RN, USA

Abstract

Background: In recent years, the prevalence of incivility in educational settings has received heightened attention in academic and popular press. In light of nursing's position as a profession of humanistic, caring interaction, measures to reduce incivility are of dire need in the academic setting. The presence of uncivil behaviors not only diminishes the modeling of professional nursing and fails to set a standard of acceptable behavior, but restricts learning and destroys the educational environment (Altmiller, 2012; Clark & Springer, 2007; Luparell, 2007; Robertson, 2012). The incidences occur student to student, faculty to student, and faculty to faculty in the clinical and classroom settings. These types of uncivil behavior can be verbal or physical, and mild to extreme. The least frequent but most violent display of uncivil behavior is the shooting of faculty and students on university campuses across the country (Anthony & Yastik, 2011; Clark, 2008; DalPazzo & Jett, 2010; Robertson, 2012). Missing from current research is the study of whether faculty, using a conscious, caring approach are able to defuse escalating uncivil encounters. The purpose of this phenomenological investigation was to describe the lived experiences of nursing faculty who have experienced or witnessed incivility in the classroom and to elicit reflection on how these situations might have been defused.

Method: A phenomenological approach was used to guide data collection and analysis. Purposive sampling will be used to recruit 10 nurse educators who self-identify as having experienced incivility in the classroom as a nurse educator. Participants meeting the inclusion criteria participated in single session, 60 minute interviews with one of the co-researchers. Inclusion criteria consisted of possessing a Master's degree in nursing and have been employed in a school-based, classroom setting as nurse educator for longer than 12 months.

Findings: Two themes were identified: The first theme, Tolerance, illustrated how perpetuation of incivility occurred. A second theme, Opportunities to Diffuse, addressed actions that could, and were, taken to deescalate incivility through conscious action.

Recommendations: Being able to identify factors and situations where uncivil actions are likely to occur can help the individuals involved prepare to intervene or diffuse the situation and avoid the actions all together. Administration of academic institutions must develop, implement, and enforce policies against uncivil behaviors and the disciplinary actions to be taken when the policies are violated. To reduce the incidences of incivility, faculty must commit to learning and utilizing effective, therapeutic communication skills. The commitment to maintaining a caring and civil environment should be supported by workshops and in-service training focused on helping individuals develop and practice the skills needed to effectively communicate with each other during stressful times. Upon entry to the nursing program, students should be immersed in the expectation that their behavior always stays professional, caring and civil. The commitment of faculty to being an example of this behavior is necessary. The caring environment is interrupted when students or faculty display uncivil, uncaring behaviors. Incivility must be addressed and dealt with immediately in order to instill and maintain the appropriate caring behaviors in nursing students. This is key to continuing the legacy of caring in the nursing profession.

References

Altmiller, G. (2012). Student perceptions of incivility in nursing education: Implications for educators. *Nursing Education Perspectives, 33*(1), 15- 20.

Anthony, M., & Yastik, J. (2011). Nursing students' experiences with incivility in clinical education. *Journal of Nursing Education, 50*(3), 140-144. doi: 10.3928/01484834-2011013-04

Clark, C. (2008). The dance of incivility in nursing education as described by nursing faculty and students. *Advances in Nursing Science, 31*(4), E:37-E:54.

Clark, C.M., & Springer, P. J. (2007). Incivility in nursing education: A descriptive study of definitions and prevalence. *Journal of Nursing Education, 46*(1), 7-14.

DalPazzo, N. K., & Jett, K. T. (2010). Nursing faculty: A vulnerable population. *Journal of Nursing Education, 49*(3), 132-136.

Luparell, S. (2007). The effects of student incivility on nursing faculty. *Journal of Nursing Education, 46*(1), 15- 19.

Robertson, J. E. (2012). Can't we all just get along? A primer on student incivility in nursing education. *Nursing Education Perspectives, 33*(1), 21-26.

Contact

slwainscott@my.okcu.edu

E 02 - Interprofessional Education and Collaboration

Promoting Wellness and Mindfulness for Nurses

Deborah A. Raines, PhD, EdS, RN, ANEF, USA
Diane Ceravolo, MSN, RN, USA

Abstract

This presentation will share the design, implementation and evaluation of a series on wellness and mindfulness for nurses. Nurses often state they are too busy to take a break or lunch, to go to the restroom or even to take a deep breath and reflect for a moment. But in order to provide quality care for others, one must first be present, care for themselves and feel nurtured and supported. Like the safety announcement on an airplane, put your oxygen mask on first…then help others. This presentation shares our experience in providing nurse leaders and first year nurses the tools needed to re-energize, re-focus and re-center and to allow them to have the energy, caring compassion and patient centered focus when providing patient care as well as when working with other member of health care team.

The series was designed as twice/month roundtables for cohorts of nurse leaders and nurses in their first year of professional nursing practice. The cohort of nurse leaders and nurses in the first year of practice were purposefully designated for this project. Nurse leaders play a key role in establishing the unit culture and for promoting high quality, patient centered care. As the leadership group becomes knowledgeable about and practitioners of mindfulness, they will be able to support their staff to become more aware of the importance of taking care of themselves, in order to better interact with others and to care for their patients. As identified by the American Organization of Nurse Executives, nurse leaders serve as initiators and the primary influence in creating positive, safe and healthful practice/work environments. The second cohort, nurses in their first year of professional practice are particularly vulnerable as they transition from the role of student nurse to professional nurse. In addition, these new nurses are often working night shift, where caring for self is critical and where they may have less interaction with and access to the resources of the organization. Providing this group mindfulness training may enhance employment retention as well as allow them to model self-care behaviors for other staff in the healthcare environment. The organization makes a significant financial investment in the hiring and orientation of new nurses. When these individuals leave a position because of stress, burnout or feeling overwhelmed the cost to the organization is between $50,000.00-100,000.00. In other words, supporting new nurses during the first year of practice is significant to career trajectory, quality patient care and the financial health of the organization.

Each interactive session was 60 minutes in duration and presented the participants with techniques to center themselves, to relax, reflect and re-energize, and to care for themselves so they are able to care for others. Group size is limited to 12 participants to encourage deep sharing and reflection.

Participants completed pre- and post-intervention survey related to anxiety, self-compassion and perceived wellness to demonstrate if the series makes a difference. Quantifiable outcomes of participation include a decrease in the participant's score on the anxiety scale and an increase in the score on the self-compassion and perceived wellness scales. In addition, patient satisfaction score before and after the intervention are being analyzed.

To facilitate replication of this endeavor by others, this presentation will focus on the process of designing, implementing and evaluating this program in a busy, acute care organization as well as the challenges and opportunities we learned from in the process.

References

Howland, L.C., & Bauer-Wu, S. (2015). The mindful nurse. American Nurse Today. 10 (9) available at: https://americannursetoday.com/mindful-nurse/

Smith, S.A. (2014). Mindfulness-based stress reduction: an intervention to enhance the effectiveness of nurses' coping with work-related stress. International Journal of Nursing Knowledge. 25 (2) 119-30. doi: 10.1111/2047-3095.12025. Epub 2014 Feb 26.

Contact

draines@buffalo.edu

E 02 - Interprofessional Education and Collaboration

The Synergy of True Interprofessional Collaboration

Nassrine Noureddine, EdD, MSN, RN, USA
Darla K. Hagge, PhD, MA, CCC-SLP, USA
Debra Brady, DNP, RN, CNS, USA
William L. Ofstad, PharmD, RPh, BCPS, CDE, USA

Abstract

Background: Students in health care professions are traditionally educated in silos yet are expected to function effectively as members of a health care team caring for complex patients in a fast-paced environment. It is not surprising that communication problems among healthcare personnel have been implicated as a cause of most patient errors (IOM, 2001, 2003; American Association of Critical Care Nurses [AACN], 2005; Joint Commission, 2005, 2007, 2008; Wachter, 2004). In response, there is a national and international clarion call to re-design healthcare education curriculum and teach students interprofessionally to better prepare a collaborative, practice ready health care workforce. The Institute of Medicine (IOM) strongly advocates that "health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team" (IOM, 2003, p. 20). Interprofessional Education (IPE) exists when students from two or more healthcare disciplines have the opportunity to "learn about, from and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010, pg. 7). The overall purpose of providing IPE for healthcare students is to create a collaborative ready workforce (WHO, 2010).

Introduction: In response to the international and national clarion call for IPE, educators at two universities created the California Interprofessional Education Research Academy (Noureddine, Hagge, Brady & Ofstad, 2014). The faculty of CA-IPERA created an innovative interprofessional curriculum that included shared didactic, simulation and community-based clinical experiences. This synergistic interprofessional collaboration resulted in significant benefits at the institutional, faculty and student levels.

The purpose of this presentation is to share the synergistic impact of an interprofessional, inter-university collaborative model. The authors will provide a brief background and description of interprofessional education, engage participants in relevant hands-on activities related to improving collaboration and teamwork, and will explore the possible synergistic benefits of implementing interprofessional education.

Interprofessional Education / IPE domains. The Interprofessional Education Collaborative (IPEC) has recently revised its four domain areas of competency. Specifically, there is one broad category: Interprofessional Collaboration (IPEC, 2016). This overarching category embraces four domains which include values and ethics for interprofessional practice, roles and responsibilities, interprofessional communication, and teamwork (IPEC, 2011). The domains were created to address and achieve the Triple Aims of Healthcare: (a) Improve patient care experience, (b) improve health of populations, and (c) reduce the overall cost of health care (IPEC, 2016).

Clinical and Educational Benefits of IPE: There are many clinical benefits of interprofessional education. Practicing healthcare professional receive improved employee morale, practices and productivity. Patients and care partners obtain improved access to healthcare services, improved medical outcomes, and greater patient safety (WHO, 2010). Healthcare students have the opportunity to apply the core content to an interprofessional clinical case study or a clinical setting. In this way, student learning is facilitated through multiple levels of Bloom's Taxonomy of Learning using a variety of teaching styles and pedagogies such as simulation, experiential opportunities, and co-curricular settings.

Accreditation Expectations for IPE: Accreditation requirements across disciplines are changing rapidly to integrate interprofessional education, especially with the explicit goals of learning to work collaboratively in interprofessional teams. The fields of pharmacy, medicine, physical therapy, and speech-language pathology all require the inclusion of IPE curriculum. Disciplines whose accrediting body require IPE may be exceptional partners in implementing IPE (Noureddine, Hagge, Brady & Ofstad, 2016).

Collaboration and Teamwork: For educators to succeed in teaching IPE they need to model teamwork, good communication and collaboration skills. To that end, they need to be aware of their own biases, personal communication styles and conflict management modes. Faculty implementing IPE need to move away from functioning as a team of experts into functioning as an expert team (Pellegrini, 2016). The content of this workshop will be delivered using interactive engaging team-based activities including administration and interpretation of personal style and conflict management tools, and introducing the audience to best practices in IPE and team building activities for a healthy work culture. Participants will implement gained knowledge and skills by participating in relevant reflective activities.

Benefits of Synergy and Collaboration: Institutional. CA-IPERA's resultant collaboration positively impacted both universities at the interinstitutional and interdepartmental levels. The universities benefited from the use of shared resources including a simulation labs, large capacity smart classrooms, and an increased number of community partnerships that created new student education opportunities and clinical experiences. This enabled the three disciplines to better meet accreditation standards (Noureddine, Hagge, Brady & Ofstad, in press).

Faculty. Individual faculty members also benefited from the IPE synergy. First, faculty participated in multidisciplinary training and certification in team-based learning, IPE, and simulation. Second, co-curriculum development flourished resulting in the adoption of new concepts and skills such as SBAR, swallow screen, vital signs and lab values. Third, several innovative IP experiences were designed including (a) didactic presentations and activities, (b) experiential learning opportunities (c) campus-based community programs and (d) community-based volunteer work. Furthermore, by working together the faculty modeled the interrelational benefits of collaboration and teamwork in multiple arenas. Finally, IPE synergy resulted in significant and ongoing scholarly contributions by faculty including regional, national and international presentations, multiple publications, and IPE consultations to other organizations (Noureddine, Hagge, Brady & Ofstad, 2016a).

Students. Students benefited from the synergy created by the interprofessional collaboration in multiple ways through: (a) participation in engaging learning activities with multidisciplinary students, (b) increased student-faculty mentoring opportunities, (c) increased opportunities to practice IPE competencies across a variety of settings, and (d) enhanced preparation to join a collaborative practice ready health care workforce (Noureddine, Hagge, Brady & Ofstad, 2016b).

Conclusion: There is a clarion call for healthcare educators to integrate IPE into the curriculum. While preparing collaborative ready health care professionals, IPE provides additional, sophisticated synergistic benefits to all stakeholders: the institutions, faculty and students.

References

Association of Critical Care Nurses. (2005). *AACN standards for establishing and Sustaining healthy work environments: A journey to excellence.* Aliso Viejo, CA: American Association of Critical Care Nurses.

Institute of Medicine (IOM) (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington, DC: National Academies Press.

Institute of Medicine (IOM) (2003). *Health professions education: A bridge to quality*. Washington, DC: National Academies Press.

Interprofessional Education Collaborative Expert Panel. (IPECEP; 2016). *Core competencies for interprofessional collaborative practice: 2016 Update*. Washington, D.C.: Interprofessional Education Collaborative.

Interprofessional Education Collaborative Expert Panel. (IPECEP; 2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, D.C.: Interprofessional Education Collaborative.

Joint Commission. (2005). *Communication: A critical component in delivering quality care* Retrieved from http://www.ingentaconnect.com/content/jcaho/jcts/2005/00000003/00000006/art00001

Joint Commission. (2007). *National Patient Safety Goals Hospital Program*. Retrieved From http://www.jointcommission.org/assets/1/6/2006_Annual_Report.pdf

Joint Commission. (2008). *2008 National patient safety goals*. Retrieved from http://www.jointcommission.org/assets/1/6/2008_Annual_Report.pdf

Noureddine, N., Hagge, D., Brady, D., & Ofstad, W. (2014). California-Interprofessional Education Research Academy (CA-IPERA). Retrieved from https://nexusipe.org/users/california-interprofessional-education-research-academy-ca-ipera

Noureddine, N., Hagge, D., Brady, D., & Ofstad, W. (2016a). Interprofessional Education & Collaborative Practice. An invited presentation at the University of California Davis Interprofessional Teaching Scholars Program in Davis, California.

Noureddine, N., Hagge, D., Brady, D., & Ofstad, W. (2016b). *Preparing collaborative ready healthcare graduates: California Interprofessional Education Research Academy (CA-IPERA) Model.* A poster session presented at the Western Institute of Nursing's (WIN) 49th Annual Communicating Nursing Research Conference, Anaheim, California.

Noureddine, N., Hagge, D., Brady, D., & Ofstad, W. (in press). Interprofessional Education: The CA-IPERA Model for Learning. *International Journal of Nursing & Clinical Practice.*

Pellegrino, C. (2016). *From a team of experts...to an expert team.* A workshop presented at the T3 Train-the-Trainer Interprofessional Faculty Development Program, in Seattle, Washington.

Raehl, C.L., Baldwin, J.N., Carter, R.A., Crabtree B.L., Yanchick, V.A., Maine, L.L. (2013). Argus Commission Report: Game Changers in Education and Health Care. *American Journal of Pharmaceutical Education*. Retrieved from http://www.aacp.org/governance/COMMITTEES/argus/Documents/2013ArgusReportApprovedEdits.pdf

Wachter, R. M. (2004). The end of the beginning: patient safety five years after 'To Err is Human'. *Health affairs*, *23*, W4.

World Health Organization. (2007). *Communication during patient hand-overs*. Joint Commission International, Vol. 1. Geneva: WHO Press. Retrieved from http://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf

World Health Organization (WHO). (2010). *Framework for action on Interprofessional education and collaborative practice*. Retrieved from http://whqlibdoc.who.int/hq/2010/WHO_HRH_HPN_10.3_eng.pdf

Contact

noureddinen@csus.edu

E 03 - Job Retention Factors

Reasons Why Dissatisfied Acute Care Registered Nurses and Health Care Assistants Remain in Their Jobs

Zelda Gibbs, PhD, RN, USA

Abstract

Financial challenges for hospitals demand strategies to ensure superior patient satisfaction scores. Healthcare employees face substantial challenges in their efforts to provide exceptional patient care and meet organizational expectations (Centers for Medicare and Medicaid Services, 2013; Top issues, 2016). Health care assistants (HCAs) are providing direct care for patients along with registered nurses (RNs). Yet, they are an understudied population in acute care facilities. Job descriptions for HCAs in acute care facilities are extremely diverse, and RNs feel reluctant to assign responsibilities to HCAs (Jenkins & Joyner, 2013; McKenzie & Turkhud, 2013). Stressful relationships between RNs and HCAs affect quality of care, patient satisfaction and retention of staff. Job retention, job satisfaction, commitment, and professional relationships can potentially suffer as a result. Generational differences between healthcare populations are also linked to relationship and retention issues in nursing (Hendricks & Cope, 2013; Schullery, 2013; Young, Sturts, Ross & Kim, 2013). *This study explored the reasons why health care employees are embedded in their jobs, even when they are dissatisfied with the circumstances under which they work.*

Job embeddedness (JE) is a construct that measures the reasons why employees stay in a job, even if they are not satisfied with this job. These reasons might be organizational or community related and are measured as fit, link and perceived sacrifices when quitting the job (Mitchell et al. 2001). JE has been linked to locus of control (Ng & Feldman, 2011), engagement, job satisfaction, commitment, job performance and intent to stay, and directly affects job retention and quality of service (Karatepe, 2013; Karatepe & Karadas, 2012; Lee, S., Lee, D., & Kang, 2012, Mitchell et al. 2001). Knowledge regarding JE of HCAs is lacking, and studies about the differences between JE of RNs and HCAs in acute care facilities could not be located.

A descriptive comparative design was used to measure: Infer differences between the total JE, organizational and community dimensions of JE, job satisfaction, intent to stay between RNs and HCAs, between three generations of RNs and HCAs, and to describe differences between the demographic data of RNs and HCAs including education, shift worked, years of experience, and hours worked per week. A convenience sample of RNs and HCAs from medical and surgical units at two Texas hospitals completed a survey of demographic data and one that measured JE variables of fit, link and sacrifice from organizational and community perspectives. Awareness of these associations combined with knowledge about the reasons why employees remain in their jobs can guide nurse managers on hiring requisites and incentives to improve retention rates.

RQ1 - Is there a difference between RNs and HCAs on Total JE, Organizational JE Subscales, Community JE Subscales, Job Satisfaction and Intent to Stay?

Independent Samples t-tests were conducted to answer the question. The only statistically significant finding showed was that RNs valued community sacrifices as more important than HCAs [t (118) = 2.41, p = .018 with a large effect size of d = .55]. A post hoc power analyses revealed a power of .50, thus a 50% probability that rejecting the null hypothesis is wrong. Post hoc analyses on the non-significant t-tests vary between .48 and .65. Post hoc power analyses below .80 might be an indication of Type II errors. Community sacrifices was conceptualized to be costs and inconvenience associated with relocating to get another job. Financial ability of RNs to invest in their communities, while HCAs might not financially able to pay for the same investments. Due to the differences in pay between RNs and HCAs it is not surprising that the community sacrifice might be perceived differently by the higher-paid employees.

RQ2: *Is there a difference between three generations of health workers in an acute care hospital on Total JE, Organizational JE subscales, Community JE subscales, Job Satisfaction and Intent to Stay?*

ANOVA analysis showed a statistically significant difference [F (2, 117) = 4.813, p = .01] in the total JE scores. A post hoc analysis revealed a medium effect size of .30 and a power of 0.60, a probability of 40% that a Type II error could have been made. Post hoc analysis revealed that the increase from Millennials to Baby Boomers [-.42, 95% CI (-.74 to -.10)] was statistically significant (p = .007). The organizational links embeddedness score was statistically different between the three groups [F (2, 117) = 26.27, p < .01] with a large effect size of 0.70. The null hypothesis is rejected: There are significant differences in organizational links JE between generational groups. The post hoc power of 0.999 fully supported the decision since a Type II error rate was smaller than 0.001. Differences between all three generations on the organizational link subscale were statistically significant, as well as the difference between Baby Boomers and Millennials on total JE. Three out of the seven questions included years employed at this organization, in this position and in the hospital industry. Baby Boomers will most likely score higher on these questions than Millennials, just because they are older. However, this does not explain the significant difference between these two generations and Gen Xers. Millennials are focused on instant results and strive to thrive in their jobs. They might be more involved in committees and work teams. The average ages for RN and HCA were the same in each generation, with results showing that the mean age for healthcare employees at these two facilities falls in the Gen-Xer generation. This finding shows that attempts for improvement should be focused on generational similarities for each population.

These differences in JE between generations (although only organizational links embeddedness between all the generations, and total JE between Baby Boomers and Millennials were significant) showed that retention strategies and incentives should be focused on methods to retain staff. The differences between generations should be kept in mind because a ‘one size fits all’ approach will not deliver positive results.

RQ3: *Can age, years worked, shift worked, level of education, organizational links, organizational fit, organizational sacrifice subscales predict job satisfaction?*

Multiple regression was conducted and the assumptions of linearity, independence of errors, homoscedasticity, unusual points and normality of residuals were met. Independence of residuals was assessed by a Durbin-Watson statistic of 1.94. Normal distribution was verified with visual inspection of the histogram and P-P Plot. Model fit was confirmed with Adjusted R2 = .678. The ANOVA table suggested a statistically and significantly prediction of job satisfaction F (7, 115) = 37.652, p < .0005. Organizational fit, organizational sacrifice and level of education added statistical significance to the prediction, p < .05. The post hoc analysis suggested an effect size of 2.11 and a power of 1.00; thus, fully supported the decision to reject the null hypothesis since a Type II error rate was smaller than 0.00.

The results revealed that RNs valued community sacrifices significantly higher than HCAs. This is a significant finding because only one other study could be located to demonstrate a positive correlation between JE and community sacrifices (Stroth, 2010) among RNs. Total JE scores between baby boomers and millennials were significantly different, while organizational links scores among all three generations showed a statistically significant difference. Organizational fit, organizational sacrifice and level of education added statistical significance to the prediction of job satisfaction.

The results from this study sketch a picture of RNs who fit well into the organizational culture and create the necessary professional links to be successful, while they also fit well in their communities and place significant value on community sacrifices. However, they scored lower on total JE, job satisfaction and intent to stay than HCAs. RNs might be well embedded in their communities (such as being, married, children in school and owning a house) but might not be embedded well enough at their particular organization or department to remain in their jobs, and might explore opportunities at other organizations or departments more freely than HCAs. In addition to this study’s results, attention to studies that showed positive results with regard to the organizational fit (Holtom, Smith, Lindsay & Burton, 2014) and community sacrifice subscales (Stroth, 2010), can reduce annual turnover and improve retention strategies significantly.

Results from this research can help administrators understand organizational and community influences on JE and the consequences that JE of RNs and HCAs have on professional relationships and quality of nursing care. Recommendations from previous studies in this context can be compared to these results and considered as strategies to improve workflow processes. Furthermore, this study provides a basis for future studies regarding the relationships between employee JE, quality of care indices, cost effectiveness and patient satisfaction.

Perceived values of HCAs to organizational sacrifices and community links can be a revelation for organizations that are striving to increase employee retention rates. Attempts to incorporate HCAs into the organization, such as offering opportunities to participate in committees, offering standardized education, certifications and a new focus on the value that this workforce brings to quality of nursing care will help to improve their organizational JE.

References

Centers for Medicare and Medicaid Services. (2013). *Open Door Forum: Hospital Value-Based Purchasing Fiscal Year 2013 Overview for Beneficiaries, Providers, and Stakeholders.* https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/Downloads/HospVBP_ODF_072711.pdf

Hendricks, J. M., & Cope, V. C. (2013). Generational diversity: What nurse managers need to know. *Journal of Advanced Nursing, 69*(3), 717-725.

http://dx.doi.org/10.1111/j.1365-2648.2012.06079.x

Holtom, B. C., Smith, D. R., Lindsay, D. R., & Burton, J. P. (2014). The relative strength of job attitudes and job embeddedness in predicting turnover in a U.S. military academy. *Military Psychology, 26*(5-6), 397. http://dx.doi.org/10.1037/mil0000055

Jenkins, B., & Joyner, J. (2013). Preparation, roles, and perceived effectiveness of unlicensed assistive personnel. *Journal of Nursing Regulation, 4*(3), 33-40. http://dx.doi.org/10.1016/S2155-8256(15)30128-9

Karatepe, O. (2013). The effects of work overload and work-family conflict on JE and job performance; the mediation of emotional exhaustion. *International Journal of Contemporary Hospitality Management*, *25*(4), 614-634. http://dx.doi.org/ 10.1108/09596111311322952

Karatepe, O., & Karadas, G. (2012). The effect of management commitment to service quality on JE and performance outcomes. *Journal of Business Economics and Management*, *13*(4), 614-636. http://dx.doi.org/10.3846/16111699.2011.620159

Lee, S., Lee, D., & Kang, C.-Y. (2012). The impact of high-performance work systems in the health-care. *The Service Industries Journal*, *32*(1), 17- 36. http://dx.doi.org/10.1080/02642069.2010.545397

McKenzie Smith, M., & Turkhud, K. (2013). Simulation-based education in support of HCA development. *British Journal of Healthcare Assistants, 7*(8), 392-397. http://dx.doi.org/ 10.12968/bjha.2013.7.8.392

Mitchell, T. R., Holtom, B. C., Lee, T. W., Sablynski, C. J., & Erez, M. (2001). Why people stay: Using JE to predict voluntary turnover. *Academy of Management Journal*, *44*, 1102-1122. http://dx.doi.org/10.2307/3069391

Ng, T. H., & Feldman, D. C. (2011). Locus of control and organizational embeddedness. *Journal of Occupational & Organizational Psychology, 84*(1), 173-190. http://dx.doi.org/10.1348/096317910X494197

Schullery, N. M. (2013). Workplace Engagement and Generational Differences in Values. *Business Communication Quarterly*, *76*(2), 252-265. http://dx.doi.org/10.1177/1080569913476543

Stroth, C. (2010). JE as a nurse retention strategy for rural hospitals. *Journal of Nursing Administration*, *40*(1), 32-35. http://dx.doi.org/10.1097/NNA.0b013e3181c47d30

Top issues confronting hospitals in 2015. (2016). *American College of Healthcare Executives.* Retrieved from https://www.ache.org/pubs/research/ceoissues.cfm

Young, S. J., Sturts, J. R., Ross, C. M., & Kim, K. T. (2013). Generational differences and job satisfaction in leisure services. *Managing Leisure*, *18*(2), 152-170. http://dx.doi.org/10.1080/13606719.2013.752213

Contact

zgibbs@tarleton.edu

E 03 - Job Retention Factors

Empowering Experienced Pediatric Nurses Working on General Medical and Surgical Units

Alexandra De Almeida Vicente, MScN, RN, OIIQ, PALS, CPR, Canada

Abstract

Nursing shortages occurring in health care systems around the world have adverse impacts on the health and well-being of populations. Understanding work-related stressors is critical if organizations are to retain nurses. While all nurses experience work-related stressors, pediatric nurses may be at a particular risk, as they face emotional stress from taking care of sick children. Research on work-related stressors in pediatric settings has focused on nurses in critical care units, leaving a gap in knowledge regarding those working in medical and surgical units. While working conditions on pediatric medical and surgical wards are clearly stressful, the sources of that stress have not been identified. Experienced pediatric nurses caring for increasingly sick and vulnerable children on medical and surgical units may be at particular risk for work-related stress. They are expected to master the skills necessary to care for patients with a wide range of diagnoses and treatment issues, while accepting increased responsibilities. This can decrease the amount of time available for direct patient care and lead to job dissatisfaction. In view of their positive impact on quality of care, it is imperative to understand the work-related stressors these nurses encounter in order to develop effective organizational interventions to minimize stressors and promote retention. The purpose of this study was to explore experienced pediatric nurses' perceptions of work-related stressors in medical and surgical units using a qualitative descriptive design with semi-structured interviews. The study took place in a medical and surgical unit at a quaternary care pediatric hospital. Purposive sampling was used, and nurses recruited until data saturation was reached (n = 12). Experienced nurses described a strong sense of responsibility for providing excellent patient care, and identified stressors that negatively impacted their ability to do so. Stressors are reflected in three themes: (1) ''The kids are getting sicker and sicker'': Difficulty ensuring excellent patient care to an increasingly vulnerable population, (2) Feeling powerless to provide quality care, and (3) Being a ''Jack-of-all-trades'': Struggling with competing demands. The aim of this presentation is to identify experienced pediatric nurses' perceptions of work-related stressors in medical and surgical settings and how they might be mitigated to promote healthy work environment. Managerial strategies for workplace empowerment will be discussed through the lens of Kanter's structural empowerment theory, Lee and Mitchell's unfolding turnover model and Benner's from novice to expert theory.

References

International Council of Nurses (2015). International Council of Nurses Biennial Report 2014–2015. Retrieved from: http://www.icn.ch/ images/stories/documents/publications/biennial_reports/ICN_ Biennial_Report_2014-2015.pdf.

Davis, S., Lind, B. K., & Sorensen, C. (2013). A comparison of burnout among oncology nurses working in adult and pediatric inpatient and outpatient settings. Oncology Nursing Forum, 40, E303–E311. doi: 10.1188/13.ONF.E303-E311

Czaja, A. S., Moss, M., & Mealer, M. (2012). Symptoms of posttraumatic stress disorder among pediatric acute care nurses. Journal of Pediatric Nursing, 27, 357–365. doi: 10.1016/j.pedn.2011.04.024

Sekol, M. A., & Kim, S. C. (2014). Job satisfaction, burnout, and stress among pediatric nurses in various specialty units at an acute care hospital. Journal of Nursing Education and Practice, 4, 115–123, doi: 10.5430/jnep.v4n12p115

Benner, P., Tanner, C. A., & Chesla, C. A. (2009). Expertise in Nursing Practice Caring, Clinical Judgment & Ethics. New York, New York: Springer Publishing Company.

Kanter, R. M. (1977). Men and Women of the Corporation. New York, New York: Basic Books.

Lee, T. W., & Mitchell, T. R. (1994). An alternative approach: the unfolding model of voluntary employee turnover. Academy of Management Review, 19, 51– 89. doi: 10.5465/AMR.1994.9410122008

De Almeida Vicente, A., Shadvar, S., Lepage, S., & Rennick, J. E. (2016). Experienced pediatric nurses' perceptions of work-related stressors on general medical and surgical units: a qualitative study. International Journal of Nursing Studies, 60, 216–224. doi: 10.1016/j.ijnurstu.2016.05.005

Contact
alexandra.dealvicente@gmail.com

E 04 - Managing Workplace Relationships

The Watson Room: Managing Compassion Fatigue in Clinical Nurses on the Front Line

Crystal Crewe, DNP, CMSRN, USA

Abstract

The concept of compassion fatigue (CF) emerged in the early 1990s in North America to explain a phenomenon observed in nurses employed in emergency departments. A precursor to burnout, CF is a well-known phenomenon associated with emotional exhaustion, depersonalization, and an inability to work effectively. In nurses, CF has been shown to reduce productivity, increase staff turnover and sick days, and lead to patient dissatisfaction and risks to patient safety. The aim of this study was to determine if the use of a Watson Room designated as a “quiet zone” with warm colors on the wall, massage chair, and soothing sounds in the workplace environment, reduced CF in clinical nurses at the bedside in acute care settings. The data came from a survey of nurses (n = 19) working in a level 1 trauma center in an acute care setting. This quantitative study was conducted over a two-week period. A single-group of nurses completed both a pre- and post professional quality of life (ProQol) survey, a 30 item self-measurement of positive and negative aspects of caring. The ProQol operationalizes in three subcategories: compassion satisfaction (10 items), burnout (10 items), and CF (10 items). The ProQOL survey results showed statistically significant differences in the mean scores in all three categories. Paired samples t tests indicate the Watson Room proved to be successful in increasing compassion satisfaction (p = .009), decreasing burnout (p = .002), and decreasing secondary trauma/CF respectively (p = .02). This study shows the importance of nurses taking care of themselves while taking care of others. Understanding CF and devising and implementing interventions to address the subject are important for nurses and patients. Relationship base care of self is very important in our organization. Upper leadership is supportive of managers creating quiet zones from pre-existing spaces to support their staff in care of self, help combat compassion fatigue and burnout.

References

Hooper, C., Craig, J., Janvrin, D., Wetsel, M., & Reimels, E. (2010). Compassion satisfaction, burnout, and compassion fatigue among emergency nurses compared 44 with nurses in other selected inpatient specialties. Journal of Emergency Nursing, 36(5), 420-427.

Jenkins, B., Warren, N. A. (2012). Concept analysis: compassion fatigue and effects upon critical care nurses. Critical Care Nursing Quarterly, 35(4), 388-395.

Mendes, A. (2014). Recognising and combating compassion fatigue in nursing. British Journal of Nursing. 23(21), 1146-1146 1p. doi:10.12968/bjon.2014.23.21.1146

Contact

crystal.crewe@vcuhealth.org

E 04 - Managing Workplace Relationships

Authentic Leadership Impact on Psychological Safety and Relationship Quality in the Acute Care Healthcare Setting

Mechelle Jean Plasse, PhD, MS, CNS, PMHNP, USA

Abstract

The quality of workplace environments is a growing concern across several industries as the impact on employee outcomes is increasingly recognized. Within healthcare the impact and importance of the workplace quality extends beyond the outcomes for the healthcare provider as this is also the healing environment for the patient. Mallibdou, Cummings, Estabrooks and Giovannetti's (2011) findings support the established literature demonstrating provider outcomes related to the health of work environment also impact patient outcomes, both of which are multifactorial events. The quality of the nurse practice environments has been associated with adverse events including failure to rescue and death. Numerous factors influence the workplace environment and patient care delivery however a common thread for these factors lie within the relational tone of the setting. Dupree, Anderson, McEvoy and Brodman's (2011) findings continues to support the concept that interdisciplinary relationship quality among providers is a central determinant to workplace health, patient safety and positive patient outcomes. Collaboration and interdisciplinary teaming are just two examples of the relationally-based constructs in healthcare. An additional relationally-based construct is leadership. Leadership behavior impacts the relational tone of a workplace, setting the foundation for relationship potential among providers, thereby influencing trust and the experience of psychological safety. Psychological safety is the tacit knowledge or belief that it is interpersonally safe to engage in vulnerable communication with colleagues. From the seminal work of Edmondson (1990) further studies on psychological safety in the healthcare setting have shown this to be a state conducive to such interpersonal risk-taking behaviors as speaking up or challenging a colleague without fear of retaliation. Edmondson, Bohmer and Pisano's (2001) work supports additional findings that in the acute care setting the experience of psychological safety can reduce error rates, including medication errors, as well as improve overall quality of care. Leadership, psychological safety and relationship quality have been correlated with both provider and patient outcomes however the mechanisms by which these variables impact such outcomes is not fully understood.

This study sought to address these gaps by exploring leadership styles potential to facilitate psychological safety among nurses through the influence on relationship quality. As previously noted, Edmondson, Bohmer and Pisano's (2001) work, and others, have demonstrated that the variables of leadership, psychological safety and relationship quality can be correlated with the provision of safe patient care, however the interplay between the variables in the day to day functioning of the unit is not fully understood. Patient and employee outcomes are multifactorial events and require contextually driven exploration to further advance the science of healthcare management and patient safety. A path analysis was used to test the hypothesized model of authentic leadership influencing team psychological safety in paths mediated by high quality relationships and workplace incivility. The findings did not fully support the hypothesized model in its entirety as a significant relationship between leadership style and psychological safety was not found. Indirect mediation effects of relationship quality on psychological safety was also not supported. However, a significant relationship found between authentic leadership and high quality relationships and an inverse significant relationship with the measures of incivility.

References

Brunetto, Y., Xerri, M., Shriberg, A., Farr-Wharton, R., Shacklock, K., Newman, S., & Dienger, J. (2013). The impact of workplace relationships on engagement, well-being, commitment and turnover for nurses in Australia and the USA. *Journal of Advanced Nursing*, n/a-n/a. doi: 10.1111/jan.12165.

Cumming, G. G., MacGregor, T., Davey, M., Lee, H., Wong, C.A., Lo, E., &…Stafford, E. (2010). Leadership styles and outcome patterns for the nursing workforce and work environment: A systematic review. *International Journal of Nursing Studies, 47*(3), 363-385.

Cummings, G. M., Midodzi, W. K., Wong, C. A. & Estabrooks, C. A. (2010 September/October). The contribution of hospital nursing leadership styles to 30-day patient mortality. *Nursing Research, 59*(5), 331-339. doi: 10.1097/NNR.0b013e3181ed74d5

DuPree, E., Anderson, R., McEvoy, M.D. & Brodman, M. (2011). Professionalism: A necessary ingredient in a culture of safety. *The Joint Commission Journal on Quality and Patient Safety,* 37(10), 447-455.

Edmondson, A., Bohmer, R.M. & Pisano, G.P. (2001). Disrupted routines: Team learning and new technology implementation in hospitals. *Administrative Science Quarterly,46*, 685- 716.

Hirak, R., Peng, A.C., Carmeli, A & Schaubroeck, J.M. (2012). Linking leader inclusiveness to work unit performance: The importance of psychological safety and learning from failures. *The Leadership Quality,* 23, 107-117. Doi:10.1016/j.leaqua.2011.11.009.

Institute of Medicine (IOM). (2011). *The Future of Nursing: Leading Change, Advancing Health.* Washington, DC: The National Academies Press.

Kelley, J.M., Kraft-Todd, G, Schapira, L. Kossowsky, J. & Riess, H. (2014). The influence of the patient-clinician relationship on health outcomes: A systematic review and meta-analysis of randomized controlled trials. *PLoS ONE* 9(4): e9427. doi:10.1371/journal.pone.0094207

Laschinger, H.K.S. & Smith, L.M. (2013). The influence of authentic leadership and empowerment on new-graduate nurses' perceptions of interprofessional collaboration. *Journal of Nursing Administration, 43*(1), 24-29.

Mallidou, A.A., Cummings, G.G., Estabrooks, C.A. & Giovannetti, P.B. (2011). Nurse specialty subcultures and patient outcomes in acute care hospitals: A multi-group structural equation modeling. *International Journal of Nursing Studies,* 48, 81-93. doi:10.1016/j.ijnurstu.2010.06.002

Pavey, L., Greitemeyer, T. & Sparks, P. (2011). Highlighting relatedness promotes prosocial motives and behavior. *Personality and Social Psychology Bulletin, 37*(7), 905-917. doi: Doi:10.1177/0146167211405994.

Rosenstein, A.H. & Naylor, B. (2011). Incidence and impact of physician and nurse disruptive behaviors in the emergency department. *Journal of Emergency Medicine,* 1-10. doi:10.1016/j.jemermed.2011.01.019.

Thompson, D. N., Hoffman, L. A., Sereika, S. M., Lorenz, H. L., Wolf, G. A., Burns, H. K. . . . Ramanujam, R. (2011). A Relational Leadership Perspective on Unit-Level Safety Climate. *Journal of Nursing Administration, 41*(11), 479-487. doi: 10.1097/NNA.0b013e3182346e31

Contact

m.plasse@comcast.net

E 05 - Does Leadership Impact Work Environment?

F 01 - Creating a Healthy Work Environment for Nurses Transitioning from Staff Nurse to Management

Creating a Healthy Work Environment for Nurses Transitioning from Staff Nurse to Management

Jennifer Sylvia Buffenbarger, EdD, MSN, RN, USA
Jeanne M. Sorrell, PhD, RN, FAAN, USA

Abstract

Healthy work environments are essential for recruitment and retention of nurse managers in the United States and internationally. Nurse managers are in key positions to positively influence patient outcomes and costs. In addition, the role of nurses as managers is becoming increasingly important in the retention of staff nurses because of their critical influence on the quality of the work environment (Roche, Duffield, Dimitrelis, & Frew, 2015). There is an expectation that new nurse managers will become competent immediately and meet those same high performance standards as experienced nurse managers (Doria, 2015). Yet many nurses are leaving their manager roles to resume a staff nurse position or to withdraw from the nursing profession completely (Djukic, Jun, Kovner, Brewer, & Fletcher, 2016). In addition, with the nursing shortage predicted to continue, the number of nurses choosing to enter management may decline (Wong, et al., 2013). Research has demonstrated that frequent turnover of nurse managers in a hospital can lead to a disruption of nursing staff performance and negatively impact patient care (Buffenbarger, 2016). This presentation focuses on a qualitative bounded case study that was implemented to explore nurse managers' experiences with turnover in order to identify strategies for enhancing retention. Two conceptual frameworks that guided the study were work empowerment and servant leadership. Research questions focused on nurse managers' perceptions of empowerment and servant leadership characteristics that were important in decisions to assume and remain in a management/leadership role. Data collection included audio-recorded interviews with 7 current or past full-time nurse managers and observation of 3 of the participants at a leadership meeting. Interview transcripts were open coded and thematically analyzed. Observation data were categorized according to empowerment and servant leadership characteristics. Five themes were identified that related to research questions: Struggling to make a difference while pulled in all directions; Opportunity for transformation; Committed but powerless; Embarking unprepared on an unplanned journey; and the presence to serve, to lead others. Findings guided development of a 12-month program for new nurse managers that integrates characteristics of servant leadership reflective of a healthy work environment. Healthy work environments are essential for patient safety and financial viability of an organization (AACN, 2016). Our presentation will address strategies that help to create a healthy work environment to assist novice nurse managers in gaining new skills and self-confidence in their role. By giving voice to the challenges and opportunities embedded in the role of the nurse manager, findings and recommendations from this research can assist both new and experienced nurse managers to work collaboratively to create a healthy work environment.

References

American Association of Critical-Care Nurses (AACN). (2016). AACN standards for establishing and sustaining healthy work environments. A journey to excellence. (2nd edition). Retrieved from http://www.aacn.org/wd/hwe/docs/hwestandards.pdf

Buffenbarger, J. S. (2016). Nurses' experiences transitioning from staff nurse to management in a community hospital. (Unpublished doctoral study). Walden University, Minneapolis, MN.

Djukic, M., Jun, J., Kovner, C., Brewer, C., & Fletcher, J. (2016). Determinants of job satisfaction for novice nurse managers employed in hospitals. *Nurse Management Review*, 1-12.

Doria, H. (2015). Successful transition from staff nurse to nurse manager. *Nurse Leader, 13*(1), 78-81.

Roche, M. A., Duffield, C., Dimitrelis, S., & Frew, B. (2015). Leadership skills for nursing unit managers to decrease intention to leave. *Nursing: Research and Reviews, 5*, 57-64. Retrieved from https://www.dovepress.com/leadership-skills-for-nursing-unit-managers-to-decrease-intention-to-l-peer-reviewed-article-NRR

Wong, C. A., Laschinger, H. K., MacDonald-Rencz, S., Burkoski, V., Cummings, G., D'Amour, D., . . . Wilk, P. (2013). Part 2: Nurses' career aspirations to management roles: Qualitative findings from a national study of Canadian nurses. *Journal of Nursing Management, 21*(2), 231-241. doi:10.1111/j.1365-2834-2012.01451.x

Contact

buffenbargerj@aol.com

F 02 - Transcending the Scarcity Narrative: Understanding and Leveraging Nursing's Strengths to Create a Healthier Work Environment

Transcending the Scarcity Narrative: Understanding and Leveraging Nursing's Strengths to Create a Healthier Work Environment

Carolyn J. Cumpsty-Fowler, PhD, MPH, USA
Erin K. Van Dyke, MSIS, USA
Deborah Dang, PhD, RN, USA

Abstract

Today's nurses are asked to provide safe, expert, compassionate, person-centered care in the midst of a complex and rapidly changing healthcare environment. Many are stressed, tired, and disengaging. Nursing turnover rates are high (averaging 17.1% in 2015)[1] which, with medically complex patients, may result in nursing concerns about staffing shortages, skills deficits and threats to patient safety[2-3]. The American Association of Colleges of Nursing's *Nursing Shortage Fact Sheet* [3] cites the stress associated with inadequate staffing and patient safety concerns as factors that impact nurses' decisions to leave the profession. Although nurse leaders should be concerned about recruitment and retention, appropriate staffing is only one of AACN's six essential standards for establishing a healthy work environment[4] Nurse leaders, who play an important role in creating healthy work environments,[2,4] must understand more than the impact of change and uncertainty on the work environment and nurses' job enjoyment; they must discover how to mitigate it by leveraging strengths in all six essential standard areas. The critical question is how?

Since 2006, our nurse-led healthy work environment research team at a large academic medical center has studied the impact of disruptive behavior on the work environment and, specifically nurses and patients[5-7]. After several years of focusing on the causes and negative consequences of disruptive behavior, and evaluating the impact of a positive-psychology intervention in nursing units, the team had a transformative insight: the lens through which we view the issues profoundly alters not only what we learn, but our capacity to respond. What we see is determined by where and how we look. When focusing attention and conversations on challenges, problems and egregious behaviors, we are choosing a scarcity (or deficits) lens. This choice impacts what we discover. Albeit unintentionally, when we focus on identifying, understanding and reducing the factors that negatively impact our work environment we reinforce four incorrect perceptions: (1) these negative factors are normative/usual; (2) there is more wrong with us than right with us, (3) the problems are beyond our control, and (4) most nurses are not senior/powerful/respected enough to influence positive change. In 2013, focus groups about job enjoyment with frontline registered nurses and nurse managers throughout the institution revealed pervasive narratives about perceived lack of power and influence to improve their work environment. These fell into two groups: "nurses *are not* (fill in an adjective) *enough*" and "nurses *do not have enough* (fill in a noun)" to influence the work environment. Concerned, the team committed to learning the reasons for these perceptions.

Even though focus group discussions identified most of the negative factors described in the job satisfaction literature,[8] without exception the greatest threat to nurses' job enjoyment was perceived or real harm to patients and families. Qualitative analysis also revealed discordance between nurses' clinical confidence and ability to problem-solve on behalf of their patients, and their perceived helplessness to change their own work environment. Specifically, the team noted that although nurses knew what needed to change, they could not describe how it would happen; often resorting to comments such as: "that's above my pay grade", negative non-verbal expressions or silence. This led us to look at what was not being said, and revealed that the foundational issue underlying job enjoyment was the presence or absence of specific trust-building behaviors in their work environments. Although nurses seldom used the word trust, the stories they told clearly described the impact of trust behaviors on the work environment. Specifically, we learned what is possible when trust building behaviors are present in the work environment, and what is compromised when they are not.

Given that trust is a complex construct, often difficult to understand and describe, the team's major recommendation was that nursing leadership adopt a trust framework to engage nursing staff in conversations about trust and trust building in the work environment. Nursing leadership committed to using the Reina Dimensions of Trust: The Three Cs model®, [9] and deployed the Reina Team Trust Scale® [10] throughout nursing. To facilitate the Reina's strengths-focused survey debriefing process, we trained a cohort of volunteer *Trust Ambassadors*, who reminded us how challenging it is to keep work environment-related conversations focused on strengths.

Together, we identified five reasons for adopting a strengths-focused approach: (1) Humans are biologically programmed to identify and remember threats and scarcity, (2) nurses are trained to be vigilant for errors and threats to patient safety, (3) institutional leadership's response to surveys is to focus on areas of weakness, (4) we initiate root cause analyses when things go wrong – not when they go well, with the result that (5) our comfort and skill with strengths-focused conversations and root cause analyses is limited.

The survey debriefing experience taught us that although nurses responded favorably to the strengths-focused debriefings and found conversations about their strengths encouraging; overcoming the scarcity-focus bias will require clear direction, tools and practice. Leadership must be vigilant for the presence of conflicting messaging to avoid reinforcing the negative narratives.

In this presentation, we will describe both completed and ongoing work to build a strengths-focused culture including: development of a strengths-focused integrated debriefing process that has been used to debrief all institutional surveys involving nurses since 2015; developing nurse leaders' self-mastery to notice and mitigate physiological response to stress, fear and scarcity; and training in inquiry to build trust and support generative conversations about nursing's strengths and resilience.

Adopting a strengths-focus does not discount the many real challenges nurses face, but changes the way we understand and respond to these. Developing a strengths-focused culture is not quick or easy, but it is an important investment in creating and sustaining healthier work environments.

References

Nursing Solutions Inc. (2016). *2016 National Healthcare Retention & RN Staffing Report*. Retrieved from http://www.nsinursingsolutions.com/Files/assets/library/retention-institute/NationalHealthcareRNRetentionReport2016.pdf

Hayes, L. J., O'Brien-Pallas, L., Duffield, C., Shamain, J., Buchan, J., Hughes, F.,…North, N. (2012). Nurse turnover: a literature review – an update. *International Journal of Nursing Studies*, 49(7), 887-905. http://dx.doi.org/10.1016/j.ijnurstu.2011.10.001

American Association of Colleges of Nursing (2014, April 24). *Nursing Shortage Fact Sheet*. Retrieved from http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf

American Association of Critical-Care Nurses (2016). *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence, 2nd edition*. Retrieved from http://www.aacn.org/wd/hwe/docs/hwestandards.pdf

Walrath, J. M., Dang, D., & Nyberg, D. (2013). An organizational assessment of disruptive clinician behavior: findings and implications. *J Nurs Care Qual*, 28(2), 110-121. http://dx.doi.org/ 10.1097/NCQ.0b013e318270d2ba

Dang, D., Bae, S., Karlowicz, K., & Kim, M. (2016). Do clinician disruptive behaviors make an unsafe environment for patients? *J Nurs Care Qual*, 31(2), 115-123. http://dx.doi.org/ 10.1097/NCQ.0000000000000150

Walrath, J. M., Dang, D., & Nyberg, D. (2010). Hospital RNs' experiences with disruptive behavior. A qualitative study. *J Nurs Care Qual*, 25(2), 105-116. http://dx.doi.org/ 10.1097/NCQ.0b013e3181c7b58e

Lu, H., Barriball, K. L., Zhang, S., White, A. E. (2012). Job satisfaction among hospital nurses revisited: A systematic review. *J Int Nurs Stud*, 49(8), 1017-1038. http://dx.doi.org/ 10.1016/j.ijnurstu.2011.11.009

Reina, D., & Reina, M. (2015). *Trust and Betrayal in the Workplace: Building Effective Relationships in Your Organization* (3rd ed.). Oakland, CA: Berrett-Kohler Publishers.

Reina, A Trust Building® Consultancy (2016). Assessments - Team Trust Assessments. Retrieved from http://reinatrustbuilding.com/assessments/team-trust-assessment/

Contact

cfowler1@jhu.edu

F 03 - Characteristics of the Nursing Practice Environment Related to Creating Healthy Work Environments for Nurses

Characteristics of the Nursing Practice Environment Related to Creating Healthy Work Environments for Nurses

Yasuko Ogata, PhD, MM, RN, PHN, Japan
Kimiko Katsuyama, PhD, RN, Japan
Sachiko Tanaka, PhD, RN, Japan
Midori Nagano, MSN, RN, Japan
Yoshie Yumoto, MSN, RN, PHN, Japan
Masaomi Ikeda, PhD, BSc, RTD, Japan

Abstract

Objectives: An advanced aging population demands increasing nursing services for the elderly. Therefore, identifying organizational factors that affect the job retention of nurses is urgently needed. There is a positive relationship between a healthy work environment (HWE) and the retention of nurses in a hospital setting (Ritter, 2011). Furthermore, a healthy work environment and Magnet status have a strong connection (Ritter, 2011). The Practice Environment Scale of the Nursing Work Index (PES-NWI) is one of the measurements that were developed based on the characteristics of magnet hospitals in the 1980s (Lake, 2002). Previous studies of the PES-NWI demonstrated that its scores were significantly related to nurse outcomes, patient outcomes, and organizational variables such as nurse turnover (Warshawsky & Sullivan Havens, 2011; Ogata et al., 2011). The PES-NWI (Lake, 2002) includes as one of its five subscales “Nurse Manager Ability, Leadership, and Support of Nurses,” which is similar to the key standards of HWE by the American Association of Critical-Care Nurses (AACN), which are “Skilled Communication,” “True Collaboration,” “Effective Decision Making,” “Appropriate Staffing,” “Meaningful Recognition,” and “Authentic Leadership.”

The purpose of this study is to explore how the nursing practice environment, including nurse managers’ leadership, is related to staff nurses’ self-rating of their health condition and their tendency to remain working in their hospitals.

Methods: In this study, two types of mail surveys were done by anonymous self-report questionnaire. The first mail survey was carried out for 7,434 staff nurses working at 22 hospitals in Japanese cities such as Tokyo, Yokohama and Osaka. For that survey, nursing directors from the 647 hospitals that had more than 200 beds and were located in cities with population higher than 200,000 were invited to join the study. From that number, 22 hospitals joined the survey in September and October 2014. University hospitals were excluded, because of the differences in the type of care offered; the main functions of university hospitals differ from those of non-university hospitals. In the questionnaire, nurses were asked questions of the PES-NWI, their self-rated health condition, items of the Kessler Psychological Distress Scale (K6), whether they would work at the same hospital next year or not, and their characteristics as nurses.

In the second mail survey, in order to identify whether nurse participants had left their hospitals or not, Directors of Nursing of the 22 hospitals were asked the ID numbers of nurses who had resigned from the hospital at the end of the fiscal year, namely the end of March 2015. The ID numbers had been originally decided by the nursing department of each participating hospital, without disclosing the names associated with the numbers.

Logistic regression analyses were done, with nurses’ self-rated health condition (healthy = 1, unhealthy = 0), K6 (5 or more = 1, 4 or less = 0) *, “intention to retain or leave the hospital next year (remain = 1, leave = 0),” whether or not they had resigned from the hospital (remain = 1, resign = 0), and the five sub-scales and composite of the PES-NWI (range: 1.0 to 4.0, the neutral midpoint: 2.5), as independent variables. In all models of the logistic regression analysis, categories of nurse age were used as control variables. Before the first survey, ethics committee approval was obtained in June 2014 from the Tokyo Medical and Dental University (Ethics Approval no.1674), where the first author serves on the faculty.

* For Japanese populations, a K6 score of 5 or greater indicates the high possibility of a diagnosis of depression.

Results: Among the 3,066 participants (response rate: 41.2%), the 2,206 full-time nurses' answers that had no missing values for the PES-NWI items and the ID numbers were analyzed (ratio of valid responses: 80.0%). The average age of the nurse respondents was 33.3 years old; 93.6% of them were female; 68.8% of them rated "healthy" for their health condition; 41.7% rated higher than 5 for K6 (range: 0-24), which is a screening measure of depressive tendency; 79.4% of them intended to remain at the hospitals in the next year; and 7.1% of them had actually resigned. Cronbach's alpha coefficients of the sub-scales of the PES-NWI were from 0.79 to 0.88.

Two sub-scales (OR: 1.61 and 1.74) out of five, including "Nurse Manager Ability, Leadership, and Support of Nurses (nurse managers' leadership)," and the composite (OR: 3.48) of the PES-NWI were significantly associated with the nurses' self-rated health condition (healthy = 1, unhealthy = 0) ($p<0.001$). Three sub-scales (OR: 0.66-0.74) out of five, including nurse managers' leadership, and the composite (OR: 0.39) of the PES-NWI were significantly associated with the nurses' K6 scores (more than 5 = 1, 4 or less = 0) ($p<0.05$). Similarly, three sub-scales (OR: 1.36-1.92) out of five, including nurse managers' leadership, and the composite (OR: 3.42) of the PES-NWI were significantly associated with the nurses' intention to remain (remain = 1, leave = 0) ($p<0.05$). Regarding nurses' resignation behavior (remain = 1, resign = 0), although the subscales of the PES-NWI were not related, the composite (OR: 1.59) was significantly related ($p<0.05$).

Discussion: "Nurse Manager Ability, Leadership, and Support of Nurses" is an important part of the nursing practice environment; managers' behaviors significantly affect staff nurses' physical and mental health and their intention to remain in or leave their job. To create a healthy work environment for nurses, authentic leadership by managers that is respected by the staff nurses is vital. The relationship between the nursing practice environment and whether they actually resigned showed that creating an attractive nursing practice environment was an important factor for retaining nurses in their hospitals. In order to assess whether there is a causal relationship among nursing practice environment and nurses' retention over a longer period, more long-term longitudinal research is needed.

References

Lake, E. T. (2002). Development of the practice environment scale of the nursing work index. Research in nursing & health, 25(3), 176-188.

Ogata, Y., Nagano, M., Fukuda, T., & Hashimoto, M. (2011). [Job retention and nursing practice environment of hospital nurses in Japan applying the Japanese version of the Practice Environment Scale of the Nursing Work Index (PES-NWI)]. [Nihon koshu eisei zasshi] Japanese journal of public health, 58(6), 409-419.

Ritter, D. (2011). The relationship between healthy work environments and retention of nurses in a hospital setting. Journal of Nursing Management, 19(1), 27-32.

Warshawsky, N. E., & Havens, D. S. (2011). Global use of the practice environment scale of the nursing work index. Nursing Research, 60(1), 17.

Contact

yogata.gh@tmd.ac.jp

F 04 - Work-Life Balance of Doctoral Nursing Program Faculty and Implications for Nursing Education

Work-Life Balance of Doctoral Nursing Program Faculty and Implications for Nursing Education

Suzanne C. Smeltzer, EdD, MS, RN, ANEF, FAAN, USA
Mary Ann Cantrell, PhD, RN, ANEF, FAAN, USA
Nancy C. Sharts-Hopko, PhD, RN, FAAN, USA
Mary Ann Heverly, PhD, MEd, BA, USA

Abstract

Purpose and Significance: Work-life balance (WLB) contributes to a healthy work environment and is an issue that may affect job performance, job satisfaction and one's intent to remain in a position. WLB is defined as one's ability to achieve and maintain a 'balance' between work and life outside work. Data describing work-life balance of PhD and DNP program faculty were collected through administration of a work-life balance measure as part of a larger survey, and an open-ended question about their experiences. Strategies that doctoral program faculty use to achieve work-life balance were also identified.

Methods: Data were collected from a random sample of 554 doctoral program faculty who completed an on-line researcher-developed survey. Doctoral program nursing faculty were asked about their work-life balance via a 15-item Work/Life Balance Self-Assessment scale that asked about the frequency with which they performed specific behaviors during the past three months using a 7-point time-related scale. They were also asked to identify strategies they use to achieve work-life balance. An open-ended item on the survey asked respondents to provide any additional comments they had related to the issues addressed in the overall survey.

Analysis: Quantitative data were analyzed using frequencies, analysis of variance, and hierarchical regression. Responses to the open-ended question were analyzed using conventional content analysis (Hsieh & Shannon, 2005).

Results: Analysis of quantitative data indicated that current faculty position, number of hours spent weekly teaching, availability of research or teaching assistants, and the presence of an MSN program option explained 7.3% of the variance in work-life balance. After controlling for these characteristics, sacrificing time for self to fulfill work responsibilities, the perception that family responsibilities are incompatible with work role, a sense their work with doctoral students was exhausting, belief that their workload is detrimental to health and well-being, and experiencing fulfillment in performing the work role together predicted an additional 56.5% of the variance in work-life balance. Results of data from the open-ended question from the 137 respondents who provided substantive responses included comments that addressed work-life balance. These included the effect of aging and retirement of senior faculty members on doctoral program faculty workloads, lack of workload credit for dissertation or capstone work, the invisible nature of doctoral teaching, issues associated with the tenure track, inadequate time for research and scholarship, the shortage of faculty in the academic unit, and the burden of administrative responsibilities.

Conclusions: The results of analysis of quantitative and qualitative data are consistent with findings of the authors' previous focus group study of DNP and PhD faculty. Although several factors associated with work-life balance are a function of faculty members' age, faculty rank, and time in their faculty role, other factors can be modified to improve faculty members' work-life balance. With the wave in retirements anticipated, strategies to do so may be important in retaining experienced faculty to teach and mentor future doctoral students.

References

Smeltzer, S. C., Sharts-Hopko, N. C., Cantrell, M A., Heverly, M., Wise, N., Jenkinson, A., & Nthenge, S. (2014). Nursing doctoral faculty perceptions of factors that affect their continued scholarship. *Journal of Professional Nursing, 30*(6), 493–501. DOI: http://dx.doi.org/10.1016/j.profnurs.2014.03.008 (Published Online: March 28, 2014).

Smeltzer, S. C., Sharts-Hopko, N. C., Cantrell, M A., Heverly, M., Wise, N., Jenkinson, A., & Nthenge, S. (2014). Challenges to research productivity of doctoral program faculty. *Nursing Outlook, 62*(4), 268-274. DOI: 10.1016/j.outlook.2014.04.007

Contact

suzanne.smeltzer@villanova.edu

F 05 - Responses to Workplace Bullying

Responding When Incivility Arises in the Workplace

Monica Kennison, EdD, MSN, RN, USA
Laura C. Dzurec, PhD, RN, PMHCNS-BC, ANEF, FAAN, USA

Abstract

Almost a decade has passed since the Joint Commission issued a Sentinel Alert linking intimidating behaviors to medical errors, patient dissatisfaction, and adverse outcomes. More recent studies confirm that workplace acts of incivility, progressing to bullying and even physical abuse in some cases, continue to significantly undermine the culture of safety that facilitates effective healthcare practice.

While professional comportment policies pay lip service to what 'should occur' in instances of intimidation and bullying, the inherent, complex and subtle contextual elements of those acts present challenges that supersede the benefits of legislated, cookie cutter approaches to their management. As a result, nurses, whether in practice or educational settings, may find themselves ill-supported as they try to navigate the choppy waters of workplace incivility, even when administrators claim to have established guidelines for addressing it. The purpose of this presentation is to describe strategies aimed to directly support individual responses to acts of workplace incivility and bullying.

The investigators used pragmatic utility to synthesize findings from published studies addressing workplace bullying. The work resulted in new insights and guidance to advance understanding of the target-to-victim cascade that occurs for many who are confronted by the confusing assaults of bullies. Moreover, findings speak to the variance of personal responses to workplace bullying and to the significance of organization-wide commitment to establishing a just culture.

Promoting civility and stemming workplace bullying has implications for nurses in all settings. Role modeling professional comportment and implementing policies that recognize the unique responses of individuals who are victimized by their bully counterparts are essential components of supportive work environments and consistent practice for acceptable behavior. However, these skills do not just happen with exposure and it behooves nurses to add to their personal repertoires these highly specialized interpersonal skills.

Continued allegiance to organizational policies that support narrow definitions of incivility and that recognize only highly visible workplace bullying affronts will not promote workplaces that are safe and healthy, nor will they support the individuals who work within them. This presentation seeks to empower nurses by providing them with a useful skillset and positive coping strategies that are appropriate to the clandestine nature of workplace incivility and bullying.

References

Beattie, L., & Griffin, B. (2014). Accounting for within-person differences in how people respond to daily incivility at work. *Journal of Occupational and Organizational Psychology, 87*, 625-644.

Malone, B. R. (2016). Intimidating behavior among healthcare workers is still jeopardizing medication safety. *Nephrology Nursing Journal, 43*(2), 157-159.

Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. *Journal of Nursing Administration, 43*(10), 536-542.

Porath, C./L., Gerbasi, A., & Schorch, S.L. (2015). The effects of civility on advice, leadership, and performance. *Journal of Applied Psychology, 100*(5), 1527-1541.

Contact

monica_kennison@berea.edu

F 05 - Responses to Workplace Bullying

Transformative Leadership for True Workplace Collaboration: Strengthening Workplace Culture through Attention to Workplace Bullying Affronts

Laura C. Dzurec, PhD, RN, PMHCNS-BC, ANEF, FAAN, USA
Monica Kennison, EdD, MSN, RN, USA

Abstract

Transformative leadership is governance devoted to change in individuals and in social systems. It emphasizes actions aimed simultaneously toward organizational effectiveness and moral commitment to organizational stakeholders. Because transformational leadership is intended to incorporate concurrent consideration of both ethics and effectiveness, its influence in governance can be considered robust and appropriate, both ethically and technically—at least in theory. The effectiveness of transformative leadership is significantly hindered, however, by acts of workplace bullying.

Even in settings in which leadership is transformative, workplace bullying is common and disruptive. Seldom are bullying's constitutive acts readily apparent. Instead, its acts tend to be surreptitious, typically involving subtle, often largely nonverbal interpersonal affronts that appear trivial to those not directly targeted by the bully. Despite its furtive and seemingly innocuous nature, workplace bullying is broadly devastating, affecting targeted victims, uninvolved bystanders, and organizations as wholes.

When bullying is allowed to transpire unconstrained, leadership actions intended to foster an effective and ethical work environment become largely inadequate, significantly hampered by the subtle interpersonal affronts that typically constitute bullying acts. Workplace bullying's paradoxical occurrence yields widespread chaos. The intent of transformative leadership is lost when workplace bullying is in force.

This presentation summarizes a metasynthesis of findings that cut across the investigators mixed-methods, qualitative studies of workplace culture and dynamics, specifically addressing factors that promulgate workplace bullying and that, ultimately, stall transformative leadership and interfere with true collaboration. Collected through systematic review and synthesis of broad, interdisciplinary research and prose, study findings provide evidence-based descriptions of some of the core mechanisms of workplace bullying**.** Without attention to those mechanisms, there can be no true collaboration, as efforts on the parts of workplace stakeholders shift from productivity concerns to concerns about personal safety.

The presentation will focus on the ways workplace bullies are able to hide in plain sight, acting to shame intended targets who become vulnerable victims by virtue of their lived histories and sense of self. Because bullying destroys collaboration in workplace cultures, we examine how, through transformative leadership, administrators can build just cultures in workplace organizations to establish and maintain a context that will not condone workplace bullying. Additionally, we address the character of *true* collaboration as it emerges in safe healthy, workplace environments, those in which administrators are able to engage fully in transformative leadership.

References

Kennison, M., Dzurec, L.C., Cary, A., & Dzurec, D. J., III. (2015). Seeking the 'magis:' A pathway to enhancing civility in higher education. *Jesuit Higher Education, 4*(1), 27-35.

Dzurec, L. C., Kennison, M., & Albataineh, R. (2014). Unacknowledged threats proffered 'in a manner of speaking:' Recognizing workplace bullying as shaming. *Journal of Nursing Scholarship, 46,* 281-291. DOI: 10.1111/jnu.12080

Dzurec, L. C. (2013). Status limbo: Analysis of nurse faculty member reports of administrator response to workplace bullying complaints. *Journal of Professional Nursing, 29,* e1-e9. [http://dx.doi.org/10/1016/j.profnurs.2013.07.001].

Caldwell, C., Dixon, R. D., Floyd, L. A., Chaudoin, J., Post, J., & Cheokas, G. (2012). Transformative leadership: Achieving unparalleled excellence. *Journal of Business Ethics*, *109*(2), 175-187.

Contact

lcdzurec@widener.edu

G 01 - Interprofessional Relationships Using Simulation

Building Healthy Relationships through Peer Review in Simulation Education

Jennifer Dwyer, MSN, RN-BC, CHSE, FNP, USA
Dylan Cooper, MD, FAEM, USA
Chassity Mays, BSN, RN, CNOR, USA
Greg Hasty, CST, LPN, CHSE, USA

Abstract

Simulation as a methodology for education has been active in our setting for ten years. Our Simulation Center is a partnership between a large multi-site healthcare system, a school of nursing and medicine located in an urban setting that is rich with academic and clinical excellence. We began primarily with School of Medicine events related to the Objective Structured Clinical Exam (OSCE) and expanded to include School of Nursing multidisciplinary cases, healthcare professional cases and in more recent years interprofessional events. As leadership and governance for the Simulation Center has evolved so has our quest for quality and excellence in education. As faculty and educators have become comfortable with simulation and the number of events has grown over the past several years it became evident that it was time to take our quality review to the next level. That required us to evaluate whether the events at the Center were creating an experience where learners can apply knowledge, skills, and attitudes in a safe learning environment. It is our mission to develop, apply, and share the best practice in healthcare simulation education. A Simulation Center Education Team was formed with a representative from each partner. A review form, a letter of our intent to peer review and a tool to communicate summative feedback on the event being reviewed was developed by the team. We team as pairs between disciplines when we review and we confer on our feedback when developing our SBAR of the event in preparation for sharing at our Simulation Center Education Team meeting held monthly. There are events occurring every week and many are repetitive which allows a variety of reviewers to observe and collate input. We discuss our review and refine our feedback into a summative review form that is distributed to the event facilitator. The response to our peer review and subsequent feedback has been varied and as we continue to provide feedback we hope to see revisions based upon or recommendations. The peer review aspect of our program is one of our steps to a journey of excellence as we seek accreditation as a center through the Society for Simulation in Healthcare.

References

Brann, MJ.; Improving Unit Performance With A Staff-Driven Peer Review Process. Nursing Forum, Apr-Jun2015; 50(2): 63-68. 6p

Cooper, LB, MD; Bellam, N; Vaduganathan, M; Educating the Next Generation of Peer Reviewers. JACC (Journal of the American College of Cardiology). May 3, 2016; 67(17): 2079-2082. 4p

Edwards, MT; A Longitudinal Study of Clinical Peer Review's Impact on Quality and Safety in U.S. Hospitals. Journal of Healthcare Management, Sep/Oct2013; 58(5): 369-384. 16p.

Marjo JM; Maas, PJ; van der Wees, CB; Koetsenruijter, J; Heerkens, YF; van der Vleuten, CPM; Nijhuis-van der Sanden, MWG; An Innovative Peer Assessment Approach to Enhance Guideline Adherence in Physical Therapy: Single-Masked, Cluster-Randomized Controlled Trial. Physical Therapy, April 2015; 95(4) 12p.

Pfeiffe, JA; Wickline, MA; Deetz, J; Berry, ES; Assessing RN-to-RN peer review on clinical units. Journal of Nursing Management 2012; 20; 390400 10p.

Contact

jdwyer@iuhealth.org

G 01 - Interprofessional Relationships Using Simulation

Study of an Interprofessional Simulation Intervention to Improve Nurse-Physician Collaboration

Lori J. Pajakowski, DNP, MSN, BSN, RN, USA
Cheryl J Erler, DNP, RN, CNE, USA

Abstract

Purpose: The purpose of this study was to evaluate for improvement in attitudes toward nurse-physician collaboration in nursing and medical students before and after an interprofessional simulation exercise, and again at three months after the intervention to evaluate for sustainment of results.

Background and Research Questions: The need for improved collaboration among healthcare professionals has been identified by both the World Health Organization (WHO, 2010) and the Institute of Medicine (IOM) in the landmark report *To Err is Human* (IOM, 2000). In a follow, up report by the IOM, simulation was identified as one strategy for implementation to improve collaboration and teamwork among healthcare providers (IOM, 2004). High-fidelity interprofessional simulation has been used successfully as an educational intervention to improve collaboration in both academic and professional settings (Klipfel, et al, 2011; Maxson, et al, 2011; Reising, et al, 2011, & Sandahl, et al, 2013). Because the studies in the literature review occurred in a variety of settings, including emergency departments, trauma centers, intensive care units, and universities, a study specifically evaluating changes in attitude of nursing students and medical students toward nurse-physician collaboration, after participating in an interprofessional simulation, was determined to be a positive contribution to the existing body of knowledge in this area. An additional gap was identified in the literature relating to the study of whether or not changes in attitudes or perceptions of nurse-physician collaboration are sustained for a predetermined length of time after completing the interprofessional simulation. The research questions for this study were: 1. Will there be a mean change in attitudes toward nurse-physician collaboration from pre- to post-intervention? 2. Will there be a difference in mean attitude toward nurse-physician collaboration between nursing and medical students? 3. Will there be a mean change in attitudes toward nurse-physician collaboration from pre- to three months' post-intervention?

Methodology/Implementation: A pre-experimental, pretest-posttest design was used to measure changes in attitude toward collaboration. The Jefferson Scale of Attitudes Toward Physician-Nurse Collaboration (JSAPNC) was chosen as the instrument of measurement for the ability to measure attitudes toward nurse-physician collaboration in medical students and nursing students (Liaw, et al, 2014). A high-fidelity simulation exercise was used with five standardized scenarios in a realistic patient care environment. A standardized debriefing session was facilitated by trained faculty members after each scenario. A convenience sample of seventh semester nursing students and third year medical students participated in all five scenarios and debriefing sessions.

Results: A statistically significant improvement in attitudes toward nurse-physician collaboration was found between pre-intervention and post-intervention surveys ($t(130) = -5.569$ with a p-value of .000), with no significant difference found between nursing and medical students at any of the three data collection points (pre-intervention data: $t(129) = .439$, $p=.662$; post-intervention data: $t(21.79) = .610$, $p=.548$; and three-month post-intervention data: $t(8.69) = 1.89$, $p=.092$). Comparison of means from both pre-intervention and post-intervention data collection points to the three-month post-intervention data collection point resulted in statistically significant decreases in the mean JSAPNC. Therefore, it can be concluded that the improvement seen in attitudes toward nurse-physician collaboration immediately after the interprofessional simulation were not sustained over time.

Conclusions and implications: The results of this study provide strong evidence for the use of interprofessional simulation as an educational tool to improve attitudes toward nurse-physician collaboration in nursing and medical students. The strength of the results of this study from pre- to post-intervention, as well as the reliability of implementation to the intervention plan, allows for replication of this high-fidelity interprofessional simulation in similar training environments. However, knowledge gained from this study indicates that an isolated interprofessional simulation exercise is not enough to sustain

collaborative practice. Further studies of repeated interprofessional simulation intervention, as well as interprofessional simulation intervention combined with didactic interprofessional education, are recommended to evaluate sustainment of attitudes toward collaboration.

References

Institute of Medicine. (2000). *To err is human: Building a safer health system*. Kohn, L.T., Corrigan, J.M., & Donaldson, M.S. (Eds.). The National Academy Press: Washington, D.C. Retrieved from http://www.nap.edu/openbook.php?record_id=9728&page=R1

Institute of Medicine. (2004). *Keeping patients safe: Transforming the work environment of nurses.* Page, A. (Ed.). The National Academies Press: Washington, D.C.

Liaw, S.Y., Siau, C., Zhou, W.T., & Lau, T.C. (2014). Interprofessional simulation-based education program: A promising approach for changing stereotypes and improving attitudes toward nurse-physician collaboration. *Applied Nursing Research*, *27*(4), 258-260.

Klipfel, J. M., Gettman, M. T., Johnson, K. M., Olson, M. E., Derscheid, D. J., Maxson, P. M., Vierstraete, H.T. (2011) Using high-fidelity simulation to develop nurse-physician teams. *Journal of Continuing Education in Nursing*, *42*(8), 347-57.

Maxson, P. M., Dozois, E. J., Holubar, S. D., Wrobleski, D. M., Dube, J. A., Klipfel, J. M., & Arnold, J. J. (2011). Enhancing nurse and physician collaboration in clinical decision making through high-fidelity interdisciplinary simulation training. *Mayo Clinic Proceedings*, *86*(1), 31-6.

Reising, D. L., Carr, D. E., Shea, R. A. King, J. M. (2011). Comparison of communication outcomes in traditional versus simulation strategies in nursing and medical students. *Nursing Education Perspectives*, *32*(5), 323-327.

Sandahl, C., Gustafsson, H., Wallin, C. J., Meurling, L., Ovretveit, J., Brommels, M., & Hanson, J. (2013). Simulation team training for improved teamwork in an intensive care unit. *International Journal of Health Care Quality Assurance, 26(2),* 174-88

Wetzel A. (2013). Critical Synthesis Package: Jefferson Scale of Attitudes Toward Physician-Nurse Collaboration. MedEdPORTAL. Available from: www.mededportal.org/publication/9631

World Health Organization (2010). Framework for action on interprofessional education and collaborative practice. Downloaded from http://who.int/hrh/resources/framework_action/en/index.html

Contact

lojcox@iusb.edu

G 02 - Nursing Incivility Interventions

Confronting Nursing Incivility: Educational Intervention for Change

Sharon Kay French, MSN, RN, USA
Ernestine Cuellar, PhD, RN, PMHCNS-BC, USA

Abstract

It is essential for nurses and nursing faculty to increase and implement interventions that decrease incivility within the nursing profession. Incivility is known by a variety of terms, such as workplace and lateral violence, abuse, and bullying, that are all detrimental to nursing (Clark, 2008). Workplace incivility continues to occur at an estimated astronomical cost of $24 billion annually in the U.S and severely impacts professional nursing practice, patient care, and nurses' health and well-being (Andersson, 1999). A key component contributing to and motivating the development of educational strategies is the identification and articulation of learning outcomes. Learning outcomes by the end of this session include the participants' ability 1) to identify and define workplace incivility as well as 2) to recognize and apply that knowledge when encountering discourteous, insolent, and bullying behaviors in both academic and clinical settings. Additionally, 3) participants will discuss the benefits of teamwork and describe strategies for creating positive behavior. Specific objectives related to the purpose of the learning activities will enable participants to apply knowledge for addressing incivility in any environment.

The purpose of this presentation is to examine strategies and interventions for confronting incivility. Topics include an incivility overview discussing causes, consequences, prevention through early detection, and the overall impact to the nursing profession. Educational strategies include communication skills and recommendations for nurses to confront and report uncivil behaviors (Clark, 2009). The discussion addresses conflict resolution, negotiation, assertiveness, personal accountability, patient safety, teamwork, and collaboration. Audience participation will enhance the learning environment.

In the past few years' efforts to address the problem have focused on identifying and defining perpetrators and behaviors that characterize incivility as well providing recommendations for improvement. The Joint Commission zero-tolerance policy and codes of conduct are steps in the right direction that require nursing commitment, promotion, and the enforcement of meaningful evidenced-based interventional solutions (Hoffman & Chunta, 2015). The American Nurses Association also strongly advocates addressing this serious problem among nurses and healthcare workers. Nurses are aware of the issues however there needs to be widespread educational opportunities offered to ensure that nursing faculty and clinicians implement these interventions. One recommendation is that educational interventions become part of the National Council of the States Board of Nursing continuing educational requirements as well as a component of nursing student education.

Although incivility is most common against nursing students, new graduate nurses are the most vulnerable to abusive behavior and leave their jobs within the first two years of employment (D'ambra, & Andrews, 2014). Several studies concluded that faculty could play a pivotal role in examining how students are socialized into the nursing profession by providing the appropriate training and coping skills within the nursing curriculum (Altmiller, 2012). The time has come for nursing educational leadership to confront incivility by changing the status quo with meaningful educational interventions thus preserving the ethical and moral fabric that exemplifies the nursing profession.

Through the adoption of skills such as conflict resolution, problem solving, personal accountability, and respectful communication the participant recognizes positive behavior and addresses negative actions. Ultimately, the participant will be able to employ the benefits of teamwork and positive behavior as part of the solution to incivility.

References

Andersson, L.M & Pearson, C.M. Tit for Tat? The spiraling effect of incivility in the workplace. *Academy of Management Review, 1999*; 24(3): 452-471.

Altmiller, G. (2012). Student perceptions of incivility in nursing education: implications for educators. *Nursing Education Perspectives, (33)*1, 15-20 6P. doi:10.5480/1536-5026-33.1.15.

Clark, C.M. (2008). Faculty and Student assessment and experience with incivility in the workplace. *Academy of Management Review, 1999*:24(3): 452-471.

Clark, C.M. (2009). Faculty Field Guide for Promoting Student Civility in the Classroom. *Nurse Educator, 34(5),* 194-197.

D'ambra, A.M., & Andrews, D. R., (2014). Incivility, retention and new graduate nurses: an integrated review of the literature. *Journal of Nursing Management., 22*(6), 735-742 8p. doi:10.1111/jonm.12060.

Hoffman, R. & Chunta, K. (2015). Workplace incivility: promoting zero tolerance in nursing. *Journal of Radiology Nursing. 34* (4), 222-227.

Contact

s.french@elsevier.com

G 02 - Nursing Incivility Interventions

The Effect of Leadership and Staffing Adequacy on Nurse Coworker Incivility in Hospitals

Jessica G. Smith, PhD, RN, USA
Karen H. Morin, PhD, RN, ANEF, FAAN, USA
Eileen T. Lake, PhD, RN, FAAN, USA

Abstract

Objective: To determine whether nurse co-worker incivility is associated with modifiable features of the hospital nurse work environment, namely nurse staffing adequacy and nurse manager effectiveness.

Background: Favorable nurse staffing and nurse work environments have been linked to better patient and nurse outcomes in multiple large studies using sophisticated quantitative methods (Aiken et al, 2011; Aiken et al, 2014; McHugh et al, 2016; McHugh & Ma, 2014). However, nurse coworker incivility has not previously been studied as an outcome of modifiable features of nurse work environments.

Methods: Donabedian's (1980) structure-process-outcomes conceptual framework was the theoretical basis for this study. Hospital staff registered nurses at 5 hospitals, 3 of which were Magnet recognized, were surveyed. A cross-sectional, correlational design was employed. Linear regression models were estimated to explain the variance in coworker incivility explained by manager effectiveness and staffing adequacy.

Results: The final analytic sample was N = 212 after data cleaning and multiple imputation. Half of the sample were 35 years of age and under. Most participants (76%) held a bachelor degree in nursing. More positive reports of nurse manager leadership were inversely correlated with lesser scores for coworker incivility (b = -.55). More positive reports of nurse staffing and resource adequacy were correlated with lower scores for coworker incivility (b = -.45). In separate linear regression models, reports of nurse manager leadership predicted 15% of the explained variance in coworker incivility (R^2 = .15, p < .01) and reports of nurse staffing adequacy predicted 7.7% of coworker incivility. In a joint regression model, perceptions of nurse manager leadership were inversely correlated (b = -.47) with coworker incivility, while nurse staffing exhibited a weaker but significant effect (b= -.19). All regression results remained stable even while controlling for the nurse's age, years of experience, and educational level.

Conclusions: Inadequate nurse staffing and ineffective nurse manager leadership undermine civility among nurse coworkers. Measures should be taken to monitor, evaluate, and address nurse manager leadership deficits and nurse staffing and resources as part of an effort to reduce coworker incivility among registered nurses. Evidence-based strategies to improve nurse manager leadership skills are needed and research efforts should address this topic.

References

American Association of Critical Care Nurses (2015). AACN standards for establishing and sustaining healthy workplace environments: A journey to excellence, 2nd, ed. Retrieved from http://www.aacn.org/wd/hwe/docs/hwestandards.pdf

Aiken, L. H., Sloane, D.M, Cimiotti, J. P, Clarke, S. P., Flynn, L, Seago, J. A. et al. (2010). Implications of the California nurse staffing mandate for other states. Health Services Research, 45(4), 904-921.

Aiken, L. H., Sloane, D. M., Clarke, S. Poghosyan, P., Cho, B., You, L., Finlayson, M., Kanai Pak, M., & Aungsuroch, Y. (2011). Importance of work environments on hospital outcomes in nine countries. International Journal of Quality Health Care.

Aiken, L. H., Sloane, D. M., Bruynell, L, Van den Heeded, K., Griffiths, P., Busse, R., et al. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. Lancet, 383(9931), 1824-1830.

American Nurses Association. (2015). American Nurses Association Position Statement on Incivility, Bullying, and Workplace Violence. Retrieved from http://www.nursingworld.org/bullying-workplace-violence

Cortina, L. M., Magley, V. J., Williams, J. H., & Langhout, R. D. (2001). Incivility in the workplace: Incidence and impact. Journal of Occupational Health Psychology, 6(1), 64-80.

Donabedian, A. (1980). Explorations in quality assessment and monitoring: The definition of quality and approaches to its assessment. Ann Arbor, MI: Health Administration Press.

Donabedian, A. (2003). An introduction to quality assurance in health care. Oxford University Press.

Duffield, C. M., Roche, M. A., Blay, N., & Stasa, H. (2010). Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing, 20,* 23-33.

Lake, E. T. (2002). Development of the practice environment scale of the nursing work index. Research in Nursing & Health, 25(3), 176-188.

Laschinger, H. K. (2014). Impact of workplace mistreatment on patient safety risk and nurse assessed patient outcomes. Journal of Nursing Administration, 44(5), 284-290.

Laschinger, H.K., Wong, C. A., & Grau, A. L. (2012). The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout, and retention outcomes: A cross-sectional study. International Journal of Nursing Studies, 49(10), 1266-1276.

Leiter, M. P., Laschinger, H. K., Day, A., & Oore, D. G. (2011). The impact of civility interventions on employee social behavior, distress, and attitudes. Journal of Applied Psychology, 96(6), 1258-1274

Lewis, P. & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. Journal of Nursing Administration, 41(7-8), S17-23.

Manning, J. (2016). The influence of nurse manager leadership style on staff nurse work engagement. Journal of Nursing Administration. E-published ahead of print.

McHugh, M. D., Brooks Carthon, M., Sloane, D. M., Wu, E., Kelly, L., & Aiken, L. H. (2012). Impact of nurse staffing mandates on safety-net hospitals: Lessons from California. Milbank Q, 90(1), 160-186.

McHugh, M. D., Rochman, M. F., Sloane, D. M., Berg, R. A., Mancini, M. E. Nadkarni, V. M. et al. (2016). Better nurse staffing and nurse work environments associated with increased survival of in-hospital cardiac arrest patients. Medical Care, 54(1), 74-80.

McHugh, M. D. & Ma, C. (2014). Wage, work environment, and staffing: Effects on nurse outcomes. Policy, Politics, & Nursing Practice, 15(3-4), 72-80.

Oyeleye, O., Hanson, P., O'Connor, N., & Dunn, D. (2013). Relationship of workplace incivility, stress, and burnout on nurses' turnover intentions and psychological empowerment. Journal of Nursing Administration, 43(10), 536-542.

Contact

smje@nursing.upenn.edu

G 03 - Organizational Change to Promote Healthy Work Environments

G 03 - Organizational Change to Promote Healthy Work Environments

Positive Practice Environment: A COO/CNO's Testimony

Maricon Dans, MSN, RN, USA

Abstract

ANCC's Pathway to Excellence Program provides a blueprint to help hospitals and health care systems create a workplace that supports a culture of excellence leading to quality improvements. Increasingly, chief nursing officers (CNOs) at Pathway-designated organizations are validating how creating healthy work environments has strengthened engagement in their own settings. When Broward Health Imperial Point (BHIP) nursing leaders sought new ways to deliver high-quality, cost-effective care in a rapidly changing environment, they turned to ANCC's Pathway to Excellence Program as a blueprint. BHIP embarked on the Pathway journey to:

- build and strengthen workplace dynamics,
- implement a successful shared governance structure,
- improve multidisciplinary practice, and
- help patients achieve optimal health and wellness.

In addition, leaders wanted external recognition of nurses' extraordinary care and positive impact on patients and peers. The Pathway journey brought BHIP's nursing practice environment to a new level and led to marked improvements in several nursing measures and outcomes. Nurse-directed performance improvement teams applied evidence-based practice changes that helped the hospital achieve the following quality outcomes:

- A 40% decrease in patient falls in two years
- A 36% reduction in CAUTI rates in one year
- A 33% reduction in CLABSIs in one year, with a projected annualized rate of 60% fewer CLABSIs through 2016
- Zero CLABSIs in the ICU for more than 18 months
- Zero HAPU, CAP, and post-op VTE for more than two years
- Significant improvement in engagement scores.

Pathway-driven changes to BHIP's shared governance structure lie at the root of these improvements. What began as a group of unit-based nursing and governing councils evolved into multidisciplinary clinical councils that include representatives from every department in the hospital. Interprofessional teamwork thrived and all of BHIP's 840 employees felt empowered and engaged. In the 2015 survey, employees gave especially high marks on decision-making, resources, teamwork, and communication. BHIP's healthy work environment helped BHIP achieve noteworthy outcomes. The hospital now exceeds national quality and safety benchmarks, with marked improvements in falls and CAUTI, CLABSI, and HAPU rates, to name a few.

References

Leiter, M. P. & Laschinger, H. K. (2006). Relationships of work and practice environment to professional burnout: Testing a causal model. *Nursing Research,* 55(2), 137–146.

Siu, H., Laschinger, H. K., & Finegan, J. (2008). Nursing professional practice environments: Setting the stage for constructive conflict resolution and work effectiveness. *Journal of Nursing Administration,* 38(5), 250–257.

Tourangeau, A. E., & Cranley, L. A. (2006). Nurse intention to remain employed: Understanding and strengthening determinants. *Journal of Advanced Nursing,* 55(4), 497–509.

Contact

Maricon.Dans@ana.org

G 03 - Organizational Change to Promote Healthy Work Environments

The Relationship Among Change Fatigue, Resilience, and Job Satisfaction of Hospital Staff Nurses

Robin J. Brown, PhD, RN, USA

Abstract

Health care is typified by change. Organizational changes have a negative impact on nurses and the effects of organizational change is being overlooked and under researched (Delmatoff & Lazarus, 2014; McMillian & Perron, 2013). Change in an organization leads to increased sick time, work disability, loss of productivity, organizational commitment, increased turnover rates (Bernerth, Walker, & Harris, 2011), stress (McMillian & Perron, 2013), emotional exhaustion (Manzano Garcio & Ayale Calvo, 2012), and change fatigue (Bernerth et al., 2011; McMillan & Perron, 2013). Change fatigue is a result of constant organizational change and has not been researched with nurses. Majority of the research on organizational change is associated with change resistance. Differences exist between change fatigue and change resistance. Resistant behaviors are intentional actions, but change fatigue is when staff become disengaged, apathetic, and passive about the changes. Because of these passive behaviors, change fatigue is unnoticed by nurse managers and under researched (McMillian & Perron, 2013).

Resilience is a personal quality that enables one to thrive in the face of adversity, such as with organizational change. Resilient nurses are better able to cope with stress and have lower levels of emotional exhaustion (Manzano Garcia & Ayala Calvo, 2012). Resilience reduces the risk of burnout, improves the retention and mental health of nurses (Shin, Taylor, & Seo, 2012), and has a positive correlation to years of work experience (Lee et al., 2015).

A study was conducted to determine if hospital staff nurses experience change fatigue and if there are differences in levels of change fatigue of novice an experienced hospital staff nurses. The Transactional Model of Stress and Coping developed by Lazarus and Folkman (1984) was used as the theoretical framework. The model proposes that stressors and ways individuals cope with stress need to be considered jointly in explaining the stress and coping process because they are interdependent. Organizational change is a frequent stressor experienced by nurses that causes stress, a decrease in job satisfaction, and change fatigue. Resilience is personal quality that can be used to adapt to the stress of organizational change.

The study assessed the relationship among change fatigue, resilience, and job satisfaction of hospital staff nurses. Participants completed an online survey, using three tools: Change Fatigue Scale, Connor-Davidson Resilience Scale (CD-RISC), and McCloskey/Mueller Satisfaction Scale (MMSS). The participants were 535 staff nurses employed in a rural or urban hospital. The study reported a significant difference between novice and experienced staff nurses in change fatigue (t= -2.9, p = .003), resilience (t= -2.3, p = .01), and job satisfaction (t = -2.0, p = .04). Experienced nurses had higher change fatigue, resilience, and job satisfaction. The study also reported a significant negative association between change fatigue and job satisfaction (r = -.295, p = .000) and change fatigue and resilience (r = -.145, p =.002). A significant positive association was found between resilience and job satisfaction (r = .251, p = .000). Multiple regression found education, gender, and hospital size are predictor variables of change fatigue. Linear trend found as size of facility and number of beds increases, change fatigue increases and as educational level increases, change fatigue decreases.

References

Bernerth, J., Walker, H. & Harris, S. (2011). Change fatigue: Development and initial validation of a new measure. *Work & Stress, 25*(4), 321-337.

Delmatiff, J & Lazarus, I. R. (2014). The most effective leadership style for the new landscape of healthcare. *Journal of Healthcare Management, 59*(4), 245-249.

Manzano Garcia, G. & Ayala Calvo, J. C. (2012). Emotional exhaustion of nursing staff: Influence of emotional annoyance and resilience. *International Nursing Review, 59*, 101-107.

McMillan K. & Perron, A. (2013). Nurses amidst change: The concept of change fatigue offers an alternative perspective on organization change. *Policy, Politics, & Nursing Practice, 14*(1), 26-32. doi: 10.1177/1527154413481811

Lazarus, R.S & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.

Lee, K. J., Forbes, M. L., Lukasiewicz, G. J., Williams, T., Sheets, A., Fischer, K., & Niedner, M. F. (2015). Promoting staff resilience in the pediatric intensive care unit. *American Journal of Critical Care, 24*(5), 422-430. doi: http//dx.doi.org?10.4037?ajcc2016720

Shin, J., Tayklor, M. S., Seo, M. (2012). Resources for change: The relationships of organizational inducements and psychological resilience to employees' attitudes and behaviors toward organizational change. *Academy of Management Journal, 53*(3), 727-748.

Contact

robin.brown@sdstate.edu

G 04 - Patient Safety and Errors Reported

G 04 - Patient Safety: Fall Prevention

A Multi-Center Study for the Psychometric Testing of the Humpty Dumpty Inpatient Scale

Deborah Hill-Rodgriguez, MSN, PCNS-BC, ARNP, USA
Jacqueline Gonzalez, DNP, MBA, ARNP, NEA-BC, FAAN, USA
L. M. Hernandez, DNP, ARNP, CPN, FNP-C, USA
Jennifer Cordo, MSN, ARNP, NE-BC, USA

Abstract

According Hill-Rodriguez, et al (2009), the Humpty Dumpty Falls Prevention Program™ was developed out of a need to identify pediatric patients at risk for their potential to have a fall event. An inter-professional team of nursing, risk and rehabilitation specialists came together to review the then current fall risk identification scales and literature. Most of the literature was focused on scales substantiated in the adult population. Due to the limitation of scales and published findings relating to pediatrics, the team developed the comprehensive Humpty Dumpty Falls Prevention Program™. The scales and corresponding program were developed based on commonalities of 200 pediatric fall events and best practices. Consisting of risk identification scales for three settings, high risk fall identification practices, and educational content to partner with parents, the program began in 2005 and has since become the most globally recognized pediatric fall risk identification program. The program assists care givers in identifying patients at risk for fall events in all 50 states and throughout the world in over a dozen countries, impacting the safety of pediatric patients worldwide.

Because falls can result in serious sequalae for pediatric patients, a six-year multi-site study was embarked upon to examine the reliability, validity, specificity and sensitivity of the Humpty Dumpty Fall Inpatient Scale™. The study period was from 2010-2015. A retrospective, cross sectional design was used to assess the psychometric characteristics of the Humpty Dumpty Fall Inpatient Scale™ for patients who fell and a comparable group of patients who did not fall. Seventeen participating institutions, both national and international, enrolled who are using the Humpty Dumpty Fall Inpatient Scale™.

The purpose of the six-year multisite study was to establish reliability of the Humpty Dumpty Fall Inpatient Scale™, determine the validity of the Humpty Dumpty Fall Inpatient Scale™, analyze the specificity and sensitivity of the Humpty Dumpty Fall Inpatient Scale™, and identify the unique characteristics of individuals classified as true positives (i.e., identified as high risk and experienced a fall) and false negatives (i.e., identified as low risk and experienced a fall). The age range of the population studied was 0-21 years of age.

A retrospective, cross-sectional design was used to assess the psychometric characteristics of the Humpty Dumpty Inpatient Fall Scale™ scores from “actual fall” patients and control patients will be derived from hospital records of patients utilizing the Humpty Dumpty Falls Inpatient Scale™. The “actual fall” sample was identified through medical record numbers via the Risk Management Department. The normal control patients were identified through medical record numbers from the Patient Admissions list for the specified time frame and randomized via computerization. At the time of chart review, all data was de-identified. Humpty Dumpty Fall Inpatient Scale™ scores of all patients who actually fell and a comparable control group who did not fall were reviewed and entered into a password protected online database from 2010 to 2015.

Recruitment consisted of institutions such as hospitals or any other type of institution with an inpatient pediatric unit. These institutions used the Humpty Dumpty Fall Inpatient Scale™ scores of all patients who actually fell and the scores of the normal control group that met inclusion criteria were included; regardless, of the patient race, ethnic group, gender, understanding of country language, or socioeconomic status. Data was collected on the seven domains of the Humpty Dumpty Fall Inpatient Scale™ from the participating institutions.

Findings of the study revealed reliability and validity of the Humpty Dumpty Fall Inpatient Scale ™. Analysis of the individual scale parameters reveal significance in rating criteria for the identification of

patients at risk for falls. As a result of the research findings, subsequent research is recommended to further refine the parameters within this inpatient scale.

References

American Nurses Credentialing Center. (2014). *Magnet recognition program application manual.* Silver Spring, MD: Author.

Catalano, K. (2005). Update on the National Patient Safety Goals – Changes for 2005. *AORN Journal, 81*(2), 335-341.

Child Health Corporation of America (CHCA), Nursing Falls Study Task Force. (2009). Pediatric falls: State of the science. *Pediatric Nursing, 35*(4), 227-231.

Graf, E. (2005a). Examining inpatient pediatric falls: Understanding the reasons and finding the solutions. *Joint Perspectives on Patient Safety, 5*(9), 5-6.

Graf, E. (2005b, November). Pediatric hospital falls: Development of a predictor model to guide pediatric clinical practice. Paper presented at the 38th STTI Biennial Convention, Indianapolis, IN.

Graf, E. (2011). Magnet children's hospitals: Leading knowledge development and quality standards for inpatient pediatric fall prevention programs. *Journal of Pediatric Nursing, 26*(2), 122-127.

Harvey, K., Kramlich, D., Chapman, J., Parker, J., & Blades, E. (2010). Exploring and evaluating five paediatric falls assessment instruments and injury risk indicators: An ambispective study in a tertiary care setting. *Journal of Nursing Management, 18*(5), 531-541.

Hill-Rodriguez, D., Messmer, P. R., Williams, P. D., Zeller, R. A., Williams, A. R., Wood, M., et al. (2009). The humpty dumpty falls scale: A case-control study. *Journal for Specialists in Pediatric Nursing: JSPN, 14*(1), 22-32.

Kingston, F., Bryant, T., & Speer, K. (2010). Pediatric falls benchmarking collaborative. *The Journal of Nursing Administration, 40*(6), 287-292.

Lacey, S., Smith, J.B., & Cox, K. (2008). Chapter 15: Pediatric safety and quality. In: R.G.

Hughes (ed.). Patient safety and quality: An evidence-based handbook for nurses. Rockville, MD: Agency for Healthcare Research and Quality.

National Database of Nursing Quality Indicators. (2014). Guidelines for data collection on the American Nurses Association's National Quality Forum endorsed measures. Kansas City, KS: University of Kansas Medical Center.

Neiman, J. & Rannie, M. (2009). I'm safe: development of a fall prevention program to enhance quality and patient safety. 8th Annual Forum NICHQ Conference, Grapevine, Texas.

Razmus, I., Wilson, D., Smith, R., & Newman, E. (2006). Falls in hospitalized children. *Pediatric Nursing, 32*(6), 568-572.

Schaffer, P. L., Daraiseh, N. M., Daum, L., Mendez, E., Lin, L., & Huth, M. M. (2012). Pediatric inpatient falls and injuries: A descriptive analysis of risk factors. *Journal for Specialists in Pediatric Nursing: JSPN, 17*(1), 10-18.

The Joint Commission. (2005). Examining inpatient pediatric falls: understanding the reasons and finding the solutions. *Jt Comm Perspect, 5*, 5-6.

Contact

deborah.hill@mch.com

G 05 - Skilled Communications for the Academic Setting

Working Together to Create a Respectful, Trusting, and Healthy Workplace for Faculty, Staff, and Students

Joanne K. Olson, PhD, RN, FAAN, Canada
Joanne Profetto-McGrath, PhD, MEd, RN, Canada

Abstract

A healthy workplace is vital to the recruitment, retention, and success of any academic and practice organization. We also believe as do others that "*Psychologically unhealthy work environments lead to higher levels of absenteeism, sick-leave usage, short-and long-term disability claims and turnover*." (Cavanaugh, 2014, p. 31). The purpose of this presentation is to describe the establishment of a healthy workplace committee (HWC) whose goal is to cultivate a culture that supports rewarding and healthy work and learning experiences for all faculty members, staff and students. In addition we aim to discuss the initiatives that were undertaken to create a healthier work environment. These initiatives coincided with the beginning a new Dean's term and the strategic plan which includes a healthy workplace focus as one of its priorities. The first step was to conduct an online anonymous survey to collect baseline information about various aspects of the work environment. The quantitative section of the survey included 35 questions which were completed using a scale with strongly agree to strongly disagree on a variety of items such as levels of job satisfaction, communication from the leadership team, respectful interactions, exposure to hostility, isolation or conflict, and balance between family and work life. The qualitative aspect of the survey provided participants with the opportunity to respond to questions such as: *What do you value about the Faculty of Nursing Workplace environment? What currently contributes to a healthy workplace for you? If the Faculty could work on two key areas to enhance a healthy workplace environment what would you recommend as top priorities?* The data from the survey revealed that faculty valued working relationships with their colleagues, and that respect and trust are important values. In response, the HWC began its work by focusing on establishing policies around behaviors and practices that support a respectful and trusting workplace. A follow-up survey was conducted two years later to determine the effectiveness of the policies and practices implemented as a result of the first survey. The work is ongoing and the ad hoc committee has become a permanent standing committee within the Faculty with representative from faculty, staff and the student body. As well, members of the committee now link with the University wellness program which includes faculty, staff and students from across the University.

References

Cavanaugh, S. (2014). Improving psychological health in the workplace. *The Canadian Nurse*, *10*(3), 31-33.

Lowe, G. (2011). *Creating Healthy Organizations,* Toronto, ON: Rotman/UTP Publishing.

Contact

joanne.olson@ualberta.ca

G 05 - Skilled Communications for the Academic Setting

Crucial Conversations in Nursing Academics: Practical Strategies

April L. Folgert, PhD, RN, USA

Abstract

The literature is replete with evidence supporting the presence of incivility, lateral violence, and bullying in nursing (Nikstaitis & Coletta, 2014; Warrner, Sommers, Zappa, and Thernlow, 2016). Most studies have focused on incivility between nurses in the inpatient setting. The prevalence of incivility among nurse academicians has only been recently studied. In 2009, Clark, Farnsworth, and Landrum developed the first known empirical instrument to measure incivility in nursing education, which was revised by Clark, Barbosa-Leiker, Gill, and Nguyen (2015).

A qualitative study by Peters (2014) revealed that nursing faculty who had been teaching for five or more years had experienced faculty-to-faculty incivility including sensing that colleagues wanted them to fail, perceived possessiveness from experienced faculty, sensing a power struggle within the department of nursing and feeling that senior faculty felt threatened by novice nursing faculty.

Burger, Kramlich, Malitas, Page-Curtrar, and Witfield-Harris (2014) suggest that the bioethical theory symphonology can help faculty facilitate difficult conversations and focus on areas where this is fundamental agreement within the context of nursing education.

While research has found incivility to be present between nurses in bedside practice and academics, strategies to address the effectiveness of strategies that decrease incivility need to be studied.

Effective communication has consistently been a strategy used across professions to create a healthy work environment (Shanta & Eliason, 2014). Major, Abderrahman, and Sweeney (2013) suggested nurses engage in crucial conversations with co-workers and decrease lateral violence. The framework suggested stems from Patterson, Grenny, McMillan, and Switzler (2002) book titled *Crucial Conversations*.

This presentation will hone in on the assumptions that lead to chaos versus dialogue, the benefits of dialogue in the workplace despite positions of authority, and how to apply practical strategies based on Patterson, Grenny, McMillan, and Switzer's (2002) book, *Crucial Conversations,* to build and maintain communication in academia. Research on the effectiveness of this strategy in nursing academics is needed.

References

Altmiller, G. (2012). Students perceptions of incivility in nursing education: Implications for nurse educators. *Nursing Education Perspectives, 33*(1), 15-20. Retrieved from http://www.nln.org/newsroom/newsletters-and-journal/nursing-education-perspectives-journal

Burger, K. G., Kramlich, D., Malitas, M; Page-Cutrara, K., & Whitfiled, Harris, L. (2014). Application of the symphonological approach to faculty-to-faculty incivility in nursing education. *Journal of Nursing Education, 53*(10), 563-568. doi: 10.3928/01484834-2010922-02

Clark, C. M., Barbosa-Leiker, C., Gill, L. M., & Nguyen, D. (2015). Revision and psychometric testing of the incivility in nursing education (INE) survey: Introducing the INE-R. *Journal of Nursing Education, 54*(6), 306-315. doi:10.3928/01484834-20150515-01

Major, K., Abderrahman, E. A., & Sweeney, J. I. (2013). Crucial conversations in the workplace: Offering nurses a framework for discussing and resolving, incidents of lateral violence. *American Journal of Nursing, 113*(4), 66-70. Retrieved from http://ajonline.com

Nikstaitis, T., & Coletta, L. S. (2014). Incivility among intensive care nurses. *Dimensions of Crucial Care Nursing, 33*(5), 293-301. Retrieved from http://journals.lww.com/dccnjournal/Pages/default.aspx

Peters, A. B. (2014). Faculty to faculty incivility: Experience of novice nurse faculty in academia. *Journal of Professional Nursing, 30*(3), 213-227. doi:10.1016/j.profnurs.2013.09.007

Warrner, J., Sommers, K., Zappa, M., & Thornlow, D. K. (2016). Decreasing workplace incivility. *Nursing Management, 47*(1), 22-30. doi:10.1097/01.NUMA.0000476622.91398.c3

Contact
alfolgert@gmail.com

H 01 - Patient Safety Culture in Magnet and Non-Magnet Hospitals in United States

H 01 - Supporting the Strength of Nurses

Critical Conversations with New Nurses

Susan Forneris, PhD, RN, CNE, CHSE-A, USA
Molly E. Kellgren, MSN, RN, CNE, CHSE, USA

Abstract

New nurses require well developed clinical reasoning skills in order to deliver safe, effective, and compassionate care. Preparing nursing students for practice, and guiding the new graduate nurse through the transition to practice demands that academic and practice-based educators use transformative strategies to develop clinical reasoning skills. A key partner in both settings is the preceptor/clinical coach. The National League for Nursing (NLN) and the International Nursing Association for Clinical Simulation and Learning (INACSL) believe that debriefing techniques hold great promise in coaching novice nurses in today's health care system (NLN, 2015). Debriefing is integral to achieving effective learning outcomes through simulation. Reflection, at the core of debriefing, is central to being critical, i.e., the ability to examine information to see the whole of reality (Freire, 1970/2000). It is a process of assessing what is relevant and determining the reasons for our actions. Nonetheless, the NLN maintains that debriefing techniques are not confined to simulation experiences (NLN, 2015). Coaching our new nurses as they enter practice requires a thoughtful approach wherein preceptors and learners question and reorder how they think, act and understand. Debriefing in the form of an interactive conversation, has the potential to transform not only nursing education but our practice environments. The NLN has developed a *Guide to Teaching Thinking* that outlines the necessary components for engaging critical conversations (Forneris and Fey, 2016). This workshop will begin with highlighting the known areas of risk as we transition students through nursing coursework into professional practice. Using the *NLN Guide to Teaching Thinking,* the workshop focus turns to developing the necessary foundational skills needed to engage in critical and supportive conversations. Strategies to guide preceptors in the identification of learning needs and development of clinical reasoning will be explored. Through the use of simulation and debriefing, participants will examine target gaps and how the coaching strategies are applied.

References

Forneris, S. and Fey, M. (in press) The NLN guide to teaching thinking. *Nursing Education Perspectives*

Freire, P. (2000). Pedagogy of the oppressed (30th anniversary ed., M. B. Ramos, Trans.). New York, NY: Continuum International Publishing Group. (Original work published 1970)

National League for Nursing (2015). Debriefing across the curriculum. Retrieved from: http://www.nln.org/docs/default-source/about/nln-vision-series-(position-statements)/nln-vision-debriefing-across-the-curriculum.pdf?sfvrsn=0

Contact

sforneris@nln.org

H 02 - Psychological Safety: A Healthy Work Environment Characteristic in a High Reliability Organization Culture of Resilience

Psychological Safety: A Healthy Work Environment Characteristic in a High Reliability Organization Culture of Resilience

Cynthia A. Oster, PhD, MBA, ANP, ACNS-BC, CNS-BC, USA
Jane Braaten, PhD, MS, RN, USA

Abstract

Background/Significance: It is estimated 400,000 people die each year due to healthcare error (James, 2014). One strategy to reducing harm has been to institute high reliability into healthcare. High reliability science is the study of "organizations in industries like commercial aviation and nuclear power that operate under hazardous conditions while maintaining safety levels that are better than in healthcare" (Chassin and Loeb, 2013). High reliability organizations (HROs) are organizations that are high-risk, dynamic, turbulent, and potentially hazardous, yet operate nearly error-free (Weick and Sutcliffe, 2007). HROs stay error-free by recognizing that small things that go wrong are often early warning signs of trouble (preoccupation with failure); recognizing that these warning signs are red flags that provide insight into the health of the whole system (reluctance to simplify); valuing near misses as indicators of early trouble and acting on them to prevent future failure (sensitivity to operations); being innovative and creative and valuing input from all corners of the organization (deference to expertise); and recognizing the value of preparing for the unexpected and the unknown, as failures rarely occur if they are expected (commitment to resilience). Becoming a HRO is now a leadership mandate from hospital boards and top executive leaders; however, HRO development must permeate the entire organization. HROs have demonstrated success in minimizing errors by creating mindful environments where employees are trained to look for and report small problems that could lead to big ones. HROs view small errors and close calls as learning opportunities; correct them and share details about them across the organization (Chassin, 2012; Shabot, 2015).

A healthy work environment (HWE) is required for high reliability. The 2004 IOM report, Keeping Patients Safe: Transforming the Work Environment of Nurses, emphasized the dominant role of the work environment within health care organizations and the importance of the work environment in which nurses provide care to patients. A HWE is one that is safe, empowering, and satisfying. HWEs are settings with policies, procedures, and processes designed to empower nurses to meet the organizational objectives and achieve personal satisfaction (Huddleston & Gray, 2016a). It is not merely the absence of real and perceived threats to health, but a place of "physical, mental, and social well-being," supporting optimal health and safety (ANA, 2016). A HWE includes appropriate staffing, authentic leadership, effective decision making, meaningful recognition, skilled communication and true collaboration (AACN, 2005). Huddleston and Gray (2016b) recommend the addition of two new characteristics: genuine teamwork and physical and psychological safety. Psychological safety means ensuring that no one is penalized if they ask for help or admit a mistake and they can openly disagree without fear of ridicule or punishment (Edmondson, 2008; Edmondson, 2016). Psychological safety is crucial in organizations where knowledge constantly changes, where workers need to collaborate, and where those workers must make decisions without management or leadership intervention (Edmondson & Lei, 2014).

A culture of safety and resilience is paramount in a HRO. All leaders, managers, health care workers, and ancillary staff have a responsibility as part of the patient centered team to perform with a sense of professionalism, accountability, transparency, involvement, efficiency, and effectiveness. All must be mindful of the health and safety for both the patient and the health care worker in any setting providing health care, providing a sense of physical and psychological safety, respect, and empowerment to and for all persons (ANA, 2016). HROs must adopt a fundamental HWE approach in how they communicate and how individuals interact. Organizational leaders must ensure there is a free flow of information; a safe environment in which to speak up and respectful interactions (Chassin, 2012; Chassin & Loeb, 2013; DuPree, 2013). Organizations require resiliency to achieve high reliability. A resilient organization maintains a high level of performance despite mounting pressures, threats and uncertainties, and is able to withstand disruption and recuperate while resuming operations (Boin & Van Eeten, 2013). When

employees feel psychologically safe, meaning staff is empowered to have a voice without being retaliated against; they will be more likely to report concerns and near misses. Therefore, patient safety and quality outcomes improve in every day clinical practice.

Purpose: The purpose of this presentation is to describe how psychological safety in the work environment at two acute care facilities contributed to the facilitation and sustainment of a culture of safety and organizational resilience driving clinical outcomes.

Scope: The scope of this project encompasses two acute care hospitals; a 50-bed community hospital and a 350-bed quaternary hospital with specialty service lines. It includes 650 clinical nurses, advanced practice nurses and nursing leadership across the spectrum of care including outpatient and ambulatory settings.

Methods: Leadership commitment to psychological safety serves as the paradigm for two organizations to be resilient, maintain gains and sustain the success of high reliability. In 2002 Dr. Amy Edmondson, a Harvard business professor expert on psychological safety in the workplace, published a seminal work describing psychological safety. Psychological safety describes individuals' perceptions about the consequences of interpersonal risks in their work environment. It consists of taken-for-granted beliefs about how others will respond when one puts oneself on the line, such as by asking a question, seeking feedback, reporting a mistake, or proposing a new idea. Nurse leaders play an important role in creating cultures that are psychologically safe. The commitment of leaders to a transformational style of leadership in order to facilitate psychological safety is essential in a resilient, learning and highly reliable organization. Transformational leaders transform organizations by motivating followers to transcend their own self-interest to improve performance though organizational learning and innovation (Grant 2012; Garcia-Morales, Jimenez-Barrionuevo, and Gutierrez-Gutierrez, 2012). Leaders within the organizations facilitate psychological safety by developing and reinforcing civility, respect, support, professionalism and accountability. Leaders insist on civility for all interactions (Blouin, 2013). Respect is the cultural norm; thereby employees are more likely to communicate with the greater team (Sutcliffe, 2011). The use of supportive language towards others is an expectation as is professionalism with accountability. Alignment of senior leadership, managers and front-line nursing staff in a psychologically safe work environment is crucial for an organization to be resilient, maintain gains and sustain the success of high reliability

The five principles of HROs served as a guiding framework or methodology to embed safety practices into two organizations with a culture of psychological safety. HRO principles (Deference to expertise, Preoccupation with failure, Sensitivity to operations, Reluctance to simplify, and Commitment to resilience) are woven into the fabric of one small and one moderate-sized healthcare organization through distinctive intervention strategies. Implementation of HRO principles into 15-minute daily safety huddles enhanced an existing Just Culture environment. Partnerships translated HRO principles into clinical practice and evaluated operationalization. Resource investment led to real-time data, analysis, feedback, technology supporting low-variation practice, and rewards/recognition promoting transparency. Leaders role model their commitment to a culture of psychological safety. HRO principle integration: Deference to expertise correctly migrated responsibility from formal executive authority to experiential competency-based decision-making; Preoccupation with failure sensitized associates to be alert to small indicators before crisis situations developed and increased near miss reporting; Sensitivity to operations cultivated situational awareness; Reluctance to simplify drove drill-down enhancing learning and practice; Commitment to resilience was strengthened through TeamSTEPPS applications which led to heightened individual and organizational resilience.

Outcomes: Perception of psychological safety improved from 66% to 74% of staff feeling free to speak up if they see something that may negatively affect patient care on the AHRQ Hospital Survey on Patient Safety Culture. Vigilance drove detection analysis and constant surveillance. Increased near miss and self-reporting demonstrate enhanced organizational transparency and professional accountability. Between 2013 and 2016, preventable harm incidents decreased 33% while patient volume and case mix index increased. Nurse sensitive indicator outcomes consistently meet or exceed national benchmarks. The 350-bed hospital reports 30% reduction in falls with injury; HAPUs stage 2+ below benchmark the majority of the time in all units; CLABSI-free in all units for greater than 3 years; and CAUTI 70% reduction in the last four fiscal years. The 50-bed hospital reports 1 year without a fall with injury and fall-free for 55 days; HAPUs stage 2+ decreased; CLABSI free 4 months; and CAUTI-free 6 months.

Implications for Practice: Nurse leaders play an important role in creating organizational cultures that are psychologically safe for staff to question practices, report problems or propose new ideas. Resilient organizations have high reliability, maintain a high level of performance and have a psychologically safe work environment. HRO principles translate to the point of care, apply to hospital environments of any size, and can be utilized effectively in every patient encounter to drive positive quality outcomes. Comprehensive integration of HRO principles results in exemplification of nursing staff understanding that their actions contribute to organizational quality and safety. A culture of safety encourages open discussion of tough issues, tolerance of disagreement, and nurtures contrasting points of view. Making this cultural shift is crucial to organizational resilience and proactive adverse event management.

References

American Association of Critical Care Nurses. (2016). AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence, 2nd Edition. Retrieved from http://www.aacn.org/WD/HWE/Content/hwehome.content?menu=hwe

American Nurses Association. (2016). Healthy work environment. Retrieved from http://www.nursingworld.org/MainMenuCategories/WorkplaceSafety/Healthy-Work-Environment

Blouin, A. S. (2013). High reliability: truly achieving healthcare quality and safety. *Frontiers of Health Services Management, 29*(3), 35-40.

Boin, A., & Van Eeten, M. G. (2013). The resilient organization. *Public Management Review*, *15*(3), 429-445.

Chassin, M.R. (2012). Health care and high reliability: a cautionary tale. 2012 5th International HRO conference. Chicago, IL.

Chassin, M.R. & Loeb, J.M. (2013). High-reliability health care: Getting there from here. *The Joint Commission.* Retrieved from http://www.jointcommission.org .

DuPree, E.S. (2014). The high reliability journey at your healthcare organization. *Hospital Executive Briefing.* The Joint Commission. Retrieved from http://www.jointcommission.org .

Edmondson, A. C. (2002). *Managing the risk of learning: Psychological safety in work teams*. Division of Research, Harvard Business School.

Edmondson, A. (2008). The competitive imperative of learning. *Harvard Business Review*, *86*(7-8), 52-59

Edmondson, A. (2016). Wicked-problem solvers, lessons from successful cross-industry teams. *Harvard Business Review*, *94*(6), 52-59.

Edmondson, A. & Lei, Z. (2014). Psychological safety: the history, renaissance, and future of an interpersonal construct. *Annual Review of Organizational Psychology and Organizational Behavior*, *1*, 23-43.

Garcia-Morales, V. J., Jimenez-Barrionuevo, M. M., & Gutierrez-Gutierrez, L. (2012). Transformational leadership influence on organizational performance through organizational learning and innovation. *Journal of Business Research, 65*, 1040-1050.

Grant, A.M. (2012). Leading with meaning: beneficiary contact, prosocial impact, and the performance effects of transformational leadership. *Academy of Management Journal, 55*(2), 458-476.

Huddleston, P. & Gray, J. (2016a). Measuring nurse leaders' and direct care nurses' perceptions of a healthy work environment in an acute care setting, Part 1. *Journal of Nursing Administration*, *46*(7/8), 373-378.

Huddleston, P. & Gray, J. (2016b). Describing nurse leaders' and direct care nurses' perceptions of a healthy work environment in acute care settings, Part 2. *Journal of Nursing Administration*, *46*(9), 462-467.

Institute of Medicine. *Keeping patients safe: transforming the work environment of nurses*. Washington, DC: National Academy Press; 2004.

James, J. T. (2014). A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety*, *9*(3), 122-128.

Shabot, M. M., Monroe, D., Inurrie, J., Garbade, D., & France, A. C. (2013). Memorial hermann: high reliability from board to bedside. *The Joint Commission Journal on Quality and Patient Safety, 39*(6), 253-257.

Sutcliffe, K. M. (2011). High reliability organizations (HROs). *Best Practice & Research Clinical Anaesthesiology*, *25*, 133 -144.

Weick K, & Sutcliffe K. (2007). *Managing the unexpected: Resilient performance in an age of uncertainty*. San Francisco, CA: Jossey Bass.

Contact

cynthiaoster@centura.org

H 03 - How Nurse Work Environments Relate to the Presence of Parents in Neonatal Intensive Care

H 04 - How Nurses Educators Cope with Incivility

H 04 - Trending Issues within Academia

Participatory Action Research: Learning about Work Environments Among Baccalaureate Nursing Faculty

Lisa A. Ruth-Sahd, DEd, RN, CEN, CCRN, USA
Norma H. Beyer, DNP, RN, USA

Abstract

The article discusses the implementation and results of a participatory action research (PAR) project carried out with baccalaureate nursing faculty from 2013 to 2016 in a private four-year college in Northeastern United States. The aim of the project was to identify issues related to work environment according to the guidelines sent forth from the American Association of Critical Care Nurses (AACN, 2005) and the National League for Nurses (NLN, 2006). While research has been carried out in clinical practice settings related to work environment and its effects on nurses and patients, there is a paucity of research assessing the entity of work environment in academic settings and it effect on faculty, students and teaching. The participating faculty all had at least one year of teaching full time and were able to identify relevant factors that affect the work environment. Via the study results the researchers noted usage of PAR have led to a deeper and fuller understanding of the factors that shape faculty members' experiences and performance as a nursing educator. The study validates that academic work environments are influenced by multiple and inter-related factors. These factors include the following: recognizing and respecting each other as faculty; creating spaces to share with one another as faculty, developing and acknowledging teaching capabilities and recognizing how they impact the healthy learning environment in the classroom; utilizing "precious" time, and valuing the efforts of this research. The faculty contend that we must do more to support a healthy work environment by setting high expectations for success, maintaining positive faculty to faculty, faculty to administrator and faculty to student relations, integrating healthy work environment curricula "such as course threads on work life balance," promoting more creative innovative pedagogies in the classroom, expanding the range of extra-curricular activities for faculty and students, and working more closely with each other to role model for our students and promote positive outcomes in our students.

References

TBD

Contact

LSahd@ycp.edu

H 04 - Trending Issues within Academia

The Effect of Play with Canines on Psychological and Physical Stress Measures in College Students

Cheryl Delgado, PhD, RN, CNL, USA
Margaret Toukonen, PhD, RN, CNS, USA
Corinne Wheeler, PhD, RN, USA

Abstract

Introduction and Background: Stress can impede learning and be a major cause of student attrition or failure to advance in studies at a timely pace. This is an increasing concern in academia. Some universities are working to create supportive student communities and a more home-like atmosphere on campus. Increasingly this includes having a pet on the premises. Successful pet therapy programs are found at many universities and according to a report in Forbes Magazine, support animals on campus is an emerging norm.

Studies on the human animal, especially canine, bond have demonstrated effective reductions in perceptions of stress, reductions in anxiety and loneliness, and increased sensitivity and focus in some patients with emotional disorders. Positive physiological responses have been documented when dogs and other animals have been used for symptom amelioration in heart failure, cancer, stroke, and chronic pain.

Anecdotal evidence supports the use of family or therapy dogs in university housing for student homesickness, loneliness and anxiety. One previous study reported significant decreases in anxiety and loneliness after contact with therapy dogs in campus open counseling sessions, but another failed to find supportive evidence for significant relief of psychological or cardiovascular changes in students in an anxiety producing task.

Research Plan: All our faculty research team members are familiar with the work of therapy animals and two own certified therapy dogs or dogs eligible for certification. Therapy dogs have the temperament and training to interact with people and attach therapeutically. Support training requires a calm accepting response to the emotional state of humans. Service dogs differ as they are trained to perform specific tasks for a disabled human.

Our plan was for students to engage in a one on one interactive session with a therapy dog during a stressful time – finals week. Psychological stress measures included a modified version of the Perceived Stress Scale (PSS) developed by Cohen, Kamark and Mermelstein, and four visual analog scales (VAS) for stress, anger, confusion and sadness. Physiologic stress was measured by blood pressure, pulse, and salivary cortisol levels. Salivary cortisol levels correlate well with serum readings which are the physiologic standard. All data was marked pre- or post-intervention and labeled with a study specific code.

The study plan was approved by the university Institutional Review Board (IRB) for human subjects and was reviewed by the Institutional Animal Care and Use Committee (IACUC). As the dogs were the study intervention not the subjects, IACUC permission was not required, but advice was solicited on appropriate conditions. The dogs were supervised by their handler owners at all times while on campus.

Students were recruited by posters throughout campus. Inclusion criteria included adult male or female students or staff at the university who were not afraid of or allergic to dogs. Volunteers made thirty minute appointments and were advised on the rules for the interactions. A biting protocol was included in the research plan and this remote risk was noted on the informed consent.

Results: Anonymity in this study was not possible because the students are known to faculty, but efforts were made to protect confidentiality, including the use of private areas for interactions and testing, and de-identifying all data forms and specimens. Basic descriptive and paired t tests were computed using the IBM SPSS 22 program. Limited demographic data was obtained from the participants. The preliminary sample consisted of 41 men and women, aged 18 to 63 (mean = 26 years) and included Caucasian, African- American and Asian students reflecting the university's student population.

Preliminary results for psychological measures documented significant reductions from pre-intervention levels. All were significant reductions; PSS (0.000) and all VAS scales (0.000). With the addition of participants from the December 2016 data collection period, we expect these numbers to remain significant. Pulse (0.031) and systolic blood (0.001) pressure were significantly reduced, but diastolic pressure reductions (0.131) were not. We expect that these results will remain significant with the addition of the participants from fall 2016. Salivary cortisol levels were measured in a commercial laboratory, and the paired t test (2-tailed) results indicated a significant (p=.040) decrease for a sample of students and some staff. To determine if the results for students alone, the fall recruitment will selectively sample students for participation.

Discussion/Conclusion: There are limitations in the study. The convenience sample was small and self -selection with a bias for positive animal interaction is possible. The modification of the PSS affected its reliability of the instrument.

Interactions with dogs modified stress and positively affected mood in college students. Physiologic changes were also positive. This supports animal assisted therapy as an effective stress management strategy for college students.

The Americans with Disabilities Act and the Fair Housing Act allows service animals when the animal serves a person with a diagnosed disability. These animals are universally accepted, but support animals are not well recognized. However, support animals on campus are popular with students attracting the attention of administrators who search for any advantage in the recruiting game. If future studies support student retention and improved performance, more programs will emerge.

References

American Humane Association. (2014). Did you know. Retrieved from http://www.americanhumane.org/interaction/support-the-bond/fact-sheets/animal-abuse-domestic-violence.html.

Bassette, L.A. & Taber-Doughty, T. (2016). Analysis of an animal-assisted reading intervention for young adolescents with emotional/behavioral disabilities. Research in Middle Level Education Online, 39(3),1-20. Dio:0.1080/19404476.2016.1138728.

Chur-Hansen, A., Zambrano, S.C. & Crawford, G.B. (2013). Furry and feathered family members: a critical review of their role in palliative care. *American Journal of Hospice and Palliative Care*, 31(6), 672-677.

Engleman, S.R. (2013). Palliative care and use of animal-assisted therapy. *Omega*, 67(1-2), 63-67.

leRoux, M. & Swarta, L. and Swart, E. (2014). The effect of an animal-assisted reading program on the reading rate, accuracy and comprehension of grade 3 students. *Child and Youth Care Forum*. 43(6), 655-673. Doi:10.1007/s10566-014-9262-1.

Marcus, D.A., Bernstein, C.D., Constantin, J.M., Kunkle, F.A., Breuer, P. & Hankon, R.B. (2012). Animal Assisted Therapy at an outpatient pain management clinic. *Pain Medicine*, 13(1), 45-57.

Pinto, L.E. & Foulkes, D. (2015). Well-being and human-animal interactions in schools: The case of the “dog daycare co-op”. *Brock Education Journal*, 24(2), 60-73.

Stewart, L.A., Dispenza, F., Parker, L. Chang, C.Y. & Cunnien, T. (2014). A pilot study assessing the effectiveness of an animal-assisted outreach program. *Journal of Creativity in Mental Health*, 9, 332-345.

Winkle, M.Y., Wilder, A. & Jackson, L.Z. (2014). Dogs as pets, visitors, therapists and assistants. *Home Healthcare Nurse*, 32(10), 589-595.

Zimmer-Gembeck, M.J. Skinner, E., Morris, H. & Thomas, Rae. (2013). Anticipated coping with interpersonal stressors: Links with the emotional reactions of sadness, anger and fear. *Journal of Early Adolescence*, 33(5) 684-709.

Contact

c.delgado@csuohio.edu

H 05 - Staffing Strategies to Improve Outcomes

Care Zones Staffing Model: Solving Workflow Barriers to Improve Patient and Nurse Outcomes

William G. Kingsley-Mota, MSN, RN, NEA-BC, USA
Barbara J. Hill, MSN, APRN, AGCNS-BC, ACCNS-AG, CCRN, USA

Abstract

Background: A 24-bed general medicine unit at Emory University Hospital has a history of implementing innovative change. This unit developed Emory Healthcare's model of patient centered, interprofessional collaborative practice (PC-IPCP), and is the original Accountable Care Unit. In spite of that, the unit experienced barriers to achieving patient safety and quality outcomes due to marked inefficiencies in the way assignments were made. Historically, assignments were made by utilizing acuity-related criteria and did not consider the unit geography, thus creating assignment patterns located on the opposite ends of the hallways that produced challenges for patient care, bedside shift report, and participation in multidisciplinary rounds. Nurses also felt their response times to patients' calls were unnecessarily delayed. This was reflected in lower than desired patient satisfaction and higher fall rates. Nurses and patients were frustrated by the inefficiencies of direct communication and the care gaps that the chaotic assignments created.

Methods: The new assignment methodology considers unit geography; the AACN Synergy Model© principle of matching the skill of nurse to patient needs; nurse participation in daily interprofessional rounds; and a buddy system, to create a strong patient safety net. A schematic flip chart was designed by the Unit Director to guide charge nurses in selecting flexible assignment options which promoted timely planned and unplanned patient care activities. The unit level leadership team took a deliberative approach, piloting one zone assignment at a time, but due to the overwhelmingly positive responses from clinical nurses, the pilot phase was shortened and the model fully implemented within two weeks.

Summary: Within six months after implementing the model, falls decreased by 58%, incremental overtime decreased by 60%, patient call light rate dropped by 49%, and the average distance walked by clinical staff decreased by 1.2 miles per day and currently remains sustained. Nurses verbalized increased satisfaction with their ability to meet their patients' quality and safety needs, and both providers and nurses described efficiencies gained in their daily collaborative practice rounds. Patient satisfaction scores remained above average. This project demonstrates application of patient-centered care, teamwork, collaboration, patient safety, and quality care.

References

Curley, M.A.Q. (1998). Patient-Nurse Synergy: Optimizing Patients Outcomes. *American Journal of Critical Care* 7(1):64-72.

Donahue, L. (2009). A pod design for nursing assignments. *AJN The American Journal of Nursing*, 109(11), 38-40.

Friese, C. R., Grunawalt, M. J. C., Bhullar, S., Bihlmeyer, M. K., Chang, R., & Wood, M. W. (2014). Pod nursing on a medical/surgical unit: Implementation and outcomes. *The Journal of nursing administration*, *44*(4), 207. doi: 1097/NNA.0000000000000051

Titler, M. G., Kleiber, C., Steelman, V. J., Rakel, B., Budreau, G., & Everett, L. et al., (2001). The Iowa Model of Evidence-Based Practice to promote quality care. *Critical Care Nursing Clinics of North America, 13, 497-509.*

Contact

william.kingsley@emoryhealthcare.org

H 05 - Staffing Strategies to Improve Outcomes

Nursing Staffing and Technology: A Relationship Formed in the Electronic Environment Benefiting Patients and Nurses

Gayle Luker, BSN, RN, CPN, USA

Abstract

The rising costs of health care are creating diminishing budgets for hospitals, impacting direct patient care hours. Previous versions of acuity systems were subjective and required additional effort by nurses. innovative technological advances have led to acuity systems that retrieve data from the electronic medical record and generate an acuity score that is objective, valid and reliable. Acuity informed staffing is a benefit to patients, staff, and budgets.

The strategy was to implement a process by which a valid acuity tool could aid in the decision making of staffing and patient assignment. The goal was to leverage the latest technology, increase objectivity, and decrease the need for additional effort from staff in determining an acuity and staffing program that electronically calculates a patient's acuity by pulling data from the electronic health record and mapping it to thousands of data points associated with identified nursing outcomes met that goal. The implementation process included key stakeholders from multiple levels of the organization including directors, finance, nursing, and information technology experts. There were several training sessions for the nursing staff that would be impacted directly by the implementation of the system. A secondary process of implementation was the identification of super-users and acuity auditors whom meet on a quarterly basis.

Data was collected from each inpatient unit before and after implementation of the electronic acuity and staffing program which demonstrated improvement with the utilization of the system. The data showed an improvement in productivity, improved staffing at the bedside, a decrease in sick time, double time and overtime. Productivity percentages improved from 65-85% to 95-105%, the ideal outcome and realized cost savings.

Nationwide hospitals would like to achieve a goal of knowing the right number of nurses to have, how to efficiently manage their schedules, and optimize the resources available to meet the needs of the patient population. Technology allows for nursing and finance to collaborate to meet this goal.

References

American Association of Critical-Care Nurses. Creating a Health Workplace: Appropriate Staffing for a Healthy Work Environment. AACN, 2013, Advanced Critical Care Volume 24, Number 3, pp. 245-248.

Moorhead, S., Johnson, M., Maas, M., & Swanson, E. (Eds.) (2013). Nursing outcomes classification (NOC) (5th ed.). St. Louis, MO> Elsevier.

Contact

gluker@chla.usc.edu

J 01 - Promoting Healthy Work Environments by Evaluating and Addressing Sleep Habits of Nursing Students

Promoting Healthy Work Environments by Evaluating and Addressing Sleep Habits of Nursing Students

Ruthie Lamar, DNP, MS, RN, USA
Cynthia M. Thomas, EdD, MS, BSN, RNc, CDONA, USA
Constance E. McIntosh, EdD, MBA, BSN, RN, USA

Abstract

Nursing students, part of the healthcare team, are often employed while in school, working various hours including 12-hour day and night shifts. In addition, increased competition for clinical sites has forced some schools to work 12-hour clinical shifts. These long work hours combined with other rigorous nursing school requirements may decrease available sleep hours and negatively impact students' sleep-wake cycles.

Researchers have found that a significant proportion of nurses and nursing students suffer from sleep abnormalities and related medical issues, as well as lower grades in those with significant lack of sleep (Dumer & Dinges, 2005; Lockley, Barger, Ayas, Rothchild, Czelsler, & Landrigan, 2007; Stickgold, 2005). Further, a study performed by Wagstaff and Lie (2011) found that work periods greater than eight consecutive hours carry an increased risk of occupational accidents that accumulates so that the increased risk of accidents after working twelve hours is two times the risk of accidents after working eight hours. Finally, shift work resulting in sleep deprivation in other healthcare workers, such as interns and residents, has been shown to be a crucial factor in contributing to medical error (Baldwin & Daugherty, 2004; Landrigan, Rothschild, Cronin, Kaushal, Burdick, Katz, Lilly, Stone, Lockley, Bates, & Czeisler, 2004; Mansukhani, Kolla, Surani, Varon, & Ramar, 2012).

While the literature presents a persuasive picture of the need for sleep and the impact sleep deprivation can have on individuals, students, and healthcare practitioners, a dearth of literature surrounding, specifically, nursing students, sleep deprivation, and associated impact of sleepiness on health and safety exists. Arguably, this lack of research on sleep habits and sleep deprivation calls for research studies, such as the one on which we report, as well as ways to address this phenomenon. Consequently, nurse educators, nurse leaders, and nursing students have a responsibility to collaborate and cultivate strategies to help students improve sleep habits and, thereby, enhance safer, healthier work environments.

A convenience sample of 328 pre-licensure nursing students from a Mid-western university was sought for the study. Internal Review Board (IRB) approval was obtained. The questionnaire and all study materials were sent to all undergraduate nursing students who had been or were currently enrolled in a nursing course with a clinical component via university email accounts, and an online survey method administered study instruments. This research was a quantitative survey pilot study that was used to determine the need for a more in-depth, comprehensive larger study.

The questionnaire was titled, *Sleep Deprivation of Nursing Students*, and included five sections with a total of twenty-one questions. Section (A) included six questions related to student demographics. Section (B) addressed aspects of personal sleep habits with two questions. Section (C) included four questions and addressed automobile and motor vehicle use after working and program clinical experiences. Section (D) included one multi-part question addressing students' expenditure of spare time. Section (E), with a total of ten questions, addressed work safety and program clinical experiences.

An invitation letter to participate in the study and a consent form was included in the survey packet sent to all study participants via email. No incentives for completing the study were identified or provided in the survey packet. Three email reminders were sent to the survey sample during the six-week study completion period.

Data was analyzed using descriptive statistics. Of the convenience sample (n=328), 179 completed the study for a 54% response rate. While participants reported a need for 8 or more hours of sleep to feel

rested, most obtained less than 6 hours of sleep prior to class or clinical experiences, potentially negatively impacting learning in the classroom and safety in the clinical setting. The majority of participants indicated that they self-medicated to stay awake and to induce sleep, consuming caffeine/stimulants or sleeping pills, depending on the perceived need. Clinical hours ranged from 7-12 hours per week, with nearly one third of respondents having 12 or more clinical hours per week.

More than half of participants were employed 8-12 hours per week and worked 7 to greater than 12 consecutive days combining employment and clinical schedules in spite of the known increase in error rates and decrease in decision making and critical reasoning after 12 hours of employment or clinical experience. Factoring in drive time to number of work hours, consecutive days between jobs, clinical experiences, and clinical hours showed the risk of accident or falling to sleep is greatly increased. More than half of participants reported fatigue after clinical experiences and when driving after work or clinical experiences. Most of participants were awake 18-19 hours out of a 24-hour day. In spite of this, though, nearly all of participants believed they engaged in safe practice at work and clinical experience and that 12 hour shifts or longer did not impact safety or decrease ability to learn.

The majority of nursing students in this study did not recognize the impact of sleep deficit and 12-hour employment or clinical experiences on learning capacity, error rates, decision making and critical thinking. Over 30 years of research has shown the negative effects of sleep deprivation, circadian misalignment and human performance in physicians and nurses. There is little, if any, investigation to date into the effects of those same variables on nursing students. Post-study, these researchers conclude that educators are responsible for recognizing that sleep, employment, and clinical variables affect safety and clinical judgment and for teaching students about the negative impact of sleep deprivation on health and safety. Additionally, educators must collaborate with nursing students and nurse leaders to determine if limits on work and clinical experiences are needed and to develop strategies that promote healthy sleep habits. Lastly, educators must be role models for balancing family/social/work life so that students can see how a healthy balance positively affects health and attitude, thereby positively impacting home and work environments.

References

Baldwin, D. & Daugherty, S. (2004). Sleep deprivation and fatigue in residency training: Results of a national survey of first- and second-year residents. *Sleep, 27*(2), 217-23.

Dumer, J. S. & Dinges, D. F. (2005). Neurocognitive consequences of sleep deprivation. *Seminars in Neurology 25:117*-129.

Landrigan, C., Rothschild, J., Cronin, J., Kaushal, R., Burdick, E., Katz, J., Lilly, C., Stone, P., Lockley, S., Bates, D., & Czeisler, C. (2004). Effect of reducing interns' work hours on serious medical errors in intensive care units. *New England Journal of Medicine, 352*(18), 1838-48.

Lockley, S. W., Barger, L. K., Ayas, N. T., Rothschild, J. M., Czeisler, C. A., & Landrigan, C. P. (2007). Effects of heath care provider work hours and sleep deprivation on safety and performance. *The Joint Commission on Accreditation of Healthcare Organizations 33*(11), 7-18.

Mansukhani, M. P., Kolla, B. P., Surani, S., Varon, J., & Ramar, K. (2012). Sleep deprivation in resident physicians, work hour limitations, and related outcomes: a systematic review of the literature. *Postgraduate Medicine 124*(4): 241-9. Doi: 10.3810/pgm.2012.07.2583

Stickgold, R. (2005). Sleep-dependent memory consolidation. *Nature 437*:1272-1278.

Wagstaff, A. & Lie, J. (2011). Shift and night work and long working hours – a systematic review of safety implications. *Scandinavian Journal of Work, Environment, & Health,* 173-85.

*Of note, there are very few relevant, well-conducted studies on sleep and healthcare workers completed in the last five years.

Contact

cmthomas@bsu.edu

J 02 - Work Environment Factors Related to Nurses' Attitude about Roles in Quality Improvement

Work Environment Factors Related to Nurses' Attitude about Roles in Quality Improvement

Pamela B. Dunagan, PhD, RN, USA

Abstract

Human factors and organizational culture have been two of the most frequently identified root causes of sentinel events as stated by The Joint Commission (2016). In an organizational culture of safety, errors and potential problems are viewed by administration through a lens of system-wide vulnerabilities. Healthcare workers feel less threatened when speaking up about patient care safety risks and have better attitudes about quality improvement efforts in an environment where openness and transparency are treasured as key elements. It was perceived that a blame-free work environment which enabled individuals to not only value competencies of safety and quality improvement, but voice concerns about errors or risks for error without reprimand or punishment (Barnsteiner, 2011; Davis et al., 2016; AHRQ, 2014; Lyndon et al., 2015) would enable nurses to feel a sense of unity and perceive common values toward a culture of safety. Additionally, nurses who felt united in their efforts toward quality improvement could have a more positive fulfilling work related state of mind allowing them to engage in work activities with vigor and dedication.

A non-experimental correlational design was used to explore the relationships between quality improvement attitudes of nurses (belief in the value of safety and quality improvement competencies and feelings about the ability to voice concerns in the process toward quality improvement efforts) and two work environment factors of social capital (specifically perceived common values and trust and sense of unity) and work engagement. The study sample (n=69) were registered nurses in a southeastern United States hospital.

Data were collected utilizing an online web survey. Quality improvement attitude was measured using a reliable (Cronbach’s alpha coefficient of 0.93) and valid tool which was developed by the investigator. Social capital with respect to perceived common values and trust and sense of unity was measured using the reliable and valid Social Capital Scale (Ernstmann et al., 2012). Work engagement was measured using the reliable and valid Utrecht Work Engagement Scale (Schaufeli and Bakker, 2006).

Using correlational analysis, statistically significant relationships between quality improvement attitudes of nurses, social capital, and work engagement were found. Nurses who valued competencies of safety and quality improvement (QSEN, 2016), and felt their voice was heard while working in a culture of safety, had a positive fulfilling work relationship and perceived a sense of unity and trust among workers.

The study implied nurses who not only valued competencies of safety and quality improvement but also felt they were a part of a transparent environment where they could report errors and risk for patient safety had a greater sense of unity, perceive trust and common values, and had a greater positive and fulfilling work related state of mind. Previous studies indicated nurses who did not feel comfortable voicing concerns for risks of safety (Davis, Harris, Mahishi, Bartholomew, & Kenward, 2016; Lyndon et al., 2015) had not reported clinical situations in which patients were put at risk (Maxfield et al., 2013) suggesting their voice in the process of quality improvement might not have been heard. In addition, organizational cultures and nurses have accepted problems as common occurrences and feel powerless to influence practice of other nurses who deviate from standards of care (Lyndon et al., 2015). When healthcare workers feel, organizational goals indicate patient safety as a priority, behaviors and attitudes which supported quality outcomes were evident and motivation to voice concerns is manifested (Weaver et al., 2013).

The full scope of this presentation is far reaching into the areas of nursing practice, education, and research. Clinical nursing administrators would find this interesting because it implies nurses have a greater sense of unity and more positive work state of mind when they perceive they have a voice in quality improvement efforts potentially leading to higher nurse retention rates. Nursing educators would

be interested in knowing that teaching nursing students to value the QSEN competencies and to speak up when competencies are not being followed leads to positive attitudes toward quality outcomes and a fulfilling work experience. A limited amount of research is available which seeks to explore nursing attitudes about quality improvement efforts. Further studies should be conducted to explore factors centered around quality improvement nursing attitudes.

References

Agency for Healthcare Research and Quality, Patient Safety Network (July, 2014). *Safety Culture.* Retrieved from https://psnet.ahrq.gov/primer/5/safety-culture

Barnsteiner J. (2011). Teaching the culture of safety. The *Online Journal of Issues in Nursing: A Scholarly Journal of the American Nurses Association.* Online publication. doi: 10.3912/OJIN.Vol16No03Man05

Davis, K. K., Harris, K. G., Bartholomew, E. G., & Kenward, K. (2016). Perceptions of culture of safety in hemodialysis centers. *Nephrology Nursing Journal, 43,* 119-126.

Ernstmann, N. (2012). Social capital and quality emphasis: A cross-sectional multicenter study in German hospitals. *International Journal of Healthcare Management, 5,*98-102. doi: 10.1179/2047971912Y.0000000007

Lyndon, A., Johnson, C., Bingham, D., Napolitano, P. G., Joseph, G., Maxfield, D. G., & O'Keeffe, D. F. (2015). Transforming communication and safety culture in intrapartum care: A multi-organization blueprint. *Journal of Obstetric, Gynecologic & Neonatal Nursing, 44,* 341-349. doi: 10.1111/1552-6909.12575

Maxfield, D. G., Lyndon, A., Kennedy, H. P., O'Keeffe, D. F., & Zlatnik, M.G. (2013). Confronting safety gaps across labor and delivery teams. *American Journal of Obstetrics and Gynecology, 209*(5), 402.e3-408.e3.doi: 101016/j.ajog.2013.07.013

Quality and Safety Education for Nurses Institute, (2016). *Competencies*. Retrieved from http://qsen.org/competencies/

Schaufeli, W. B., & Bakker, A. B. (2006). The measurement of work engagement with a short questionnaire: A cross-national study. *Educational and Psychological Measurement, 66* (4), 701-716. doi: 10.1177/0013164405282471

The Joint Commission, Comprehensive Accreditation Manual for Hospitals Update 2 (January, 2016). *Patient Safety Systems.* Retrieved from www.jointcommission.org/search/keywords=camh+2016&sitename=Joint+Commission&guid=23f170ebd6094c36b595d872fc31646a&f=sitename%252cdate&date=January+2016

Weaver, S. J., Dy, S., Lubomski, L. H., & Wilson, R. (2013). Promoting a Culture of Safety. In *Making Health Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK133379/

Contact

pdunagan@berry.edu

J 03 - How One Organization Used Evidence to Address Lateral Violence Among Nurses

How One Organization Used Evidence to Address Lateral Violence Among Nurses

Diane S. Salter, MSN, BA, RN, CPAN, NE-BC, USA
Toye Moore, BSN, RN, USA
Angela Robinson, MSN, RN, CCRN, NE-BC, USA
Cynthia Stermer, MSN, RN, RN-BC, ACNS-BC, USA
Susanlee Wisotzkey, PhD, MSHSA, BSN, BA, RN, NE-BC, HNB-BC, CCRN, USA
Barbara L. Buchko, DNP, MS, RNC-MNN, USA

Abstract

Bullying and lateral violence in nursing is a serious problem and damages the dignity of the individual and the profession. A common definition of bullying at work is “repeated actions by one or more persons that are unwanted by the victim and cause humiliation, offense, and distress” (Sauer, 2012, p. 48). This form of incivility violates the professional expectation of mutual respect. These recurring behaviors, whether overt or covert, demean and demoralize a victim, which affects his or her ability to complete work tasks (Sauer, 2012). Bullying among healthcare workers is a threat to a culture of safety in the workplace (Lim & Bernstein, 2014). In addition to decreased job satisfaction and poor retention, unprofessional behaviors by nurses pose a threat to a healthy work environment and increases the chance of errors, delays in care, conflict, and can become the root cause of adverse events and poor patient outcomes (Longo & Hain, 2014). Bullying has become a major contributor to absenteeism, work dissatisfaction, decreased productivity, and work-related injuries, with an estimated cost of over $4 billion a year (Hubbard, 2014).

Study findings support that bullying behaviors are precipitated by both individual and systemic factors. Organizations that have written policies in place stating that bullying behaviors are not tolerated must strictly enforce these policies and investigate all claims (Sauer, 2012). Nurses also need to be aware of their own behaviors in perpetuating lateral and vertical violence. Developing effective communication skills is instrumental in cultivating strong interpersonal relationships. Although the nurse leader is pivotal in ensuring respectful work places, there needs to be shared accountability among all nurses in caring for self and others by confronting those who exhibit toxic behaviors (Cervalo, Schwartz, Foltz-Ramos, & Caster, 2012).

Research emphasizes the importance of both education and cognitive rehearsal in addressing bullying among nurses. Cognitive rehearsal consists of didactic instruction, identifying and rehearsing specific phrases related to bullying, and practicing the phrases to become skilled at using them (Griffin & Clark, 2014). The Joint Commission recommends: skill-based training and coaching; nonconfrontational surveillance; evaluation processes to determine staff perceptions of bullying behaviors; and organizational policies that are strictly enforced and allow nurses to report these behaviors without fear of retribution. Although elimination of bullying behaviors may be unrealistic, research suggests that recognition of bullying behaviors and the use of cognitive rehearsal can give nurses confidence in confronting those that exhibit these disruptive behaviors (Lee, Bernstein, & Nokes, 2014).

In 2012, the evidence-based practice and nursing research (EBP/NR) council of a large community teaching hospital identified that some nursing units within the organization had RN-RN interaction scores from the National Database of Nursing Quality Indicators (NDNQI) survey that were lower than the national benchmark. Council members considered that bullying or lateral violence could be a contributing factor. The council conducted an EBP project to identify the best strategies to prepare registered nurses (RNs) to recognize and respond to bullying to support the goal of improved RN-RN interaction. A comprehensive review of the literature was completed revealing best practice recommendations and the development of an action plan. Recommendations included:

- Performing an organizational assessment
- Clearly defining bullying and lateral violence (LV) behaviors
- Developing an awareness campaign

- Providing education to nurse leaders and nursing staff
- Using cognitive rehearsal in education
- Developing policies and procedures that clearly delineate expected behaviors and consequences of bullying

The first step of the action plan was to conduct an organizational assessment to determine the extent and severity of lateral violence among nurses. Lateral and Vertical Violence in Nursing Survey was used to determine the prevalence of lateral and vertical violence among RNs (Stanley, 2011). The survey was emailed to 1,425 RNs with a 34% return rate. The results of the study were as follows:

- 77% observed lateral violence
- 52% observed vertical violence (downward)
- 55% observed vertical violence (upward)
- 51% reported being a recipient of lateral violence
- 45% reported being a victim of verbal violence
- 23% reported being a victim of non-verbal violence

The current practice to address bullying behavior was found in the employee code of conduct and in clinical evaluations under “teamwork.” Consequences for bullying were not consistent among nursing leadership, and there were no policies addressing bullying among nurses. As a result of these findings a task force was created to develop and implement a strategic plan to reduce bullying behaviors among RNs. The plan would incorporate strategies from the evidence and extend over a three-year period. The plan was presented to nursing leadership and adopted for the entire nursing department. Year one (2014) included an awareness campaign and development of a position statement. Year two (2015) encompassed implementation of a compact and education plan. Education also included review of the just culture model for nurse leaders in dealing with incidences of bullying. Accountability was measured using the results of the 2016 employee engagement survey instead of the NDNQI since the organization chose to use a new survey tool recommended by the Advisory Board.

The first part of the education plan was to conduct a workshop to educate charge nurses and provide them with the tools they needed to address bullying among nurses. Charge nurses were the main focus of the education plan because more than half of the examples of vertical violence identified the issue as charge nurse to staff. The title of the workshop was “Working in the Salad Bowl.” The workshop was 1.5 hours in length and included both didactic instruction and cognitive rehearsal. The information included: the definition of lateral and vertical violence; impact of bullying on patients and staff; characteristics of bullies; self-awareness; personal and professional boundaries; expectations on professionalism; ways to resolve conflict; and tips on breaking the bullying cycle (Leekley & Turnure, 2012). Cognitive rehearsal consisted of three real-life scenarios. At the completion of class, the charge nurses were expected to demonstrate the ability to recognize, respond, and de-escalate episodes of bullying. More than 300 charge nurses have completed the training, and the information has been incorporated into the charge nurse and preceptor classes.

The 2016 employee engagement scores showed improvement in two categories related to the topic of bullying. Nurses’ scores in the category, “abusive behavior is not tolerated by my organization,” increased from 55.3% to 58.5% (benchmark 77.9%). In the category, “I have good personal relationships with coworkers in my unit/department,” there was an increase from 78.8% to 82.6% (benchmark 85.9%). In one nursing unit, the nurse leader used a focused approach on bullying education. The nurse manager required all staff members (regardless of role) to attend the workshop. A compact on expectations was signed by each staff member. Each month an article on bullying is assigned and is a topic of discussion at staff meetings. Staff are coached and encouraged to address episodes of bullying. Nurse leaders on this unit hold staff to high standards of peer-to-peer accountability, and take action when bullying is reported. The employee engagement scores in this unit showed significant improvement. In the category “abusive behavior is not tolerated by my organization,” scores increased from 60% to 96%. “I have good personal relationships with coworkers in my unit/department,” improved from 76% to 100%.

Education and cognitive rehearsal are evidence-based strategies that are effective in addressing those behaviors that are detrimental to the physical and psychological well-being of nurses and the patients they serve (Griffin & Clark, 2014). Through a focused approach, which includes education, cognitive rehearsal, and shared accountability, significant improvements can be made in reducing bullying among nurses. For these strategies to be successful in the future throughout all of nursing, RNs must role model behaviors that contribute to outstanding patient care, competent and compassionate staff, and healthy and healing interpersonal relationships. Creating a healthy work environment, where patients and nurses thrive will foster a culture of accountability and elevate our professional nursing practice.

References

Cervalo, D.J., Schwartz, D.G., Foltz-Ramos, K.M., & Caster, J. (2012). Strengthening

communication to overcome lateral violence. *Journal of Nursing Management, 20*,

599-606.

Griffin, M., & Clark, C.M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing, 45*(12), 535-542. doi:10.3928/00220124-20141122-02

Hubbard, P. (2014). What is horizontal violence? *Alberta Registered Nurse, 69*(4), 16-18.

Lee, Y.J., Berstein, K., Lee, M., & Nokes, K.M. (2014). Bullying in the workplace: Applying evidence using a conceptual framework. *Nursing Economic$, 32*(5), 255-267.

Leekley, L., & Turnure, S. (2012). *The real healthcare reform. How embracing civility can beat back burnout and revive your health career*. Durham, NC: In the Know, Inc.

Lim, F.A., & Bernstein, I. (2014). Civility and workplace bullying. Resonance of Nightingale's persona and current best practice. *Nursing Forum, 49*(2), 124-129.

Longo, J., & Hain, D. (2014). Bullying: A hidden threat to patient safety. *Nephrology Nursing Journal, 41*(2), 193-199.

Sauer, P. (2012). Do nurses eat their young: Truth and consequences. *Journal of Emergency Nursing, 38*(1), 43-46.

Contact

dsalter2@wellspan.org

J 04 - Toward a Healthy Work Environment: Honoring the Voices of Frontline Nurses

Toward a Healthy Work Environment: Honoring the Voices of Frontline Nurses

Tracey M. Long, MSN-MPH, BA, RN-BC, CPH, USA
Deborah Dang, PhD, RN, USA
Jennifer R. Day, PhD, BSN, BA, RN, USA
Carolyn J. Cumpsty-Fowler, PhD, MPH, USA

Abstract

Clear and concise communication is a key component of a professional work environment; especially in healthcare, where communication lapses can lead to patient safety events. Transparent two-way communication is a key part of establishing and maintaining a healthy work environment. A critical part of this transparency is giving a voice to frontline staff and valuing the input they provide.

An example of the impact of transparent, two-way communication and its link to a healthy work environment is the evaluation of the Johns Hopkins Nursing Professional Practice Model (JHNPPM). A professional practice model provides the framework to guide nursing practice and support frontline staff, but only if nurses are aware of it. A pilot evaluation of the JHNPPM was conducted to gauge nurses' familiarity and engagement with the existing PPM. While nurses spoke eloquently about their practice, evoking similar themes contained in the PPM, few could speak to the model or its components.

Instead of creating an educational campaign around the existing PPM, which is the traditional approach according to the literature, the leadership of Johns Hopkins Nursing supported the revision of the PPM using the voices of frontline nurses. If the professional practice model was in their words, nurses would not have to learn about a model, they would simply speak to their practice.

To begin this task, nurses who volunteer as Magnet Ambassadors were asked to record informal conversations with peers on their units and talk about what it means to be a Hopkins nurse. Conversations were anonymized, transcribed, and a thematic analysis was performed on the qualitative data. Results of the analysis were vetted by the Magnet Ambassadors (MA's) and brought to nursing leadership for input and clarification until a new PPM evolved.

The PPM workgroup consistently championed for the voices of the nurses to remain in the forefront of the process. By continuously reviewing progress with the MA's, the workgroup increased their engagement in the process, and built a high level of trust with nurses who realized their voices were being heard and honored. MA's commented on the increase in positivity in their units when nurses realized their voices were the driving force behind the new model.

Maintaining transparent, two-way communication has led to the creation of a meaningful professional practice model that supports a healthy work environment.

References

American Association of Critical-Care Nurses. (2016). *AACN Standards for establishing and sustaining healthy work environments: A journey to excellence.* Aliso Viejo: American Association of Critical-Care Nurses.

Blosky, M. & Spegman, A. (2015). Let's talk about it: Communication and a healthy work environment. *Nursing Management*, 32-38.

Dang, D., Bae, S., Karlowicz, K., & Kim, M. (2016). Do clinician disruptive behaviors make an unsafe environment for patients? *Journal of Nursing Care Quality*, 115-123.

Hartung, S. & Miller, M. (2013). Communication and the healthy work environment. *The Journal of Nursing Administration*, 266-273.

Lindberg, P. & Vingard, E. (2012). Indicators of healthy work environments - a systematic review. *Work*, 3032-3038.

Morton, P. (2015). Creating and sustaining healthy work environments. *Journal of Professional Nursing*, 165-167.

Contact

ddang@jhmi.edu

K 01 - Stress and Quality of Life in Nursing

K 01 - Stress and Quality of Life in Nursing

Helping Nurses Cope with Stressful Workplace Events Through the Use of Storytelling

Danna L. Curcio, PhD, RNC, FNP, USA

Abstract

The purpose of this presentation is to provide insight and knowledge about an important, efficient, and cost effective intervention to decrease workplace stress. Nursing sick and dying children can be a source of great stress and high exposure to such events can cause burnout and compassion fatigue (Ko & Kiser-Larson, 2016). This may eventually lead to an impact on nursing competencies and productivity including absenteeism, decreased work performance, and quality of patient care (Fathi, Nasae & Thiangchanya, 2012; Milliken, Clements & Tillman, 2007). Addressing workplace stress may also help reduce hospital costs associated with these issues.

The National Consensus Project for Quality Palliative Care (2013) selected specific domains containing supportive measures to help nurses provide quality patient care through stress management. Additionally, stress-reducing interventions have the potential to create positive work environments, positive emotional health, and in turn, positive patient care outcomes. There are several interventions that have been utilized and the intervention of storytelling was researched as the most cost effective option.

Storytelling can be seen as an important intervention to help decrease stress. It is a verbal recounting of a perceived meaningful event to one or more individuals that share similar experiences. By the use of storytelling, nurses' may be able to manage their stress while being provided the opportunity to discuss concerns and simultaneously provide support to other nurses who experience similar events (Cook, et al, 2012; Macpherson, 2008). Also, through the intervention of storytelling nurses can reflect on and make sense of the experience they tell about, creating meaning, which allows for coping and learning when similar events transpire.

This intervention was used for a pilot study involving 9 pediatric nurses working in both a neonatal intensive care unit and an inpatient pediatric unit. The method for conducting this research was both qualitative and quantitative in nature. In using a mixed-method approach quantifying data, using the Perceived Stress Scale (Cohen, Kamarck & Mermelstein, 1983) and qualitative data, using 3 questions created by this researcher, yielded information about stress reduction interventions in this participant population. This intervention is a simple approach to stress reduction options and may be considered for use worldwide, as stressful workplace environments are not limited in boundaries.

Learner objectives:

1. The learner will be able to explain the steps of an effective storytelling intervention.

One feature of storytelling is the creation of dyads and/or small groups who self-identify with co-workers they feel comfortable with and who can provide support. Next a schedule should be set for meeting times, days, and places. Once the schedule is established the intervention should follow a set routine of steps to take such as identification of the storyteller and listener, prompting questions to guide the process, and reversal of roles for others to participate as storyteller.

2. The learner will be able to utilize this intervention in their own practice.

Once the storytelling intervention is understood, the steps that guide the intervention can be used for stress reduction. Nurses who choose to participate and who believe that the intervention will help with their workplace stress levels can utilize storytelling at any time.

3. The learner will be able to appraise the importance of the intervention of storytelling so that perceived workplace stress will be reduced.

During the process of storytelling the nurses reflect on, and make meaning of, the experience. Verbally communicating stories of patient events promotes healing by understanding and making sense of

traumatic experiences creating a sense of connectedness, providing personal resilience, increasing coping, and decreasing stress (East, Jackson, O'Brien & Peters, 2010).

References

Cook, K.A., Mott, S., Lawrence, P., Jablonski, J., Grady, M. R., Norton, D., Liner, K. P., Cioffi, J., Hickey, P., Reidy, S., Connor, J. A. (2012). Coping while caring for the dying child: Nurses' experiences in an acute care setting. *Journal of Pediatric Nursing,* 27, e11-e21.

Fathi, A., Nasae, T., Thiangchanya, P. (2012). Workplace stressors and coping strategies among public hospital nurses in Medan, Indonesia. *Nurse Media Journal of Nursing, 2*(1), 315-324.

Ko, W., Kiser-Larson, N. (2016). Stress levels of nurses in oncology outpatient units. *Clinical Journal of Oncology Nursing 20*(2), 158-164.

Contact

nursedlc@aol.com

K 02 - Support through Mindful Interventions

Mindfulness Training: Building a Supportive Environment

Carol Boswell, EdD, RN, CNE, ANEF, FAAN, USA
Jessica Tully, MSN, RN-BC, CMSRN, CNML, USA
Teresa Mills, RN BS, RN, USA

Abstract

Mindfulness training methods have been employed effectively and productively in healthcare organizations to reduce stress, anxiety, emotional fatigue, depersonalization, depression, and burnout. These strategies have been beneficial for stimulating personal triumphs, self-confidence, empathy, concentration, and frame of mind. Utilizing these approaches, institutions have creatively diminished employee health costs, augmented personal output, impacted job contentment, and decreased negative physiologic markers (Francis, n.d.). Individuals and organizations should undertake to tackle the uneasiness and challenges experienced by employees to ensure that the workplace is a health work environment.

A West Texas acute care agency recognized a mounting concern with staff members stressed with numerous conflicting priorities, processing recurrent challenges and uncertainty in a complicated environment. As a consequence of these hardships, a choice was made to cultivate a focused mindfulness training program which could be provided to a broad diversity of agency employees to support them in developing a deliberate and suitable process in any setting they were encountering (Schaufenbuel, 2014). The program entailed various distinctive and unique components to permit the growth of a program that was user-friendly, timely, and individualized.

A pilot study related to the Mindfulness Training project received institutional review board approval to conduct the project. A cohort was begun in early fall, 2016. The program utilized a six-week program. Within this period, participants were provided a selection of reading, videos, and activities to complete to gain comfort and expertise with different strategies to address stress, anxiety, fatigue, depression, and burnout. For each week, the participants were compelled to participate in some form of mindfulness activity on a daily basis for a minimum of 5 minutes. Each week, the participants were provided an opportunity to debrief in regard to their journey toward mindfulness competency. During these debriefing sessions, new skills and techniques were discussed and demonstrated along with opportunities to discuss the integration of these skills and techniques into the regular work environment. By providing resources, strategies, and debriefing, the health care environment assumed a more positive, supportive atmosphere.

This session will provide an overview of the process used to develop the Mindfulness Program. Participants will be able to discuss strategies that worked with in this setting along with barriers and challenges encountered which allowed for the evolution of the program. This session will offer ideas for the participants to engage in their own settings with like-minded individuals. Recommendations for assessing the environment will be provided. The presenters will provide suggestions to be used to develop a program in other settings.

References

Francis, C.A., (n.d). Mindfulness in the workplace. Retrieved from: http://www.mindfulnessmeditationinstitute.org/mindfulness-in-the-workplace/

Schaufenbuel, K., (2014). Bringing mindfulness to the workplace. UNC Kenan-Flagier Business School.

Contact

Carol.Boswell@TTUHSC.EDU

K 02 - Support through Mindful Interventions

Creating a Healthy Work Environment through Mindful Interventions

Elizabeth Ann Vaclavik, DNP, RN, OCN, USA

Abstract

A healthy work environment is essential not only to nursing but all of healthcare. It leads to good patient outcomes, patient satisfaction and nurse satisfaction as well as decreased turnover and burnout (Blosky, 2015; Lawrence, 2011; Rushton, 2015). Healthcare has turned its focus on the work environment in an effort to improve patient outcomes and staff satisfaction, resulting in increased research on staff engagement, patient experiences and the work environment. AACN's healthy work environment initiative has a dual focus: the physical environment and the interpersonal milieu including communication, relationships and caring. According to Blosky and Spegman (2015), studies have identified a healthy work environment occurs when there is effective and caring communication among staff leading to a cohesive sense of team and friendship.

Within the workplace, nurses operate under a code of ethics (Winland-Brown, 2015). They work with compassion and respect, having a commitment to the patient to help improve their health and advocating for their rights while remaining accountable for their practice.

Moral distress results when nurses are directed to actions they believe are not ethically appropriate and feel a sense of powerlessness to challenge these directives (Epstein, Delgado, 2010). Other factors such as poor communication, pressure to reduce costs or lack of administrative support may lead to moral distress as well. According to Epstein and Delgado (2010), two main sources of moral distress are inadequate communication of end of life care/goals of care between providers and patients and when healthcare providers give a false sense of hope to patients and families.

According to Hamric, Borcher and Epstein (2012), moral distress can be measured using a scale that identifies the root cause. The moral distress scale (MDS) has been validated using several types of healthcare workers, including physicians and nurses and identifies three root causes of moral distress; clinical situations, internal constraints and external constraints. The 4-point scale addresses each area not only identifying the level of distress a situation causes, but the frequency with which the provider experiences the situation. It is also important to note that different areas of healthcare and different roles may identify different causes of moral distress so it is critical the leader utilize the scale to measure the distress of their staff.

Once moral distress and its root cause is identified, action needs to be taken. Lievrouw et al (2016) lists four ways for individuals to cope. Using thoroughness or compromise means everyone on the team is included and accountable, while autonomy and intuition excludes the physician from the interventions. In different work environments, different approaches may be necessary. Epstein (2010) identifies the need to speak up when faced with morally distressing situations. This will help to build support networks among the disciplines. Along with speaking up there should be education on moral distress and a workshop on dealing with moral distress.

Critical reflective practice, or CRP was developed by Lawrence (2011) as a way to use reflective practices to enhance self-awareness, self-esteem and sense of empowerment. CRP involves being mindful of one's self within their professional practice and processing situations as a way to continually grow and develop as a professional.

Resiliency has been a focus to help alleviate moral distress as well (Rushton, Batcheller, Schroeder, Donohue, 2015). Resiliency is viewed as using spirituality and hope when faced with distress and suffering. While this provides insight into moral distress, more actions may be needed to alleviate moral distress.

Mindfulness based stress reduction, or MBSR is an effective intervention in coping with moral distress (Smith, 2014). Kabat-Zin (2011) describes the impact of being in the moment, ever mindful of where you are at the moment and accepting whatever situation you are in. While the official MBSR training involves an intensive eight-week course, Smith (2014) found a four-week course was also effective, with a focus

on meditation, journaling and reflection. Horner, Piercy, Eure and Woodard, (2014) describe a study using mindfulness training to impact compassion, satisfaction, burnout and stress which resulted in increased patient and nurse satisfaction.

In one particular academic medical center, nurses on an oncology unit completed a satisfaction survey identifying only 9% of the staff were satisfied. Following a descriptive analysis using focus groups and support groups, staff identified hopelessness, sadness, and sense of futility and powerlessness; all symptoms of moral distress. The moral distress scale (MDS) was used to identify any root causes of moral distress. The main cause of moral distress among staff was observing other healthcare providers giving patients a false sense of hope. Over 80% of respondents not only listed false hope as being very distressing, but also happening with great frequency.

A personalized program was developed that included critical debrief sessions following events on the unit as well as support sessions following a death for reflection. In addition, Code Lavender Bags were made including tissues, a gift card for a cup of coffee, chocolate, lavender sachet, and a card with a personalized message from the unit leader. Yoga was started for both shifts, and bedside rounding with the interdisciplinary team was encouraged and supported by leadership. An eight-week mindfulness program was also implemented to a core group of staff. Communication was enhanced among nurses and physicians during support debriefs.

Several months after full implementation of the interventions a staff satisfaction survey was again sent out. Satisfaction scores were at the national benchmark of 36%. The moral distress scale (MDS) was again administered and no significant moral distress was noted among the nursing staff. Patient satisfaction scores are also among the highest within the organization.

Creating a healthy work environment is critical among healthcare organizations to successfully provide quality patient care with improved outcomes. Each leader must focus on their staff to identify the aspects of their environment that lead to moral distress and take action to minimize those effects. We may not be able to change other's practices, but we can learn how to perceive others practices and reflect on our own practices and the meaning of the practice.

References

Blosky, M.A., Spegman, A. (2015). Communication and a healthy work environment. *Nursing Management,* 46(6), 32-38.

Hamric, A.B., Borcher, C.T., Epstein, E.G. (2012). Development and testing of an instrument to measure moral distress in healthcare professionals. *AJOB Prim Res*. 3(2):1-9.

Horner, J.K., Piercy, B.S., Eure, L., Woodard, E.K. (2014). A pilot study to evaluate mindfulness as a strategy to improve inpatient nurse and patient experiences. *Applied Nursing Research*, 27, 198-201.

Kabat-Zinn, J. (2011). Mindfulness for beginners: Reclaiming the present moment-and your life. Goulder, CO: Sounds True, Inc; 2011.

Lawrence, L.A. (2011). Work engagement, moral distress, education level, and critical reflective practice in intensive care nurses. *Nurs Forum,* 46(4):256-268.

Lievrouw, A., Vanheule, S., Deveugele, M., DeVos, M, Pattyn, P., Belle, V., and Benoit, D.D. (2016). Coping with moral distress in oncology practice: Nurse and physician strategies. *Oncology Nursing Forum*, 43(4), 505-512.

Rushton, C.H., Batcheller, J., Schroeder, K., Donohue, P. (2015). Burnout and resilience among nurses practicing in high-intensity settings. *AJCC,* 24(5), 412-420.

Smith, S.A. (2014). Mindfulness-based stress reduction: An intervention to enhance the effectiveness of nurses' coping with work-related stress. *International Journal of Nursing Knowledge*, 25(2), 119-130.

Winland-Brown, J., Lachman, V.D., Swanson, E.O. (2015). The new code of ethics for nurses with interpretive statements: Practical clinical application, part I. *MedSurg Nurs*. 24(4), 268-271.

Contact

momofthreern@yahoo.com

K 03 - Supporting Healthy Work Environments

Creating Healthy Work Environment Standards for Academia

Rebecca Bouterie Harmon, PhD, RN, USA
Regina M. DeGennaro, DNP, RN, CNS, AOCN, CNL, USA
Meg F. Norling, BSN, RN, USA

Abstract

This work describes the efforts at one School of Nursing to create a Healthy Work Environment (HWE) that supports all members of the academic community—students, staff and faculty. The need for healthier work environments—to improve patient care, teamwork, and nurse retention—is well established in the clinical setting and was codified by the American Association of Critical Care Nurses (AACN) in 2005 and again in 2016. This work describes the progress made in the development of an academic Healthy Work Environment based on the work of Fontaine et al (2012) and calls for the addition of a critical seventh standard—self-care. Foundational to all of the healthy work standards, self-care deserves explicit recognition, especially in light of widespread nursing burnout and compassion fatigue. Academic institutions, which lay the foundation and help establish norms for future nursing practice, have a unique opportunity to encourage and model self-care. Nurses who take care of themselves strengthen their personal and professional resilience, which in turn helps to improve patient care and mitigate burnout and compassion fatigue. Registered Nurse (RN) turnover, an important and widely used measure in analyzing the healthcare workforce, is high for newly licensed RNs. It is estimated that the one-year turnover rate for this group is over 17%; the two-year rate is over 33% (Kovner, Brewer, Fatehi, & Jun, 2014). High turnover is not only expensive in the clinical setting, but can negatively affect teamwork and patient outcomes. More attention to detail and nurturing needs to occur in order to prepare, support and retain our new—and existing-- nursing workforce. Academic institutions have a unique opportunity to promote awareness and practice of healthy work habits for all. Schools of nursing can support the culture of civility and self-care by intentionally guiding employees in strategic ways to support inclusivity and interprofessional education in a healthy work environment. Faculty, staff, and students need empowerment to engage in self-care activities. Resilience and self-care activities are not "frills"; they are integral to a successful transition to, and longevity in, all areas of nursing. For over a decade the ANCC HWE standards have helped clinicians to improve nursing practice and patient care. It is time to add a seventh standard of self-care. Changing a community's culture is hard work and requires commitment by many over time. For change to be sustainable, structural and organizational change is also needed. The future of nursing depends on it.

References

Clark, L., Calvillo, E., dela Cruz, F., Fongwa, M., Kools, S., Lowe, J., & Mastel-Smith, B. (2011). Cultural Competencies for Graduate Nursing Education. *Journal of Professional Nursing, 27,* 3, 133-139.

Fontaine, D., Koh, E., & Carroll, T. (2012) Promoting a Healthy Workplace for Nursing Faculty and Staff. *Nursing Clinics of North America,* 47, 557-566.

Harmon, R.B., Fontaine, D., Plews-Ogan, M., & Williams, A. (2012). Achieving transformational change: Using appreciative inquiry for strategic planning in a school of nursing. *Journal of Professional Nursing,* 28, 2, 119-124.

Contact

rbh8a@virginia.edu

K 03 - Supporting Healthy Work Environments

Developing a Supportive Environment for Our Healthcare Workers

Kim Tharp-Barrie, DNP, RN, SANE, USA
Tracy Williams, DNP, RN, USA

Abstract

In preparation for a three-year strategic plan, our organization recently surveyed nurses throughout our five-hospital system to understand how we could better maintain and protect our health care staff. We found that staffing shortages, long work hours, retention issues, and inability to maintain a satisfactory work-life balance were the main issues affecting staff. Knowing that these stressors affect employees' relationships at all levels, our leadership has developed a number of programs that encourage a healthy workplace where employees feel heard, valued, and experience personal satisfaction. Our organization created an Institute for Nursing (I4N) to support the professional growth and practice of nursing. The I4N serves nurses in the system in a variety of ways through their four centers: Nursing Practice, Professional Development, Nursing Outreach, and Nursing Research. The I4N provides a supportive environment for health care workers and has taken steps to insure that our work environment is one that is safe, empowering, and satisfying. Our organization has a chief nursing office in each health care facility to support and give leadership to nursing issues. We have developed a Virtual Employee Model which supports programs that are used to develop the physical, mental and social well-being of all health care workers. We offer pre-college programs that assist employees to realize their dream of attaining a college degree and clinical advancement and leadership development programs which promote life-long learning. We have developed several new programs to attract, train and retain college students and graduate nurses. In order to prepare our new staff to make a successful transition from student to practice, we have developed an apprentice program, an extern program and a new nurse residency program. The purpose of the Nurse Apprenticeship Program is to intentionally invest in future nurses prior to graduation from an accredited nursing program. The ultimate goal is to improve the quality of patient care, as well as address the need for additional, well-trained nurses' post-graduation. The objectives for the program are to create a two year, tiered experience to follow the guidelines for an accredited apprentice program; exposure and experience in specialty areas prior to graduation; decreased orientation time post-graduation; and decreased turnover by matching their clinical interest with unit specialty prior to graduation. The purpose of the Nurse Extern Program was to allow nursing students the opportunity for a summer of clinical immersion. The seven-week program ran from May to July, where a nursing student was paired with a licensed nurse on a unit of their stated preference. Their clinical skills were validated prior to admittance by a nursing faculty at their enrolled school. The objectives for the new Nurse Residency Program are to produce an increase in new graduate nurse retention rates at the six month, one year, and three year marks and to engage new graduate nurses in activities that foster immersion into our system, strengthen nursing practice, and promote professional development. The monthly three hour workshops are designed to support the new graduate nurse's professional development, evidence-based practice understanding, and enhanced confidence in professional interactions with peers and colleagues, and reflection time. We understand that communication must be open, honest, and allow all parties the opportunity to express themselves. This creates an opportunity for open dialogue, sharing of ideas and team problem solving. In order to encourage honest, positive dialogue we offer continuing education classes to inspire constructive dialogue and behavior among our staff such as lateral violence, diversity in the workplace, and self-care for healthcare, to name a few. We work to identify factors contributing to stress and burnout and learn techniques to balance life physically, mentally and spiritually. We offer a free program for counseling for all employees and their families. We have an NGood Health Program which provides information on healthy food and healthy behaviors which resulted in our organization winning the 2015 Business First Healthiest Employers Award in its category of 5,000 to 49,000 employees. We have an award winning new employee orientation program and onboarding to bring people into our organization with information about what resources are available to them and what the expectations the organization has for them. A healthy work environment means providing one that is safe, empowering and satisfying; an environment where staff has the opportunity to work in a place of "physical, mental, and social well-being," supporting optimal health and safety. With the programs in place, our organization is poised to continue to provide a healthy work environment where employees feel

heard, valued, and experience personal satisfaction. These efforts earned designation as a National League for Nursing (NLN) Center of Excellence 2013-2017 based on, “their visionary leadership sets the standard for nursing education to build a strong and diverse nursing workforce to advance the nation’s health, guided by the core values of caring, integrity, diversity and excellence.”

References

Sanner-Stiehr E, Ward Smith P. (2014). Lateral violence and the exit strategy. *Nurs Manage*, 45, 3, 11-15.

McFadden, Kinley. Oct 8, 2013. *Tips on Creating a Healthy, Efficient and Positive Work Environment.* Retrieved from http://smartbusinesstrends.com/tips-creating-healthy-efficient-positive-work-environment

Contact

kim.tharp-barrie@nortonhealthcare.org

L 01 - Integrating Nursing Peer Review and a Restorative Just Culture for a Healthy Work Environment

Integrating Nursing Peer Review and a Restorative Just Culture for a Healthy Work Environment

Jane Braaten, PhD, MS, RN, USA
Cynthia A. Oster, PhD, MBA, ANP, ACNS-BC, CNS-BC, USA

Abstract

Background: Healthy work environments empower staff and foster effective interpersonal relationships and collaboration (American Association of Critical Care Nurses, 2016). A structure to integrate these characteristics into the workflow is necessary for change (Huddleston & Gray, 2016). Nursing peer review is an integral structure to ensure a healthy work environment and positive clinical outcomes. However, the implementation of peer review is still limited and can seem punitive due to a narrow focus on the person being reviewed (George & Haag-Heitman, 2015). This often leads to weak interventions that have a limited impact on patient outcomes and often are isolated to an individual rather than the system. This type of review often is damaging to the recipient and does not foster a healthy work environment. A healthy work environment calls for a restorative review that not only values the person who was harmed, but also the person being reviewed.

Sidney Dekker (2012) describes the difference between a retributive just culture in which there is blame and payment for harm and a restorative just culture as one that focuses on harm that needs healing and the community obligation to collectively find a solution to that harm considering not only the person who was harmed but the individual who may have been involved in the harm. Dekker's model focuses on: healing those who are hurt from an event including first and second victims; asking *what* is responsible instead of *who* is responsible, getting to the truth through multiple accounts, understanding why actions made sense within the context of the situation, and foremost, building and healing relationships and trust through the process (Dekker, 2015). Nursing peer review implemented through the lens of a restorative just culture has the potential to build peer relationships, enhance a safety culture, and achieve sustainable changes that improve outcomes for patients.

Purpose: The purpose of this project is to describe a process for pairing a restorative just culture into nursing peer review in order to heal, learn, collaborate, retain staff, and improve outcomes for patients.

Relevance/Significance: Nursing peer review was described in 1988 by the American Nurses Association (ANA) as the process by which practicing nurses systematically assess, monitor, and make judgments about the quality of care their peers provide as measured against professional standards of practice. This definition has not changed; however, the patient safety landscape has changed, warranting a new lens through which nursing can implement peer review.

A nursing peer review process that focuses on a restorative just culture, effective peer to peer feedback and systems learning can be an effective tool to use to build a healthy work environment. There is a sparse amount of literature on how to effectively integrate just culture into nursing peer review and also a lack of information on aspects of a restorative culture in healthcare. Creating a model to integrate restorative just culture principles into nursing peer review and focus on strong system level interventions can lead to effective changes that will move outcomes and prevent adverse events by promoting honest, effective communication and collaboration between nurse peers as well as learning for the whole hospital.

Strategy and implementation: Review of literature showed a gap between organizational implementation of just culture and integration into the professional nursing peer review process. The project hospitals strengthened the standard peer review by creating a tool that integrated the tenants of a restorative just culture into the review format. The three duties of just culture are reviewed prior to the formal evaluation to view the evaluation within the correct duty: duty to avoid causing harm, duty to follow a rule, and duty to produce an outcome. Then the situation is placed into the three categories of human error, risky behavior or reckless behavior in order to decide upon scoring the actions of the individual and/or discuss system factors of error. Addition of the restorative nature of just culture then includes the

following process pieces: Assessing first and second victims of the situation and the need and resources for healing, allowing for all accounts to be heard and understood in the context of the situation assuring that hindsight bias is recognized and minimized, and assessing for solutions collaboratively that hold the individual as well as the system accountable. The final step to the process is to close the loop by allowing the individual involved in the event, the opportunity to provide feedback to the nursing peer review group in order to assure that the group is promoting learning, healing, relationship and trust. Education to the nursing peer review group prior to implementation included just culture, causes of error, human factors effects, and causes of bias when reviewing human behavior such as hindsight bias and outcome bias.

Evaluation: The Nursing Peer Review group has reviewed 25 cases referred from occurrence reports, adverse events, physician referrals, and peer referrals. The main outcomes desired from nursing peer review include an expert review of the case; understanding from the individual who experienced the event point of view; collaboration between the nurse peer reviewer and reviewee for solutions, and referrals to system level groups for system learning. A mainstay of the process is closing the loop by asking the nurse who was reviewed to give feedback to the group regarding how well we communicated and collaborated and mutually provided a solution that will prevent the issue from happening again. Higher levels outcomes also have included a reduction in fall rate, a reduction in oversedation rate and an impact on failure to rescue. Nurse retention rate and effect on Patient Safety Culture are in process of evaluation.

Implications for practice: Organizations are challenged to meet quality outcomes performance standards and are also challenged to nimbly change nursing practice to drive positive outcomes. Peer review integrated with a restorative just culture drives nursing leaders to intervene at the point of care to align individual practice and system designs with standards of care and a healthy work environment.

References

American Association of Critical Care Nurses. (2016). *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence,* 2nd Edition. Retrieved from http://www.aacn.org/WD/HWE/Content/hwehome.content?menu=hwe

American Nurses Association (ANA). (1988). *Peer Review Guidelines*. Kansas City, MO: ANA.

Dekker, S. (2015). *Safety Differently: Human Factors for a New Era*. Boca Raton, FL: CRC Press.

Dekker, S. (2012). *Just culture: Balancing safety and accountability* (2nd Ed.). Burlington, VT: Ashgate.

George, V & Haag-Heitman B. (2015). Essential Components of a Model Supporting Safety and Quality. *Journal of Nursing Administration,* 45(7/8): 398-403.

Huddleston, P. & Gray, J. (2016). Measuring nurse leaders' and direct care nurses' perceptions of a healthy work environment in an acute care setting, Part 1. *Journal of Nursing Administration*, *46*(7/8), 373-378.

Contact

janebraaten@centura.org

L 02 - Registered Nurses' Lived Experiences of Peer-to-Peer Incivility in the Workplace

Registered Nurses' Lived Experiences of Peer-to-Peer Incivility in the Workplace

Susan Condie, PhD, RN, CNS, PHN, ACNS-BC, CNE, NE-BC, CHEP, USA

Abstract

Incivility negatively interferes with patient care delivery, nursing retention, as well as medical costs. Disregard for another's knowledge and skills through rude and discourteous actions that prevent others from thriving is an actual depiction of an uncivil workplace. The purpose of this qualitative study was to explore registered nurses lived experiences of peer to peer incivility in the workplace. An aim of this study was to understand the participants' experiences of peer to peer incivility in the workplace, its effect on patient safety and nursing job satisfaction and retention.

Descriptive phenomenology was used for this study on the lived experience of being a registered nurse who has encountered peer to peer incivility in the workplace. Participants were enrolled using a combination of purposive and snowball sampling. Semi-structured interviews were audiotaped and conducted with participants who had experience with peer to peer incivility in the workplace. Data were collected until saturation was achieved. The audiotapes were transcribed and analyzed for common themes that represented the participants' experiences with peer to peer incivility. Based on the findings of this study, suggestions are offered for further research and required actions to elevate the work atmosphere of the nurse from uncivil to a healthy and professional workplace.

The study findings have substantial implications for nursing education, nursing practice, nursing research, and nursing science. This investigation provides novel information about experiences with uncivil peers and relates the experience to being in a war-zone. The study also allowed the participants to discuss their lived experience of peer to peer incivility in nursing. Some participants shared their perceptions of the impact on safe patient care, retention of nurses, and medical costs. Finally, this study suggests what it is like to be a nurse who has experienced peer to peer incivility and how that experience has affected their decision to remain in their nursing position.

References

Clark, C. M. (2013). *Creating & sustaining civility in nursing education.* Sigma Theta Tau International. Retrieved from http://www.reflectionsonnursingleadership.org/Pages/Vol36_1_Clark.aspx

Clark, C. M. (2014). Seeking civility: Strategies to create and sustain healthy workplaces. *American Nurse Today, 9,* 18–21, 46.

Contact

susancondie2487@gmail.com

L 03 - Autonomy, Role Ambiguity, and Collaborative Relationships Impact Novice Nurse Practitioner Turnover Intention in Primary Care

Autonomy, Role Ambiguity, and Collaborative Relationships Impact Novice Nurse Practitioner Turnover Intention in Primary Care

Asefeh Faraz, PhD, RN, APRN, FNP-BC, USA

Abstract

The purpose of this study was to describe the individual characteristics, role acquisition and job satisfaction of novice nurse practitioners (NPs), and identify the factors associated with their successful transition and turnover intention in the first year of primary care (PC) practice. This research study was a descriptive, cross-sectional quantitative design conducted via online survey administered by Qualtrics. A national sample of NPs who had graduated from an accredited NP program and were practicing in a PC setting for 3-12 months participated in the study.

The study was comprised of a researcher-created demographic and background questionnaire and several psychometrically tested instruments: Psychological Empowerment Meaning Subscale, a modified Social Support Questionnaire Short Version (SSQ6), the Role Ambiguity Scale, Grundy's Confidence Scale, The Misener Nurse Practitioner Job Satisfaction Scale, and the Anticipated Turnover Scale. Five open-ended questions were included at the end of the questionnaire to assess aspects of the workforce transition not otherwise captured.

The average participant (n=177) was female, 35 years old, Caucasian, married, and not presently supporting dependents. Results showed that 57.6% of the sample attended a traditional master's program, 41.2% had six or more years of prior RN experience, and 90.4% reported having a workplace mentor whom they could ask questions. Professionally, the average participant held a master's degree in nursing, is a family NP and works 40 or more hours per week. In addition, the following were the most commonly occurring characteristics of the sample: six or more years of previous RN experience; no prior healthcare related employment other than RN, and working in a private practice PC setting.

Variables showing significant relationships to turnover intention ($p<.01$) included: role ambiguity (-.51), professional autonomy (-.62), and quality of professional and interpersonal relationships (-.57). Multiple regression results indicated that turnover intention was significantly influenced by higher professional autonomy (b=-.44, t=-3.42, p=.001) and lower role ambiguity (b=-.20, t=-2.14, p=.03). The regression model explained approximately 48% of the variance in turnover intention for the sample.

Results could potentially aid employers in focusing their efforts on developing programs to increase professional autonomy and improve role clarification within their organizations, as well as routinely assess these factors in NPs they employ. Health care organizations should consider ensuring professional autonomy for novice NPs, while providing some level of formal orientation and support. Creating a practice environment that emphasizes professional autonomy of the NP is one in which mutual collaboration occurs and NPs are allowed to practice to the full extent of their education with clarified roles and responsibilities. This is essential for NP autonomy to flourish, thereby improving satisfaction and increasing retention.

Furthermore, greater clarity and increased awareness of other health care providers (HCPs) in the practice setting of the NP role is needed in many organizations. Employers may benefit from educating their staff, particularly other HCPs, about the role and scope of practice of NPs. Many are proponents of collaborative and inter-professional education to increase awareness and understanding among various HCPs at an earlier stage so that they may more effectively communicate in the workplace. NP transition-to-practice programs may be effective in decreasing role ambiguity, in particular through use of reflective journaling.

The first step in developing intervention programs is to understand the needs of the population. This study found that increasing professional autonomy and decreasing role ambiguity are critical to facilitating the successful transition of novice NPs in PC settings. The common denominator to accomplishing both of these goals is improving collaborative relationships in the practice setting. There are multiple campaigns

underway to improve interprofessional collaborative practice, including recent recommendations by the IOM, Robert Wood Johnson Foundation (RWJF), and the Interprofessional Education Collaborative (comprised of AACN, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges, and Association of Schools of Public Health).

This research study demonstrated that greater professional autonomy in the workplace is a critical factor in turnover intention in novice NPs in the PC setting. Additionally, decreased role ambiguity is a strong predictor of turnover intention and should be an area of focus. Both of these factors may be influenced by collaborative relationships in the workplace. Further research is needed to evaluate the successful transition of novice NPs into the workforce to determine ways of providing adequate professional autonomy, decreasing role ambiguity, and how best to support them during the transitional period.

References

American Association of Nurse Practitioners. (2015). State Nurse Practice Acts and Administrative Rules, 2015. Accessed November 11, 2015 from http://www.aanp.org/images/documents/state-leg-reg/stateregulatorymap.pdf

Barnes, H. (2015). Exploring the factors that influence nurse practitioner role transition. *The Journal for Nurse Practitioners, 11*(2), 178-183. doi:http://dx.doi.org/10.1016/j.nurpra.2014.11.004

Buerhaus, P.I., DesRoches, C.M., Dittus, R., & Donelan, K. (2015). Practice characteristics of primary care nurse practitioners and physicians. *Nursing Outlook, 63*(2), 144-153. doi: http://dx.doi.org/10.1016/j.outlook.2014.08.008

Cassidy, A. (2013). Health policy brief: Nurse practitioners and primary care (updated). *Health Affairs*. Accessed November 19, 2013 from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=92

DeMilt, D.G., Fitzpatrick, J.J., & McNulty, R. (2011). Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. *Journal of the American Academy of Nurse Practitioners,* 1-9. doi: 10.1111/j.1745-7599.2010.00570.x

Fairman, J.A., Rowe, J.W., Hassmiller, S., & Shalala, D.E. (2011). Broadening the scope of nursing practice. *New England Journal of Medicine, 364,* 193-196. doi:10.1056/NEJMp1012121

Flinter, M. (2012). From new nurse practitioner to primary care provider: Bridging the transition to FQHC-based residency training. *OJIN: The Online Journal of Issues in Nursing, 17*(1). doi: 10.3912/OJIN.Vol17No01PPT04

Harrington, S. (2011). Mentoring new nurse practitioners to accelerate their development as primary care providers: A literature review*. Journal of the American Academy of Nurse Practitioners, 23*(4), 168-174. doi: 10.1111/j.1745-7599.2011.00601.x

Hill, L.A., & Sawatzky, J.A. (2011). Transitioning into the nurse practitioner role through mentorship. *Journal of Professional Nursing: Official Journal of the American Association of Colleges of Nursing, 27*(3), 161-167. doi: 10.1016/j.profnurs.2011.02.004

Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.: Interprofessional Education Collaborative.

Poronsky, C.B. (2012). A literature review of mentoring for RN-to-FNP transition. *Journal of Nursing Education, 15*(11), 623-631. doi:10.3928/01484834-20120914-03

Sargent, L. & Olmedo, M. (2013). Meeting the needs of new-graduate nurse practitioners: a model to support transition. *Journal of Nursing Administration, 43*(11), 603-610. doi: 10.1097/01.NNA.0000434506.77052.d2

Scholtz, A., King, K. & Kolb, S. (2014). The care model of the future: Supporting APRNs through an innovative transition to practice program. *Journal of Pediatric Healthcare, 28*(3), 276-279. doi: http://dx.doi.org/10.1016/j.pedhc.2013.11.002

U.S. Department of Health and Human Services Health Resources and Services Administration (2013). Projecting the supply and demand for primary care practitioners through 2020 in brief. Accessed December 29, 2015 from http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/primarycare/primarycarebrief.pdf

Zapatka, S.A., Conelius, J., Edwards, J., Meyer, E., & Brienza, R. (2014). Pioneering a primary care adult nurse practitioner interprofessional fellowship. *The Journal for Nurse Practitioners, 10*(6), 378-386. doi: 10.1016/j.nurpra.2014.03.018

Contact

asefeh.faraz@aya.yale.edu

L 04 - Nursing Empowered Leaders: A Study Describing Who We Are and Who We Want To Be

Nursing Empowered Leaders: A Study Describing Who We Are and Who We Want To Be

Judi Allyn Godsey, PhD, RN, USA
Tom Hayes, PhD, USA

Abstract

Numerous articles have been written describing the disconnect between the perceived image of nursing and the unfavorable, inaccurate, stereotypical representations of nursing commonly fed by the media (Morris, 2007; Cabiniss, 2011; Kelly et al., 2011; Rezaaie-Adaryani et al., 2012). Media representations of nurses have typically included their role as subservient to physicians, angels of mercy, or sex objects (Cunningham, 1999; Mendez & Louis, 1991; Pierce, S., Grodal, K., Smith, L. S., Elia-Tybol, S., Miller, A. & Tallman, C., 2002; Ward, Styles and Bosco, 2003). Researchers have consistently called for the profession of nursing to pursue branding strategies that take charge of the nursing image (Pinkerton, 2002; Parish, 2004; Dominiak, 2004; Baldwin et al., 2010 and Cabiniss, 2011). A common theme in the literature describes an ongoing lack of a consistent brand identity for nursing. (Goodin, 2003; Zarea et al.,2009; Emeghebo, 2006; Cabiniss, 2011 and Rezaie-Adaryani et al., 2012). No published studies could be identified prior to this research which used valid instruments to identify, measure, and describe the current and most desired brand image for the profession of nursing.

Perceptions of the current versus most desired brand image of the nursing profession were compared in a national sample of Registered Nurses (n=264). Participants were administered electronic surveys consisting of a series of Nursing Brand Image Scales. These scales were developed by the researchers to measure and compare the current versus the desired brand image and brand position of the nursing profession. The “Nursing’s Current Brand Image Scale” (NCBIS) consists of 42 words and phrases describing the nursing profession. It uniquely ranks, and then rates each of the descriptors for the nursing profession. The “Nursing Desired Brand Image Scale” (NDBIS) rates and then ranks the same 42 words and phrases, but from the standpoint of those traits considered most desirable for the nursing profession. Perceptions of current versus desired image were then compared and contrasted. Lastly, the “Nursing Current Brand Position Scale” (NCBPS) consists of 10 brand position statements constructed from the most commonly selected descriptors identified by nurses on the NBIS. Nurse participants were asked to select only one current brand image position statement which they felt “Most Accurately Describes” the nursing profession, followed by the statement which “Least Describes”, and finally, the statement which is “Most Appealing” for the profession of nursing. The internal consistency reliability for each scale was excellent.

The top five "current descriptors" for the nursing profession were: "advocates" (48%), "caring/compassionate" (33%), "critical thinkers" (32%), "patient centered/focused" (25%), and "essential members of the healthcare team" (19%). Descriptors chosen least, or not at all: "powerful/decision-makers", "autonomous", "interprofessional", "researchers", and "health experts" (0-2%). Brand position statements most frequently selected as currently representative of nursing focused on themes of "caring", "patient centeredness", "advocacy" and "holistic care". However, nursing as a "caring profession" decreased significantly ($p = 0.00$) as a "most desired" brand image, while "nurses as leaders in education, research and practice" increased significantly ($p = 0.00$) to become a "most desired" brand position statement. Almost three-fourths of nurses responded "no" when asked if nursing has a consistent brand image.

Results of this study demonstrated that significant gaps exist on two levels regarding the brand image of the profession of nursing. Incongruences were found between how nurses perceive their profession currently versus how they would like to be perceived. Interestingly, respondents reported that “nurses themselves” were primarily responsible for managing their own professional brand image.

Numbering more than 3.3 million, Registered Nurses make up the largest group of healthcare professionals in the nation. The authors contend that the large scale, strategic management of a

profession's brand identity is a primary responsibility of the major nursing professional associations at the national level, rather than reliance on individual "nurses themselves". This study provides further support that the nursing profession needs to manage its brand identity in a more deliberate and consistent manner. This research could inform the design of a more accurate and distinctive set of brand positioning statements which represent nurses as leaders in education, research and practice and essential leaders during an era of healthcare transformation.

References

Please note: Some references are older than 5 years due to the historical nature of this review, and the lack of availability of current research on this topic.

Cabaniss, R. (2011). Educating nurses to impact change in nursing image. *Teaching and Learning in Nursing 6, p. 112-118.*

Dominiak, M.C. (2004). The concept of branding: Is it relevant to nursing? *Nursing Science Quarterly,* 17. 295-300.

Pierce, S., Grodal, K., Smith, L. S., Elia-Tybol, S., Miller, A. & Tallman, C. (2002). Image of the nurse on internet greeting cards. Journal of Undergraduate Nursing Scholarship, 4, (1), p. 1-13.

Rezaei-Adaryani, M., Salsali, M., & Mohammadi, E. (2012). Nursing Image: An Evolutionary Concept Analysis, *Contemporary Nurse*, 43 (1), 81-89.

Ward, C., Styles, L., & Bosco, A. M. (2003). Perceived status of nurses compared to other health care professionals. Contemporary Nurse, 15, (1-2), p. 20-28.

Contact

nurse.judi@yahoo.com

Poster Presentations

PST - Poster Presentations

Enhancing Patient Safety and Student Nurses' Clinical Experiences Through the Use of Student Competency Checklists

Rachel A. Ramsey, MSN, RN, CNE, USA
Mackenzie Herring, IPPNS, USA
Heather van Frankenhuyzen, IPPNS, USA
Milica Milicevic, IPPNS, USA
Zackery Allen, IPPNS, USA
Laurine Khamalah, IPPNS, USA

Abstract

The student nurse experience is unforgettable. It is one of exciting opportunities, new knowledge, and challenges. Clinical experiences in particular offer student nurses chances to step out of their comfort zones, experience the full spectrum of the nursing role, and undergo personal and professional growth. When health care providers, faculty, clinical instructors, and student nurses work according to the same expectations, these experiences can produce seamless learning for the students and cohesive, quality, safe patient care. Unfortunately, the complexity of the clinical environment presents many opportunities for inconsistent, confusing, disorganized, and intimidating situations for the student nurse (Bjorg, Leland, & Gunnar Dale, 2013; Coyne & Needham, 2012). These circumstances not only impact the learning experience for student nurses, they also lead to unsafe conditions and dangerous opportunities for error (Krautscheid, 2008). A group of student nurses at one Midwest university investigated the factors that produce these situations. This investigation became the impetus for a student nurse-driven project focused on improving clinical experiences for student nurses and facilitating safe patient care.

Communication has been identified repeatedly as a major factor in the quality and safety of patient care (Maxfield, Grenny, Lavandaro, & Groah, 2011), as well as student nurses' learning experiences (Bjorg et al., 2013; Coyne & Needham, 2012; Krautscheid, 2008; Morley, 2014). Based on this knowledge, the student nurses conducted informal surveys with other students and nursing staff to identify how those involved felt about the clinical experience at the large urban hospital where clinical learning experiences are arranged. The major issue identified was that both students and nurses are unsure of their roles and responsibilities during the learning partnership.

The student nurses then identified strategies to combat this problem. The first strategy involved creating a course-specific list of nursing competencies and skills that students should achieve during their clinical experiences.

The students collaborated with nursing faculty in the university's medical surgical nursing course to identify specific and general nursing competencies and skills, which became known as "competency checklists." The items were organized into the following categories: Independent; with supervision; and observation only. The document produced from these lists was a checklist for the clinical instructor, nursing staff, and the student nurses that would clarify what students can and cannot do during their clinical experiences, thereby facilitating communication and appropriate delegation. A second document was created from this list, which became known as the "self-assessment" list. This list provided students with a tangible interpretation of the clinical learning objectives and was meant to promote student nurses' self-assessment and to guide them in identifying learning opportunities.

A pilot study for the competency checklist and self-assessment began in the fall semester of 2016. The competency checklists were distributed to lead course faculty, who incorporated the documents into the clinical learning experiences. Surveys were administered to participants at the implementation of the pilot study and will be administered again after 6 weeks. The aims of this pilot study are to increase student nurse and patient safety by improving communication among those involved in the clinical learning partnership. Specifically, the project focused on clarifying the scope of practice, responsibilities, and learning goals of the student nurses involved in the medical surgical course at this university.

At the end of this pilot study the project leaders hope to find that student nurses experienced clarity regarding their role in the clinical learning partnership, improved communication with clinical staff,

increased confidence in seeking relevant learning experiences, and increased opportunities to participate in relevant learning experiences.

References

1. Bjorge, D., Leland, A., & Gunnar Dale, J. (2013). What factors facilitate good learning experiences in clinical studies in nursing: Bachelor students' perceptions. *International Scholarly Research Notices*, *2013*, 1-7.
2. Coyne, E., & Needham, J. (2012). Undergraduate nursing students' placement in specialty clinical areas: Understanding the concerns of the student and registered nurse. *Contemporary Nurse*, *42*(1), 97-104.
3. Maxfield, D., Grenny, J., Lavandaro, R., & Groah, L. (2011). The silent treatment. Why safety checks and checklists aren't enough to save lives. Retrieved from http://www.silenttreatmentstudy.com/download/
4. Morley, D. A. (2014). Supporting student nurses in practice with additional online communication tools. *Nurse Education in Practice*, *14*(1), 69-75.

Contact

coffra03@ipfw.edu

PST - Poster Presentations

A Toolbox to Diminish Lateral Violence in the Workplace

Sara C. Germann, MS, RN, ANP, USA
Shannon Moore, MSN, RN, USA

Abstract

Lateral violence, also known as horizontal violence and workplace bullying, is extremely prevalent in nursing as it has been noted to impact up to 90% of nurses at some point in their career (Smith et al., 2010). Both novice and experienced nurses have reported being impacted by these behaviors which can be both overt and covert in nature. These behaviors can lead to "a decreased sense of well-being, physical health complaints, and depressive symptoms" (Dehue et al., 2012). The psychological and physical complaints range from sleep disturbance, anxiety symptoms, post-traumatic stress disorder symptoms and suicidal ideation to new onset cardiovascular disease symptoms (Christie & Jones, 2014). The outcomes of this type of abuse include loss of confidence and a lack of trust in coworkers as well as resignation and even the victims becoming the perpetrators of the behaviors (Stanton, 2015). Because of the multiple impacts this violence can have, the American Nurses Association (ANA) issued a "zero tolerance" policy for lateral violence and recommends that employers have resources available for nurses to learn to combat this type of violence (ANA, 2015).

The lateral violence toolkit is a compilation of resources including a presentation utilizing the most current research on the subject. These resources include a description of lateral violence with identified behaviors delineated in order to enable nurses to identify instances of violence in their own workplaces. Additionally, links to existing resources will be provided to allow for ease of access to identified communication techniques and training. Communication techniques to address lateral violence in the workplace will be briefly presented and further explicated in a linked presentation with videos demonstrating those techniques for modeling behavior. Finally, a presentation discussing effective techniques to decrease lateral violence is attached to inform nurse managers of how to incorporate the lateral violence toolkit into their unit.

References

American Nurses Association. (2015). *Incivility, bullying and workplace violence.* Retrieved from file:///C:/Users/user/Downloads/PosStat-Endorsed-ANA-Incivility-Bullying-Violence%20(1).pdf

Dehue, F., Bolman, C., Vollink, T., & Austin, P. (2012). Coping with bullying at work and health related problems. *International Journal of Stress Management, 19*(3), 175-197. doi: 10.037/a0028969

Christie, W. & Jones, S. (2014). Lateral violence in nursing and the theory of the nurse as wounded healer. *Online Journal of Issues in Nursing, 18*(4), 1-11. http://dx.doi.org/10.3912.OJIN.Vol19No01PPT01

Smith, L.M., Andrusyszyn, M.A., & Laschinger, H. (2010). Effects of workplace incivility and empowerment on newly graduated nurses' organizational commitment. *Journal of Nursing Management, 18,* 1004-1015.

Stanton, C. (2015). Action needed to stop lateral violence in the perioperative setting. *Journal of the Association of Perioperative Nurses, 101*(5), P7-9. http://dx.doi.org/10.1016/S0001-2092(15)00320-8

Contact

germanns@uindy.edu

PST - Poster Presentations

Identifying and Measuring Nurse Leader Communication Behaviors

Susan G. Hopkinson, PhD, RN-BC, USA

Abstract

In the clinical setting, communication is a primary nursing activity, accounting for 62-84% of total nursing time.[1-5] In the United States, communication has been identified as the third leading root cause for sentinel events accounting for over 20% in root cause analyses,[6] whereas a Danish study found verbal communication errors in 52% of root cause analyses. A core leadership competency in healthcare,[7] effective communication behaviors foster collaborative relationships and ineffective communication behaviors act as a barrier.[8,9]

Nurse leader communication has been identified as a component of structural empowerment that impacts empowerment of nurses.[13] According to the theory of structural empowerment, the hierarchic structure of the organization influences behaviors of leaders and their followers.[10] Empowerment of staff nurses by nursing leaders has been associated with positive outcomes such as trust, job satisfaction and performance.[10-12]

Negative leadership behaviors, such as decreased leader communication, is correlated with lower perceptions of productivity and morale.[14] These toxic behaviors include belittling or embarrassing employees, boasting, yelling and criticizing in front of others.[14,15] Communication behaviors associated with bullying, such as raising of eyebrows, snide remarks, abrupt responses, lack of openness, bickering, and complaining about others have been associated with absenteeism, intention to leave and staff turnover.[16-18]

A gap exists, however, in how to assess and develop these leader communication behaviors to assist in shaping a healthy work environment. The communication assessment tools currently available, either in the literature or publicly, rely primarily on self-assessment. The literature indicates that self-assessment conducted individually is not necessarily accurate or reliable,[19,20] especially for persons with the least developed skills and most confidence within the assessed area.[21] A recommendation is to integrate external feedback with self-assessments.[22]

The purpose of this study was to identify and measure the characteristics of nurse leader communication behaviors through external feedback. The primary aim was to develop a survey instrument that measured the characteristics of nurse leader communication behaviors as perceived by staff nurses. The secondary aim was to determine if these behaviors are related to staff nurse psychological empowerment.

This exploratory instrument development study used the following steps recommended by DeVellis:[23]1) identify constructs, 2) generate items, 3) test content and face validity, 4) evaluate construct validity, and 5) evaluate criterion related validity. The coded and aggregated findings from four focus groups of inpatient nurses and nurse leaders (n = 16) were used to validate the a priori concepts from the literature. After the research team developed 208 initial items, four experts in research and/or nursing leadership reviewed the items for content validity. Based on the feedback, the items were modified and reduced to 125 items that were then reviewed by four staff nurses from the target population for face validity. The 108 final items are currently being piloted in a small convenience sample of inpatient staff nurses concurrently with a 12-item Psychological Empowerment Scale for criterion-related validity. With a current response rate of 34, efforts are being made to increase the response rate to at least 50 prior to data analysis.

The ordinal survey item data will be analyzed for item means, variances, and item-scale correlations. Although controversial, a preliminary confirmatory factor analysis will be conducted to guide further refinement of the items in the developed instrument. The correlation between communication behaviors and nurse psychological empowerment will be explored using the frequency of positive communication behaviors by nurse leaders as the explanatory variable (or variables) and the PES scores as the criterion variable. The results are currently pending.

The developed instrument may help shape communication behaviors by nurse leaders as they have a direct impact on a healthy work environment. Focused external feedback on leader communication behaviors could bridge the gap in the existing available tools for leadership development. Through identification of specific strengths and areas for improvement in the nursing leaders within a facility, targeted educational interventions or even one-on-one mentorship could be implemented to improve the environment. A core leadership competency, positive or empowering communication is essential in creating and sustaining a healthy work environment.

References

1. Alvarez B, Coiera E. Interruptive communication patterns in the intensive care unit ward round. Int J Med Inf. 2005;74(10):791-796.
2. Coiera EW, Jayasuriya RA, Hardy J, Bannan A, Thorpe MEC. Communication loads on clinical staff in the emergency department. Med J Aus. 2002;176(9):415-418.
3. Edwards A, Fitzpatrick L-A, Augustine S, et al. Synchronous communication facilities interruptive workflow or attending physicians and nurses in clinical settings. Int J Med Inf, 2009;78(9):629-637.
4. Spencer R, Coiera E, Logan P. Variation in communication loads on clinical staff in the emergency department. Ann Emerg Med. 2004;44(3):268-273.
5. Fairbanks RJ, Bisantz AM, Sunm M. Emergency department communication links and patterns. Ann Emerg Med. 2007;50(4):396-406.
6. The Joint Commission. (2015). Sentinel event statistics released for 2014. Retrieved from http://www.jointcommission.org/assets/1/23/jconline_April_29_15.pdf
7. Stefl ME. Common competencies for all healthcare managers: the healthcare leadership alliance model. *J Healthc Manag*. 2008;53(6):360-374.
8. Joint Medical Executive Skills Institute: Effective Communication Module. https://jmesi.army.mil/login.aspx. Last accessed 26 September 2014
9. ANA/AONE Principles for Collaborative Relationships between Clinical Nurses and Nurse Managers. http://www.aone.org/resources/PDFs/ANA_AONE_Principles_of_Collaborative_Relationships.pdf. Accessed September 17, 2012
10. Kanter RM. Men and Women in the Corporation. New York, NY: Basic Books; 1993.
11. Laschinger HKS, Finegan J. Using empowerment to build trust and respect in the workplace: a strategy for addressing the nursing shortage. Nurs Econ. Jan-Feb 2005;23(1):6-13.
12. Ning S, Zong H, Libo W, Qiujie L. The impact of nurse empowerment on job satisfaction. J Adv Nurs. 2009;65(12):2642-2648.
13. Laschinger HKS, Gilbert S, Smith LM, Leslie, K. Towards a comprehensive theory of nurse/patient empowerment: applying Kanter's empowerment theory to patient care. J Nurs Manag. 2010;18:4-13.
14. Rouse RA. Ineffective participation: reactions to absentee and incompetent nurse leadership in an intensive care unit. J Nurs Manag. 2009;17:463-473.
15. Reed GE. Toxic leadership. Mil Rev. Jul-Aug 2004;67-71.
16. Hogh A, Hoel H, & Carneiro, IG. Bullying and employee turnover among healthcare workers: a three-wave perspective study. J Nurs Manag. 2011;19:742-751.
17. Simons S. Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. Adv Nurs Sci. 2008;31(2):E48-E59.
18. Pearson A, Laschinger H, Porritt K, Jordan Z, Tucker D, Long L. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. Int J Evid Based Healthc. 2007;5(2):208-253.
19. Healthc Risk Manage, 2012 Aug; 34 (8): 90-1.
20. Turner PR, Parodi A. Theoretically-driven infrastructure for supporting health care teams training at a military treatment facility. Mil Med. 2012;177 (2),139-44.
21. Baker DP, Amodeo AM, Krokos KJ, Slonim A, Herrera H. Assessing teamwork attitudes in healthcare: development of the TeamSTEPPS teamwork attitudes questionnaire. Qual Saf Health Care. 2010;19:e49.
22. Castner J. Validity and reliability of the Brief TeamSTEPPS Teamwork Perceptions Questionnaire. J Nurs Meas. 2012;20 (3),186-98.
23. DeVellis RF. Scale Development: Theory and Applications, 3rd ed. California: SAGE Publications, Inc; 2012.

Contact

susan.g.hopkinson.mil@mail.mil

PST - Poster Presentations

Caring for Persons Addicted to Opioids

Mary Coyle, PhD, MS, BS, RN, PMHCNS-BC, USA
Elizabeth Rini, PhD, RN, CNE, USA
Sharon K. Mailey, PhD, RN, USA

Abstract

Purpose: The purpose of this descriptive study is to determine whether an educational intervention improves nurses' attitudes of caring for patients with opioid addiction. The specific aim of this study is to determine if there a difference in nurses' attitudes towards persons with opioid addictions after an educational intervention.

In 2012 an estimated 2.1 million people in the United States experienced substance use disorders related to prescription opioid analgesics and an estimated 467,000 were addicted to heroin (SAMHSA, 2012). In addition, 1 out of 5 patients with non-cancer pain or pain - related diagnoses are prescribed opioids (CDC, 2015). Within this environment, health care providers are vital in preventing prescription drug addiction (Hall, Hawkinberry, Moyers-Scott, 2010); West Virginia leads the nation in the rate of fatal drug overdoses (WVDHHR, 2015). Nurses are currently caring for persons with acute and chronic health issues and co-existing opioid addiction.

As a result of this opioid epidemic, acute care agencies are experiencing an increase in persons admitted with comorbid substance dependence. With frequent hospitalizations patients require complex care for the associated comorbidities such as infections, withdrawal symptoms and/or mental illnesses. Staff nurses are critical to identify, prevent and intervene in opiate addiction. Nurses in clinical settings are equipped with skills which include: health promotion; providing patient education, support and coaching within a therapeutic relationship (Clark, 2012). As a foundation of nursing practice, a therapeutic relationship addresses patient problems by creating a partnership between nurse and patient, using therapeutic communication and empathy. A therapeutic commitment flows from the therapeutic relationship measuring the degree a nurse feels prepared with knowledge, professional support and personal ownership of a patient's condition (Nilsen, 2013).

Nurses first identify and examine values, attitudes before attempting to understand the meaning of the patient's experience. In this process, negative biases are prevented from interfering with the care provided (Nielson, 2013). Negative attitudes towards patients with illicit drug use impacts the therapeutic nurse-patient relationship and clinical outcomes (van Boekel Browers, van Weeghel, & Garretsen, 2013). This happens when health care providers with negative attitudes towards substance abusers tend to overlook their substance misuse behavior thereby failing to assess and intervene (Howard & Chung, 2000). Limited research exists on nurses' attitudes about caring for persons with opioid addiction during this current opioid epidemic. An evidence-based educational intervention will be provided September 16, 2016 to define the epidemiology of opioid abuse, recognize addiction as a disease with consequences and apply screening brief intervention and referral to treatment (SBIRT) to clinical case scenarios. The findings of this study will provide a better understanding of student nurses' attitudes towards persons with opioid addiction to then design changes in baccalaureate nursing (BSN) curriculums. The findings will also enable educational/practice interventions specifically directed to patients addicted to drugs.

Subject Selection: Those eligible to be participants in the study will be enrolled nursing students in Shepherd University Nursing Education Program. These BSN students will be attending an 8-hour training program on opioid addiction September 16, 2016 at Shepherd University. The Department of Nursing Education's Academic Support Specialist will invite students to participate. The Drug and Drug Problems Perceptions Questionnaire (DDPPQ) questionnaire will be given during class time; however, students may opt out if they choose. The course instructor will not be involved in the recruitment of students or the scoring. Participation will be enlisted by asking attendees if they chose to participate in two questionnaires before and after the education conference.

Procedures: The PIs will develop packets that include pre-test questionnaire of the Drug and Drug Problems Perceptions Questionnaire (DDPPQ). Students will identify themselves only with the 6 digits of

their mother's birthdate. For instance, if their mother was born on May 28,1950, the student would assign the following number 052850. The questionnaire is proctored and a script will be read providing directions to complete the packet. The student's participation acts as consent. This pretest questionnaire with 22 questions is completed prior to the educational training. 15 minutes are allotted. The questionnaire is attached. A demographic questionnaire will ask for the following: Age; level of education; ethnicity; training or experience with substance use; years of clinical practice and if the participant had contact (defined as at least once a week) with a person who uses opioids legally and/or illegally. In the week following the educational training the post-test questionnaire will be administered to the students using the exact procedure as the pre-test. Students will identify themselves only with the 6 digits of their mother's birthdate. The questionnaire is proctored and a script will be read providing directions to complete the packet. The student's participation acts as consent. The Educational Intervention Program

The educational intervention program will be conducted by a group of community leaders, persons who are experienced in addiction, a nurse practitioner with expertise in addiction nursing, a psychologist with expertise in SBIRT and a psychiatrist. The training will consist of lectures, discussions and interactive application activities with time allotted for questions and answers.

Design: A descriptive design, will examine the relationship between pre- and post-test attitude scores before and after an educational intervention on opioid addiction. A convenience sample of approximately 100 participants attending an educational conference will be used for the study.

Instrumentation: The Drug and Drug Problems Perceptions Questionnaire (Watson, Maclaren, & Kerr 2006) assesses the healthcare provider's attitude and therapeutic commitment to patients using or abusing medication or illicit substances. It is also called a therapeutic commitment survey (Nilsen et al, 2013). This questionnaire is used to assess the needs for targeted educational interventions. The Drugs and Drug Problems Perceptions Questionnaire (DDPPQ); (Watson et al, 2006) is a 20 -item instrument, which is a valid and reliable tool for measuring attitudes and therapeutic commitment in working with drug-abusing patients (Hohman, Finnegan, & Clapp, 2008; Watson et al., 2006). It was adapted from the Alcohol and Alcohol Problem Perception Questionnaire (Cartwright, 1980). The responder is asked to rate agreement on a Likert scale of 1 (strongly agree) to 7 (strongly disagree). Components of the scale reflect drug abuse and clinical treatment knowledge (role adequacy), job supervision, collegial assistance (role support), job satisfaction, motivation and professional responsibility (role legitimacy) (Watson et al., 2006). Overall, lower scores reflect more positive attitudes and a higher therapeutic commitment toward patients with drug dependency or abuse (Watson et al., 2006). A Cronbach's alpha for the scale is 0.87 (role adequacy = 0.94, role support = 0.78, role satisfaction = 0.08, role self-esteem = 0.69, and role legitimacy = 0.89). With a larger sample an alpha of 0.95 was reported (Rodgers-Banaccorsy, 2010). Test- retest reliability by analysis of variance is 0.82 (Watson et al., 2006).

Data Collection: Data will be collected before the educational intervention and upon completion of the conference.

Analysis of Data: Through descriptive statistics paired *t* tests will examine group differences in the pre- and post test scores to answer the research question. Pearson correlations and regression analysis will be performed on factors thought to be associated with nursing students' attitudes and therapeutic commitment scores.

Results: To be obtained after September 16, 2016 educational intervention.

References

CDC 2015 Centers for Disease Control and Prevention (2015). NCHS Data Brief: Number 190, March 2015: Drug-poisoning Deaths Involving Heroin: United States, 2000-2013.Retrieved from http://www.cdc.gov/nchs/data/databriefs/db190.htm

Clark, L. (2012). The therapeutic relationship and mental health nursing: It is time to articulate what we do! *Journal of Psychiatric and Mental Health Nursing,* 19,839-843.

Nilsen, S.L., Stone, W.L., Burleson, S.L., (2013). Identifying medical-surgical nursing staff perceptions of the drug-abusing patient. *Journal of Addictions Nursing,* 24(3),1688-172.

Contact

maraeco@aol.com

PST - Poster Presentations

Equipping Students and Nurses to Recognize and Respond to Lateral and Horizontal Violence

Patty Peebles, BSN, RN, CACN, USA

Abstract

This poster presents a workshop for student nurses with two main emphases. The first is to create a space where compassionate presence, respectful listening, and thoughtful dialogue are demonstrated and practiced, setting a template from which to evaluate future communication and behavior. (Burke & Williams, 2011; Cangelosi, 2008; Chinn & Falk-Rafael, 2015) The second emphasis is to define, explore, and learn responses to lateral and vertical violence, both in the academic and clinical setting. (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012; Egues & Leinung, 2014) A growing body of evidence shows that bullying is an issue that affects both individuals' well-being, patient safety, and the health of institutions, and that the problem is evident in nursing education as well as healthcare settings. (Seibel, 2014; Spence Laschinger & Nosko, 2015; Park, Cho, & Hong, 2015) This prevalence inspires the understanding that comprehensive action is important, but that there is no one sweeping solution. This workshop addresses one aspect of the problem in attempting to equip nursing students with an understanding of the problem, opportunities for self-reflection and group learning, and hands-on exercises that allow for experimentation with viable responses to bullying in nursing education. (Lachman, 2014; Ironside, 2015; Hutchinson & Jackson, 2015; Gillespie, Brown, Grubb, Shay, & Montoya, 2015; Egues & Leinung, 2014 Bulman, Lathlean, & Gobbi, 2014) Because bullying can take such a personal and professional toll on any individuals, in settings from primary schools to corporations, the concern for changing this behavior is real. With the added consideration of caring for caregivers, priorities for excellence in education and healthcare, and a fundamental appeal in the profession of nursing to the dignity of all persons, addressing the problem in nursing is urgent. This workshop is intended to provide a space where students can be oriented to expectations of compassion and excellence in dealing with one another, not only with patients. Because evidence shows that bullying occurs in nursing education, and also that sometimes students can't identify bullying behaviors or viable solutions, this can be one step in changing a problem that is pervasive in nursing.

References

Bulman, C., Lathlean, J., & Gobbi, M. (2014). The process of teaching and learning about reflection: Research insights from professional nurse education. *Studies In Higher Education*, *39*(7), 1219-1236. Retrieved from: http://www.srhe.ac.uk/publications/studies_in_higher_education.asp

Burke, L., Williams, M. (2011). Celebrating a commitment to care: Building concernful practices among practitioners. *Journal of Nursing Education, 50*(1), 51-54. doi:10.3928/01484834-20101029-07

Cangelosi, P. (2008). Accelerated nursing students and theater students: Creating a safe environment by acting the part. *Nursing Education Perspectives*, *29*(6), 342-346. Retrieved from: http://www.nln.org/newsroom/newsletters-and-journal/nursing-education-perspectives-journal

Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Journal Of Nursing Management*, *20*(5), 599-606. doi:10.1111/j.1365-2834.2012.01402.x

Chinn, P. L., & Falk-Rafael, A. (2015). Peace and power: A theory of emancipatory group process. *Journal Of Nursing Scholarship*, *47*(1), 62-69. doi:10.1111/jnu.12101

Egues, A. L., & Leinung, E. Z. (2014). Antibullying workshops: Shaping minority nursing leaders through curriculum innovation. *Nursing Forum*, *49*(4), 240-246. doi:10.1111/nuf.12083

Gillespie, G., Brown, K., Grubb, P., Shay, A., Montoya, K. (2015). Qualitative evaluation of a role play bullying simulation. *Journal of Nursing Education Practice. 5*(7): 73–80. doi: 10.5430/jnep.v5n6p73

Hutchinson, M., & Jackson, D. (2015). The construction and legitimation of workplace bullying in the public sector: Insight into power dynamics and organizational failures in health and social care. *Nursing Inquiry*, *22*(1), 13-26. doi:10.1111/nin.12077

Ironside, P. M. (2015). Narrative pedagogy: Transforming nursing education through 15 years of research in nursing education. *Nursing Education Perspectives*, *36*(2), 83-88. doi:10.5480/13-1102

Lachman, V. D. (2014). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *MEDSURG Nursing*, *23*(1), 56-60. Retrieved from: http://www.medsurgnursing.net/cgi-bin/WebObjects/MSNJournal.woa

Park, M., Cho, S., & Hong, H. (2015). Prevalence and perpetrators of workplace violence by nursing unit and the relationship between violence and the perceived work environment. *Journal Of Nursing Scholarship*, *47*(1), 87-95. doi:10.1111/jnu.12112

Seibel, M. (2014). For us or against us? Perceptions of faculty bullying of students during undergraduate nursing education clinical experiences. *Nurse Education In Practice*, *14*(3), 271-274. doi:10.1016/j.nepr.2013.08.013

Spence Laschinger, H. K., & Nosko, A. (2015). Exposure to workplace bullying and post-traumatic stress disorder symptomology: The role of protective psychological resources. *Journal Of Nursing Management*, *23*(2), 252-262. doi:10.1111/jonm.12122

Contact

pkpeebles@gmail.com

PST - Poster Presentations

Creating a Civil Work Environment

Shalanda N. Perkins, MSN, RN, USA

Abstract

Purpose: Many studies report that incivility, workplace bullying, and lateral/horizontal violence in the clinical setting is common. Working in a high stress environment, such as an acute behavioral health unit, is one factor that is thought to increase the level of incivility in the workplace. The literature demonstrates significant physical and psychological distress, diminished clinical decision making ability, and reduced organizational commitment to those involved (Spence-Laschinger, 2014). Consequences of uncivil behaviors lead to an increased risk of patient injury, a high rate of nursing turnover, and a financial drain on healthcare institutions (Ceravolo, Schwartz, Foltz-Ramos, & Castner, 2012). Based upon the current research, implementing several civility initiatives in tandem will decrease the incidence of workplace bullying and create a healthier workplace (Griffin & Clark, 2014).

Design: The study is a pre/post intervention design. A pre-intervention evaluation tool, Clark's Workplace Civility Index, will allow all participants to take an introspective look at his or her own level of civility. An education on the use of cognitive rehearsal strategies and mentoring will be given via the e-learning platform. It will include a lecture on the use of cognitive rehearsal as a primary intervention for acts of incivility and how mentoring will be used as a supportive role. A virtual simulation was included to demonstrate a common form of incivility and how the use of the pre-planned cognitive rehearsal statements can be effective. Several scenes were included to reinforce the education provided. Laminated index cards or "badge buddies" were included in the participant packet that list all cognitive rehearsal statements. Additionally, the primary researcher will be on the practicum unit to serve as a mentor. The mentoring role is an evidence-based strategy to increase confidence in addressing incivility directly and reduce the psychological consequences of such encounters. This can be achieved by providing presence, active listening, demonstrating professional communication, and facilitating the use of the suggested interventions. The unit leadership were included as participants in the study to ensure that the micro level and mesa level staff was covered with the same evidence-based strategies.

References

Ceravolo, D. J., Schwartz, D. G., Foltz-Ramos, K. M., & Castner, J. (2012). Strengthening communication to overcome lateral violence. *Journal of Nursing Management*, *20*, 599-606. http://dx.doi.org/10.1111/j.1365-2834.2012.01402.x

Griffin, M., & Clark, C. M. (2014). Revisiting cognitive rehearsal as an intervention against incivility and lateral violence in nursing: 10 years later. *The Journal of Continuing Education in Nursing*, *45*(12), 535-542. http://dx.doi.org/10.3928/00220124-20141122-02

Spence-Laschinger, H. K. (2014). Impact of workplace mistreatment on patient safety risk and nurse-assessed patient outcomes. *Journal of Nursing Administration*, *44*(5), 284-290. http://dx.doi.org/10.1097/NNA.0000000000000068

Contact

sperkins@chamberlain.edu

PST - Poster Presentations

Reducing Hostility in Nursing

Vicki S. Wetter, DNP, RN, USA

Abstract

Hostility is common in every professional but even more so with nursing. A review of the literature showed that all nurses are victims of hostility, to varying degrees, at some time during their career. This includes nurse to nurse, nurse to student, nurse to manager and nurse to care provider hostility. By learning how to use positive communication, nurses may be able to reduce hostility in their work environment. Nurses may also utilize the education module to teach other health care providers about the importance of assertive, not aggressive communication skills. King's goal attainment theory and Knowle's adult learning theory were used as the theoretical framework for this project. This project proposes to develop and validate a self-paced 20-minute computer-based Hostility Educational Module focusing on hostility and teaching of positive communication skills to address hostility in the work environment. This proposal also designed a pilot study for comparison with standard education for future implementation. The newly-developed educational module was presented to 5 doctoral faculty members to review and evaluate using a 10-question Likert type scale survey. Descriptive analysis of the evaluation data was completed for validation. Validation results revealed that all experts strongly agreed that the module contained appropriate information which was easy to understand. They also strongly agreed that the examples within the module were pertinent to the subject matter being taught. Most experts agreed that the module was visually appealing and easy to navigate. Revisions will be made and a plan for future pilot study implementation post-graduation will be planned. Positive social change will occur by educating veteran and novice nurses about hostility and the need to improve positive communication skills in order to reduce work place hostility. Nurses can become the change agent to reduce or eliminate the issue of hostility and/or bullying within the profession of nursing.

References

Townsend, T. (2012). Breaking the bullying cycle. American Nurse Today. Retrieved from http://www.americannursetoday.com/article.html.

Prato, D. (2013). Students' voices: The lived experience of faculty incivility as a barrier to professional formation in associate degree nursing education. Nurse Education Today. 33 (2013). 286-90.

Contact

wetter1987@icloud.com

PST - Poster Presentations

Nursing Students Communication Skills Training in the Face of Incivility or Bullying

Penny A. Sauer, PhD, RN, CCRN, CNE, USA
Margaret M. Verzella, MSN, RN, USA
C. Elise Thompson, PhD, RN, USA

Abstract

Background: Nurses must be able to effectively communicate information to other members of the healthcare team. Between 33% and 72.6% of nurses' experience bullying in their work environment (Berry, Gillespie, Gates, & Schafer, 2012; Laschinger, Grau, Finegan, & Wilk, 2010). Bullying and incivility can negatively impact a nurse's ability to communicate vital information to other team members. The Joint Commission reports that a root cause of the majority of sentinel events involve communication (Joint Commission, 2015). There have been several initiatives aimed at improving communication between healthcare team members, but these programs are aimed at practitioners, not students. Nursing students have limited opportunities to practice communication with healthcare providers. Students are often exposed to incivility and bullying in clinical settings, but often do not report or seek help in dealing with these challenges (Anthony, Yastik, MacDonald, & Marshall, 2014). Schools of nursing teach students to report findings using Situation Background Assessment Recommendation (SBAR) and Concerned Uncomfortable Safety (CUS) from Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS™). However, these skills are not always reinforced in the clinical setting. Learned communication skills are more difficult to implement when confronted with incivility or bullying,

Researchers have reported that when people are faced with incivility or bullying the victims have increased anxiety levels (Einarsen, Hoel, Zapf, & Cooper, 2011). Nursing students are particularly vulnerable to increased levels of anxiety when faced with incivility or bullying. These negative behaviors can cause students to doubt their ability to function as a student nurse, decreasing their self-efficacy and damaging the learning environment.

Nursing students that have the opportunity to practice skills in simulation have decreased anxiety and increased self-efficacy in those skills (Megel et al., 2012). This suggests that a simulation scenario in which students can practice communication skills in dealing with incivility and bullying in the workplace could alleviate some anxiety and increase self-efficacy in their communication skills when exposed to these situations as a registered nurse.

Methods: Participants will be recruited from undergraduate nursing students who are enrolled in a baccalaureate nursing program in the Southeastern United States. Institutional Review Board approval will be obtained from the University. Subjects will be given a pre-test survey that will include demographic information, the State Trait Anxiety Instrument (STAI), and the General Self Efficacy scale (GSE). All students will complete an online module on communicating with difficult people. All students will complete a simulated nursing scenario that includes bullying behavior, with debriefing. Research participants will repeat the STAI and the GSE after the simulation activity. Data will be analyzed using SPSS, using a t-test analysis to compare mean values between pre- and post-testing.

Purpose: The purpose of this intervention study is to evaluate how an education session and simulation practice experience on difficult communication impacts students' anxiety and self-efficacy. The hypothesis underpinning this study is that learning strategies to deal with difficult communication and practice of these skills will decrease student's anxiety about communication and increase their self-efficacy when faced with incivility and bullying.

References

Anthony, M., Yastik, j., MacDonald, D. A., & Marshall, K. A. (2014). Development and validation of a tool to measure incivility in clinical nursing education. *Journal of Professional Nursing, 30*(1), 48-55. doi:http://dx.doi.org/10.1016/j.profnurs.2012.12.011

Berry, P. A., Gillespie, G. L., Gates, D., & Schafer, J. (2012). Novice nurse productivity following workplace bullying. *Journal of Nursing Scholarship, 44*(1), 80-87. doi:10.1111/j.1547-5069.2011.01436.x

Einarsen, S., Hoel, H., Zapf, D., & Cooper, C. (2011). *Bullying and harassment in the workplace*. Boca Raton, FL: CRC Press; Taylor and Francis Group.

Joint Commission. (2015). Joint Commission Online. Retrieved from http://www.jointcommission.org/assets/1/23/jconline_April_29_15.pdf

Laschinger, H. K. S., Grau, A. L., Finegan, J., & Wilk, P. (2010). New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing, 66*(12), 2732-2742. doi:10.1111/j.1365-2648.2010.05420.x

Megel, M. E., Black, J., Clark, L., Carstens, P., Jenkins, L. D., Promes, J., . . . Goodman, T. (2012). Effect of high-fidelity simulation on pediatric nursing students' anxiety. *Clinical Simulation in Nursing, 8*(9), e419-e428. doi:http://dx.doi.org/10.1016/j.ecns.2011.03.006

Contact

sauerp@uncw.edu

PST - Poster Presentations

Teaching Graduate Teaching Assistants Effective Ways to Communicate, Coach, and Collaborate with Students

Pamela Karagory, DNP, MBA, MSB, BSN, RN, CNE, USA
Karen J. Foli, PhD, MSN, RN, FAAN, USA
Ruth A. Fiedler, EdD, MS, BSN, APRN, PMHCNS-BC, CNE, USA
Marilyn Wideman, DNP, RN, FAAN, USA

Abstract

Background: The national shortage of nursing faculty continues to have a significant impact on the ability of schools of nursing to meet the current and future demands for professional nurses prepared at all educational levels (AACN, 2014). (American Association of Colleges of Nursing, 2014). The empirical evidence indicates that the cause of the faculty shortage is multifactorial; it includes economic factors, role transition challenges, increasing complexity of the nurse educator role, and the aging of the baby boomer population of nurse educators. Role transition and the increasing complexity of the nurse educator role create additional obstacles that contributes to the nursing faculty shortage (Slimmer, 2012). The magnitude of the nursing faculty shortage creates an urgency to develop, implement, and evaluate effective strategies to fill vacant faculty positions.

Purpose: One current and long-term strategy utilized by schools of nursing to combat the faculty shortage is to hire Graduate Teaching Assistants (GTAs) to fill clinical instructor roles. Considering the continuing faculty shortage, utilizing GTAs as clinical instructors is a viable and cost effective approach to meeting the clinical learning needs of students and supporting the current and future healthcare demand for professional nurses. Clinical instructors face complex situations requiring evidenced based educational and evaluation strategies. Without foundational nurse educator knowledge, skills, and collegial support, clinical instructors experience increased stress, isolation, and role dissatisfaction (Evans, 2013) Without ongoing mentoring that accentuates timely communication, coaching, and collaboration, GTAs face a risk of exacerbated stress, frustration, and isolation that impacts their success in the clinical instructor role and has a direct impact on student learning outcomes (Helms-Lorenz & Maulana, 2016).

Method: Recognizing the need to increase the use of GTAs to meet its strategic initiatives and enrollment benchmarks, a Midwestern school of nursing developed and implemented a formal Graduate Teaching Assistant (GTA) Mentoring program. The project goals focused on increasing the GTAs' teaching self-efficacy, knowledge, and skills, as well as student satisfaction with the GTAs' teaching abilities.

Participants/Sample: Six GTAs with no prior clinical teaching experience, and one with one year of experience participated in the project. They provided clinical instruction to 77 students representing 17% of the undergraduate student population; these 77 students included sophomore, junior, and senior levels. Project implementation was efficient, effective, and time sensitive to the confounding work demands of GTAs. Mentor support to GTAs was provided by the project director, who is also serves as the Director of the Undergraduate Program.

The GTA Mentoring Program components were:

Online Clinical Teaching Educational Modules: To assist the GTA participants in developing their clinical teaching knowledge and skills an online educational program was designed by the mentor/program director, and reviewed by three clinical faculty colleagues within the school of nursing. The online education modules were developed based on nurse educator best practices, and guided by the National League of Nursing (NLN) nurse educator core competencies (NLN, 2014).

Module One: Foundations of Effective Clinical Teaching: Preparation and Strategies

Module Two: Teaching Strategies to Foster Student Clinical Reasoning and Critical Thinking

Module Three: Effective Student Assessment and Evaluation: Maximizing Student Success.

The Institutional Review Board reviewed this protocol and deemed it an exempted study. GTA participants were required to review learning modules materials, participate in self-reflection discussions, and complete a post-test and program evaluation to receive continuing nursing education (CNE) credit hours. As an incentive for participating in the project, all seven participating GTAs completing the online modules and discussion participation earned a CNE certificate of completion.

Face-to-Face Coaching: Face to face discussions were conducted on a regular basis and when immediate clinical teaching support was required "Just in Time" coaching was achieved through digital texting

Scheduled Email Communication: To support ongoing collaboration and communication bi-monthly touch point emails were sent to GTAs in which clinical teaching tips and school of nursing updates were imbedded. This method of communication provided regular and planned opportunities for collaboration, discussion, and coaching and was delivered by the project director who serves as the Director of Undergraduate Programs at the School of Nursing.

Data Collection/Analysis: To determine project outcomes and impact, a mixed methods, pre- and post-intervention study design was used to determine if there was an increase in GTAs' teaching self-efficacy, clinical teaching knowledge, skills, and student satisfaction of their clinical teaching experience. Self-Efficacy Towards Teaching Inventory surveys were modified and adapted with permission from original authors and disturbed online to GTAs and students pre- and post-program implementation (Nugent, Bradshaw, & Kito, 1999).

For this quantitative analysis, traditional statistical methods (e.g., paired t-tests) are being used to identify student and GTA perspectives and compare differences pre- and post-program implementation. Qualitative data was derived from in-depth semi-structured interviews conducted with GTAs before and after all planned mentoring program components were completed. Thematic content analysis by two independent coders is being conducted on the qualitative responses (Elo, et al., 2014; DeSantis & Ugarriza, 2000;). Quantitative findings and identified themes will guide future development, modification, standardization, and expansion of the mentoring project to meet the current and future GTA mentoring needs. Data collection is complete and data analysis is underway.

References

American Association of Colleges of Nursing (AACN). (2014). Nursing faculty shortage fact sheet. Retrieved from: http://www.nche.edu/media-relations/FacultyShortageFS.pdf

DeSantis, L.A., & Ugarriza, D., (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, 22(3), 351-372. doi:10.1177/019394590002200308

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. Sage Open, 1-10. doi: 10.1177/2158244014522633

Evans, J., (2013). Factors influencing recruitment and retention of nurse educators reported by current nurse faculty. *Journal of Professional Nursing*, *29*, 11-20. doi: 10.1016/j.profnurs.2012.04.012

Helms-Lorenz, M., & Maulana, R. (2016). Influencing the psychological well-being of beginning teachers across three years of teaching: Self-efficacy, stress causes, job tension and job discontent. *Educational Psychology*, *36*(3), 569-594. doi: 10.1080/01443410.2015.1008403

Nugent, K. E., Bradshaw, M. J., & Kito, N., (1999). Teacher self-efficacy in new nurse educators. *Journal of Professional Nursing*, *15*(4), 229-237.

Slimmer, L., (2012). A teaching mentorship program to facilitate excellence in teaching and learning. *Journal of Professional Nursing, 28*(3), 183-185.

Contact

pkaragor@purdue.edu

PST - Poster Presentations

Promoting Healthy Work Environments: Improving RN Attitudes Towards End-of-Life Care

Sondra B. Lee, BSN, BSMBY, RN, USA
Jeffery Wade Forehand, DNP, RN-BC, USA
Judith L. St. Onge, PhD, RN, CNE, USA
Kristi A. Acker, DNP, FNP-BC, AOCNP, ACHPN, USA

Abstract

Purpose: The presentation intent is to disseminate the findings from a recent DNP Project aimed at changing acute care nurses' attitudes towards end-of-life care by reducing the communication anxiety through the effects of an evidence-based communication intervention.

Background: Nurses are charged with providing quality end-of-life care for their patients. The aging baby boomer generation will create an increased number of patients and families approaching the end-of-life or dealing with life limiting illness. For example, in 2014, the percentage of the population age 65 and older was 14.5%. This number is expected to rise to 21.7% by 2040. In 2014 it was estimated that 80% of the population age 65 and older had multiple chronic conditions. This number is expected to continue to rise. Ultimately, this will translate into more end-of-life care issues in the acute care hospital setting. Furthermore, research suggests that over 80% of Americans would prefer to die at home, but the reality is that 60% die in acute care hospitals. Sadly, the few that die in hospice care were referred only in the last few weeks of life.

Literature has demonstrated that acute care nurses providing end-of-life care often feel inadequate, unsupported, and have dissonance that arises from the quality of care they were able to provide versus what they felt they should be delivering. This type of care especially challenges novice nurses. Many nurses feel anxious and unprepared to provide the type of care these patients need, especially when it comes to talking with patients and families about death and dying. These conversations are often the most difficult to have. Because behavior is impacted by attitudes, these attitudes have an effect on the care that is delivered. Research validates that anxiety negatively impacts attitudes towards these types of conversations and discussions and leads to decreased quality of care. The anxiety and negative attitudes also lead to increased stress in the workplace, which studies have shown can adversely affect physical and mental health of healthcare providers. Death anxiety has been shown to have a direct impact on outcomes in the workplace of nurses. It has been linked to burnout, decreased engagement, and absenteeism, especially in younger nurses. Nursing researchers support and encourage the use of evidence-based interventions aimed at increasing the knowledge, skills, and attitudes of nurses regarding end-of-life communication.

Project Description: The DNP Project aims to change nursing attitudes' positively, towards conversations with patients and families that are nearing or at end-of-life. The DNP Project was evaluated using a quasi-experimental one-group pretest posttest design completed between August and October of 2016. A random convenience sample was taken from registered nurses working in an acute care setting at a 787-bed regional medical center in the southeastern United States who voluntarily attended an evidence-based communication intervention on communication at end-of-life. The End-of-Life Nursing Education Consortium (ELNEC) communication module was used as the intervention. The ELNEC curriculum is evidence-based and uses the framework of the COMFORT curriculum for its communication module and was designed for nurses for end-of-life care. Exclusion criteria included anyone who was not a registered nurse providing direct patient care in the hospital setting or who was an advanced practitioner.

Methods: Prior to intervention implementation, Institutional Review Board approval was obtained. Demographic data collected included age, years of nursing experience, area worked, level of education, and history of previous end-of-life education. The tool used to collect data in this study was the Frommelt Attitude Towards Care of the Dying (FATCOD). Permission to use the tool was provided by the copyright owner. The FATCOD consists of thirty questions with a 5 point Likert type scale. The reliability and validity of FATCOD has been established numerous times. The Pearson coefficient was found to be r = 0.90-

0.94. The content validity index (CVI) was 1.00 and the inter-rater agreement was 0.98. The End-of-Life Nursing Education Consortium communication module was used as the training intervention. This included videos and role play scenarios for participants to practice the communication techniques introduced in the content.

Results: To date a total of 118 participants have participated in the evidence-based intervention. The project is currently in progress. Data analysis and full results will be complete and available for presentation at the time of the conference.

Conclusion: It is anticipated that an impact on attitudes will be seen through improved responses on the tool. Improved end-of-life knowledge and communication skills will reduce nurse anxiety and improve attitudes towards end-of-life care and communication. By decreasing nurse anxiety in end-of-life care, workplace engagement will be supported. The positive attitude change and practice change would translate into positive patient outcomes and positive experiences for the nurses.

References

Administration on Aging (AoA), Administration for Community Living, U.S. Department of Health and Human Services. (2015). *A Profile of Older Americans: 2015.* Retrieved from http://www.aoa.acl.gov/Aging_Statistics/Profile/2015/docs/2015-Profile.pdf

Bloomer, M. J., Endacott, R., O'Connor, M. & Cross, W. (2013). The 'dis-ease' of dying: Challenges in nursing care of the dying in the acute hospital setting. A qualitative observational study. *Palliative Medicine, 27*, 757–764. doi: 10.1177/0269216313477176

End-of-Life Nursing Education Consortium. (2015). *End-of-Life Nursing Education Consortium core curriculum faculty guide.* Published in partnership with the American Association of Colleges of Nursing (AACN), Washington, DC and City of Hope, Duarte, CA. Retrieved from http://www.aacn.nche.edu/ELNEC

Gagnon, J., & Duggleby, W. (2014). The provision of end-of-life care by medical-surgical nurses working in acute care: A literature review. *Palliative and Supportive Care, 12,* 393-408. doi: 10.1017/S14778951513000965

Gerteis, J., Izrael, D., Deitz, D., LeRoy, L., Ricciardi, R., Miller, T., & Basu, J. (2014). *Multiple chronic conditions chartbook* [AHRQ Publications No, Q14-0038]. Rockville, MD: Agency for Healthcare Research and Quality.

He, W., Goodkind, D., & Kowal, P. (2016). *An aging world: 2015* [U.S. Census Bureau, International Population Reports, P95/16-1]. Washington, DC: U.S. Government Publishing Office

Health Resources and Services Administration. (2013). *The U.S. nursing workforce: Trends in supply and education – October 2013*. Retrieved from http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/nursingworkforce/nursingworkforcefullreport.pdf

Institute of Medicine. (2015). *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

McCourt, R., Power, J. J., & Glackin, M. (2013). General nurses' experiences of end-of-life care in the acute hospital setting: A literature review. *International Journal of Palliative Nursing, 19,* 510-516. doi: 10.12968/ijpn.2013.19.10.510

Peters, L., Cant, R., Payne, S., O'Connor, M., McDermott, F., Hood, K., . . . Shimoinaba, K. (2013). How death anxiety impacts nurses' caring for patients at the end of life: A review of literature. *The Open Nursing Journal, 2013*(7), 14-21. doi: 10.2174/1874434601307010014

Sliter, M. T., Sinclair, R. R., Yuan, Z., & Mohr, C. D. (2014). Don't fear the reaper: Trait death anxiety, mortality salience, and occupational health. *Journal Of Applied Psychology*, *99*, 759-769. doi:10.1037/a0035729

Stanford School of Medicine. (2015). *Where do Americans die?* Retrieved from https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/

Contact

slee139705@troy.edu

PST - Poster Presentations

"Flying" the Phoenix Way

Susan A. Orshan, PhD, RN, USA
Marilyn Miller, PhD, RN, CRNP, CS-P, USA
Mirella Brooks, PhD, FNP-BC, APRN, USA

Abstract

A healthy work environment can be summed up in a single word—communication. There are multiple lines of communication pathways within the virtual academic environment of the School of Advanced Studies at the University of Phoenix. These pathways foster unique opportunities for student and faculty growth and development.

Free of the restraints of traditional gatekeeping and keepers, communication is fostered through multiple venues. Nursing and non-nursing faculty have direct access to each other and administration through our University-based Leadership Journal, faculty meetings offered on the degree program level, the School level, and the University level, and our unique PhoenixConnect portal. Of course, email, phone and video calling are also utilized as effective means of communication when a more "direct" approach may be appropriate, such as for faculty mentoring (Smith, 2015).

Through PhoenixConnect, our University-based blogging system, ongoing discussions are available to students, faculty, and administrators according to their interests and needs. Open interdisciplinary forums along with "by invitation only" forums provide opportunities to connect with others who share the same interests, and facilitate the exchange of information and support on multiple levels (Breen, 2013; Hollyhead, Edwards, & Holt, 2012; Ko & Kuo, 2009; Schwartz, Wiley, & Kaplan, 2016).

Requirements for "classroom" teaching are incorporated into all administrative contracts, and all administrators who meet the criteria for serving on doctoral committees are encouraged to participate as either a committee member or dissertation chairperson. Lead Faculty Area Chairs (LFACs), who serve as the "first line of administration" conduct program content meetings for faculty where information is integrated with lively discussion and policy updates, and scholarly exchanges are supported. The LFACs share the insights generated in the meetings with higher level administrators who utilize the feedback to strengthen the organizational vision and mission (Erskine, 2009)

The key to our positive work environment is the multiple opportunities for communication. All day, every day, students, faculty, and administrators from around the world come together for the social and scholarly exchanges that are at the core of our healthy, productive academic environment at the University of Phoenix School of Advanced Studies.

References

Breen, H. (2013). Virtual collaboration in the online educational setting: A concept analysis, *Nursing Forum, 48*(4), 262-270.

Erskine, L. (2009). A question of leadership, *Leadership in Action, 28*(6), 12-13.

Hollyhead, A., Edwards, D.J., & Holt, G.D., (2012) The use of Virtual Learning Environment (VLE) and Social Network Site (SNS) hosted forums in higher education: A preliminary examination, *Industry and Higher Education, 26*(5), 369-379.

Ko, H.C. & Kuo, F.Y. (2009). A blogging enhances subjective well-being through self-disclosure, *CyberPsychology & Behavior, 12*(1), 75-79.

Schwartz, S.L., Wiley, J.L. & Kaplan, C.D. (2016). Community-building in a virtual teaching environment, *Advances in Social Work, 17*(1), 15-28.

Smith, W.B. (2015). Relational dimensions of virtual social work education: Mentoring faculty in a web-based learning environment, *Clinical Social Work Journal, 43*(2), 236-245.

Contact

sorshan@email.phoenix.edu

PST - Poster Presentations

Implementing Crucial Conversations in a Fast-Paced, High-Stress Environment

Matthew S. Howard, MSN, RN, CEN, CPEN, CPN, USA
Miranda S. Cassity, BSN, RN, USA

Abstract

Purpose: This presentation was initiated as a performance improvement effort aimed toward improving the work culture in a high-acuity and high-stress environment. With the full implementation of this program, the authors expect to improve attitudes toward, and effectiveness in, holding difficult conversations that are necessary between co-workers.

Relevance/Significance: Oftentimes necessary conversations are missed as a result of nursing staff feeling uncomfortable toward initiating difficult or uneasy subjects. Staff nurses need to have a way to address their concerns with others when issues arise. When nursing staff do not address issues, frustrations and tempers rise which is a leading cause of nurse burnout. Patient care outcomes are negatively affected, and there is an overall decreased job performance.

Strategy and Implementation: Evidence shows that educating nursing students on how to initiate difficult conversations can improve nursing confidence and assertiveness (Hunta & Marini, 2012). Use of role play effectively allows the student to voice any concerns in a safe environment prior to an actual situation arising. The authors proposed training of new hire nursing staff within a high-acuity emergency department at a Level I trauma center in the Midwest. This educational activity would train staff on how to effectively implement and engage in difficult and critical interpersonal conversations. The educational activity will be delivered during the orientation to the emergency department which typically lasts for eight to twelve weeks. The educational activity is designed to aide staff in learning techniques on how to initiate, and remain professional during, difficult conversations. Lecture and role play have been shown to increase recollection and performance (Lewis et al., 2013). These techniques will be used during the duration of the staff orientation period. This will occur in one-hour group sessions with their preceptors on multiple work days. In order to provide time to implement and practice what they have learned, there will be several days in between educational sessions. Participants will be educated on word choice and self-awareness which will be reinforced by department preceptors involved in the program.

Evaluation: Post-orientation data will be collected for participants involved in the program. A self-reported positive change in attitude and practice will be expected after the activity. The participants will complete a short-term post-orientation evaluation where qualitative and quantitative data will be gathered. The initial cohort of participants will then be followed and reevaluated over the first year of their employment. It is expected that the long-term evaluations will show a self-reported positive change in practice and comfort with holding critical conversations with constructive outcomes.

Implications for Practice: Evidence suggests that after implementation of such a program, the authors could increase staff assertiveness by 11% and increase self-esteem by 16% in the department. With favorable evaluations, the authors wish to broaden the educational activity to current staff within the emergency setting which would increase opportunities for collaborative and interdisciplinary learning experiences with physicians and other healthcare providers and ultimately improve patient care.

References

Clancy, C. (2014). *Critical conversations in healthcare: Scripts & techniques for effective interprofessional & patient communication*. Indianapolis, IN: Sigma Theta Tau International.

Clark, C. M. (2014). Seeking civility. *American Nurse Today, 9*(7), 18-46 29p.

Elmblad, R., Kodjebacheva, G., & Lebeck, L. (2014). Workplace incivility affecting CRNAs: A study of prevalence, severity, and consequences with proposed interventions. *AANA Journal*, *82*(6), 437-445 9p.

Hunta, C., & Marini, Z. A. (2012). Incivility in the practice environment: A perspective from clinical nursing teachers. *Nurse Education In Practice*, *12*(6), 366-370 5p. doi:10.1016/j.nepr.2012.05.001

Lewis, D., O'Boyle-Duggan, M., Chapman, J., Dee, P., Sellner, K., & Gorman, S. (2013). 'Putting Words into Action' project: using role play in skills training. *British Journal Of Nursing*, *22*(11), 638-644 7p.

Newton, J. M., Henderson, A., Jolly, B., & Greaves, J. (2015). A contemporary examination of workplace learning culture: An ethnomethodology study. *Nurse Education Today*,*35*(1), 91-96 6p. doi:10.1016/j.nedt.2014.07.001

Nicholson, T., & Griffin, B. (2015). Here today but not gone tomorrow: incivility affects after-work and next-day recovery. *Journal Of Occupational Health Psychology*, *20*(2), 218 225 8p. doi:10.1037/a0038376

Porath, C. L., Gerbasi, A., & Schorch, S. L. (2015). The effects of civility on advice, leadership, and performance. *Journal Of Applied Psychology*, *100*(5), 1527-1541 15p. doi:10.1037/apl0000016

Ünal, S. (2012). Evaluating the effect of self-awareness and communication techniques on nurses' assertiveness and self-esteem. *Contemporary Nurse: A Journal For The Australian Nursing Profession*, *43*(1), 90-98 9p. doi:10.5172/conu.2012.43.1.90

Slade, D. (2015). *Communicating in hospital emergency departments*. New York, NY: Springer.

Walker, R., Cooke, M., Henderson, A., & Creedy, D. K. (2013). Using a critical reflection process to create an effective learning community in the workplace. *Nurse Education Today*, *33*(5), 504-511 8p. doi:10.1016/j.nedt.2012.03.001

Contact

cassity.miranda@gmail.com

PST - Poster Presentations

Dedicated Education Unit: An Academia and Clinical Practice Partnership Aimed at Improving Outcomes

Cynthia L. Jones, MSN, RN, USA
Sherry S. Chesak, PhD, RN, USA
Jennifer M. McGuire, MAN, RN, RN-BC, USA
Diane Forsyth, PhD, RN, USA
Sonja J. Meiers, PhD, RN, USA
LeAnn M. Johnson, MS, RN, NEA-BC, USA
Martha M. Scheckel, PhD, RN, USA

Abstract

The academic-practice gap is an area of concern when dealing with the education of future health care professionals. The transition from hospital-based training to academically based training for nurses contributed inadvertently, but substantially to the development of a wide chasm between the academic and practice sectors (Beal, 2012). Traditional clinical experiences for nursing students involve the faculty member being the expert and imparting knowledge and experiences on their students as time permits. This approach to clinical education limits the students' opportunities to learn about the workflow and culture on a nursing unit. Because students are traditionally only on the unit one time per week, for an average of five hours, their perspective of floor nursing is fragmented at best.

With the ever-increasing complexity of patients, the quality of nursing care being delivered has also come into question. Failure to complete nursing care has been shown to result in adverse outcomes, including medication errors, patient falls resulting in injury, and nosocomial infections (Kalisch, Tschannen, & Lee, 2011; Maloney, Fencl, & Hardin, 2015; Papastavrou, Andreou, & Efstathiou, 2014; Papastavrou, Andreou, Tsangari, Schubert, & De Geest, 2014). "Missed care refers to any aspect of required patient care that is omitted (either in part or in whole) or delayed. Missed nursing care is an error of omission" (Kalisch, Landstrom, & Hinshaw, 2009, p.1511).

Investing in the exploration of interventions that may reduce missed nursing care is worthwhile (Papastavrou, Andreou, Tsangari et al., 2014). These interventions would need to address improved communication with other departments, improved teamwork on the patient care unit, increased job satisfaction among nursing staff, and improved staffing to accommodate changes in patient acuity and volume (Kalisch et al., 2011). The dedicated education unit (DEU) model is an intervention that has the potential to address all of these concerns. To date, few studies have addressed the impact of the implementation of a DEU on quality of care delivered.

The DEU model attempts to bridge the academic-practice gap by using existing resources, reframing roles, and allowing nursing students to participate fully as members of a patient care unit. The DEU is a partnership between a practice and academic institution, which puts expert bedside nurses in the role of primary educator for nursing students. These bedside nurses, known as Clinical Nurse Teachers (CNT) in this study, are current with medications, clinical procedures, and facility regulations and practices, as well as the inner workings of the health care system. The DEU model offers access to information, support, resources, and opportunities for continuous learning, which all lead to a sense of empowerment among staff and students (Purdy, Laschinger, Finegan, Kerr, & Olivera, 2010).

In this study, a Midwestern academic medical center has partnered with a Midwestern state university to pilot the DEU clinical model. The purpose of this study is to assess the feasibility of implementing a DEU clinical education model on a medical/surgical/progressive care unit, and to evaluate preliminary outcomes of the model related to student, faculty, staff, and nursing unit leadership perception of and satisfaction with the clinical design, teamwork on the unit and incidences of missed nursing care. Patient safety and satisfaction outcomes were also evaluated. The purpose of this presentation is to provide methods of implementation of the DEU model, as well as findings related to the impact of the DEU model on satisfaction, teamwork, and quality of care.

This Institutional Review Board (IRB) approved study involved a prospective, quasi-experimental design, enrolling 112 participants, including 104-unit staff (registered nurses, patient care assistants, health unit coordinators) and fourteen undergraduate nursing students. A mixed method approach to data collection was implemented, incorporating both quantitative and qualitative research techniques.

Data were collected at two different time points. The fall 2015 data set serves as the control group, as the traditional clinical model was still in use. The spring 2016 data set represents the intervention group, when the DEU clinical model was implemented. Quantitative data were gathered using the following tools: Clinical Nurse Teacher Survey (CNTS), MISSCARE Survey, and Clinical Learning Environment Supervision and Nurse Teacher Scale (CLES+T).

The CNTS elicits perspectives from staff on the DEU about the "quality of clinical education that students received" while on the unit (Nishioka, Coe, Hanita, & Moscato, 2014, p. 295). Response rates for the CNTS were 31% (*n* = 74) and 60% (*n* = 25) for fall 2015 and spring 2016 semesters, respectively. The MISSCARE Survey (Kalisch, Xie, & Ronis, 2013) measures staff perceptions of errors of omission of nursing care. Missed nursing care was utilized as an indicator of quality in this study. Response rates for the MISSCARE survey were 26% (*n*= 104) for both fall 2015 and spring 2016 semesters. The CLES+T was completed by the nursing students and is designed to gather information about the "optimal state of the learning environment, supervisory relationship, and role of the NT [Nurse Teacher]" (Saarikoski, Isoaho, Warne, & Leino-Kilpi, 2008, p. 1234). Response rates for the CLES+T survey were 100% for both fall 2015 *(n* =6) and spring 2016 *(n*=8) semesters.

Quantitative data were also gathered regarding unit-specific patient safety and satisfaction outcomes as routinely collected by the academic medical center. These outcomes included rate of hospital acquired catheter-associated urinary tract infections (CAUTIs) per 1,000 Catheter Days, rates of VTE (venous thromboembolism) prophylaxis application documented, patient overall rating of their experience at the hospital, patient perception of communication about medications, patient perception of communication with nurses, patient perception of responsiveness of hospital staff, and patient perception of pain management.

A descriptive analysis was performed to summarize baseline characteristics of the participants, including participant demographics. These results will include age, gender, and ethnicity of both the CNTs, as well as the nursing students.

Focus group interviews were conducted separately with CNTs and nursing students to examine their perceptions of the clinical design and potential impact on outcomes. Overall, anecdotal evidence has been positive from both groups, with thematic analyses in progress. Predominant themes (i.e., issues, feelings, or opinions repeated/common across multiple participants) will be identified individually by the primary investigator and a second investigator who both have previous experience with qualitative data analysis. The two investigators will then meet to compare and contrast each other's findings and will collaboratively integrate the findings into one structure.

The main intent of this investigation was to determine the feasibility of the DEU model and to ensure no deleterious impact on the outcomes measured. Although an aim of this study was to examine the relationship between a clinical teaching model and patient/staff perceptions of care, the study design and sample sizes did not allow for a cause-effect or causal relationship to be established. However, the outcomes of this study may assist in creating healthy work environments as more positives are revealed about the DEU clinical model.

References

Beal, J. A. (2012). Academic-service partnerships in nursing: An integrative review. *Nursing Research and Practice, 2012*, 1-9. http://dx.doi.org/10.1155/2012/501564

Kalisch, B. J., Landstrom, G. L., & Hinshaw, A. S. (2009). Missed nursing care: A concept analysis. *Journal of Advanced Nursing, 65*(7), 1509-1517. http://dx.doi.org/10.1111/j.1365-2648.2009.05027.x

Kalisch, B., Tschannen, D., & Lee, K. (2011). Does missed nursing care predict job satisfaction? *Journal of Healthcare Management, 56*(2), 117-131.

Kalish, B., Xie, B., & Ronis, D. L. (2013). Train-the-trainer intervention to increase nursing teamwork and decrease missed nursing care in acute care patient units. *Nursing Research, 62*(6), 405-413. http://dx.doi.org/10.1097/NNR.0b013e3182a7a15d

Maloney, S., Fencl, J. L., & Hardin, S. R. (2015). Is nursing care missed? A comparative study of three North Carolina hospitals. *MedSurg Nursing, 24*(4), 229-235.

Nishioka, V. M., Coe, M. T., Hanita, M., & Moscato, S. R. (2014). Dedicated education unit: Nurse perspectives on their clinical teaching role. *Nursing Education Perspectives, 35*(5), 294-300. http://dx.doi.org/10.5480/14-1381

Papastavrou, E., Andreou, P., & Efstathiou, G. (2014). Rationing of nursing care and nurse-patient outcomes: A systematic review of quantitative studies. *The International Journal of Health Planning and Management, 29*; 3-25. http://dx.doi.org/10.1002/hpm.2160

Papastavrou, E., Andreou, P., Tsangari, H., Schubert, M., & De Geest, S. (2014). Rationing of nursing care within professional environmental constraints: A correlational study. *Clinical Nursing Research, 23*(3), 314-335. http://dx.doi.org/10.1177/1054773812469543

Purdy, N., Laschinger, H. K., Finegan, J., Kerr, M., & Olivera, F. (2010). Effects of work environments on nurse and patient outcomes. *Journal of Nursing Management, 18*, 901-913. http://dx.doi.org/10.1111/j.1365-2834.2010.01172.x

Saarikoski, M., Isoaho, H., Warne, T., & Leino-Kilpi, H. (2008). The nurse teacher in clinical practice: Developing the new sub-dimension to the clinical learning environment and supervision (CLES) scale. *International Journal of Nursing Studies, 45*, 1233-1237. http://doi:10.1016/j.ijnurstu.2007.07.009

Contact

Cjones@winona.edu

PST - Poster Presentations

Bridging Inter-Generational Gaps to Increase Collaboration and Retention: Implications for Nurse Leaders

Ericka J. Sanner-Stiehr, PhD, RN, USA

Abstract

The composition of the nursing workforce is changing rapidly, with three generations of Boomers, Generation Xers (Gen-X), and Millennials working in health care. The majority of leadership positions are occupied by Boomers and Gen-Xers, with Gen-Xers poised to take over as Boomers retire. Meanwhile, Millennials have moved into the nursing workplace with their own distinctive set of workplace expectations and talents. Unfortunately, lack of relatability and disconnect in workplace expectations among the generations often leads to friction and impedes true collaboration. The current nursing work environment may not align with the values of Millennials, leading to increased turnover and attrition if their expectations are not met. Substantial vacancies will be created when the Boomers retire, making retention of Gen-Xers and Millennials crucial to preserving an adequate nursing workforce. Administrators can take action to bridge inter-generational gaps, promoting collaboration, meeting changing workplace expectations, and retaining younger generations of nurses.

A review of the literature was combined with extant information and internet sources such as blogs, social media, and opinion-editorial pieces. This search included but was not limited to nursing, to gain a comprehensive understanding of generational values and characteristics that may influence work patterns. Results of this exploration revealed an increasing social dialogue about the often-diverging perspectives and potential contributions of each generation. Though the distinguishing traits described in this presentation may not apply to every individual, the clear themes in inter-generational characteristics emerged.

Boomers are likely to be comfortable functioning within the current hierarchical structure of health care where the use of titles and navigating organizational channels to communicate is expected. They may accept long hours of physical presence at work, close managerial oversight, team projects, and the concept of paying one's dues for promotion. Despite often struggling to keep pace with rapid technological advances in the workplace, this group possesses invaluable professional expertise that can benefit younger generations of nurses.

Gen-Xers also have two to three decades of valuable experience to share with their contemporaries. Often described as independent, adaptable, and resilient, Gen-Xers overcame their adolescent reputation as "slackers" to excel at self-management and entrepreneurial endeavors. They prefer individual work and are likely to change jobs in order to meet personal goals and needs. Gen-Xers value work-life balance and flexible work schedules, eschewing the traditional work-to-live approach often embraced by Boomers. They are unlikely to be impressed with titles and often skeptical of authority. However, they are also remarkably adaptable to changing work climates and proficient users of technology.

Millennials tend to favor group consensus, desire frequent feedback about their work, and expect to contribute to decision making. Informal work environments appeal to this group; they are less likely to navigate organizational channels of communication or use titles. Millennials value rapid opportunities for advancement and flexibility from organizations, often contributing to outsiders perceiving them as "entitled". Outpacing previous generations, this group possesses a sophisticated relationship with technology providing them with an invaluable skill set.

Administrators can take three main steps to bridge generational gaps. First, facilitating inter-generational mentorships can promote understanding and combine the unique talents of each group and all individuals. Secondly, creating age-diverse teams allows the perspectives of all ages to be considered in decision-making. This strategy may be of particular importance with Millennials who expect their ideas and contributions to be solicited and valued. Finally, workplace models aimed at retention of younger nurses should include flexibility and choices to meet changing workplace expectations.

References

Beacon Health Options. (2012). Meet the multigenerational workforce. Retrieved from http://vosearch.valueoptions.com/cgi-bin/MsmGo.exe?grab_id=0&EXTRA_ARG=SUBMIT%3Dsubmit&host_id=42&page_id=396&query=Generations&hiword=GENERATE%20GENERATED%20GENERATES%20GENERATING%20GENERATION%20GENERATIONAL%20Generations%20

Fromm, J. (2015). Millennials in the workplace: They don't need trophies but they want reinforcement. Retrieved from http://www.forbes.com/sites/jefffromm/2015/11/06/millennials-in-the-workplace-they-dont-need-trophies-but-they-want-reinforcement/#c73b755127ae

Keepnews, D. M., Brewer, C. S., Kovner, C. T., & Shin, J. H. (2010). Generational differences among newly licensed registered nurses. *Nursing Outlook*, *58*(3), 155–163. http://doi.org/10.1016/j.outlook.2009.11.001 {*Retained as important and unique study}

Kovner, C. T., Djukic, M., Fatehi, F. K., Fletcher, J., Jun, J., Brewer, C., & Chacko, T. (2016). Estimating and preventing hospital internal turnover of newly licensed nurses: A panel survey. *International Journal Of Nursing Studies*, *60*, 251–262. http://doi.org/10.1016/j.ijnurstu.2016.05.003

Lifecourse Associates. (2016). Generational archetypes. Retrieved from http://www.lifecourse.com/about/method/generational-archetypes.html

Wetherell, S., Gavert, E., Ellis, S., & O'Donovan, R. (2015). The "disruptive" generation: Millennials in the workplace. *Market Leader*, (Quarter 4), 40–42.

Contact

sannerstiehre@umsl.edu

PST - Poster Presentations

Identifying Japanese Staff Nurses' Perceptions of "Hatarakinikusa" in Hospitals; Creating a Positive and Agreeable Workplace

Kasane Kashima, MNSc, RN, Japan
Naomi Funashima, DNSc, RN, Japan
Toshiko Nakayama, DNSc, RN, Japan

Abstract

The concept of “Hatarakinikusa” is a Japanese concept familiar to one’s life at work and expressing one’s negative or disagreeable perceptions about situations or other factors in one’s workplace which prevent it from being a good place to work.

Background: Nurses’ positive work environments enhance not only their satisfaction but also improve patient safety and quality of care. Although a large number of studies aimed at creating a positive work environment for nurses exist, no study has comprehensively identified all aspects of “Hatarakinikusa”, even though they reflect Japanese nurses’ perceptions of the work environment directly. Furthermore, many related studies have been done from the organizational point of view. However, individual nurses’ autonomous contributions are also very important to reduce “Hatarakinikusa” to improve the work environment. To promote these contributions of individuals, it is necessary to understand nurses’ perceptions of “Hatarakinikusa”.

Aim: The purpose of this article is to identify staff nurses’ perceptions of “Hatarakinikusa” in hospitals using a qualitative and inductive approach, and to discuss how individual nurses reduce “Hatarakinikusa” to make their workplaces a good place to work.

Method: A questionnaire asking for nurses’ perceptions of “Hatarakinikusa” in their workplace was created. Content validity of the questionnaire was established by conducting two pilot studies. Content analysis for nursing education based on Berelson’s methodology was applied. This study was conducted as part of a larger study.

Result: Four hundred and forty-five nurses returned (return rate 55.8%) and 352 valid responses were analyzed. Thirty-seven categories expressing staff nurses’ perceptions of “Hatarakinikusa” included; 1)the presence of personnel whose characteristics are not desirable for collaboration, 2)poor level of establishment of a collaboration system, 3)absence of personnel who willingly respond to requests to communicate about work situations, 4)negative responses to requests to exercise one’s occupational rights, 5)demands for attendance at activities which encroach upon one’s private life and 6)compulsory work-related study regardless of necessity or one’s willingness.

Discussion: This study found that “Hatarakinikusa” includes 1), 3), and 4), which could be improved by ones’ own efforts. These categories are useful as objective points of view for reflection on one’s attitude toward others. This study also found that “Hatarakinikusa” includes some aspects such as 4), 5), and 6), which have not been paid much attention in other countries. However, these are important for Japanese nurses. Decreasing “Hatarakinikusa” make it easier for nurses to continuing nursing.

Conclusion: Thirty-seven categories expressing staff nurses’ perceptions of “Hatarakinikusa” were identified. It was suggested that not only organizational but also individual contributions are very important in improving nursing work environments and that by decreasing “Hatarakinikusa”, quality of care could be improved as a result of nurses remaining in their jobs for a longer time and developing their careers.

References

Choi, S.P., Cheung, K., & Pang, S. M. (2013). Attributes of nursing work environment as predictors of registered nurses’ job satisfaction and intention to leave. *Journal of Nursing Management, 21*(3), 429-439.

Kirwan, M., Matthews, A., & Scott, P. A. (2013). The impact of the work environment of nurses on patient safety outcomes: a multi-level modelling approach. *International Journal of Nursing Studies, 50*(2), 253-263.

Contact

kashim@chiba-u.jp

PST - Poster Presentations

Building Effective Mentorship Dyads with the Use of Attachment Theory

Carann Elizabeth Tribbett, MSN, RN, CCRN, USA
Vicky H. Becherer, PhD, RN, USA

Abstract

New nurse educators often characterize their transition into the professional faculty role as being fraught with anxiety, uncertainty, and a general lack of confidence (Ferguson, 2011). A frequently identified factor that hinders the role transition is a lack of formal pedagogical education (Schoening, 2013) One evidence-based solution to combat this emotionally tumultuous challenge is through the use of formalized mentoring programs (Ferguson, 2011). According to Brody et al. (2016), 82% of mentored nurse educators report a willingness to mentor others, and 95.5% of the mentored nurse educators would recommend mentorship to new nurse educators. Unfortunately, despite the many benefits of formalized mentorship programs they are not common in nursing education and faculty culture.

Significance: Informal mentorship has existed in practice professions throughout history, with nursing being no exception (Ferguson, 2011). Formalization of the mentor relationship originally appeared in business literature and again spread to nursing (Chen, Watson, & Hilton, 2016). Formalized mentor relationships between professional nurses have become more popular and have proven extremely effective in the socialization of new nurse educators (Nick et al., 2012). Despite the many benefits to mentors and protégé, there is no preparation for these roles in postsecondary educational institutions (Schoening, 2013). This Capstone project proposes the inclusion of formal preparation for mentorship in masters' programs, with the inclusion of Attachment Theory and attachment style testing to enhance personalization of goal setting and assist in pairing of mentorship dyads.

Mentorship in the literature has been proven to shape new nurse faculty by producing improved job performance, early and more successful career socialization, increased career advancement, retention of talented nurse educators, increased publication rates, improved scholarship, and development of leaders (Ghosh & Reio Jr., 2013). Findings also indicate that there are benefits for mentors as well as protégés when participating in mentor relationships (Ghosh & Reio Jr., 2013). Among the mentor benefits were improved job satisfaction and increased commitment to organizations (Ghosh & Reio Jr., 2013).

Conversely, failure of the mentoring relationship has been shown to negatively affect both mentors and protégé (Straus, Johnson, Marquez, & Feldman, 2014). Protégé of failed mentorships reported decreased job satisfaction, greater rates of anxiety, decreased work life balance, and intention to or having already left a position where the mentor relationship took place (Straus et al., 2014). Mentors of failed mentor relationships report decreased job satisfaction, feeling unsupported by organization, decreased lack of commitment to organization, increased rates of anxiety, decreased scholarship, and decreased work life balance. The number one reason given for failure of the mentor relationship is personality differences (Straus et al., 2014).

Literature Review: Database searches for the terms "Personality Testing" yield a variety of results. There were a large number of results debating the use of personality testing results, and a comparison of tools. With a huge variety of tests offered by an industry operating in the $500 million range, there is no shortage of studies (Psychometric Success, 2013). The use of personality testing for personnel selection is the topic most commonly found in the scholarly literature searches completed across multiple databases. There is a gap in research exploring the use of personality tests for team or group building and mentorship (Diekmann, Konig, & Saarlandes, 2012).

Chosen for inclusion in this literature review were the Myers-Briggs Type Indicator (MBTI), Big Five Instrument, and the Experiences in Close Relationship Scale (ECR) the short form adapted for business. The three tools were chosen based on frequency of use reported by the searched literature and examined using reliability, validity, and social desirability. Reliability is defined as the reproducibility of the measurement of a scale (Chen, Watson, & Hilton, 2016). Validity is defined as to what extent a tool measures the concept that it claims to measure (Chen et al., 2016). Social desirability is defined as the

tendency of respondents using self-rating inventories to score themselves with items perceived as more popular (Backstrom & Bjorklund, 2013).

Myers Briggs Type Indicator: The MBTI was the most frequently found tool on review of literature. Diekmann et al. (2012) reported the MBTI to be the instrument most frequently used by organizations, narrowly beating out the Big Five Personality Inventory. Grant (2016) described the MBTI as "the fad that won't die" (p.1). Pittinger (2010) and Diekmann et al. (2012) list numerous issues with reliability and validity with the MBTI, and both disagree with the widespread use. The MBTI is not recommended by this author for use in a formalized mentorship program because of the reliability and validity (0.21-0.91) data and that much of the data is out of date to make it appropriate for scholarly inclusion, as well as a complete lack of data found on social desirability for the MBTI.

The Big Five Personality Inventory: The Big Five Personality Test was frequently resulted in the literature review. The Big Five is popular for use in organizations (Diekmann et al., 2012). Hee (2014) reports validity rates of 0.8- 0.9 and reliability rates of 0.71-0.77. With scores recommended above 0.6, the Big Five scores fair to good (Hee, 2014). Lee et al. (2009) recommends utilization of the Big Five for use in mentorship programs although the publication is several years out of date as it was originally published in 2000 and reprinted in 2009. Furnham et al. (2011) produced a study that illustrated a strong correlation between Big Five results and academic performance. Social desirability is a concern for this tool, as it prompted the change in category "Neuroticism" to "Emotional Stability" shortly after the introduction of the tool (Diekmann et al., 2012). Research by Backstrom and Bjorklund (2013) substantiated the continued effects of social desirability within the Big Five, even after renaming, but conclude that social desirability may not negate use of the tool for recruiting job candidates, and possibly for use in a mentorship program, but would be of considerable note for research purposes (Backstrom & Bjorklund, 2013).

Adult Attachment Scale: The Adult Attachment Scale (AAS) is a tool well supported by literature and backed by the Attachment Theory (Wei, Russell, Mallinckrodt, & Vogel, 2011; Miles, 2011). The Attachment Theory was developed by John Bowlby and Mary Aisnworth (1969/1982) to examine the bond between children and parents (Germain, 2011). Multiple studies have successfully demonstrated the expansion of Attachment Theory to assist in the understanding of adult relationships, especially in times of stress (Germain, 2011; Miles, 2011). Several attachment measurement tools are available and most with good reliability and validity data (Frias, Shaver, Mikulincer, 2014). The AAS tool boasts fair to good reliability (0.78-0.93) and validity (0.77-0.87) rates. This tool is available online for free with extensive information on use of results (Miles, 2011; Paetzold, 2015). When examined for social desirability attachment studies have not been found to be contaminated with bias (Frias, Shaver, Mikulincer, 2014). Literature review does yield substantial data on recommendation for use in improving close relationships, and is even mentioned by Miles (2011) for use in mentoring (Paetzold, 2015). Based on support in the scholarly literature, reliability, and validity the author has chosen the AAS for application to formalized mentorship programs and dyad pairing.

Evaluation Process: Evaluation of the proposed change would be two-fold. Students of the course or seminar would be asked to complete a survey at the beginning and end of the course or seminar pertaining to mentorship, and a follow-up post-graduation survey would also be implemented to see if the student participated in a mentor relationship, formal or informal, and if the coursework was of assistance. Measurement of this data could lead to further revision of coursework, and possible avenues of new research into professional nurse mentorship programs thus guiding further change according to Lewin's change theory model (unfreeze-changing-refreeze) (Shirey, 2013). Qualitative analysis of the survey data would be gathered for publication and adaption to new areas of nursing where mentorship would be welcomed for staff retention or culture change is needed.

References

Backstrom, M., & Bjorklund, F. (2013). Social desirability in personality inventories: Symptoms, diagnosis and prescribed cure. *Scandinavian Journal of Psychology*, *54*(1), 152-159. http://dx.doi.org/10.1111/sjop.12015

Brody, A. A., Edelman, L., Siegel, E. O., Foster, V., Bailey Jr., D. E., Bryant, A. L., & Bond, S. M. (2016, April 4). Evaluation of a peer-mentoring program for early career gerontological nursing faculty and it's potential for application to other fields in nursing and health sciences. *Nursing Outlook 64*(4) 332-338. http://dx.doi.org/10.1016/j.outlook.2016.03.004

Chen, Y., Watson, R., & Hilton, A. (2016). A review of mentorship measurement tools. *Nurse Education Today*, *40*(1), 20-28. http://dx.doi.org/10.1016/j.nedt.2016.01.020

Diekmann, J., Konig, C. J., & Saarlandes, U. D. (2012). Personality testing in personnel selection: Love it? leave it? understand it! In I. Nikolaou, & J. Oostrom (Eds.), *Employee recruitment, selection, and assessment: Contemporary issues for theory and practice*. Hove, UK: Psychology Press.

Ferguson, L. M. (2011). From the perspective of new nurses: What do effective mentors look like in practice? *Nurse Education in Practice*, *11*(2), 119-123.

Frias, M.T., Shaver, P.R., & Mikulincer, M. (2014). Chapter 15: Measures of adult attachment and related constructs. In Boyle, G. J., Saklofske, D. H., & Matthews, G. (Eds.), *Measures of personality and social psychological constructs* (pp. 446-479). San Diego, CA: Elsevier Inc.

Furnham, A., Nuygards, S., & Chamorro-Premuzic, T. (2013). Personality, assessment methods and academic performance. *Instructional Science*, *41*(4) 319-338.

Germain, M. L. (2011). Formal mentoring relationships and attachment theory: Implications for human resource development. *Human Resource Development Review*, *10*(2), 123-150. http://dx.doi.org/10.1177/1534484310397019

Ghosh, R., & Reio Jr., T. G. (2013, April 5). Career benefits associated with mentoring for mentors: A meta-analysis. *Journal of Vocational Behavior*, *83*(1), 106-116. http://dx.doi.org/10.1016/j.jvb.2013.03.011

Grant, A. (2016, January 31). Goodbye to MBTI, the fad that won't die. *The Huffington Post*. Retrieved from www.huffingtonpost.com/adam-grant

Hee, O. C. (2014, April 4). Validity and reliability of the big five personality traits scale in Malaysia. *International Journal of Innovation and Applied Studies*, *5*(4), 309-315.

Lee, F. K., Johnston, J. A., & Dougherty, T. W. (2009, March 12). Using the five-factor model of personality to enhance career development and organizational functioning in the workplace. *Journal of Career Assessment*, *8*(4), 419-427. http://dx.doi.org/10.1177/106907270000800411

Miles, K. (2011, September 23). Using attachment theory in mentoring. *Nursing Times*, *107*(38) 23-25.

Nick, J. M., Delahoyde, T. M., Del Prato, D., Mitchell, C., Ortiz, J., Ottley, C., ... Siktberg, L. (*2012*, February 8). Best practice in academic mentoring: A model for excellence. *Nursing Research and Practice*, *2012*(1), 1-9. http://dx.doi.org/10.1155/2012/937906

Paetzold, R. L. (2015). Attachment theory in organizational settings. In J. A. Simpson, & W. S. Rholes (Eds.), *Attachment theory in research: New directions and emerging trends* (pp. 261-286). New York, NY: The Guilford Press.

Pittinger, D. J. (2010). Measuring the MBTI and coming up short. *Journal of Career Planning and Placement*, *15*(1), 72-81.

Psychometric Success. (2013). Understanding the personality test industry. Retrieved from http://www.psychometric-success.com

Schoening, A. M. (2013, May/June). From bedside to classroom: The nurse educator transition model. *Nursing Education Perspectives*, *34*(3), 167-172.

Shirey, M. R. (2013). Lewin's theory of planned change as a strategic resource. *Journal of Nursing Administration*, *43*(2), 69-72. Retrieved from http://dx.doi.org/

Straus, S. E., Johnson, M. O., Marquez, C., & Feldman, M. D. (2014, January). Characteristics of successful and failed mentoring relationships: A qualitative study across two academic health centers. *Academic Medicine*, *88*(1), 82-89. http://dx.doi.org/10.1097/ACM.0b013e31827647a0

Wei, M., Russell, D. W., Mallinckrodt, B., & Vogel, D. L. (2011). The experiences in close relationship scale (ECR)-short form: Reliability, validity, and factor structure. *Journal of Personality Assessment*, *88*(2), 187-204. http://dx.doi.org/

Contact

carannandgreg@yahoo.com

PST - Poster Presentations

Practice Assimilation for New Graduate Registered Nurses: A Clinical and Academic Nurse Leader Collaborative

Angela James, DNP, RN, CMSRN, FNP, USA
Katrina D. Jackson-Britt, MSN, RN, PHN, USA
Carol Rose DeLilly, PhD, RN, USA
Sharaun Sandoz-Britt, MSN/Ed, RN, CMSRN, USA

Abstract

Purpose: To bring together visionary nursing leaders to prepare New Graduate Registered Nurses (NGRN) for entry into professional practice.

Background: Nursing literature is replete with facilitators and inhibitors to work environments affecting the transition of New Graduate Registered Nurses (NGRN) into practice. Growing evidence suggests that a positive workplace greatly impacts role integration and retention of NGRN. New graduate RN retention in the first year of employment is a challenge for hospitals, ranging from a low of 25% to a high of 64% (Friedman, Delaney, Schmidt, Quinn, and Macyk, 2013). New graduate registered nurses require an effective preceptorship process in their first year of practice (Haggerty, Holloway, and Wilson, 2013). Nurse leaders have a significant and obligatory duty to provide transformational leadership and to ensure a constructive work environment for NGRN. Moore, Leahy, Sublett, and Laning (2013) conclude that nursing leadership at the unit level establishes the tone for interpersonal relationships among nurses. In this work, the Nurse Manager Leadership Partnership Learning Domain (NMLPLD) and Quality and Safety in Nursing Education (QSEN) (Table A) frameworks are utilized to inform dual partnerships between unit level nurse leaders and nurse academic leaders. This coalition will establish a productive, collaborative, and affirming practice environment for NGRN. The sustainability of a structured orientation plan for NGRN is dependent on support from nursing leadership and all nursing staff. This shared decision-making should address the development of clinical skills and clinical decision making, and describes the NGRN orientation plan implemented on a post-surgical neurological unit.

The formation of healthy work settings necessitates robust collaboration among health system support, nursing academia and nursing leadership. Retention of NGRN is enhanced when healthcare organizations partner with nursing academia in the implementation of QSEN competencies that mirror actual clinical workplace expectations. (Sullivan, Fries, and Relf, 2012). A resilient infrastructure that supports healthy workplace behaviors is influenced through the buy-in from internal and external stakeholders, and increases retention of NGRN.

Henderson, Ossenberg, and Tyler (2015) note that novices placed importance on the need for emotional support and collegiality. Nurse leaders who are attentive to signs of poor adaptation and decreasing morale among NGRN are more likely to intervene and provide support to reduce the strain of role transition among these nurses, thus preventing early resignation among this population. Nursing leadership in collaboration at the unit level requires a transformational leadership style that manages up nurses identified as having an interest and appropriateness for the preceptor role. Furthermore, true collaboration with nursing staff can identify nurse preceptors and convey the benefits of the role to nurses who may not self-identify as emerging leaders.

Methods: The Nurse Manager Leadership Partnership Learning Domain and Quality and Safety in Nursing Education (QSEN) frameworks to inform the development and implementation of a structured orientation manual to prepare NGRN in the post-operative care of patients with neurologic conditions. This project will employ a descriptive design utilizing a pre- and post-survey developed by the nursing unit leadership, NGRN who have completed orientation on a post-operative neurological surgical unit, and nursing faculty. Inclusion criteria for NGRN includes less than one year licensure as a registered nurse assigned to work on an acute care neurological nursing unit. Inclusion criteria for preceptors includes the completion of a hospital-based preceptor course and two years of continuous full-time employment on an acute care neurological surgical unit. This orientation plan will require that all NGRN attend a 90 day preceptored orientation plan during their transition into practice on a post-operative neurological surgical

unit. Unit nurse leaders and selected preceptors will utilize a comprehensive orientation manual developed by a new graduate registered nurse, specific to post-operative neurological nursing care for the NGRN orientation plan. This manual serves as supplemental instruction to be utilized with hands-on preceptored orientation. The NGRN orientation plan will assist in the development of specialized clinical critical reasoning and psychomotor skills pertinent to this specialized unit. Furthermore, NGRN will be supported and assessed in their ability to manage nursing care of fragile post-operative neurological surgical patients who demonstrate a high acuity level. In addition, the NGNR orientation will promote the development of knowledge of nurse sensitive indicators with the incorporation of Quality and Safety in Nursing Education (QSEN) competencies.

Discussion: This ongoing project aims to present evidence of successful role transition for NGRN. Project findings further aim to report positive emerging themes in post survey responses in areas of job satisfaction, intent to remain in the practice setting, decreased early resignation, improved critical reasoning, decreased anxiety, and acquisition of technical skills of NGRN.

Implications for Nursing Practice: True collaboration among all stakeholders can translate into greater familiarity with specialty units, delivery of QSEN competencies and enhanced adaptation to organizational culture for NGRN. A reputation for excellent leadership, care provision, unit culture, and mentoring are key drivers that attract NGRN. Healthy work environments impact retention of NGRN. Preceptors help to bridge the gap between the classroom and clinical practice settings. The need for an orientation plan for NGRN that specifically targets complex nursing units is essential to practice; however, the facilitation and implementation of these programs remains elusive (Boehm and Tse, 2013). Currently there are no nationally agreed upon standards of expected new graduate performance (Bull, Shearer, Phillips, and Fallon, 2015). Therefore, healthcare institutions in partnership with nursing academia can link theoretical content with expected nursing praxis to ease role transitions for NGRN on complex post-operative neurological surgical units.

References

Boehm, L. B. & Tse, A. M. (2013). Application of guided imagery to facilitate the transition of new graduate registered nurses. *The Journal of Continuing Education in Nursing, 44*(3), 113-9.

Bull, R., Shearer, T., Phillips, M., & Fallon, A. (2015). Supporting graduate nurse transition: Collaboration between practice and university. *The Journal of Continuing Education in Nursing, 46*(9), 409-415.

Friedman, M. I., Delaney, M. M., Schmidt, K., Quinn, C., & Macyk, I. (2013). Specialized new graduate RN pediatric orientation: A strategy for nursing retention and its financial impact. *Nursing Economics, 31*(4), 162-70; quiz 171.

Haggerty, C., Holloway, K., & Wilson, D. (2013). How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary Nurse: A Journal for the Australian Nursing Profession, 43*(2), 162-71.

Henderson, A., Ossenberg, C., & Tyler, S. (2015). 'What matters to graduates': An evaluation of a structured clinical support program for newly graduated nurses. *Nurse Education in Practice, 15*(3), 225-231.

Moore, L. W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding nurse-to-nurse relationships and their impact on work environments. *Medsurg Nursing, 22*(3), 172-9.

Sullivan, D.T., Fries, K. S., & Relf, M. V. (2012). Exploring the changing landscape of jobs for new graduates: Practice, education, and new graduate imperatives. *Creative Nursing, 18*(1), 17-24.

Contact

ugorn@yahoo.com

PST - Poster Presentations

Care Coordination Training at a Community Health Center

Latresha M. McKinnor, DNP, RN, USA

Abstract

Purpose of Study: Care coordination is an essential element of population health with an emphasis on a team-based, patient-centered approach. Based on an assessment of the care coordination program at a community health center in central Illinois, it was determined that a structured care coordination (CC) training, focused on the role of the care coordinator, was needed to improve care. The purpose of this project was to develop, implement and evaluate a CC training to increase care coordinator self-efficacy and measure their ability to implement core components of their role, which included a daily workflow and discharge planning.

Primary Practice Setting: Primary care clinic in a community health center.

Methodology and Sample: A quasi-experimental, one-group pre/posttest quality improvement design was used to determine if a pilot CC training affected self-efficacy for four care coordinators. Outcome data were collected via written questionnaires and chart review and analyzed using descriptive statistics, Mann-Whitney U and Spearman Correlation tests.

Results: A pre/posttest questionnaire was used to evaluate the degree of change in self-efficacy. Of the four care coordinators in the primary care setting, two participants completed usable pre/posttests (n=2). The pre/posttest result indicated a 55% increase in self-efficacy of the care coordinators. Review of the written documentation by the care coordinators after CC training of the four elements of the care coordinator workflow, which outlined their daily responsibilities, demonstrated that 50% of the participants correctly identified all four elements and 50% correctly identified two of the four elements.

Implications for Case Management Practice: Evidence reveals that care coordination reduces healthcare costs and improves quality of care for patients in the healthcare system. However, adequate training programs are imperative for the professional development of the care coordinator to perform their role. As it relates to this CC training pilot study, one implication for practice is the need for additional training. This will be important as the care coordinators at this community health center continue to move into the full scope of their role. Another implication is the need for an adequate number of providers in the primary care setting. This is important in forming a quality care team. Lastly, the need for the development of a multidisciplinary workgroup which includes: care coordinators, providers, medical assistants and administration. Recommendations include developing and implementing a process of collecting and providing data to the care coordinators of the appropriate patients for follow up appointments after ED visits, hospitalizations and for preventative care. Likewise, there needs to be an annual care coordination competency that is either web-based or in-person training for continuing education. Finally, employee recognition and continuous communication would help increase staff engagement and create a culture in which the common goal is to provide patient-centered care and maximize clinical quality.

References

AcademyHealth. (2012). *What works in care coordination? Activities to reduce spending in medicare fee-for-service*. Retrieved from https://www.academyhealth.org/files/RICareCoordination.pdf

Agency for Healthcare Research and Quality (AHRQ). (2015a). *Care coordination*. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html

Agency for Healthcare Research and Quality (AHRQ). (2015b). *Care management issue brief – Care management: Implications for medical practice, health policy, and health services research*. Retrieved from http://pcmh.ahrq.gov/sites/default/files/attachments/Care-Mgmt-Issue-Brief-No-15-0018-EF.pdf

American Psychological Association. (2016). *Teaching tip sheet: Self-efficacy: Important topic*. Retrieved from http://www.apa.org/pi/aids/resources/education/self-efficacy.aspx

DeVries, A., Li, C.H., Sridhar, G., Hummel, J.R., Breidbart, S. & Barron, J.J. (2012). Impact of medical homes on quality, healthcare utilization, and cost. *American Journal of Managed Care, 9*, 534-544.

Fisher, J.D. & Fisher, W.A. (1992). Changing AIDS-risk behavior. *Psychological Bulletin, 3*, 455-474.

Green, E.P., Wendland, J., Carver, M.C., Rinker, C.H. & Mun, S.K. (2012). Lessons learned from implementing the patient-centered medical home. *International Journal of Telemedicine and Applications, 2012*, 1-8.

Health Resources and Services Administration (HRSA). (2011). *Quality improvement*. Retrieved from http://www.hrsa.gov/quality/toolbox/methodology/qualityimprovement/

Huijg, J.M., Gebhardt, W.A., Dusseldorp, E., Verheijden, M.W., Van der Zouwe, N., Middelkoop, B.J.C & Crone, M.R. (2014). Measuring determinants of implementation behavior: Psychometric properties of a questionnaire based on the theoretical domains framework. *Implementation Science*, *9*, 1-15

Issel, L.M. (2013). *Health program planning and evaluation: A practical, systematic approach for community health* (3rd ed.). Burlington, MA: Jones & Bartlett.

Joo, J.Y. & Huber, D.L. (2014). Evidence-based nurse case management practice in community health. *Professional Case Management, 19*, 265-273.

National Committee for Quality Assurance (NCQA). (n.d.). *Patient-centered medical home recognition*. Retrieved from http://www.ncqa.org/Programs/Recognition/Practices/PatientCenteredMedicalHomePCMH.aspx

National Quality Forum. (2015). *Effective communication and care coordination*. Retrieved from http://www.qualityforum.org/Topics/Effective_Communication_and_Care_Coordination.aspx

Primary Care Development Corporation (PCDC). (2013). *Care coordination fundamentals: Learn more*. Retrieved from http://www.pcdc.org/performance-improvement/special-content/care-coordination-manual/care-coordination-for-front.html?referrer=http://www.pcdc.org/performance-improvement/special-content/care-coordination-manual/care-coordination.html

Rosenberg, K. (2012). RN population care coordinators: A new approach to chronic illness could serve as a national model. *American Journal of Nursing, 112*, 16.

Rural Health Information Hub. (2016). *Care coordinator model implementation consideration*. Retrieved from https://www.ruralhealthinfo.org/community-health/care-coordination/3/care-coordinator-model-implementation-considerations

Taliani, C.A., Bricker, P.L., Adelman, A.M., Cronholm, P.F. & Gabbay, R.A. (2013). Implementing effective care management in the patient-centered medical home. *American Journal of Managed Care*, 19, 957- 964.

Taylor, E.F., Machta, R.M., Meyers, D.S., Genevro, J. & Peikes, D.N. (2013). Enhancing the primary care team to provide redesigned care: The roles of practice facilitators and care managers. *Annals of Family Medicine*, 11, 80-83.

Contact

latresha.mckinnor@yahoo.com

PST - Poster Presentations

Implementing a Birth Preference Protocol for Intrapartal Women to Promote Collaboration, Autonomy and Patient Satisfaction

Carrie Sue Halsey, MSN, CNS-AD, RNC-OB, ACNS-BC, USA

Abstract

Laboring women have a right to informed consent and autonomy of their healthcare decisions. Having control over one's own healthcare decisions is an important element of autonomy and one that should be extended to pregnant women, just as it is to other healthcare populations. The American Congress of Obstetricians and Gynecologists supports informed consent and autonomy of women (Informed Consent, 2009). The Association of Women's Health, Obstetric, and Neonatal Nurses' (AWHONN) positions statement Nursing Support of Laboring Women (2011) describes the responsibility of nurses to advocate and support laboring women. A Birth Preference Protocol is developed and implemented to address the practice change needed to bring the clinical nurse team at Texas Children's Hospital Pavilion for Women into line with the positon statements of both ACOG and AWHONN.

The Humanbecoming theory (Parse, 2001) is the framework and theoretical basis for the described practice change. The theory of Humanbecoming is used to influence change in nursing care and alter the view of patients which facilitates the desired culture shift. Pregnant women are easily objectified and there is a common assumption in obstetrics that the only thing that women do (or should) care about is the health of her infant. Human subjectivity is not addressed due to providers being focused on cervical dilation and patient throughput (Bournes & Mitchell, 2014). Birth plans, which are the written expression of the mother's values regarding her birth, are often dismissed, derided or blamed for unexpected outcomes. In situations like this, nurses are creating a reality with their patients that have vastly different meanings. According to Parse's definition of freedom, nurses and patients can choose the attitude they will maintain towards any situation (Parse, 2001). The Birth Preference Protocol is the structure by which the clinical nurse and laboring woman create a birth experience that is mutually satisfying, safe and desirable. True collaboration between clinical nurses and women in labor is reached through the building of trust through communication. Barriers to collaboration are addressed and overcome through the implementation of the Birth Preference Protocol and Parse's Theory of Humanbecoming.

References

Anderson, C. J., & Kilpatrick, C. (2012). SUPPORTING Patients' Birth Plans. Nursing For Women's Health, 16(3), 210-218. doi:10.1111/j.1751-486X.2012.01732.x

Attanasio, L., McPherson, M., & Kozhimannil, K. (2014). Positive Childbirth Experiences in US Hospitals: A Mixed Methods Analysis. Maternal & Child Health Journal, 18(5), 1280-1290. doi:10.1007/s10995-013-1363-1

Beck, C. (2004). Post-Traumatic Stress Disorder Due to Childbirth: The Aftermath. Nursing Research, 53(4), 216-224.

Barefield, C. (2015). Get the 'SKINNI' on reducing pressure ulcers. Wound Care Advisor, 4(5), 21.

Bournes, D., & Mitchell, G. (2014). Human becoming. In *Nursing Theorists and Their Work* (8th ed., pp. 464-495). St. Louis: Elsevier Mosby.

Byrth, J. & Aromataris, E. (2014). Health professionals' perceptions and experiences of open disclosure: a systematic review of qualitative evidence. *The JBI Library of Systematic Reviews*. 12(5):237-318.

Cook, K., & Loomis, C. (2012). The Impact of Choice and Control on Women's Childbirth Experiences. Journal Of Perinatal Education, 21(3), 158-168. doi:10.1891/1058-1243.21.3.158

D'arcy, M & Xue, Y. (2013). Informed Consent: Hospital. *Recommended Practices.* The Joanna Briggs Institute.

Duteau, J. (2010). Understanding the lived experience of loss and grieving in persons with end stage renal disease: a human becoming approach. *CANNT Journal*, *20*(2), 18-22.

Farahat, A. H., Mohamed, H. S., Elkader, S. A., & El-Nemer, A. (2015). Effect of Implementing a Birth Plan on Womens' Childbirth Experiences and Maternal & Neonatal Outcomes. Journal Of Education And Practice, 6(6), 24-31.

Fleming, S. E., Smart, D., & Eide, P. (2011). Grand Multiparous Women's Perceptions of Birthing, Nursing Care, and Childbirth Technology. Journal Of Perinatal Education, 20(2), 108-117. doi:10.1891/1058-1243.20.2.108

Hadar, E., Raban, O., Gal, B., Yogev, Y., & Melamed, N. (2012). Obstetrical outcome in women with self-prepared birth plan. The Journal Of Maternal-Fetal & Neonatal Medicine: The Official Journal Of The European Association Of Perinatal Medicine, The Federation Of Asia And Oceania Perinatal Societies, The International Society Of Perinatal Obstetricians, 25(10), 2055-2057. doi:10.3109/14767058.2012.678438

Halsey, C. S., Gray, S. L., & Patrick, G. (2016). Using a Model for Change Management to Increase the Nurse Certification Rate. Journal of Obstetric, Gynecologic & Neonatal Nursing, 45(3). doi:10.1016/j.jogn.2016.03.051

Hiatt, Jeff. *ADKAR: A Model for Change in Business, Government, and Our Community*. Loveland, CO: Prosci Learning Center Publications, 2006. Print.

Informed Consent. (2009, August). Retrieved August 24, 2016, from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Ethics/Informed-Consent

Iwata, H., Mori, E., Tsuchiya, M., Sakajo, A., Maehara, K., Ozawa, H., & ... Tamakoshi, K. (2015). Predicting early post-partum depressive symptoms among older primiparous Japanese mothers. *Japan Journal Of Nursing Science.* Jbi Library of Systematic Reviews: 2012 - Volume 10 - Issue 4 - p 232–306 doi:10.11124/jbisrir-2012-46

Kapfhamer, J. D., Menon, S., & Spellecy, R. (2012). The Importance of Risk Tolerance in Maternal Autonomy. American Journal Of Bioethics, 12(7), 53-54.

Kuo, S., Lin, K., Hsu, C., Yang, C., Chang, M., Tsao, C., & Lin, L. (2010). Evaluation of the effects of a birth plan on Taiwanese women's childbirth experiences, control and expectations fulfilment: A randomised controlled trial. International Journal Of Nursing Studies, 47(7), 806-814. doi:10.1016/j.ijnurstu.2009.11.012

Lewis, L., Hauck, Y. L., Ronchi, F., Crichton, C., & Waller, L. (2016). Gaining insight into how women conceptualize satisfaction: Western Australian women's perception of their maternity care experiences. BMC Pregnancy & Childbirth, 161. doi:10.1186/s12884-015-0759-x

Longtin, Y., Sax, H., Leape, L., Sheridan, S., Donaldson, L., & Pittet, D. (2010). Patient participation: current knowledge and applicability to patient safety. Mayo Clinic Proceedings, 85(1), 53-62. doi:10.4065/mcp.2009.0248

Magoma, M., Requejo, J., Campbell, O., Cousens, S., Merialdi, M., & Filippi, V. (2013). *The effectiveness of birth plans in increasing use of skilled care at delivery and postnatal care in rural Tanzania: a cluster randomised trial.* Tropical Medicine & International Health: TM & IH, 18(4), 435-443. doi:10.1111/tmi.120

Meyer, S. (2013). Control in childbirth: a concept analysis and synthesis. Journal Of Advanced Nursing, 69(1), 218-228. doi:10.1111/j.1365-2648.2012.06051.x

Miller, S., & Skinner, J. (2012). Are First-Time Mothers Who Plan Home Birth More Likely to Receive Evidence-Based Care? A Comparative Study of Home and Hospital Care Provided by the Same Midwives. Birth: Issues In Perinatal Care, 39(2), 135-144. doi:10.1111/j.1523-536X.2012.00534.x

Nilsen, E. S. (2013). Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. Cochrane Database Of Systematic Reviews, (2), doi:10.1002/14651858.CD004563.pub2

Nursing Support of Laboring Women. (2011). Nursing for Women's Health, 15(5), 448-449. doi:10.1111/j.1751-486X.2011.01673.x

Parse, R. (2001). *Qualitative inquiry: The path of sciencing.* Boston: Jones and Bartlett.

Pfuntner, A., Wier, L., & Stocks, C. (2013). Statistical Brief #148: Most Frequent Conditions in U.S. Hospitals, 2010. Retrieved from http://www.hcup-us.ahrq.gov/reports/statbriefs/sb148.jsp

Rothstein, M. A. (2014). Autonomy and Paternalism in Health Policy: Currents in Contemporary Bioethics. Journal Of Law, Medicine & Ethics, 42(4).

Sato, S., & Umeno, Y. (2011). The relationship between the recognition of postpartum mothers' birth plan and the degree of satisfaction with delivery. Journal Of Japan Academy Of Midwifery, 25(1), 27-35.

Schwartz, J. (2010). Across the president's desk. Birth plans: why pay attention? International Journal Of Childbirth Education, 25(1), 5.

Sheridan, C. P., Yekinni, I., Oyeye, G., Ogunleye, K., Oluyede, G., O'Sullivan, K., & ... Higgins, J. R. (2011). Comparing birth plan preferences among Irish and Nigerian women. British Journal Of Midwifery, 19(3), 172-177.

Suárez-Cortés, María, Armero-Barranco, David, Canteras-Jordana, Manuel, & Martínez-Roche, María Emilia. (2015). Use and influence of Delivery and Birth Plans in the humanizing delivery process. *Revista Latino-Americana de Enfermagem*, *23*(3), 520-526. Epub July 03, 2015.https://dx.doi.org/10.1590/0104-1169.0067.2583

The Four Core Values of Texas Children's - Texas Children's Hospital People. (2015, November 16). Retrieved August 24, 2016, from http://texaschildrenspeople.org/the-four-core-values-of-texas-childrens/

Ways to Give - Texas Children's Hospital. (n.d.). Retrieved August 14, 2016, from http://waystogive.texaschildrens.org/reasons-to-give/video/patient-care/the-vision-and-mission-of.html?referrer=http://waystogive.texaschildrens.org/reasons-to-give/video/patient-care/the-vision-and-mission-of.html

Wiley, J., Westbrook, M., Greenfield, J. R., Day, R. O., & Braithwaite, J. (2014). Shared decision-making: the perspectives of young adults with type 1 diabetes mellitus. Patient Preference And Adherence, 8423-435. doi:10.2147/PPA.S57707

World Bank. (n.d.). Maternal mortality ratio (modeled estimate, per 100,000 live births). Retrieved April 1, 2015, from http://data.worldbank.org/indicator/SH.STA.MMRT?

Contact

perinatalempowerment@gmail.com

PST - Poster Presentations

Promoting Student Success through Collaboration: Implementation of a Student Success Center

Shandra D. Burton, MSN, APHN-BC, USA

Abstract

Improving the success of academically underprepared students who are in need of developmental or remedial education is a key challenge for faculty. The mission of the Student Success Center is primarily focused on student personal and academic success which guides our interactions with students. We seek positive outcomes for students by carefully attending to the barriers they are experiencing with the goal of self-empowerment and behavioral change on the part of those students using a collaborative learning approach. The Center will give students a learning environment that motivates students to make positive life choices like making academics a priority, attending classes daily, and utilizing resources to obtain success in the classroom. The Student Success Center is expected to be operating fully by the Fall 2016 term.

The presentation will examine the implementation of a Student Success Center in a university setting in the Southwest that fosters an open and responsive environment for students. The center also encourages faculty to take an active collaborative role in student success. Dedicated faculty and teaching assistance will work with students using a self-evaluation tool to assess individual strengths/weaknesses. An individualized academic success plan is developed in collaboration with the student.

After participating in Student Success Center programs for an appropriate amount of time, and within the context of each student's individual needs, students become more independent, self-confident and efficient learners.

The Student Success Center will create an appropriate infrastructure to increase communication, promote collaboration, and align resources, to meet student needs.

Collaboration plays an important role in academic success. Implementation of a Student Success Center could promote an environment to nurture students academically. Student Success Center needs further study upon implementation to ascertain contributing factors to student success, NCLEX first time pass rates, professional socialization and other factors. This model could be replicated across colleges of nursing nationally.

References

Cole, L., & Adams, M. (2014). A Multifaceted Progression Approach to Enhancing Student Success. Nurse Educator, 285-289.

Pennington, T., & Spurlock, D. (2010). A Systematic Review of the Effectiveness of Remediation Interventions to Improve NCLEX-RN Pass Rates. Journal of Nursing Education, 485-492.

Reinhardt, A., Keller, T., Summers, L., & Schultz, P. (2012). Strategies for Success: Crisis Management Model for Remediation of At-Risk Students. Journal of Nursing Education J Nurs Educ, 305-311.

Contact

shburton@salud.unm.edu

PST - Poster Presentations

ICU Healthy Word Environments: A Concept Analysis

Sharon A. Little-Stoetzel, PhD, RN, USA

Abstract

Background: Nurses' healthy work environments are defined inconsistently in the nursing literature. Clarifying the concept of a healthy work environment would benefit employees, patients, leaders, and organizations as well as provide an empirical definition for future research.

Objective: The purpose of this research was to develop an empirically based definition of a healthy work environment in the intensive care unit using Rodgers' and Knafl's (2000) evolutionary concept analysis method.

Methods: This evolutionary concept analysis method included data collection and analysis in two phases. Phase 1 data collection and analysis included a random sample of 20% of the literature, as recommended by Rodgers and Knafl, published between 2008 and 2012 from the sociology, psychology, nursing, and business databases regarding healthy work environments. Phase 2 data collection included interviews with 11 ICU staff nurses and 10 ICU nurse managers using an interview guide developed from the themes that emerged from the literature sample.

Results: An empirically based definition of an ICU healthy work environment was developed: *a healthy work environment in ICU is one that is individually perceived to include positive work-group relationships and effective teamwork and that supports a nurse holistically by nurturing his or her physical, psychosocial, professional, and spiritual components of health.* Antecedent themes included: adequate staff and supplies, effective leadership, participation in decision-making and professional standards. Consequence themes included: quality product/outcome, organizational sustainability, and decreased turnover. Themes from the interviews were framed with AACN's standards of a healthy work environment and Watson's Human Caring Theory.

Conclusions/Recommendations: As a result of the study, recommendations for leaders include to work toward creating and supporting an environment where ICU staff nurses have positive work-group relationships and effective teamwork. Researchers at the AACN (2005) noted true collaboration among all members of the team requires "constant attention and nurturing" (p. 21) by leadership. Nurse leaders must ensure formal processes and structures are in place that facilitate effective teamwork, including unit council structures and effective communication avenues. As suggested in the study, healthy intensive care work environments should also provide physical, psychosocial, professional, and spiritual support for nurses.

References

American Association of Critical Care Nurses. (2005). AACN standards for establishing and sustaining healthy work environments: A journey to excellence. *American Journal of Critical Care, 14*(3), 187-196. Retrieved from http://ajcc.aacnjournals.org/

Kramer, M., Maguire, P., & Brewer, B. (2011). Clinical nurses in Magnet hospitals confirm productive, healthy unit work environments. *Journal of Nursing Management, 19,* 5-17. doi:10.1111/j.1365-2834.2010.01211.x

Lefebre, N., DeCicco, J., & Ray, K. (2011). Developing and sustaining nursing leadership for healthy work environments. *Nursing Leadership, 24*(4), 34-43.

Littlejohn, P. (2012). The missing link: Using emotional intelligence to reduce workplace stress and workplace violence in our nursing and other health care professions. *Journal of Professional Nursing, 28*(6), 360-368. doi:10.1016/jprofnurs.2012.04.006

Rodgers, B., & Knafl, K. (2000). *Concept development in nursing: Foundations, techniques, and applications.* Philadelphia, PA: Saunders.

Contact

stoetzel@graceland.edu

PST - Poster Presentations

Teamwork: Strategies to Prevent and Minimize Patient Aggression

Jennifer L. Appollo, MSN, RN, RN-BC, PMHNP, PMHNP-BC, USA
Patricia M. O'Connell, BSN, RN-BC, USA
Joyce Frank, BSN, MPH, RN, USA

Abstract

Espinosa et al. (2014) found that improving the milieu through early intervention and consistent structure and activities can reduce aggressive behavior and the need for seclusion and restraint. Boumans et al. (2015) found that staff's frequency of seclusion participation was positively related with the tendency to seclude. A literature review further identified that key influences over conflict are: anticipating aggression, staff team composition, physical environment, and leadership's role in assisting front line staff. Factors that contribute to aggression on inpatient units include: denial of a patient request by staff, staff demanding a patient act a certain way, staff requesting that the patient desist from some action, inflexibility of staff in meeting patients' needs/wants, locked doors both to and within unit, patient to patient interaction, and informing patient of bad news/loss. Factors identified as key influences in aggression reduction are: care planning, staff education, staff cohesiveness, role modeling/patient education and overall positive regard for patients. This project aimed to more specifically identify the characteristics, statistics and influences of one particular acute inpatient psychiatric unit, often composed of aggressive and violent patients on an involuntary legal status. The goal was to elucidate what about this particular unit makes its aggression level, as indicated by its seclusion and restraint statistics, relatively low given the acuity of its patient population. A survey was created and was completed by each staff member to get a consensus of what was most important when caring for the aggressive patient from this perspective. An in-depth case example was discussed at multiple, interdisciplinary staff meetings to identify the various interventions that made up the care plan and how this plan of care was carried out by the staff on the unit. The findings conclude that aggression can be reduced and possibly eliminated when teamwork is at the heart of successful early intervention.

References

1. Boumans, C.E., et al. (2015). Seclusion and the importance of contextual factors: An innovation project revisited. *International Journal of Law and Psychiatry*, http://dx.doi.org/10.1016/j.ijlp.2015.03.001
2. Bowers, L. et al. (2014). Safewards: the empirical basis of the model and a critical appraisal. *Journal of Psychiatric and Mental Health Nursing*, **21**, 354-364.
3. Espinosa, L., Harris, B., Frank, J., Armstrong-Muth, J., Brous, E., Moran, J., and Georgi-Cipriano, J. (2014). Milieu improvement in psychiatry using evidence-based practices: the long and winding road of cultural change. *Archives of Psychiatric Nursing*, http://dx.doi.org/10.1016/j.apnu.2014.08.004

Contact

pao9014@nyp.org

PST - Poster Presentations

Bridging the Gap between Academia and Practice in Service Excellence and Core Quality Measures

Crystal Joy Wilkinson, DNP, RN, CNS-CH, CPHQ, USA
Elizabeth H. Boyd, MSN, BS, RN, RNC-MSN, USA

Abstract

Nursing shortages, fiscal restraints, complex healthcare organizations and regulations, increasing patient acuity and the explosion of knowledge and technology have increased the need for nursing graduates to arrive in the work setting with the ability to move quickly into practice. Nursing residency programs were designed to facilitate the complex process that prepares new graduate nurses for practice, taking the novice nurse from a beginner to more competent provider. Nursing residency programs last anywhere from six weeks to six months and are estimated to cost around $65,000. Historically there has been a gap between nursing schools and hospitals on how well prepared graduate nurses are when they reach this critical juncture. Due to recent changes in Medicare and Medicaid reimbursement nurse residency programs have an increased focus on two particular areas: 1) Competency in service excellence; and 2) the nurse's role in compliance with core quality measures. Healthcare organizations feel these topics are not adequately addressed in nursing programs but could be included integrated into competency-based curriculum and would align well with patient-centered care and evidence-based practice content. Collaboration between nursing schools and hospitals on these priority topics could close these gaps and speed transition to practice, saving time and money.

Approach: The aim of this project is to identify gaps in customer service skills and core quality measures in new graduates and nursing residents and develop and implement an assessment tool specifically designed to measure competency in these two high priority areas. Currently a tool that addresses these topics does not exist. This project involved extensive collaboration between the participating nursing schools, two major hospital systems and their education and management staff. Focus groups involving administrators and educators with varying years of experience were conducted to identify key concepts and constructs related to the study competencies. The individuals and organizations participating helped to define gaps, define competencies and provide perspectives on the new graduate and nursing residency experience. The data was used in the assessment tool and curriculum development. The curriculum was designed and implemented by the participating nursing programs and offered to programs across the state of Texas. The goal of the project is to increase competency in the new graduates and new hires in the two topic areas. The objective was to reduce the time and cost of ensuring competency for the study topics in the residency program. Consultation on use of the tool and the process will be provided through onsite visits or a web-based tool kit to increase spread and sustainability of the project.

Conclusion: The tools developed and the information obtained from this project will be generalizable to healthcare organizations and schools of nursing across the country. This project is unique in its innovative and cooperative structure and could be used as a model by other organizations seeking to bridge the gap in preparing nurses for practice and for ensuring high quality in evidence-based practice and excellence in customer service.

References

Bowie, P., McNab, D. Ferguson, J, de Wet, C., Smith, G. MacLeod, M., McKay, J. & White, C. (2015). Quality improvement and person-centeredness: a participatory mixed methods study to develop the 'always event' concept for primary care.

Chang, C. S., Chen, S. Y., & Lan, Y. T. (2013). Service quality, trust, and patient satisfaction in interpersonal-based medical service encounters. *BMC Health Services Research, 13*, 22-6963-13-22.

Hsu, L. L., Hsieh, S. I., Chiu, H. W., & Chen, Y. L. (2014). Clinical teaching competence inventory for nursing preceptors: Instrument development and testing. *Contemporary Nurse, 46*(2), 214-224.

Contact

crystal.wilkinson@ttuhsc.edu

PST - Poster Presentations

A Study Concerning Nursing Students' Sense of Ethics Which Govern Their Behavior during Clinical Training

Maki Tanaka, MSN, RN, PHN, Japan

Abstract

Clinical training is a setting where nursing students develop the required sense of ethics while providing patient care and observing the behavior of nurses. It's also a perfect educational opportunity for instilling nursing ethics where students can learn methods to cope with ethical problems. We believe people's behaviors reflect the sense of ethics of the person, and behaviors to cope with ethical problems encountered during clinical training provide a mirror that reflects the sense of ethics of students. To understand this better, we conducted a study by focusing on what sense of ethics students displayed and how they may be expected to be influenced by the clinical training.

Our purposes were to clarify the ethical problems which the nursing student faced during training in a clinical setting, and to identify the characteristics of the coping behavior and to explore how the sense of ethics differ among nursing students.

The findings in this study are new, and findings like these have not been published previously. It is hoped that the findings will contribute to nursing education in present day Japan, where ethics education has not been systematically pursued so far, but has been left to the competence of the teacher. In addition, our findings will be useful to establish a basic methodology that shows how to deal with issues in nursing ethics education and what it is necessary to do to develop the understanding of the ethics points and attitudes of the students.

Our sample is 11 Nursing students who have had the experience of participating in training in a clinical setting. We conducted semi-structured interviews and created transcriptions based on our own guidelines, and made use of the narrative approach to analyze the qualitative data.

We identified 23 ethical problems in the narratives of the students. They are mostly about interactions between nurses and patients, and about the behaviors or attitudes of nurses towards patients. When encountering a problem, students will be surprised and wonder if this can be right? and result in reactions like "I don't like it". Then, what coping behavior do they fall back on? We found that many of the students do not engage in any active behavior when encountering ethical problems. Many nursing students wondering if something is really right, or "just watched", and "thinking how they should do something." Some students asked teachers for opinions, but those were only few. Most students conformed to this kind of unquestioning behavior. We explored the sense of ethics of nursing students based on their coping behaviors when encountering ethical problems. From these considerations, we feel that students are worried about what to consider most important, the "relationships with nurses" or the "relationships with patients". Here, they lean towards valuing the relationship with nurses who cause a particular problem rather than concern themselves about the patients involved in the problem. We came to understand that most students place value on the "relationship with nurses", and refrain from voicing their opinions to the nurses even when thinking that there is "something wrong" in the way of dealing with problems. They rationalize that "This is a rule here", and that "Students should not express their opinions". To think and accept that "This is a rule here" involves a change of their existing sense of ethics, and it results in a displacement of the "pre-clinical training" sense of right and wrong. This is what may happen when students put a higher value on the relationship with nurses than on that with patients.

In this way, understanding what students rely on in making decisions in clinical training and the sense of ethics they bring to the work will make a significant contribution to the concept of nursing education in the future.

We are planning to develop this research into a quantitative study and also to make cross-cultural comparisons. When a clear sense of ethics is a determinant for good nursing practices, we may expect that through this study there will be many nurses who would play active roles in the future.

References

Ramos, Flávia Regina Souza, (2015). Ethical conflicts and the process of reflection in undergraduate nursing students in Brazil. Nursing Ethics, 22(4), 428-439.
Erdil F; Korkmaz F. (2009). Ethical problems observed by student nurses. Nursing Ethics, 16(5),589-598.
Park, Eun-Jun. (2012). An integrated ethical decision-making model for nurses. Nursing Ethics, 19(1), 139-159.

Contact

makimaki@nagano-nurs.ac.jp

PST - Poster Presentations

Creating a Psychologically Healthy Workplace in Nursing Education

Matt F. Hoffman, DNP, APRN, FNP-C, USA
Debra W. Matthews, PhD, RN, USA

Abstract

Background: The presence of nursing incivility in the workplace continues to be identified in the literature as an ongoing obstacle within academic and clinical work environments (Condon, 2015). The American Psychological Association (APA) Center for Organizational Excellence (2016) has identified five psychologically healthy workplace (PHW) practices: (1) employee involvement, (2) work-life balance, (3) employee growth and development, (4) health and safety, (5) employee recognition. The nursing profession may utilize these practices as a means to ameliorate incivility and create a psychologically healthy workplace.

Purpose: This project surveyed academic nursing faculty and staff on each of the APA's five workplace practices in order to assess the work environment and to better enable strategic and shared decision-making efforts.

Methods: The research team used Plan, Do, Study, Act (PDSA) cycles to identify and test changes predicted to improve results in each of the five PHW categories (APA, 2016). The Texas A&M University College of Nursing faculty and staff (*n*=59) completed a survey focused on the five PHW categories. Upon completion, data was analyzed using SPSS and emphasis was placed on comparing responses between academic position and gender. Scale items within the survey were evaluated for reliability. Logistic regression was used to account for potential confounding variables. A two-day workshop designed for faculty and staff was held and organized for participants to hear from guest speakers on the topics of "Implicit Bias" and "Fostering Civility in the Learning Environment." The presentations included small group activities and opportunities for participants to share and practice strategies for identifying and deterring implicit bias and incivility in the work environment. After the presentations, participants were randomly assigned to groups, comprised of both faculty and staff, and assigned two tasks: 1) define behaviors and values faculty and staff would like to see as norms for collegial interaction, and 2) evaluate and discuss the survey data for assigned PHW criteria and identify current opportunities or obstacles along with suggested strategies for improvement. Behavioral norms were voted upon by all workshop participants to identify the most commonly agreed upon values and norms. Lastly, the identified PHW opportunities and suggested strategies were compiled and shared with all participants. At the completion of the workshop, participants received a post-workshop survey to evaluate how the workshop and speakers enhanced understanding related to improving workplace climate. The primary outcome measures were identified areas of opportunities with suggested strategies for improvement and change. These areas were based on the PHW categories and survey results. The secondary outcome measures were defined behaviors for collegial interaction and percent of participants with an enhanced understanding of issues related to improving workplace climate as measured by self-report within the post-workshop survey.

Results: At the completion of the workshop, participants (n=56) identified opportunities and strategies for improvement for each PHW category. The variance in participants from the initial survey to those at the completion of the workshop is attributed to employee turnover between the survey release and the workshop. The PHW category (1), employee involvement, opportunity was to ameliorate workplace ostracism for all employees by increasing awareness/mindfulness of unique personalities, increase transparent communication, actively seek opinions, and inclusion of different work groups. The PHW category (2), employee growth and development, opportunity was to implement a staff mentorship program and improve the current faculty mentorship program. Suggested strategies included considering diverse needs for mentoring, using the literature to build a more robust mentoring plan, and consider incorporating focus groups for the updated mentoring plans. The PHW category (3), employee recognition, opportunity was to establish an employee recognition program within our unit by polling faculty and staff on what activities and behaviors they would like to receive formal recognition. Additionally, seek more information by investigating what and how other programs and institutions

incorporate formal recognition/awards programs. The PHW category (4), health and safety, opportunity focused on improving physical and mental health through the integration of existing university and local health resources and incorporation of monthly mental health "brown bag" events. The final PHW category (5), work-life balance, identified work-family conflict as an area of opportunity for improvement with strategies directed towards implementing focused analysis of workload distributions by administration, maintaining continuity in workload assignments, and assigning work according to strengths and interests. Participants defined and voted on the following behavioral norms for collegial interaction within the college of nursing: We will perform random acts of kindness for each other; We purposefully seek out opportunities to uplift, encourage, and celebrate our colleagues; We will adhere to the Aggie Core Values; We strive to remain approachable and encourage feedback; We do not speak negatively about colleagues in their absence. Post-workshop survey response rate was 37.5% (n=21) with 62% of respondents strongly agreeing and 24% agreeing the workshop enhanced their understanding of issues related to improving the workplace climate.

Conclusion: The project is ongoing. Incorporating education and collaboration with shared decision-making efforts has increased communication concerning obstacles to creating a psychologically healthy workplace. Additional PDSA cycles are planned to incorporate college of nursing talent and pre-existing work groups to test the strategies identified by faculty and staff, test adherence to the agreed upon behavioral norms, and implement continuing education as it pertains to creating a psychologically healthy workplace.

References

American Psychological Association (APA) Center for Organizational Excellence. (2016). Resources for employers. Retrieved from https://www.apaexcellence.org/resources/creatingahealthyworkplace/

Condon, B.B. (2015). Incivility as bullying in nursing education. *Nursing Science Quarterly, 28*(1), 21-26. doi: 10.1177/0894318414558617

Contact

mhoffman@tamshc.edu

PST - Poster Presentations

A Workplace Violence Nursing Simulation: The Development of the Intervention for Pre-Licensure Nursing Students

Angel Johann Solorzano Martinez, MSN, MBA, RN, USA

Abstract

Background: Workplace violence is an undesired phenomenon affecting nurses and nursing students. Nursing simulations allow nursing students to learn and practice skills in an innovative controlled setting. A simulated scenario using a standardized patient (SP) behaving as an agitated psychiatric patient was developed for second semester undergraduate nursing students enrolled in a psychiatric nursing course. Providing appropriate training to nursing students to manage incidents of workplace violence is imperative for their safety in psychiatric nursing clinical rotations. A mental health nursing simulation focusing on workplace violence employing a SP can provide the nursing students the opportunity to build knowledge and skills to be applied in their psychiatric clinical settings.

Theoretical Framework: The theoretical framework that guided this instructional strategy was composed of social learning theory and experiential theory.

Objectives: The workplace violence nursing simulation (WVNS) was developed for nursing students. The WVNS aims include to enhance the students' confidence managing agitated patients, augment their knowledge about evidence-based interventions for de-escalating patients, promote their ability to assess signs of aggression displayed the SP, employ evidence-based interventions to manage an agitated patient, and evaluate the usefulness of the nursing simulation scenario with the SP

Design: Quasi-experimental and evaluative design with pre- and post-test surveys

Setting: The WVNS was conducted in the nursing department's premises of a public university in San Francisco, California. The university's simulation laboratory and classrooms were employed.

Instructional Strategies: Face-to-face discussions, online presentation, one encounter with the SP, recording of the encounters, debriefing by the SP and the project leader.

Results: Quantitative data will be statistically analyzed to assess the WVNS aims. Themes will be identified from the qualitative data obtained.

Conclusions: The WVNS created an experiential learning environment and may enhance the nursing students' confidence and knowledge prior to their psychiatric nursing clinical rotation. The evidence-based interventions learned may help manage and prevent incidents of workplace violence in clinical settings.

References

Brown, A. M. (2015). Simulation in Undergraduate Mental Health Nursing Education: A Literature Review. *Clinical Simulation in Nursing*, *11*(10), 445-449 5p. doi:10.1016/j.ecns.2015.08.003

Doolen, J., Giddings, M., Johnson, M., de Nathan, G.G., & Badia, L.O. (2014). An Evaluation of Mental Health Simulation with Standardized Patients. *International Journal of Nursing Education Scholarship,* 11(1), 1-8 8p. Doi:10.1515/ijnes-2013-0075

Goh, Y., Selvarajan, S., Chng, M., Tan, C., & Yobas, P. (2016). Using standardized patients in enhancing undergraduate students' learning experience in mental health nursing. *Nurse Education Today,* 45167-172. doi:10.1016/j.nedt.2016.08.005

Contact

anjohann@yahoo.com

PST - Poster Presentations

Using the Competence Scale for Senior Clinical Nurses to Examine Safe Staffing

Itsuko Akamine, PhD, MHS, RN, PHN, Japan
Masaki Shinjo, PhD, BS, Japan

Abstract

Background: To achieve the intended outcome of healthy work environments, in the form of quality care, safe patient outcomes, and nurse recruitment and retention, attention must be directed to the invisible, cognitive work of nursing (i.e., work that promotes suitable work flow and care delivery), and to factors that support or complicate this invisible work [1]. Nurse staffing has always been a complex issue, but delivery of safe, quality, cost-effective patient care is important, along with the creation of a safe environment for patients and medical professionals.

The perception of adequacy of a staffing scale is a 6-item scale assessing the most common factors affected by nurses' perceptions of adequate staffing [2]. One of the central themes was to develop the role of the Senior Charge Nurse (SCN) and equip these clinical leaders with the information and tools needed to monitor and improve quality in their areas [3].

We developed the Competence Scale for Senior Clinical Nurses (CS-SCN) [4]as a concise scale to measure and evaluate the competence of senior clinical nurses. The CS-SCN comprises five factors: "Role accomplishment", "Self-management", "Research", "Practice and coordination", and "Work implementation". Measuring competence is important to achieve safe and appropriate nurse staffing,

Objective: The aim of this study was to examine whether the CS-SCN is a useful marker of appropriate nurse staffing.

Methods: A cross-sectional questionnaire survey using the CS-SCN was undertaken at a hospital in Japan in 2013. Subjects comprised 219 senior clinical nurses (27 males, 191 females) defined as those with ³5 years of clinical experience. Total score for each factor was calculated by wards which were involved of internal medicine, surgery, ICU, ER, OR, obstetrics and gynecology, etc. We compared competence scores for each factor by ward. We tested whether differences in scores were statistically significant by Kruskal-Wallis test, and distributions were tested by box plot.

This study was approved by the research ethics committee of the authors' institution.

Results: No competence scores showed significant differences, but distributions for the competence score of wards by box plot were different. With regard to the total score (range:22-88) of all factors, the highest level was 86, and the lowest level was 35. Score ranges were 7–28 for "Role accomplishment", 2–8 for "Self-management", 2–8 for "Research", 5–20 for "Practice and coordination", and 6–24 for "Work implementation". Mean total score was 61.2 (range, 45–76) for highest-level ward and 49.5 (range, 42–61) for lowest-level ward.

Conclusions: The results suggest that CS-SCN offers useful scale for measuring safe nurse staffing.

Conflicts of interest: The authors declare no potential conflict of interest with respect to the research and authorship.

Acknowledgments: This work was supported by Japan Society for the Promotion of Science, the Ministry of Education,
Culture, Sports, Science, and Technology (KAKENHI grant No. 26463250), Japan.

References

1. Patricia R. E, (2010). The complex work of RNs: Implications for healthy work environments. The Online Journal of Issue in Nursing, 15(1), 1-12.
2. Marlene K., Claudia S. (2005). Revising the essentials of magnetism tool: There is more to adequate staffing than numbers. Journal of Nursing Administration, 35(4), 188–198.
3. Royal College of Nursing (2010). Guidance on safe nurse staffing levels in the UK. London: RCN. Available at www.org.uk (Internet).

4. Itsuko A., Miyoko U., Masaki S., Eri N. (2013). Development of competence scale for senior clinical nurses. Japan Journal of Nursing Science, 10, 55–67.

Contact

iakamine@okinawa-nurs.ac.jp

PST - Poster Presentations

Examination Using the Improving Nurse Competence Program for Senior Clinical Nurses to Achieve Safe Staffing

Masaki Shinjo, PhD, BS, Japan
Itsuko Akamine, PhD, MHS, RN, PHN, Japan

Abstract

Background: Short staffing compromises care both directly and indirectly, and results in elevated staff stress and reduced staff wellbeing, increasing both absences due to sickness and staff turnover [1]. Daily staffing levels are insufficient to meet patient needs safely, so safe staffing relies on good management to fill budgeted posts and achieve effective deployments, and availability of staff to work [2].

Less is known about the leadership skills of senior charge nurses that are effective for ensuring the safety of both patients and staff in their wards [3]. The primary issue remains the delivery of safe, quality, cost-effective patient care; this can only be accomplished if and when nurses, administrators, financial leaders, and politicians work together and respect one another's points of view to resolve this complex problem [4]. Senior clinical nurses play an important role in ensuring patient safety and delivering high-quality care to address these issues. In 2008, we developed the Improving Nurse Competence Program for Senior Clinical Nurses, comprising 6 months' address, presentation and evaluation.

Objective: The aim of this study was to clarify whether the Improving Nurse Competence Program is appropriate for nursing staff.

Methods: Subjects comprised 11 senior clinical nurses (2 males, 9 females) who participated in this program. A questionnaire survey was administered before and after the program, and the senior clinical competence score was calculated using the Competence Scale for Senior Clinical Nurses (CS-SCN) [5]. P-values were calculated to determine significant differences between before and after the program using the Wilcoxon test. The protocol of this study was approved by the research ethics committee of Okinawa Prefectural College of Nursing. In addition, administrative approval was obtained from the subject's hospital.

Results: P-values for total score, "Role accomplishment", "Self-management", "Research", "Practice and coordination", and "Work implementation" were 0.029, 0.025, 1.000, 0.012, 0.258 and 0.942, respectively. CS-SCN scores for total score, "Role accomplishment" and "Research" were significantly increased after completing the program. The program appeared to improve nursing competence in senior clinical nurses, and the CS-SCN measured the improvements in competence level achieved by participating in the program.

Conclusions: These findings suggest that the Improving Nurse Competence Program is useful to ensure the safety of patients and staff in the ward. This program and CS-SCN may contribute to adequate safe nurse staffing.

Acknowledgement: This study was supported by Japan Society for the Promotion of Science, the Ministry of Education, Culture, Sports, Science, and Technology (KAKENHI grant No. 26463250), Japan.

Conflicts of interest: The authors declare no potential conflict of interest with respect to the research and authorship.

References

1. Royal College of Nursing (2010). Guidance on safe nurse staffing levels in the UK. London: RCN. Available at www.org.uk (Internet).
2. Patricia R. E. (2010). The complex work of RNs: Implications for healthy work environments. The Online Journal of Issue in Nursing, 15(1)
3. Cakil A., Rhona F. (2014). Senior charge nurses' leadership behaviours in relation to hospital ward safety: A mixed method study. International Journal of Nursing Studies, 51, 768–780.
4. Robin H. (2013). Regulating patient staffing: A complex issue. Health care reform & issues in nursing, Academy of Medical-Surgical Nurses, Available at www.amsn.org (Internet).

5. Itsuko A., Miyoko U., Masaki S., Eri N. (2013). Development of competence scale for senior clinical nurses. Japan Journal of Nursing Science, 10, 55–67.

Contact

mshinjoopcn@okinawa-nurs.ac.jp

PST - Poster Presentations

Adequate Staffing, Retention, and Recruitment Strategies

Julie Ann Brooks, MSN, RN, USA
Robyn Weilbacher, MSN, RN, CENP, CNML, PCCN, USA
Kimberly L. Siemons, MSN, RN, CCRN, USA

Abstract

A healthy work environment (HWE) is vital to quality patient care, nurse satisfaction, and organizational success. Employers must understand the factors that contribute to unhealthy work environments and a commitment to developing solutions to create a HWE. In order to determine the health of our environment the Chief Nursing Officers of Mercy used the AACN (American Association of Critical Care Nursing) "Standards for Establishing and Sustaining a Healthy Work Environment" to gather results on the state of our organization. The six essential standards are 1) skilled communication, 2) true collaboration 3) Effective decision making 4) Appropriate Staffing and 5) Meaningful recognition. (AACN.org) Due to the current state of nursing in regards to the nursing shortage our state is experiencing, our project focuses on the multiple methods used to create a HWE in order to enhance retention and recruitment.

The Missouri Hospital Association 2015 Workforce survey revealed that RN employee turnover has increased over the last 3 years from 10.2% to 15.7% while vacancy rates rose from 3.4% to almost 10% in 2015. The annual average openings for a registered nurse in Missouri are 886 (Missouri Hospital Association, 2015 Workforce survey).

With a large and complex health system situated primarily in the Midwest all facing a shortage of nurses the Chief Nursing Officers (CNO) from across the Mercy system came together to share best practices related to recruitment and retention. In an attempt to place effort on each hospital's best opportunities, it was decided to format key initiatives related to recruitment and retention by using the key concepts of the AACN Healthy Work Environment (HWE). The HWE assessment had previously been used to assist individual units in assessing culture and creating positive change. This would be the first time an entire system would participate in one large exercise around the HWEs.

The AACN's HWE standards align with the core competencies for health professionals by the Institute of Medicine (IOM). They are indeed designed to be used as a guide for prioritization and reflection by units, hospitals and systems. HWE measures the current realities of the work environment, and aligning with the standards reaffirms safe and respectful work teams.

After identifying any and all recruitment and retention strategies from each hospital, the best practices were placed under the HWE standard that best represented its intended goal or outcome. Once the identified strategies were paired with a HWE standard, each opportunity was numbered using Benner's novice to expert model related to maturity of each hospitals efforts. After ranking each best practice, CNOs rated the HWE standards based on most opportunity to least opportunity (novice work to expert work). This allowed each hospital to pick the top 1-2 areas for which to devote the greatest effort related to recruitment and retention strategies. It also allowed for a great deal of sharing between hospitals

Mercy Hospital Saint Louis identified appropriate staffing and meaningful recognition as the top two priorities. The CNO and Chief Executive Officer (CEO) worked collaboratively to understand best practices that linked these two standards and developed strong teams to design and implement changes that would move these two standards to maturity. Four primary focus areas were evaluated and implemented over a six-month period; Base rate pay increase to market comparability, increase in night shift differential where staffing is hardest to recruit, loan forgiveness programs and career ladder. These recruitment and retention strategies were communicated in August with immediate positive reaction from our bedside staff.

One of the many avenues that we currently use is to offer flexible staffing options. Mercy facilities offer weekend option position in two different formats. Weekend option 1.0 offers the coworker the opportunity to work every weekend with a higher differential and the ability to have three weekends off per year. . Weekend option 0.75 offers the coworker the opportunity to work every weekend with a lower differential

rate and only working three out of the four weekends per schedule. This provides the coworker opportunities of home-life and work balance.

Shift incentives are regularly offered when a coworker picks up a shift for a priority need prior to the actual scheduled shift. Incentives shifts are placed into a scheduling system accessible online where the dollar amount changes based on the units need. Incentives can be higher if the RN commits to it early.

Patient care technicians are included in the staffing grid. These grids are modified based on unit needs. Some units chose to go with lower nurse to patient ratios in lieu of using a patient care technician.

Our facility offers a structured on boarding process for nursing. Each new nurse attends seven days of orientation to the facility. This includes a new co-worker orientation, computer training, registered nurse orientation, safe patient handling and coworker protection training. This provides a solid foundation before moving to the specialized training.

Fellowships are offered throughout each service line in order to prepare the registered nurse for specialized training. Nursing Fellowships range in length of time determined by each area and based on the expected progression of the novice nurse.

Nursing school senior practicums are offered in all of our facilities. This provides the nursing student an opportunity to learn in an environment where they eventually would like to practice. Not only does this provide a great platform for the future fellowship nurses but gives the nursing student the opportunity to decide if this is truly where they may want to work.

In order to address vacillation in staffing needs on our units a program was created to cross train from lower levels of acuity to the higher levels of acuity with additional fellowship classes, preceptored shifts and didactic information related to the new area. This provides relief to the unit and allowing the nurses to broaden their knowledge base.

References

http://www.aacn.org/wd/hwe/docs/hwestandards.pdf

Benner, P.E. (1984). From Novice to Expert: Excellence and Power in Clinical Nursing

Ulrich, B.T., Lavandero, R., Woods, D., Early, S. Critical Care Nurse Work Environments 2013: Status Report. Critical Care Nurse. 2014;34(4):64-79.

Contact

Robyn.weilbacher@mercy.net

PST - Poster Presentations

The Service Line Model: A Novel Model for Delivering Medical-Surgical Nursing Services

Mark Stephen McClelland, DNP, RN, CPHQ, USA

Abstract

Hospital-based nursing has become extremely complex since the emergence of the modern hospital in the early 1900s. The organizational design for delivery of nursing services has been based on the nursing unit. Given the profound changes underway throughout the healthcare industry the nursing unit may not optimize the delivery of nursing care. The Service Line Model (SLM) for delivery of medical-surgical nursing care should be thought of as a replication of the roles and processes used by physicians to support the rise of the hospital industry. The SLM is driven by the Attending Nurse (AN) role, quite similar in functioning and stature to the attending physician role. And just as medical services evolved into the subspecialties recognized today, nursing care can be organized by subspecialties (service lines). The disruptive innovation of this model is that it organizes nurses along service lines instead of nursing units and nurses carry caseloads instead of being given assignments.

Roles

Attending Nurse. The ANs are seasoned practitioners knowledgeable of patient care needs. They ensure the patient's needs are identified appropriately and care is delivered in accordance with hospital policy and national standards. More often than not the AN will complete the patient's admission assessment. The AN rounds on his/her caseload of patients several times a day and collaborates with colleagues in the service lines and members of other disciplines to establish and implement the plan of care. It is anticipated the AN will demonstrate leadership within the inter-disciplinary team. The AN's work is tightly focused on care coordination and transition planning.

Service Lines. Rather than belonging to a nursing unit and being a generalist, nurses belong to a service line and become specialists. Nurses are not assigned to a group of patients located on one unit; they carry a caseload of patients across several geographic locations. Nurses working within a service line are accountable for the assessment, planning, implementation, and evaluation of their patients' care needs, as they relate to the *domain of care* delivered by their service line.

Domains of Nursing Care

1. Care Planning and Coordination - See Attending Nurse.
2. Mobility and Sensory - Activities of daily living optimization. Sensory optimization.
3. Mind-body and Mental Health - Orientation optimization. Self-generated healing.
4. Fluid Balance - Intravascular access. Intake and output optimization.
5. Wound and Skin - Prevention and treatment of skin and tissue deficits. Healthy skin promotion.
6. Nutrition and Elimination - Bowel and bladder optimization. Food intake.
7. Heart, Lung and Data - Cardiopulmonary optimization. Management of clinical data streams to relevant service lines.
8. Medication Management - Medication distribution. Medication reconciliation.
9. Quality and Safety - Staff and systems competency. Learning organization optimization.

Supporting Roles - Two additional roles support the SLM. *Admission nurses* serve as backup to the AN when the AN is unavailable to perform the initial nursing assessment. When not admitting patients Admission Nurses are helping out in the emergency department to facilitate identification, decision-making, and patient flow related to potential admissions. *Patient care nursing assistants*, unaligned with a service line and probably geographically based, work closely with the AN to assure technical and routine tasks are performed efficiently and effectively.

How Patients Are Cared For

- Instead of being generalists, organized by nursing units, and receiving daily assignments, medical/surgical nurses are specialists, belong to service lines, and manage caseloads of patients (15-20 patients/caseload).
- The “rounding model” of care delivery works effectively providing physician services and could work effectively delivering nursing services. Each service line will round on their patient caseloads at least once per shift, more often as need indicates.
- All service lines will be initially involved with each patient. The amount of their ongoing contribution to care will be determined by the patient’s needs.
- Service lines will be comprised of RN/technician dyads.
- Nurses will carry caseloads, not be given assignments. Caseloads are shared by several nurses to ensue continuous coverage. After an absence, the nurse will return to his or her caseload. When a patient is readmitted to the hospital the caseload concept maximizes the opportunity that they will be cared for by the same staff
- Service lines will be responsible for ensuring an adequate number of staff is available.

Governance

- A shared governance structure within each service line will be responsible for most required management activities.
- A shared governance coordinating council of service line representatives report to nursing administration.
- Peer review committees within each service line will be responsible for evaluating ongoing and annual competency of staff.

Potential Benefits: Reduces clinical variation: Rather than being a series of tasks, “care” becomes the business of the service line. Nurses will “own” care and work to establish the evidence base for care provided by their service line. The SLM gives nursing control over its practice and may virtually eliminate missed care.

Identifies nursing’s contribution: The SLM provides clarity to identify and measure nurses’ contribution. Encounters will be coded in relative value units. Ultimately, such knowledge will lead to formulas for determining the true costs of providing nursing services.

Next steps: Determine model’s strengths and weaknesses: Focus groups can determine the robustness of SLM domains for capturing all potential patient needs and the strengths and weaknesses of the model.

Development of productivity standards: The basic unit of nursing service delivery is the “encounter”. Caseload size will be determined by the number of patients a service line nurse could round-on during 8 and 12 hour shifts.

Determine the clinical divisions differentiating caseloads: Caseloads would be derived first by medical/ surgical patients, then in larger hospitals, by specialty areas. The acuity of patient needs predictably present in the population will determine the number of caseloads.

Conclusion: The healthcare industry is perfectly designed to achieve the outcomes it produces. In years past the nursing unit was pragmatic and effective; however, hospital and medical technological growth, and the emergence of professional nursing practice have surpassed the nursing unit’s capacity to serve as an effective organizing platform. To eliminate the task orientation in nursing it may be time to rethink the nursing unit. The SLM is an organizational design capable of consistently meeting the range of patient care needs while creating a unified mental model of nursing service delivery.

References

Duffy, J.R. (2016). *Professional practice models in nursing*. New York: Springer.

Kalisch, B., Tschannen, D., Lee, H. & Friese, C. (2011). Hospital variation in missed nursing care. *American Journal of Medical Quality*, *26*(4): 291–299. doi:10.1177/1062860610395929.

Manthey M. (1980). *The Practice of Primary Nursing*. Boston: Blackwell.

Contact

mcclelm@ccf.org

PST - Poster Presentations

Program for Promoting Self-Management of Health Status for Nursing Students Based on Oriental Medical Concepts

Shu Chun Chien, PhD, RN, Japan
Yoshiko Wazumi, PhD, RN, Japan
Toshie Yamamoto, PhD, RN, PHN, Japan
Takeshi Matumoto, PhD, MSN, RN, Japan
Takashi Maeda, PhD, RN, PHN, Japan
Tomoko Katagiri, MSN, RN, Japan
Akiko Nagata, MSN, MN, RN, Japan
Fusako Kawabe, PhD, RN, Japan

Abstract

Purpose: Most nursing curriculums include many courses spanning medical knowledge, technology, and nursing skills. However, our research has established that nursing students often show symptoms or signs of afflictions such as menstruation disorders, algomenorrhea, constipation, skin allergies, headaches, and so on. These symptoms or signs are known as the “pre-disease” stage (i.e., the stage before an illness is diagnosed) in Oriental medicine in Japan. It is worthwhile to help nursing students recognize the influence of these symptoms or signs and then make efforts to improve them through their daily lives. Based on one major concept of oriental medicine, chronic diseases are considered to be the result of our physical condition becoming unbalanced and turning into health disorders. The purpose of the current research is to apply this concept to develop, and examine the effectiveness, of a program aimed at helping to improve the symptoms or signs in the “pre-disease” stage of nursing students.

Methods: The subjects for this study included five female nursing students from University A, located in the Kanto region, and seven (three male, four female) students from University B, located in the Tohoku region. Concerning gathering data about the subjects, a combination of data-collecting wearable wrist bands, personal documents covering a span of about two weeks, and interviews were used to record daily life data, including such information as their waking and sleeping times, diet, exercise and important life events for at least six months.

Aside from uncomfortable symptoms or signs being confirmed through interviews, the physical condition of the subjects was also measured through *Ryodoraku* – a technique developed by Dr. Nakatani Yoshio that employs a machine to measure the electric potential difference of meridians on the skin in order to ascertain physical strength and the balance of the autonomic nerve system. Furthermore, an acupuncturist took each student’s pulse and advised them concerning how to apply finger pressure on acupuncture points to alleviate their discomfort. The relationships between the uncomfortable symptoms or signs, the results of the *Ryodoraku* measurements, and the daily life data were analyzed by time-series on an individual basis. Researchers reflected on the results with the subjects in order to help them recognize the relationships between their health problems and their daily lives.

Results: Of the five participants from University A, two were undergraduates and three were graduate students, whereas the seven participants from University B were all undergraduates. The participants were all in their 20s and 30s. Their symptoms and signs included algomenorrhea, constipation, menstrual irregularity, edema of the lower leg, feelings of cold, muscle stiffness of the shoulder, skin allergies, and gastrointestinal symptoms. Their lifestyles were all characterized by hard schedules replete with studies and extracurricular activities from their junior high school days until the present. The changes were reflected in the *Ryodoraku* scores.

The average scores corresponding to before, during (at an interval of 2.5 to 3 months after beginning), and at the end of the study for the two universities are compared. With the exception of case A’ at University B, all of the subjects’ average scores at first became higher and then returned to their initial levels at the end of the study because of the students’ busy schedules, including, for example, exams or job hunting. However, besides case B’ at University B, the balance of the autonomic nerve system of all subjects improved over the course of the period from the interval to the conclusion of the study. The

symptoms or signs showed improvement if the subjects practiced the advised finger pressure on acupuncture points or changed their lifestyles.

The scores of University B were higher than those of University A. The researchers believe that because the deviation value of University A was higher than that of University B, the study assignments were more difficult for the subjects from University A, which influenced their daily lives in ways such as diet, rest, exercises and physical condition. Another likely reason considered was that as most subjects from University B lived together with their families they were able to receive support from their families for maintaining their physical status.

Conclusions: The results showed that the program could help nursing students by promoting self-management to improve their uncomfortable symptoms and signs with the assistance of the researchers. However, the demanding social lives of nursing students, which include not only studies but also such things as extracurricular activities and part-time jobs, obviously affect their private lives. Their lives were difficult to maintain in their present status. This also suggested that six months of support from researchers was not sufficient for the students to fully effect changes and master new lifestyles. Additional strategies need to be incorporated or developed in order to maintain the effects of the program.

Physical symptoms are affected by personal lifestyle, and are also reflected in an individual's *Ryodoraku* measurements. Educating nursing students so that they can understand the relationship between symptoms and signs, lifestyles and visualization of their physical strength and the balance of the autonomic nerve system with *Ryodoraku* measurements is helpful for enabling them to change their lifestyles based on the concepts of Oriental medicine. This, in turn, will aid them in helping patients to improve their physical condition through natural, noninvasive care methods. It can also be a benefit to medical expenses.

References

Bartlett, M. L., Taylor, H., & Nelson, J. D. (2016). Comparison of Mental Health Characteristics and Stress Between Baccalaureate Nursing Students and Non-Nursing Students. *Journal of Nursing Education, 55*(2), 85-88. doi:10.3928/01484834-20160114-05

Cai, D., Stone, T. E., Petrini, M. A., & McMillan, M. (2016). "An exploration of the health beliefs of Chinese nurses' and nurse academics' health beliefs: A Q-methodology study'. *Nursing & Health Sciences, 18*(1), 97-104. doi:10.1111/nhs.12251

Han, K., Choi-Kwbn, S., & Kim, K. S. (2016). Poor dietary behaviors among hospital nurses in Seoul, South Korea. *Applied Nursing Research, 30*, 38-44. doi:10.1016/j.apnr.2015.10.009

Contact

chien@chiba-u.jp

PST - Poster Presentations

Nursing Barriers to Implementation of Daily Sedation Interruption

Penny A. Sauer, PhD, RN, CCRN, CNE, USA
Loni E. Tyndall, USA

Abstract

Background: Mechanically ventilated, critically ill patients often require a continuous infusion of sedation in order to provide safe and effective medical and nursing care. Continuous infusion of benzodiazepines, opioids or propofol are often used to manage ventilated patients (Berry & Zecca, 2012). Over 790,000 patients require mechanical ventilation each year in the United States (Wunsch, Linde-Zwirble, & Angus 2010), many of which often require continuous sedation (Reade, Finfer 2014). The use of continuous infusions can lead to prolonged length of stay in intensive care units (ICU) which increases delirium and muscle wasting, ultimately decreasing patient quality of life (Barr et. al, 2013). Implementing daily interruption of sedation (DIS) in eligible patients is associated with lowering the aforementioned complications from prolonged continuous infusions (Barr et al., 2013). Despite the evidence supporting the use of DIS in mechanically ventilated adults in ICU, a survey of physicians, nurses, and pharmacists, only 40% (N=904) reported using DIS (Tanios, de Wit, Epstein, Devlin 2009). Various barriers to DIS included lack of nursing acceptance, concern about patient initiated device removal and respiratory compromise (Tanios, et al 2009) as well as ambiguity about why, who, and how to do daily sedation interruption (Miller, Bosk, Iwashyna, Krein 2012). While previous studies have asked health care professionals about DIS barriers, this study focuses on barriers ICU nurses identify in implementing daily interruption in sedation protocols.

Purpose: The purpose of this pilot study is to determine factors that influence nurses' decision to implement daily interruption of sedation.

Method/Design: A cross sectional descriptive quantitative research design using survey methodology will be used to explore barriers nurses experience to implemented DIS. Institutional Review Board approval will be obtained from the University.

Sample: The participants in this study will be a convenient sample of nurses who are currently employed in critical care units and care for patients receiving continuous sedation.

References

Barr J, Fraser G, Puntillo K, Eli W, Gelinas C, Dasta JF, Jaeschke R (2013). Clinical practice guidelines for the management of pain, agitation and delirium in adult patients in the intensive care unit. *Society of Critical Care Medicine, 41*(1), 1-44. doi: 10.1097.

Berry, E., Zecca, H. (2012). Daily interruptions of sedation: A clinical approach to improve outcomes in critically ill patients. *Critical Care Nurse, 32*(1), 43-51. doi: 10.4037/ccn2012599

Miller MA, Bosk EA, Iwashyna TJ, Krein SL. (2012). Implementation challenges in the intensive care unit: the why, who, and how of daily interruption of sedation. *Journal of Critical Care, 2012* (27), 218-225. doi: 10.1016.

Reade MC, Finfer S. Sedation and delirium in the intensive care unit. *New England Journal of Medicine.* 2014; 370 (5): 444-454.

Tanois MA, de Wit M, Epstein SK, Devlin JW. Perceived barriers to the use of sedation protocols and daily sedation interruption: a multidisciplinary survey. *Journal of Critical Care.* 2009; 24(1): 66-73. doi: http://dx.doi.org/10.1016/j.jcrc.2008.03.037

Wunsch H, Linde-Zwirble WT, Angus DC, et al. The epidemiology of mechanical ventilation use in the United States. *Critical Care Medicine.* 2010; 38 (10).

Contact

let7588@uncw.edu

PST - Poster Presentations

Study of Promoting Health Management for Nurses Working at a Highly Advanced Treatment Medical Center

Toshie Yamamoto, PhD, RN, PHN, Japan
Shu Chun Chien, PhD, RN, Japan
Takeshi Matsumoto, PhD, MSN, RN, Japan
Yuka Kanai, MSN, RN, Japan

Abstract

Purpose: The labor situation of 18,639 nurses employed at national medical centers in Japan was surveyed in 2009 through questionnaires. One of the results was that 49.1% of the respondents felt “very tired”, while 45.7% felt “moderately tired.” In other words, approximately 96% of the nurses felt tired. Their symptoms or signs included dyspepsia, diarrhea, constipation, hypertension, decreased immunity, menstruation disorders, and so on. The results also revealed the problems the nurses faced in their lives, including unbalanced diets, alcohol/drug abuse, low job satisfaction, and sympathetic dominance.

As in other countries, highly advanced treatment has always been offered at medical centers. The priority of nursing effort is focused on disease control rather than on health management. Disease control is characterized by a consistent focus on the physical dimensions of health. Relatively speaking, health management, by contrast, focuses not only the physical dimensions, but also the psychological and social dimensions of health. From a nursing perspective, human beings are generally conceived of as a harmonious unity of mind and body, characterized by cognition and metabolism respectively. Health problems, in terms of both their causes and the solutions undertaken to alleviate them, must therefore also be approached in a comprehensive way. Yet while the necessity of such an approach has become clear, there had not previously been any research conducted on nurses’ own health management based on this perspective.

Lower back pain and algomenorrhea are frequent complaints among women, and female nurses are no exception. The purpose of this study is to examine the effectiveness of applying acupuncture and self-reflection on daily lifestyle as a means of treating lower back pain and algomenorrhea for nurses working at national medical centers in Japan. Information pertaining to the nurses’ lifestyles was recorded by researchers before every instance of acupuncture treatment. Whether or not their symptoms or signs changed was also evaluated based on this data.

Methods: The subjects were six female nurses from a national medical center located in the Kanto region in Japan. Subjects already receiving treatment for lower back pain and/or algomenorrhea were excluded.

Data was collected over a period of three months from October to December (a total of 12 times in all), as follows:

(i) At the start of the study and again one month after the conclusion of the study, all subjects completed a “Japan Lower Back Pain Evaluation Questionnaire” and/or a “Japan Menstrual Distress Questionnaire” as well as a State-Trait Anxiety Inventory (STAI) by themselves.

(ii) Subjects received one session of acupuncture treatment for about 50 minutes each week at their hospital clinical setting. Before and after each treatment their pain level was assessed with a Visual Analog Scale.

(iii) The health activities of the subjects’ daily lives, including such information as their waking and sleeping times, diet, exercise and concerns were collected through semi-structured individual interviews, each lasting approximately 10 minutes.

Data was analyzed by time-series on an individual basis.

Results: The subjects were all in their 20s through 40s. Here we discuss them as two age groups: those in their 20s-30s, and those in their 40s. Three had lower back pain while the others all suffered from

algomenorrhea. All of the subjects were willing to participate in the study for three months continually, and expressed that acupuncture treatment was effective for controlling their pain.

The results of the Visual Analog Scale for pain showed that one month after the study began their level of pain showed signs of improvement. However, the results were different between the 20~30s group and the 40s group one month after the conclusion of the study. Subjects in the former group expressed that their pain had returned to original levels, whereas those in the latter group expressed that they had been able to maintain an improved condition through lifestyle changes. The scores from the “Japan Lower Back Pain Evaluation Questionnaires” and the “Japan Menstrual Distress Questionnaires” are given in Table 1.

The data collected during the interviews showed that the lifestyles of the subjects in their 20s to 30s had not substantially changed since their adolescent days. They were single or married without children, and desired to continue their daily lives although they felt that the acupuncture treatment had proven helpful in improving their symptoms during the study period. Within a month after the conclusion of the study their symptoms returned.

The subjects in their 40s were married and lived with their families. All of them expressed that the demands of hard work at the hospital and housework at home led to their not having enough time for their own health concerns before participating in this study. They reported acquiring a consciousness of having achieved good health through the course of the study. Therefore, even after the conclusion of the study they tried to arrange their lifestyles to prevent their symptoms from returning.

The acupuncture treatment and self-reflection proved effective in helping the nurses to alleviate their lower back pain and algomenorrhea. Long-term effectiveness depended on the motivation of the subjects. It was difficult for the nurses in their 20s and 30s to maintain a good health condition after the three-month period of interaction with the researchers ended. On the other hand, the nurses in their 40s saw continued effectiveness because, in addition to caring for themselves, they were experienced in handling the responsibility of arranging the daily lives of family members. We could say that since human beings are social creatures, their relationships with others can be a source of willpower to promote health consciousness.

References

Japan Federation of Medical Worker's Unions.2014）. Reports of the labor situation of nursing stuff. Medical Worker, Supplement, 16-19.

Hospital Council of Faculty and Staff Union of Japanese University. (2009).

The labor situation of nurses employed at national medical centers in Japan after 7:1 ratio started: Nurses are exhausted. Sep.

Contact

ytoshie@faculty.chiba-u.jp

PST - Poster Presentations

Improving Workplace Incivility Utilizing the AACN Healthy Work Environment Standards

Amy L. Scott, MSN, RN, CPN, USA

Abstract

Workplace incivility is “low-intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect (Andersson & Pearson, 1999, p. 457). Incivility in the workplace is more prevalent in today’s healthcare environment. The cost can be not only financially devastating but also mentally and physically damaging to staff, organizational culture and impact patient outcomes (Einarsen, Hoel, & Notelaers, 2009, Bria, Baban, & Dumitrascu, 2012, Hutchinson & Jackson, 2013).

The environment in which nurses’ practice, can have a significant impact on the quality of care they provide, the level of teamwork in the unit and the satisfaction and outcomes that patients experience. The AACN Standards for Establishing and Sustaining Healthy Work Environments identify six standards that should be in place in order to create and sustain a healthy work environment (HWE).

Emergency Departments are high stress, see high volumes of patients and experience life and death situations often. It is imperative to have, skilled communication, true collaboration, effective decision making, appropriate staffing, meaningful recognition, and authentic leadership to provide safe, effective and exemplary care to patients and their families.

The incivility spiral framework demonstrates how uncivil behavior in an environment will eventually lead to more aggressive behavior. Providing education and implementing interventions to align with the healthy work environment standards can help decrease incivility, improve the environment for all staff, patients and families.

The purpose of this study was to evaluate the impact of healthy work environment interventions implemented by a shared governance council on improving incivility in a pediatric emergency department. A pre- and post-survey design was used. The only relationship found of statistical significance was between years of experience and the total Cortina score. Years of experience was noted to be negatively correlated (r= -.312, p=0.26), at a 0.05 level of significance with increased experiences of incivility.

References

Ulrich, B. T., Lavandero, R., Woods, D., & Early, S. (2014, August). Critical care nurse work environments 2013: A status report. *Critical Care Nurse*, *34*(4), 64-79.

St. Michael’s Hospital. (2015, January 28). Communication is key to emergency department success, new study says. *ScienceDaily*. Retrieved from Retrieved April 9, 2015 from www.sciencedaily.com/releases/2015/01/150128082239.htm

Blake, N., Mills, M., & Guerrero, V. (2012). Radiology nursing staff use the HWE assessment tool to improve the work environment. *AACN Advanced Critical Care*, *23*(2), 128-132. http://dx.doi.org/10.1097/NCI.0b013e3182501cb8

Hodgins, M., MacCurtain, S., & Mannix-McNamara, P. (2014). Workplace bullying and incivility: a systematic review of interventions. *International Journal of Workplace Health Management*, *7*(1), 54-72. http://dx.doi.org/10.1108/IJWHM-08-2013-0030

Hanrahan, M., & Leiter, M. P. (2014). Workplace mistreatment: Recent developments in theory, research, and interventions. In P. Y. Chen, & C. L. Cooper (Eds.), *Work and wellbeing: Wellbeing: A complete reference Guide* (1st ed., pp. 263-294). Chichester, West Sussex, UK: John Wiley & Sons, Ltd.

Contact

alscott@cmh.edu

PST - Poster Presentations

The Effect of an Eight-Week Self-Care Program on Self-Perceived Compassion Fatigue

Kathleen W. King, MSN, RN, APRN, AANP, FNP-BC, USA
Me (May) Fuimaono-Poe, MSN, FNP-BC, USA

Abstract

Purpose: The purpose of this study was to explore the impact of a personalized self-designed care plan on the burnout risk in registered nurses. The specific aim is to compare changes in self-reported compassion fatigue, burnout, and secondary traumatic stress scores using the Professional Quality of Life Questionnaire, in a group of registered nurses.

Background/significance: Nurses face extraordinary stress in the current healthcare environment. Nurses provide compassionate care to patients who experience illnesses and events that are often sudden, disfiguring, and life threatening. Compassion fatigue (CF) is the combination of secondary traumatic stress and burnout (BO) experienced by nurses who may experience secondary effects when caring for patients. Prolonged exposure to stress without effective mindfulness-based stress reduction (MBSR) mechanisms could lead to a host of physical and emotional problems. This effects the workplace, and is linked to absenteeism, higher attrition, medical errors and decreased productivity related to fatigue, irritability and poor communication.

Method: In a Quasi-experimental research design, the registered nurses (RNs) were recruited to participate in a demographic questionnaire and the Professional Quality of Life Scale (ProQOL) surveys in an eight-week self-care program. The ProQOL is a 30-item tool that uses a likert-type responses that range from 0 (never) to 5 (very often). It has three subscales: burnout (BO), compassion satisfaction (CS) and secondary traumatic stress. Recruitment was at the workplace and voluntary, participants agreed to weekly entries into an on-line software website survey monkey. Scores were compared before and after participation in the program. At the end of the study, the participants were asked their opinion regarding the helpfulness of the study.

Results: There were 120 RNs recruited in this study and 86 participants entered pre-intervention ProQOL data and 103 entered post-intervention data. Forty individuals were able to be matched with both pre- and post-data based on self-identified identification and passwords and compared. It showed a lower statistically significant BO score after participating in the program (P=0.033). There was marginally significant increase in the CS score after participating in the program (P=0.54). There was no significant change in secondary traumatic stress scores. There were 92 responses to the qualitative open ended question and 61 participants believed that this eight-week self-care program was helpful but 10 did not and 21 were not sure

Conclusions: There was a statistically significant change in the post scores in the reduction of BO without significant changes in CF and secondary stress.

References

Asuero, A. M., Queralto, J.M., Pujol-Ribera, E., Berenguera, A., Rodriguez-Blanco, T., & Epstein, R. M. (2014). Effectiveness of a Mindfulness Education Program in Primary Health Care Professionals: A Pragmatic Controlled Trial. *Journal of Continuing Education in the Health Professionals,* 34 (1), 4-12. doi: 10.1002/chp

Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., and Shapiro, S. (2005) The Effects of Mindfulness-based Stress Reduction on Nurse Stress and Burnout, Part II. *Holistic Nursing Practice,* 19 (1), 26-35.

Kemper, K., Bulla, S., Krueger, D., Ott, M. J., McCool, J. A., & Gardiner, P. (2011). Nurses' Experiences, Expectations, and Preferences for Mind-Body Practices to reduce Stress. *BMC Complementary and Alternative Medicine,* 11 (26), 1-9, http://biomedcentral.com/14726882/11/26

Ledoux, K. (2015). Understanding compassion fatigue: understanding compassion. *Journal of Advanced Nursing,* 71(9), pp. 2041-2050. doi: 10.1111/jan,12686

Maslach, C., & Jackson, S. E. (1981). The Measurement of Experienced Burnout. *Journal of Occupational Behavior,* 2, 99-113. http://dx.doi.org/10. 1002/job.4030020205

Potter, P., Deshields, T., Berger, J.A., Clark, M., Olsen, S., & Chen, L. (2013). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum,* 40(2). pp. 180-187

Stamm, B. H. (2010), The ProQOL (Professional Quality of Life Scale: Compassion Satisfaction and Compassion Fatigue). Whitefish, MT: ProQOL.org. retrieved 10/23/2015www.proqol.org

Contact

mefuimaono@yahoo.com

PST - Poster Presentations

Creation of a Serenity Room in an Acute Care Hospital Setting:

Susanlee Wisotzkey, PhD, MSHSA, BSN, BA, RN, NE-BC, HNB-BC, CCRN, USA

Abstract

Nurses face physical, emotional, and mental stress in their daily work. Job-related stress is linked to decreased job satisfaction and patient satisfaction. Researchers describe job-related stress as; burnout, compassion fatigue, and vicarious traumatization. (1,2, 10) Nurses at a community teaching hospital, through the EBP/nursing research forum, focused on the topic of nurse stress and burnout as a means of addressing job satisfaction, staff morale and patient satisfaction. The group formed the EBP practice forum group in the fall of 2014. The evidenced based practice project was discussed and decided upon. Seventeen nurses in an acute care hospital from varied backgrounds and area of specialty volunteered to appraise the evidence using the Johns Hopkins Nursing Evidence-Based Practice model. The team met on three occasions to discuss the assigned articles and synthesize evidence for recommendations.

The PICO question, “What self-care strategies are most effective for increasing job satisfaction/ morale of acute care nurses? A comprehensive literature search was conducted using PubMed and CINAHL data bases. The keywords were job satisfaction, morale, nurse, self-care, interventions, stress, stress-reduction, and burn out, compassion fatigue, wellness, and job stress. The initial search yielded sixty articles, of which twenty-six were relevant and reviewed by the team. The evidence appraisal of the twenty-six articles included: no Level I articles, two Level II articles (both with a B rating), five Level III articles (all with a B rating), no Level IV articles and eight Level V articles (all with B rating). Fifteen, of the twenty-six articles, were of good quality evidence; seven were research and eight were non-research article.

Consistent findings, through the literature review included; providing education about self-care, stress recognition, effects of stress, use of mindfulness based stress reduction programs and recognizing risk factors contributing to increased stress. The practice recommendations based on the findings; explore resources available within the healthcare system to provide help for nurses coping with job-related stress, moral distress and compassion fatigue/resiliency. Examples listed included; retreats, counseling, education, walk-in wellness clinics offering integrative therapies, meditation, spiritual development, physical activity, grief counseling, peer to peer support and Nurse Manager support of self-care. (5, 14)

Identification of strategies to reduced stress and increase in job satisfaction were compiled from the literature. The description of self-care strategies included, but not limited to; educational seminars, mindfulness programs, time off, yoga, regular exercise, nutrition, meal breaks, and improved communication. (5, 14) Institutional resources for nurses to cope with morale distress and compassion fatigue included, but not limited to; retreats, meditation, counseling, education and physical activity. Additional strategies included debriefing colleague support, serenity room and recognition of risk factors. (2, 7, 18, 23)

Implementation strategies were reviewed, discussed and based on analysis of feasibility related to financial impact and space constraints. The one strategy, the evidenced based practice group decided to focus on, to decrease stress and promote self-care, was the creation of a serenity room within the acute care hospital setting. This would create a space intended to provide a stress-free environment for staff. A quiet haven away from caustic stress factors, such as; negativity, complaining, and blaming behaviors. (4, 6, 8, 9, 11, 15, 21, 24, 25) A tranquil space for self-reflection and recharging resiliency.

Following are primary points and potential challenges to creating a serenity room, after the decision to move forward is determined. The team championed the initiative by presenting the information passionately to hospital leadership. The CNO supported and provided the approval to find space. Understanding, space is a premium commodity in a landlocked facility. It took several months of due diligence to find a space that was vacated. The request for the space was taken through the appropriate channels and facility requirements for occupancy. The space was approved April 2015. The next steps involved finding charitable donors for the furnishings, books, music, electronics and necessary renovation. Construction time and talent was donated for the built-in bookcase, but there was a cost for

the materials. There was an associated cost with the oversized chair due to the need for it to be reupholster with hospital grade fabric to meet Department of Health codes. The final cost of completion for everything, furnishings, renovation, books, electronics and a Keurig was under $1000.00, which was funded by the department of nursing.

July 2016, the serenity room open for staff use. Data has been and continues to be collected through badge swipe access. Only the numbers of swipes are collected. An aggregate number is compiled each month and graphically shared with Nursing Leadership. The percent of usage is calculated based on fifteen minute intervals, twenty-four hours per day and the number of days in the month. Overall access and use of the serenity room increased from July 2015 through January 2016. Interesting note, the highest access month was January 2016. A study on the effect of holiday stress and the increased need for self-care may be a future area of focus.

References

1. Aycock, N. & Boyle, D. (2009). Interventions to manage compassion fatigue in oncology nursing, *Clinical Journal of Oncology Nursing, 12*(2), 183-191. doi: 10.1188/09.CJON.183-191
2. Boyle, d. A. (2011). Countering compassion fatigue: a requisite nursing agenda. *OJIN: The Online Journal of Issues in Nursing, 16*(1), manuscript 2. doi: 10.3912/OJIN.Vol16No01Man02
3. Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., & Shapiro, S. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout, Part II. *Holistic Nursing Practice, 19*(1), 26-36.
4. Cohen-Katz, J., Wiley, S. D., Capuano, T., Baker, D. M., & Shapiro, S. (2005). The effects of mindfulness-based stress reduction on nurse stress and burnout, Part III. *Holistic Nursing Practice, 19*(2), 78-86.
5. Davies, W.R. (2008). Mindful meditation: Healing burnout in critical care nursing. *Holistic Nursing Practice, 22*(1), 32-36
6. Duncan, A. D., Liechty, J.M., Miller, C., Chinoy, G. & Ricciardi, R. (2011). Employee use and perceived benefit of a complementary and alternative medicine wellness clinic at a major military hospital: Evaluation of a pilot program. *The Journal of Alternative and Complementary Medicine, 17*(9), 809-815. doi: 10.1089/acm.2010.0563
7. Epp, K. (2012). Burnout in critical care nurses: a literature review. Dynamics, 23(4), 25-31.
8. Fetter, K. L. (2012). We grieve too: One inpatient oncology unit's interventions for recognizing and combating compassion fatigue. *Clinical Journal of Oncology Nursing, 16*(6), 559 – 561. doi: 10.1188/12.CION.559-561
9. Grafton, E., Gillespie, B. & Henderson S. (2010). Resilience: The power within. *Oncology Nursing Forum, 37*(6), 698-704. doi: 10.1188/10.ONF.698-705
10. Meadors, Pl & Lamson, A. (2007). Compassion fatigue and secondary traumatization: Provider self-care on intensive care units for children. *Journal of Pediatric Health Care, 22*(1), 24- 34. doi:10.1016/j.pedhc.2007.01.006
11. Meadores, P., Lamson, A. & Sira, N. (2010). Development of an educational module on provider self-care. *Journal of Nurses in Staff Development, 26*(4), 152-158, doi:10.1097/NND.0b013e3181b1b9e4
12. Potter, P., Deshields, T., Berger, J. A., Clarke, M., Olsen, S., & Chen, L. (2013). Evaluation of a compassion fatigue resiliency program for oncology nurses. *Oncology Nursing Forum, 40*(2), 180-187. doi:
13. Tabor, P. D. (2011). Vicarious traumatization: Concept analysis. *Journal of Forensic Nursing, 7*, 203-208. doi: 10.1111/j.1939-3938.2011.01115.x
14. Wilson, M. A., Goettemoeller, D. M., Bevan, N. A., & McCord, J. M. (2013). Moral distress: levels, coping and preferred interventions in critical care and transitional care nurses. *Journal of Clinical Nursing, 22*, 1455-1466. doi: 10.1111/jocn.12128
15. Zadeh, S., Gamba, N., Hudson, C., Wiener, L. (2012). Taking care of care providers: A wellness program for pediatric nurses. *Journal of Pediatric Oncology Nursing, 29*, 294-299. doi: 10.1177/1043454212451793
16. Zeller, J. M. & Levin, P. F. (2013). Mindfulness interventions to reduce stress among nursing personnel: An occupational health perspective. Workplace Health & Safety, 61(2), 85-89.

Contact

swisotzkey@wellspan.org

PST - Poster Presentations

Mindfulness for Stress Reduction in the Workplace

Betsy Murphy, MS, RN, HNB-BC, ERYT, USA

Abstract

Research has shown that patient outcomes and clinical judgment improve in caring-healing environments. Current trends are for healthcare facilities to provide education in wellness, which includes stress reduction activities for their employees as a way to improve self-care, the work environment, and ultimately patient care.

Significance: Mindfulness is a method for paying attention in the present moment, without judgement, and has many applications for the use in clinical settings, providing leadership and management support for staff as well as tools that enhance the nurse-patient interactions and outcomes.

Mindfulness is a well-respected and evidence-based technique that supports the humanistic and holistic caring paradigm developed by dominant nursing theorists, Barbara Dossey and Jean Watson. Holistic theory invites nurses to develop a deep personal understanding and sensitivity to provide effective patient care and avoid burnout/compassion fatigue.

Strategy and Implementation: Two programs were implemented that provided mindfulness training to health care personnel. Nurses were the predominant participants in each program. Both included both pre- and post-stress level assessments and evaluations. One program provided 60 hospital clinical staff a one hour CE presentation on Mindfulness Based Stress Reduction for the Workplace. The second program was a 20-hour Mindfulness Based Stress Reduction program offered to the clinical staff of an onsite medical clinic that provides healthcare services to the underserved and homeless populations.

Evaluation: The pre- and post-interventions were the Perceived Stress Scale (PSS-10) and the Mindfulness Survey. Evaluation of programs pre- and post-results demonstrated participants improved their ability to manage stress, pay attention to the present moment and had a greater sense of inner peace.

Implications for Practice: The use of mindfulness training, even in small amounts (1-hour presentation) can decrease stress and improve the wellbeing of clinical staff. This directly improves patient care, decreases clinical errors, and reduces symptoms of burnout and compassion fatigue

References

Frisvold, M., Lindquist, R., & Peden-McAlpine, C. (2012). Living life in the balance of midlife: Lessons learned from mindfulness. *Western Journal of Nursing Research, 34*(2), 265-278.

Goodman, M. & Schorling, J. (2012). A mindfulness course decreases burnout and improves well-being among healthcare providers. *International Journal Psychiatry in Medicine, 43*(2), 119-128.

Mackenzie, C., Poulin, P., & Seidman-Carlson, R. (2006). A brief mindfulness-based stress reduction intervention for nurses and nurse aides. *Applied Nursing Research, 19*, 105-109.

Praissmann, S. (2008). Mindfulness-based stress reduction: A literature review and clinician's guide. *Journal of the American Academy of Nurse Practitioners, 20,* 212-216.

Stahl, B. & Goldstein, E. (2010). *A Mindfulness-based stress reduction workbook.* Oakland, CA: New Harbinger Press.

Watson, J. (2008). *Nursing: The philosophy and science of caring* (Rev ed.). Boulder, CO: The University Press of Colorado.

Contact

yogahealthrn@yahoo.com

PST - Poster Presentations

Creating Healthy Work Environments in Critical Care Nursing

Esteen Ladson Barnes, MS, BSN, MPA, RN, CCRN, USA
Anthony Basile, DNP, RN, CCRN, USA
Camille Scarciotta, MSN, RN, CCRN, USA
Dorothy Jean Graham Hannah, DNP, MPA, RN, BC, USA

Abstract

Having unhealthy working conditions in healthcare results in the erosion of the quality, efficiency and safety of patient care delivery and attrition from the profession of nursing. As payors of care for healthcare systems move towards reimbursement models where the value of care is more significant than the quantity of care delivered, evidence based interventions that address unhealthy work environments will become less uncertain and more of an inevitability to meet the care delivery demands in today's society. Current trends in healthcare and the expectation of the public has made the expectations of healthcare delivery more complex than ever before. Working within an effective interdisciplinary team is key in the achievement of optimal patient outcomes. Nurse Leaders serve as the change agents that are responsible for the successful implementation of the evidenced based intervention to support change within the practice environment to foster healthy work environments. As transformational leaders that utilize the leadership skill of emotional intelligence, nurse leaders will be able to positively influence the behavior of all care providers by building trusting relationships that foster true collaboration between leadership, nursing staff, and other healthcare disciplines to accept changes in the practice environment that encourage healthy interdisciplinary interactions.

Having a healthy work environment in healthcare, especially for the profession of nursing plays a major role in the dynamics of patient care delivery and for those who provide the care. Therefore, it is imperative that work environments foster the development of interprofessional relationships that support the fundamental aspects of caring in the nursing practice setting. The relationship based care model (RBC) is fundamental in the creation of healthy work environments that foster high quality patient care delivery and optimal patient outcomes. In addition, fostering an ethical work environment that provides a forum for nurses to function freely as ethical agents serves as a medium that will support and assist nursing staff to engage and to be able to successfully transcend through clinical, emotional and ethical difficulties that have the potential of negatively impacting the work environment so to safeguard patient care delivery and outcomes.

References

Aboumatar, H.J., Chang, B.H., Al Danaf, J., Shaear, M., Namuyinga, R., Elumalai, S., & ... Pronovost, P.J. (2015). Promising practices for achieving patient-centered hospital care: A national study of high-performing US hospitals. *Medical Care, 53* (9), 758-767. doi: 10.1097/MLR.0000000000000369

American Association of Critical Care Nurses (AACN). (2016). *AACN standards for establishing and sustaining healthy work environments: A journey to excellence* (2nd ed.). Aliso Viejo, CA: American Association of Critical Care Nurses.

Rushton, C. H., & Stutzer, K. (2015). Addressing 21st century nursing ethics: Implications for critical care nurses. *AACN Advanced Critical Care*, *26*(2), 173-176. doi:10.1097/NCI.0000000000000083

Woolley, J., Perkins, R., Laird, P., Palmer, J., Schitter, M. B., Tarter, K., ... Woolsey, M. (2012). Relationship-based care: Implementing a caring, healing environment. *MedSurg Nursing*, *21*(3), 179.

Contact

eladson@maimonidesmed.org

PST - Poster Presentations

Finding Resolutions to Common Core Challenges in Nursing Engagement

Allison Kathleen Peters, DNP, RN, CNOR, NEC, USA

Abstract

Abstract: In a profession where it is crucial to be engaged, nurses may be the least engaged of all healthcare providers. As reflected in the research reviewed for this project, patients cared for by engaged nurses have better outcomes in their care. As nursing leaders, it is critical to understand what factors foster nursing engagement and how we can create the work atmosphere needed for nurses to achieve and maintain high levels of engagement in their workplace. To better understand the basic factors that help facilitate a healthy work environment for nurses, the Maslow Hierarchy of Inborn needs was paired with a corresponding Maslow Triangle of employee needs to investigate the effects of evidence-based workshops on levels of nursing engagement. This quality improvement project was conducted in a large academic medical center that has 850-beds and a Level I Trauma Center in its third Magnet® designation status. The two top rated engagement challenges in the unit were identified through the National Database of Nursing Quality Indicators (NDNQI) survey. Selected staff development workshops were conducted along with the utilization of the evidence based Press-Ganey® Action Planning Tips Guide (Toolkit) which targeted specific engagement challenges. 32 nurses participated in this project. The effectiveness of the project and its impact on nursing engagement was measured by comparing responses pre- and post-workshops using Utrecht Work Engagement Survey (UWES). In addition, the Practice Environment Scale of the Nursing Work Index (PES-NWI) was given post implementation of the project. Increases in vigor, dedication and absorption were measured and observed across all of the engagement benchmarks evaluated. Limiting factors included length of time project was in place and study size. As part of Magnet status, nursing satisfaction/engagement is required to be measured and maintained at a high level and this project supports that it is a potentially modifiable construct.

References

Bargagliotti, L. A. (2012). Work engagement in nursing: a concept analysis. *Journal of Advanced Nursing*, *68*(6), 1414-1428. doi:10.1111/j.1365-2648.2011.05859.x

Brunetto, Y., Xerri, M., Shriberg, A., Farr-Wharton, R., Shacklock, K., Newman, S., & Dienger, J. (2013). The impact of workplace relationships on engagement, well-being, commitment and turnover for nurses in Australia and the USA. *Journal of Advanced Nursing*, *69*(12), 2786-2799.

Laschinger, H., Leiter, M. P., Day, A., Gilin-Oore, D., & Mackinnon, S. P. (2012). Building empowering work environments that foster civility and organizational trust. *Nursing Research*, 61(5), 316-325. doi:10.1097/NNR.0b013e318265a58d

Contact

petal@ufl.edu

PST - Poster Presentations

Advanced Practice Nurse Orientation: New Directions

LaDawna Goering, DNP, APN, ANP-BC, USA

Abstract

Purpose of the Presentation: The purpose of the poster presentation is to outline the development of a comprehensive advanced practice nurse (APN) orientation program directed toward improving the transition of APNs into today's healthcare work environment and improve APN job satisfaction and retention.

Background: The need for hospital acute care advanced practice nurses continues to grow (Yeager, 2010). Studies have shown that APN practice provides safe, effective, efficient, and patient-centered care that is evidence-based (AANP, 2015; AANP, 2013; Kilpatrick et. al, 2015). The nurse-practitioner (NP) care model has shown to decrease length of stay and hospital costs thereby increasing hospital profits (AANP, 2013). Kutzleb (2015) found that the NP care model coordinates, manages, and monitors outcomes in chronic disease and high-risk patient populations, decreasing readmissions and increasing patient quality outcomes. This makes the APN an essential member of the acute care healthcare team, and APN retention fundamental to continuity of care.

Problem: With the need for increased acute care advanced practice nurses, comes the healthcare organization responsibility to orient new APNs to a complex work environment. After an increased APN, turnover rate during the last two years, the APN committee identified high APN turnover rates and poor job satisfaction among APNs as two barriers to providing a professional nurse practitioner (NP) model.

Intervention: A needs survey was conducted to assess the current APN's experience when on-boarding to the organization. There was a 69% response rate with all 69% survey responses indicating a need for change to the current APN orientation process. The data was analyzed and grouped by effective and ineffective processes identified by the survey. Then the data was presented to the committee for discussion and review. A literature review was conducted and summarized to the committee regarding APN orientation programs and mentor models, and then a committee was formed to address revising the existing program.

The quality improvement project included focusing the orientation program on essential identified elements: orientation to the healthcare organization, administrative requirements, the credentialing process, APN council introduction, important contact information, identification of system resources, and interdisciplinary team introduction and shadowing in addition to specialty clinical education and immersion experiences. Essential APN resources for professional development were also developed and created in an APN manual. Mentorship and peer support with feedback and networking was also embedded into the program.

On hire the new APN is now sent all administrative paperwork for general organizational requirements and for credentialing with instructions to complete prior to the first day of employment. Bahouth & Besposito-Herr (2009) and Yeager (2010) found streamlining the administrative activities allowed for earlier assimilation into the work environment. Yeager (2010) also identified shadowing experiences and critical thinking tools to assist the new NP in moving from the Novice to Expert model, as described by theorist Benner (1985) as credited earlier by Dreyfus and Dreyfus. However, this transition requires both a planned process and experience (Gardner, 2012; Benner, 1985). Based on the Benner model of transitioning from novice to expert, a newly directed work environment for APNs was created to facilitate this process.

A welcome letter from the APN council and the assigned mentor is included in the employment packet. Leggat, Balding, and Schiftan (2015) found that pairing an experienced nurse practitioner with a new or less experienced practitioner showed an improvement in effective clinical leadership competencies. Each new APN is assigned a peer within their workgroup and a mentor that practices in another specialty area. The resource manual is also provided to the APN to reference throughout the orientation period. Didactic, simulation–based education, and peer support are provided prior to transitioning to full clinical practice

(Bahouth & Besposito-Herr, 2009). Depending on the area of practice, specific clinical education and immersion experiences will then follow.

Conclusions: Preliminary qualitative data from new APNs indicate that the improvements have been beneficial to new APNs. The effectiveness of the new project is being evaluated by on-going surveys and APN retention rates.

Nursing Implications: Future implications for the APN orientation program include improving transition to a healthy work environment and APN practice, resulting in improved clinical leadership and APN retention.

References

American Academy of Nurse Practitioners (AANP). (2015). Quality of nurse practitioner practice. Austin, TX. Retrieved from: https://www.aanp.org/images/documents/publications/qualityofpractice.pdf

American Academy of Nurse Practitioners (AANP). (2013). Nurse practitioner cost effectiveness. Austin, TX. Retrieved from: https://www.aanp.org/images/documents/publications/costeffectiveness.pdf

American Academy of Nurse Practitioners (AANP). (2006). Mentoring assessment. *Fellows American Academy of Nurse Practitioners: Invitational Think Tank*. Retrieved from: https://www.aanp.org/images/documents/fellows/MentoringAssessment.pdf

Bahouth, M. & Esposito-Herr, M. (2009). Orientation program for hospital-based nurse practitioners. *American Association of Critical Care Nurses: Advanced Critical Care,* 20(1), 82-90

Baumgartner, R. & Williams, T. (2014, June-August). Advanced practice provider mentoring pilot project: Program development and evaluation. *The Tennessee Nurse*. 10-11.

Benner, P. (1984). From Novice to Expert: Excellence and Power in Clinical Nursing Practice. Addison-Wesley, Menlo Park, California.

Brown, M. & Olshansky, E. (1998). Becoming a primary care nurse practitioner: Challenges of the initial year of practice. *The Nurse Practitioner*, 23(7), 46-66.

Gardner, L. (2012). From Novice to Expert: Benner's legacy for nurse education

Gibson, T., & Heartfield, M. (2005). Mentoring for nurses in general practice: An Australian study. *Journal of Interprofessional Care*, 19, 50-62.

Nurse Education Today, 32 (4), 339-340. doi: http://dx.doi.org/10.1016/j.nedt.2011.11.011

Goldschmidt, K., Rust, D., Torowicz, D., & Kolb, S. (2011). Onboarding advanced practice nurses: Development of an orientation program in a cardiac center. *The Journal of Nursing Administration*, 41(1), 36- 40.

Harrington, S. (2011). Mentoring new nurse practitioners to accelerate their development as primary care providers: A literature review. *Journal of the American Academy of Nurse Practitioners*, 23, 168-174.

Hill, L. & Sawatzky, J. (2011). Transitioning into the nurse Practitioner role through mentorship. *Journal of Professional Nursing*, 27(3), 161-167.

Kacel, B., Miller, M., & Norris D. (2005). Measurement of nurse practitioner job satisfaction in a midwestern state. *Journal of the American Academy of Nurse Practitioners*, 17, 27-32.

Kilpatrick, K., Reid, K., Carter, N., Donald, F., Bryant-Lukosius, D., Martin-Misener, R., & ... DiCenso, A. (2015). A systematic review of the cost-effectiveness of clinical nurse specialists and nurse practitioners in inpatient roles. *Nursing Leadership, 28*(3), 56-76.

Kutzleb, J., Rigolosi, R., Fruhschien, A., Reilly, M., Shattic, A., Duran, D., & Flynn, D. (2015). Nurse practitioner care model: Meeting the health care challenges with a collaborative team. *Nursing Economics*, 33(6), 297-304.

Leggat, S., Balding, C., & Schiftan, D. (2015). Developing clinical leaders: The impact of an action learning mentoring programme for advanced practice nurses. *Journal of Clinical Nursing,* 24, 1576-1584. doi: 10.1111/jocn.12757

Yeager, S. (2010). Detraumatizing nurse practitioner orientation. *Journal of Trauma Nursing*, *17*(2), 85-101. doi:10.1097/JTN.0b013e3181e73607

Contact

ladawnagoering@me.com

PST - Poster Presentations

Healthy Work Environments for Retention of Hospital Nurses in Japan

Sachiko Tanaka, PhD, RN, Japan
Yasuko Ogata, PhD, MM, RN, PHN, Japan
Midori Nagano, MSN, RN, Japan
Kimiko Katsuyama, PhD, RN, Japan
Yoshie Yumoto, MSN, RN, PHN, Japan

Abstract

Objective: Nursing staff who assist patients at healthcare facilities and/or in local communities play an important role to provide patients safe and high quality nursing care. At present, however, the demand for nurses exceeds the supply, and Japan is facing the problem of a nursing shortage as seen in other countries in the world. Nursing professionals develop their abilities and skills mainly through years of clinical experience to become nursing experts. Preventing experienced nurses from leaving their profession, and retaining them at medical facilities for as long as possible can prove to be highly effective and important measures to ensure the number of quality nurses. Many previous studies on the nurse turnover in Japan have focused on newly qualified nurses' intentions to leave, and do not properly investigate the factors involved in leaving, which might concern the work environment, including psychosocial factors, such as life events of giving birth to a new baby and raising a child, and/or the factors involved in continuing work, which would include job satisfaction and the charm of nursing. In addition, only a small number of studies analyze these points by examining individual nurses' situations.

Therefore, this study was intended to clarify the factors involved in Healthy Work Environments (HWE) for retention of hospital nurses in Japan. This study is important for hospital nurses who wants to know what is Healthy Work Environments (HWE), and they keep work healthy.

Methodology: The nursing directors of 525 hospitals with 200 or more beds for acute care that are located in core cities, government ordinance cities or special wards of Tokyo in Japan were asked to cooperate with the survey, and seven directors showed willingness to cooperate. Written requests for a personal interview were sent to members of the nursing staff at these seven hospitals, and18 interviewees were randomly selected from the 100 nurses who responded positively. Interviews were conducted with the 11 nurses who were actually able to arrange an interview with the researcher. Interview questions included, why they were continuing to work at their current workplace, and what they considered necessary for HWE, which would allow them to continue working. The interview survey was carried out after obtaining approval from the Medical Research Ethics Committee of Tokyo Medical and Dental University.

Results: The research subjects were two male and nine female nursing professionals. The mean age was 39.3 years (SD ± 7.3), the mean number of years of experience was 14 years and nine months (SD ± nine years and seven months), and the mean years of service at their current workplace was 11 years and five months (SD ± eight years and eight months).

Eight out of 11 interviewees gave economic reasons as the main reason for them to continue working. Some answered that there was no specific reason to leave their job. The following reasons were given as reasons why some of their colleagues had left the profession: long overtime, difficulties with balancing work and private life, negative impact on their children, being bothered by phone calls from the workplace while they were off duty, having to attend meetings when off duty. It was found that they wanted support and strong leadership from their superiors.

Discussion: Economic reasons were given by most of the subjects as the reason for continuing to work. The lack of reason that would make them quit has also been mentioned. However, if nursing staff work only or mostly for economic reasons, they may keep changing their workplace in search of better remuneration, which would be an obstacle to effective career development. For nursing professionals to work healthily and enthusiastically, and to provide quality nursing care, it is necessary to enhance the positive factors why they remain in their profession, including a higher level of job satisfaction, and to improve their working conditions, such as reducing overtime and providing better work-life balance. It has

also been suggested that the managerial capability of a nurse's superior is a key factor to the nurse's HWE.

Conclusion:

1. Economic reasons are the most common reasons why the 8 interviewees continue their careers.

2. Long overtime, not being able to establish a good work-life balance, having to attend meetings or perform other duties on a holiday are some reasons why their colleagues had quit their jobs.

3. Support and strong leadership are expected of superiors.

Based on the above findings, it has been suggested that the management skills of Nursing manager, who are in a position of managing the nursing staff, are key to the creation of nursing professionals' HWE.

References

1）Sachiko Tanaka, Ayaka Goto, Yasuko Ogata, Toshie Yumoto, Tamami Shimokoshi, Kimiko Katuyama, Midori Nagano (2015) ：A Study on the Kind of Working Environments that Hospital Nurses Prefer to Continue Their Work at the Same Place of Employment. Nihon Kango Hyouka gakkaishi,5(1), 11-17.

2）Upenieks, V, V. (2013). What's the attraction to Magnet hospitals? Nursing Management, February.43-44.

3)Desiree Ritter (2011). The relationship between healthy work environments and retention of nurses in a hospital setting. Journal of Nursing Management,19.27-32.

Contact

satanaka@jikei.ac.jp

PST - Poster Presentations

Empowering the Team: An Orthopedic Project Sparks a Change

Yvette Lorea, BSN, RN, CMSRN, USA
Rachael Borden, BSN, RN-BC, USA
Mary Hernandez, BSN, RN-BC, USA

Abstract

Purpose: Creating a happy, healthy, comfortable workplace is essential to the success of an individual unit. Promoting a culture of collaboration and support can help boost productivity, increase morale, and yield an engaged team.

Method: Making purposeful, authentic efforts to create this culture demonstrates a brand of leadership that empowers the team. The efforts & accomplishments of staff should be publicly recognized, while improvement opportunities can be discussed as lessons learned to increase awareness and communicate expectations. The challenges inherent in maintaining an engaged staff can be offset by a genuine leadership style that uses reciprocal communication rather than authoritative instructions. Unit leaders should not view themselves as the sole influencer; rather, a team is most successful when the members of that team encourage their peers to grow by setting an example to follow, particularly for those new to the floor or to the nursing role. Efforts should be made to grow and retain top contributors on the floor who are well-liked by their peers. Effective leaders recognize that their team consists of unique individuals, each with different motivators and strengths. Making efforts to build relationships with staff, including regular 1-on-1s and team outings, will allow leaders to personalize direction individually. Getting to know the person, and not just the employee, will naturally cause a selfless leader to have that person's best interest at heart, including a healthy work-life balance. Setting expectations for communication plays an important role; staff are directed to 'close the loop', or respond to requests for assistance by their peers, and follow through these commitments. Additionally, communication is expected to be positive or purposeful; pessimistic, detractive, or otherwise unnecessary negative communication is immediately corrected

Discussion: After initiating these practices, a series of events occur. Employee engagement scores increase by 15 percent, reduction in turnover, clinical ladder advancement occurs, and National Certification accomplishment expands for team members.

Evaluation: Application and execution of this project produces a workplace culture wherein staff feel supported by their peers, and they will in turn feel obliged to reciprocate. This ongoing project continues with newly hired staff. Collaboration will continue to be persistent with nursing leadership and review of outcomes obtained.

References

Brunges, M., & Foley-Brinza, C. (2014). Projects for Increasing Job Satisfaction and Creating a Healthy Work Environment. *AORN Journal*, *100*(6), 670-681. doi:10.1016/j.aorn.2014.01.029

Huddleston, P. (2014). Healthy Work Environment Framework Within an Acute Care Setting. *Journal Of Theory Construction & Testing*, *18*(2), 50-54

Contact

yvette.lorea@mhshealth.com

PST - Poster Presentations

Teaching and Learning Compassionate Care through Introduction of Self-Care Practices in a School of Nursing

Regina M. DeGennaro, DNP, RN, CNS, AOCN, CNL, USA
Rachael Zrimm, SN, USA

Abstract

Healthcare professionals are challenged daily with long work hours, high workloads and increasing patient acuity. Prolonged stress can take a toll on the health of clinicians and can interfere with the quality of the patient care that they provide. Teaching students, clinicians and the community about opportunities to find joy in their work of caring for people is a priority at this School of Nursing. This describes an analysis of a program at a School of Nursing in which innovative workshops are provided to encourage attention to self-care and promote compassionate interactions in healthcare settings. Drop-in sessions of yoga, meditation and mindfulness practices are held weekly and are well attended, reflecting the eagerness of students, faculty and staff to engage in resilience-building practices. Demographic data, program timeframes, and participant evaluations paint a picture of a flourishing community. The cultivation and nourishing of a resilient and compassionate healthcare workforce through innovative educational and experiential programs is embraced. The vision includes high functioning healthcare environments with vibrant healthcare professionals in which heart and humanness are valued and embodied. Clinicians, professors and students are learning concrete ways to introduce compassion into every patient interaction and strengthening their own resilience in the process. Programs, retreats and workshops are centered on mindfulness, self-care and resilience. Purposeful instruction in compassion is considered critical to nurturing strong and empathic clinicians who are safe, less likely to experience burnout and more deeply in tune with their patients and themselves. Mindful attention to self-care boosts the well-being and professional longevity of clinicians and others. Feedback from participants has reinforced that workshops and resilience retreats benefit healthcare workers and the quality of care they believe they are capable of providing. Program outcomes illustrate the importance of teaching about self-care and inviting it into a community of learning. Promoting compassionate care practices in education can inform methods for supporting an empathic and caring healthcare workforce. Aspects from this program may be adapted to other organizations where there is interest in promoting clinician resilience and optimizing patient care outcomes.

References

1. Bauer-Wu, S. & Fontaine, D. (2015). Prioritizing Clinician Wellbeing: The University of Virginia's Compassionate Care Initiative. *Global Advances in Health and Medicine,* 4, 5, 16-22.

2. Howland, L. & Bauer-Wu, S. (2015). The Mindful Nurse. American Nurse Today, 10, 9, 12-13, 43.

Contact

rmd3e@virginia.edu

Invited Posters

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Evaluating a Healthcare System's Use of the Wright Competency Assessment Model

Angela J. Deere, BSN, RN, CCRN, EMS, USA

Abstract

Competence in the health care industry is a fundamental expectation of healthcare organizations, consumers, regulatory boards, and accrediting agencies. Ensuring staff-members are competent is a complex process involving every discipline, at every level, ranging from the executive suite to the bedside caregiver. Donna Wright (2005) developed her model on competency assessment to address the dynamic nature of the health care field. She identified proven principles that could be applied to a multitude of situations where competency assessment was necessary. The three main principles of Wright's model are as follows: 1. Competencies are collaboratively identified; 2. The learner is at the center of the competency process; 3. Leaders create a culture of success with a dual focus-positive employee behavior and organizational mission. Wright utilizes 11 validation methods in her model with the goal of successfully evaluating the dynamic needs of the health care field. The validation methods evaluate three common domains of learning: critical thinking, technical, and interpersonal skills. These domains of learning are necessary for all levels of providers in health care today.

This study looked at one multi-hospital health care system's use of the Wright Competency Assessment Model 9WCAM) among the Emergency Departments (ED). The health care system consisted of four hospitals' Emergency Departments. A survey was sent to and completed by each of the unit educators and was based on the current year's competency evaluation process. An analysis of the data collected identified that there was an inconsistent use of the model among the ED's of a specific health care system, although it was chosen as the approved model for use several years prior. Three of the four hospitals reported using the Wright Competency Assessment Model and of the three the used it, none of them used all components of the model. The results revealed that there was a gap in understanding regarding the intended, proper application of the model.

References

Schanne, L. C., Stern, S., Hand, C., Collins, M., Kirk, G., Kweeder, S., . . . Meehan, D. (2016). From chaos to competency: Implementing a new competency process in a multihospital system. *The Journal of Continuing Education in Nursing*, *47*(3), 111-117.

Levine, J., & Johnson, J. (2014). An organizational competency validation strategy for registered nurses. *Journal for Nurses in Professional Development*, *30*(2), 58-65.

Contact

deere.9828@knightnet.urbana.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Implementation of a Standardized Handoff during Transition of Care from the ED to the ICU

Melinda Abbring, BSN, RN, USA

Abstract

Patient safety and communication are crucial to the nursing handoff. Emergency department (ED) patients transferring to the intensive care unit (ICU) have life-threatening impairments. Stabilization of critically ill patients may not occur until after the handoff has occurred. Often, vital patient information may be omitted. EDs can be chaotic with numerous distractions that adversely affect the nursing handoff. The Institute of Medicine published two groundbreaking patient safety publications highlighting handoffs: *To Err is Human: Building a Safer Health System* (1999) and *Crossing the Quality Chasm* (2004). In 2006, the Joint Commission recognized handoffs by adding transition of care with the National Patient Safety Goal 2E (2014). The purpose of this evidence-based practice project is to implement a standardized handoff from the ED to the ICU to improve nursing communication and patient safety. The review of literature supported implementation of a standardized handoff. Melnyk and Fineout-Overholt's (2001) hierarchy of evidence ranked 15 separate sources: Two level III, one level IV, five level V, four level VI, and three level VII. The Johns Hopkins Nursing Evidence-Based Practice Model and Guidelines revealed six high quality sources and nine good quality sources. The Stetler Model provided guidance and direction during implementation of this project. Rogers' Diffusion of Innovation was used to assess nurses' willingness to adopt the handoff intervention. A 205-bed, non-profit, Midwestern hospital was the setting for this intervention. The ED and ICU managers, the nurse educator, and the Chief Nursing Officer all understood and supported the proposal. Education of the standardized handoff occurred over a one week period during staff meetings and change of shift in the ED and ICU. A PowerPoint® presentation was given and questions from nurses in both the ICU and ED were answered. At that time, a demographics form was completed as well as a pre-intervention questionnaire asking nurses about the current handoff practice. This handoff implementation continued for eight weeks. At the end of the implementation phase, ED and ICU nurses will complete a post-implementation questionnaire. Communication and patient safety will be compared from the two months prior to implementation of the standardized handoff to the two months during implementation using a paired t test. Descriptive statistics will compare pre-intervention and post-intervention questionnaires regarding nursing attitudes and communication on a Likert Scale along with completeness of the handoff items. The time patients spend in the ED waiting for an ICU bed prior to arrival to ICU and MIDAS risk reports will be audited and compared to the two months prior to implementation of a standardized handoff. It is anticipated that implementation of a standardized handoff will improve both nursing communication and patient safety.

References

Klim, S., Kelly, A., Kerr, D., Wood, S., & McCann, T. (2013). Developing a framework for nursing handover in the emergency department: An individual and systematic approach. *Journal of Clinical Nursing, 22*, 2233-2243.

Toccafondi, G., Albolino, S., Tartaglia, R., Guidi, S., Molisso, A., Venneri, F., …Barach, P. (2012). The collaborative communication model for patient handover at the interface between high-acuity and low-acuity care. *British Medical Journal Quality Safety, 21,*58-66.

Zou, X., & Zhang, Y. (2016). Rates of nursing errors and handoffs-related errors in a medical unit following implementation of a standardized nursing handoff form. *Journal of Nursing Care Quality, 31*(1), 61-67.

Contact

mindy.abbring@valpo.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Living with a Defibrillator

Tiffanee F. Wazny-Kohl, BSN, RN, CCDS, USA

Abstract

Patients with implanted cardiac defibrillators face fear, uncertainty, and many unknowns when deciding to have the device implanted. The implanted cardioverter defibrillator, or ICD, is a small titanium device implanted inside the body that is capable of delivering shock therapy directly to the heart to reverse life threatening arrhythmias. The phenomenon of uncertainty related to ICD patients has been studied internationally at length and in a few domestic quantitative studies, however few recent qualitative studies have been conducted in the USA on this topic. This qualitative study employed face-to-face interviews with five adult participants who talked about their experiences related to living with the device. Because the criteria for ICD implant changes often, many patients have the device implanted and are given little information pre-operatively. Mishel's Theory of Uncertainty was adopted for use in this study. The tool utilized was a battery of four questions developed by the researcher to ask specific details of each participant related to living with the device, their feelings of uncertainty, and lifestyle adaptation. The questions asked included "tell me about the experience of living with your defibrillator"; "tell me about a time when you experienced uncertainty specifically related to the ICD and how you dealt with it"; "tell me about any special considerations that you take while living with the device"; and "describe the timing of your diagnosis related to implant, and how these experiences affected your overall lifestyle". Patients were recruited through a device clinic in one hospital. Three dominant themes were identified including fear, uncertainty, and peace/acceptance of the device implant. Subjective statements were included in the final publication of the study results. Recommendations for further research include a larger participant population, looking at the experiences of men vs. women, and studying the specific idea of what having the ICD means to each patient.

References

Mert, H., Argon, G., & Aslan, O. (2012). Experiences of patients with implantable cardioverter defibrillators in Turkey: a qualitative study. *International Journal of Caring Sciences;* 5(1); 50-55.

Mishel, M. & Barron, C.R. (2012). Stress, Uncertainty, & Health. In Rice, V.H. (Ed.). *Handbook of Stress, Coping & Health,* 2nd ed. (pp.510-533). Los Angeles, CA: Sage.

Palacios-Cena, D., Losa-Iglesias, M.E., Alvarez-Lopez, C., Cachon-Perez, M., Reyes, A.R., Salvadores-Fuentes, P. & Fernandez-de-las-Penas, C. (2011). Patients, intimate partners and family experiences of implantable cardioverter defibrillators: qualitative systematic review. *Journal of Advanced Nursing;* 67 (12); 2537-2550. DOI: 10.1111/j.1365-2648.2011.05694.x.

Contact

tfwaznyk@svsu.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Health Literacy of Diabetics at a Free Community Health Clinic

Fay Patsy T. Catacutan, BS, USA
Laura E. Strietelmeier, MDiv, BS, USA
Katy A. Doumtsop, BS, CNA, USA
Mary Eileen Walsh, PhD, MSN, BSN, APN, RN-BC, FAHA, USA

Abstract

Background: According to the National Assessment of Adult Literacy, only 12% of U.S. adults have proficient health literacy and over 77 million people have difficulty with common health related tasks, including following directions on a prescription drug label. Even with extensive research discoveries related to the pathology of diabetes, the complications of the disease state continue to rise. In diabetes, health literacy includes knowledge of the disease, self-care behaviors, and glycemic control. Individuals with inadequate health literacy levels have poorer health outcomes regardless of illness, social and economic status, education, gender, and age. Individuals with diabetes who attend a free community health clinic may have limited resources and education, which further compound their health outcomes.

Purpose: The purpose of this study was to assess health literacy of individuals with diabetes who attend a free community health clinic.

Theoretical/Conceptual Framework: Orem's Self-Care Deficit Theory was used as the guiding framework. Self-care is an essential component to managing diabetes. Nurses need to educate individuals on self-care practices in accordance with their health literacy level.

Methods: The sample consisted of individuals who attend a free community health clinic ages 18 years and older who self-identify as having been diagnosed with diabetes. Individuals received an overview of the study and provided informed consent. Participants answered demographic and health questions and responded to 3 health literacy questions using a Likert scale.

Results: To date, 29 type 2 and 2 type 1 diabetics (21 females, 10 males) ages 27-84 years, 71% (22) white, 16% (5) Latino/Hispanic, and 13% (4) black/African American completed the study. Of these 58% had more than high school education and 41.9% were unemployed. Health literacy questions indicated that 38.1% were not at all confident in filling out medical forms by themselves, 35.5% had problems understanding written information, and 23.8% required help to read hospital materials.

Limitations: This was a convenience sample of a single community health clinic with unequal representation by race and gender.

Conclusions: Preliminary findings suggest that health literacy level should be considered when providing self-care education to diabetics. Written health care information should be appropriate to the identified health literacy level, discussed with the individual and another support care person. Comprehension of information should be reassessed.

References

Kutner, M., Greenberg, E., Jin, Y., and Paulsen, C. (2006). The Health Literacy of America's Adults: Results From the 2003 National Assessment of Adult Literacy (NCES 2006–483). U.S. Department of Education. Washington, DC: National Center for Education Statistics.

Contact

FAY.CATACUTAN@GMAIL.COM

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Combating Workplace Violence: An Evidence-Based Initiative

Diana L. Giordano, MSN, RN, FNP-BC, USA

Abstract

Multiple factors (e.g., a misperception of what constitutes violence and lack of administrative response following violent events) may precipitate a lack of compliance in hospital employees' reporting patient-to-staff violent incidents, as well as lead to poor staff perception of personal safety and support from hospital administration. Lack of recognition of the true incidence and underreporting of verbal violence, which often precedes physical violence, may contribute to a false sense of security within a healthcare facility.

The purpose of this evidence-based practice (EBP) project is to evaluate the effectiveness of instituting an institutional practice policy, implemented on (a) reports of patient-to-staff violence incidents and (b) staff perception of safety and support from hospital administration in Northwest Indiana hospital.

Retrospective analyses of the facility's online incident reporting system, security request calls, restraint application, and data from a previously deployed WPV employee survey was utilized to identify the ED as having had the highest reported occurrence of patient/visitor violence, security assist calls, restraint applications, as well as the lowest perception of safety and support from facility administration.

The WPV policy included procedural direction and signage was drafted and posted indicating the facility's policy stance on having a zero-tolerance environment to violence against staff, patients, and visitors. Four-hour policy in-services addressed (a) the importance or reporting violence, (b) what constitutes violence, and (c) the follow through procedure to be expected when a report is made. Multiple educational sessions were presented throughout the month of November, 2016 to accommodate the varying shifts of the ED staff.

To evaluate the impact of the intervention, WPV surveys will be administered 8-weeks post-implementation and reporting of violent incidents will be tracked via Risk Pro Monitor (the facility's current system). Inferential statistics will be used to evaluate differences in perceptions of safety and administrative support. Descriptive statistics will be used to compare reports of violence. Then, insert your projections here. And end with, statistical significance for all analyses will be established at $p < .05$.

References

1. Emergency Nurses Association (2016). Workplace violence prevention: Know your way out: Recognize, avoid, prevent, and mitigate emergency department violence. Retrieved from https://ena.peachnewmedia.com/store/streaming/index.php.

2. Emergency Nurses Association Institute for Emergency Nursing Research (2011). Emergency department violence surveillance study. Retrieved from http://www.ena.org/IENR/Pages/WorkplaceViolence.aspx.

3. International Association for Healthcare Security & Safety. (2012). Security Design Guidelines for Healthcare Facilities. Glendale Heights: IAHSS.

4. Occupational Health and Safety Administration (OHSA, 2015). Guidelines for preventing workplace violence for healthcare and social service workers. Retrieved from https://www.osha.gov/Publications/osha3148.pdf.

Contact

diana.giordano1@valpo.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Stigma in COPD and Lung Cancer: A Systematic Review

Seoyoon Woo, BSN, RN, USA
Jennifer Dimitrief, USA
Janet, L. Larson, PhD, MN, BSN, RN, FAAN, USA

Abstract

Objectives: People with chronic obstructive pulmonary disease (COPD) and lung cancer are stigmatized by their history of smoking, but little is known about the similarities and dissimilarities in stigma associated with each condition. A comparison of the two could be useful in advancing the science. This systematic review aimed: 1) to compare existing literature on stigma in people with COPD and lung cancer and 2) to identify existing measures of COPD-related and lung cancer-related stigma.

Methods: We conducted a systematic search of CINAHL/PsycINFO/PubMed/Scopus databases for articles related to stigma in COPD or lung cancer through October 2015. We performed a quality assessment and synthesized findings according to concepts in the models of health-related stigma in people with COPD and lung cancer (Berger et. al., 2011 and Cataldo et al., 2011).

Results: A total of 42 studies met criteria for review: 17 addressed stigma in people with COPD (6 quantitative and 11 qualitative) and 25 addressed stigma in people with lung cancer (14 quantitative and 9 qualitative). We identified no well-established measures of COPD-related stigma; most of the COPD research was qualitative and/or employed unvalidated questions about stigma. The most commonly used measure for lung cancer stigma was the Cataldo Lung Cancer Stigma Scale (Cataldo et. al. 2011); it was used in 8 studies. People with COPD linked stigma to smoking, the diagnosis itself, symptoms of COPD (cough and shortness of breath) and stigma triggers such as the use of inhalers and supplemental oxygen. People with lung cancer linked stigma to their smoking behavior and previous- and current-smokers reported higher levels of stigma than people who never smoked.

Conclusions: People with COPD and lung cancer are similar in their perceptions of stigma, “they did it to themselves”. Less is known about COPD-related stigma in part because there are no reliable and valid measures of COPD-related stigma. It may useful to develop a single instrument that measures stigma in both diseases, thereby facilitating further comparison that could lead to a better understanding of the underlying mechanisms for stigma in these chronic diseases.

References

Berger, B. E., Kapella, M. C., & Larson, J. L. (2010). The experience of stigma in chronic obstructive pulmonary disease. *Western journal of nursing research*, 0193945910384602.

Cataldo, J. K., Slaughter, R., Jahan, T. M., Pongquan, V. L., & Hwang, W. J. (2011, January). Measuring stigma in people with lung cancer: psychometric testing of the cataldo lung cancer stigma scale. In *Oncology nursing forum* (Vol. 38, No. 1, p. E46). NIH Public Access.

Contact

sywoo@umich.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Application of Smartphone/Mobile Devices for STD and HIV Prevention

Abimbola Bolanl Lasisi, MS, BSc, CAHIMS, USA
Huey-Shys Chen, PhD, RN, MCHES, FAAN, USA

Abstract

Problem: STD and HIV are major public health crisis in the United State. Study shows that about 1.1 million of American are living with HIV and 110 million cases of STD. Incidence rate of HIV and STD are 56,000 and 20 million respectively. 1 in 5 HIV patients are unaware of their HIV status. Smartphone applications are increasingly used for sexually transmitted disease (STD) and HIV treatment, although little focus has been on STD and HIV prevention.

Purpose: The purpose of this review is to synthesize and evaluate existing literature on using smartphone/mobile devices to prevent STD and HIV in order to ultimately decrease STD and HIV risk factors.

Search Strategy: The CINAHL, EBSCOhost, PsycINFO, Google Scholar, and PubMED databases were utilized to attain articles. Keywords included mobile phone, mobile applications, HIV, STD, application, APP, and Smartphone. Selection criteria included: information on HIV/STD disease, information on risk reduction/ safer sex, condom promotion, HIV/STD testing information. Limits included English language, publication within the last 15 years, and academic journals.

Results: The search resulted in 14 total studies that met the inclusion criteria. Studies were published between 2000 and 2015. Level of evidence was assessed by Melnyk and Fineout-Overholt's evaluation guidelines. The level of evidence ranged from two to seven including randomized controlled design, literature review, correlative study, descriptive study, and expert opinions.

Synthesis of Evidence: Review of evidences shows that smartphone or mobile phone applications on HIV/STD prevention are successful to attract user attention and positive reviews. Studies suggested introduction of evidenced based interventions for HIV/STD prevention through smartphone or mobile phone applications are successful tools to reduce HIV/STD risk factors; however, there is limited evidence for usability and effectiveness of cultural sensitive applications to be used with different populations. Also, several researchers suggested that future research should consider evaluating interventions with similar approaches for STD/HIV prevention.

Implications for Practice: Smartphone applications can help researchers engage with people all over the world. According to the most current evidence-based literature, delivery of STD/HIV prevention information through smartphone or mobile phone application would significantly decrease STD/HIV risks. Researchers can work with app developers to design a comprehensive, culture sensitive smartphone application on STD/HIV prevention.

References

Jones Rachel, Hoover R. Donald, Lacroix, J. Lorraine, (2013). A randomized controlled trial of soap opera videos streamed to smartphones to reduce the risk of sexually transmitted human immunodeficiency virus (HIV) in young urban African American women. Nursing outlook Aug 2013 61(4): 205-215.

Sun Christina, Stowers Jason, Miller Cindy, Bachman Laura, Rhodes Scott (2015). Acceptability and feasibility of using established geosocial and sexual networking mobile application to promote hiv and std testing among men who have sex with men. Aids & behavior (2015) 19:543–552.

Contact

abimbola.lasisi@utoledo.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Risk Behaviors and Preventive Interventions for Deaf and Hard-of-Hearing Youth

Ying Xue, BSNc, RN, USA
Yu-han Zheng, BSN, RN, USA
Yu-ku Chen, BSN, RN, USA
Huey-Shys Chen, PhD, RN, MCHES, FAAN, USA

Abstract

Problem: Although the number of sign language users in the United States has not been measured by census efforts, estimates range between 500,000 and 2 million users. 17.1% lost their hearing before age 19 and 6.6% lost their hearing before age 3. Compared with the hearing population, they have poor health knowledge and inequitable access to medical and behavioral care in our health system due to cultural and language barriers. The deaf populations are at high risk for health disparities.

Purpose: The purposes of this literature review are to synthesize current literature on health risk behaviors of deaf and hard-of-hearing youth and to summarize health risk preventive interventions that have been used in deaf and hard-of-hearing youth population.

Search Strategy: The CINAHAL, PubMed, Google Scholar, and Proquest were used to obtain evidences and unpolished students' dissertations and theses. Keywords included deaf, hard of hearing, health needs, risk behaviors, health promotion. The Limits included date of publication no earlier than 2000, English language, peer reviewed journals, and opinions of authorities or expert committees.

Results of Literature Search: The search resulted in 16 articles that met inclusion criteria. The level of evidence ranged from level 3 to 7 with no systematic literature review and no randomized controlled trials.

Synthesis of Evidence: Studies have found that previous studies focused on health risk behaviors of deaf and hard-of-hearing you include mental health (suicide), physical abuse, unintentional injuries, alcohol, tobacco, and other drug use; risky sexual behaviors; HIV prevention, overweight; and physical inactivity. Synthesis of evidence supported that deaf individuals have higher rates of suicide and mental disorder, higher rates of obesity, higher rates of unintentional injury risk, higher rate of substance abuse (alcohol, tobacco, and other drug use), and increased rates of HIV and sexually transmitted infections than those who are hearing.

Implications for Practice: Limited evidence has emerged to support health preventive interventions for deaf and hard-of-hearing youth. It's suggested that further research using a variety of study designs is needed to close gap in our understanding of health risk prevention issues in this population.

References

Berman, B. A., Guthmann, D. S., Crespi, C. M., & Liu, W. (2011). Development and testing of an antitobacco school-based curriculum for deaf and hard of hearing youth. *American Annals of the Deaf,* 155(5), 592-604.

Ellis, M. K., Lieberman, L. J., & Dummer, G. M. (2014). "Parent influences on physical activity participation and physical fitness of deaf children. *Journal of Deaf Studies and Deaf Education,* 19(2), 270-281.

Mall, S. (2012). Parents' anxieties about the risk of HIV/AIDS for their deaf and hard of hearing adolescents in South Africa: A qualitative study. *Journal of Health Psychology,* 17(5), 764-773.

Contact

YIng.Xue@rockets.utoledo.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

The Experience and Meaning of Physical Activity in Assisted Living Facility Residents

Carol M. Vos, MSN, RN, USA
Janet L. Larson, PhD, RN, FAAN, USA
Nancy Gallagher, PhD, RN, APRN-BC, USA
Denise Saint Arnault, PhD, RN, FAAN, USA
Laura Struble, PhD, RN, GNP-PC, USA
Lydia Li, PhD, LSW, USA

Abstract

Purpose: Physical activity (PA) can counter negative health outcomes, decrease metabolic risk and prevent premature frailty but little is known about PA in assisted living facility (ALF) residents. The purpose of this study was to explore the experience and meaning of PA in AFL residents as a preliminary step in the development of future research aimed at increasing PA in this population. Method: A qualitative exploratory research design was used. One-on-one semi-structured interviews were conducted. Subjects described historical and current PA and the meaning of PA for them. Interviews were audio taped and transcribed verbatim. Raw data were reduced and analyzed using a modified version of Moustakas' (1994) phenomenological methodology. Results: The sample was 20 older adults in assisted living aged 57-96 years (M=77.4, SD=10.6). Sixteen (80%) were females, mean length of stay in the ALF was 27.6 months (SD=26.0), and 13 (65%) used a walker occasionally. Twenty-seven meaning units were derived from 20 interviews and clustered into five themes. PA was defined in broad terms that included all bodily movement and social engagement. Residents were sedentary but saw themselves as physically active, in part because they compared themselves to others perceived as less active. Residents' PA was dependent on a schedule imposed by facility staff and family availability. This scheduling was viewed positively. Health problems limited PA, however residents were motivated by potential positive health outcomes to work through the limitations. PA meant functional disability could be delayed and that one could hope and plan for the future. Conclusions: Residents saw PA as important for healthy living but did not engage in the amount and types of PA that would impart health benefits such as improved physical function. Comparisons to others reinforced an attitude that present levels of PA were satisfactory when in fact most of the PA described involved seated, leisure activities and not PA. Further work is needed to help ALF residents understand the difference between sedentary behavior and PA as a next step in future research.

References

(CDC) Center for Disease Control and Prevention: Physical Activity is Essential to Healthy Aging. (2014). Retrieved from: http://www.cdc.gov/physicalactivity/everyone/guidelines/olderadults.html

Chen, Y., Li, Y., & Yen, M. (2015). Predictors of regular exercise among older residents of long-term care institutions. *International Journal of Nursing Practice,* 1-8. doi: 10.1111/ijn.12401

Contact

carolvos@umich.edu

RSG STR - Rising Stars of Research and Scholarship Invited Student Posters

Development and Testing of the Nurse Manager EBP Competency Scale

Clayton J. Shuman, MSN, RN, USA
Marita G. Titler, PhD, RN, FAAN, USA

Abstract

BACKGROUND: Nurse managers are ideally situated within an organization to influence implementation and use of evidence-based practices (EBP) (Birken, Lee, & Weiner, 2012; Stetler, Ritchie, Rycroft-Malone, & Charns, 2014). Although EBP competency is one of five core competencies espoused by the Institute of Medicine, nurse managers' report a lack of confidence in EBP (Gifford, Lefebre, & Davies, 2014). Few studies have examined the role of nurse managers in promoting EBPs and no instruments are available to measure nurse manager EBP competencies. To explicate the relationship among the role of nurse managers, the practice culture that fosters application of evidence, and patient outcomes, it is imperative that a valid and reliable instrument to measure nurse manager EBP competencies is developed for use in future research. The purpose of this study was to develop a reliable and valid tool to measure competencies of nurse managers regarding EBP.

METHODS: Items for the Nurse Manager EBP Competency Scale were premised on the Promoting Action on Research Implementation in Health Services' (PARIHS) context domain and developed from prior research, resulting in 16-items on a Likert response scale (0= not competent; 1= somewhat competent; 2= fully competent; 3= expertly competent). After eight EBP experts analyzed face and content validity, the scale was pilot tested with four nurse managers from medical-surgical units. For this study, 130 inpatient and ambulatory nurse managers from one academic medical center and two community hospitals were invited to participate. A gift card lottery drawing and email reminders encouraged response. Cronbach's alpha was used to evaluate reliability and exploratory factor analysis with Varimax rotation evaluated validity of the Nurse Manager EBP Competency Scale.

RESULTS: 83 nurse managers (n=49 inpatient; n=34 ambulatory) completed the scale resulting in a 63.8% overall response rate. Cronbach's alpha for the entire scale was .95. Exploratory factor analysis resulted in a 16-item scale with two subscales, EBP Knowledge (n= 6 items, α=.90) and EBP Activity (n= 10 items, α=.94).

CONCLUSION: The Nurse Manager EBP Competency Scale is a brief, psychometrically sound measure of nurse manager EBP competency. As the first measure of this context element, the scale can enhance our understanding in future studies regarding how nurse manager EBP competency effects EBP implementation.

References

Birken, S. A., Lee, S. Y. D., & Weiner, B. J. (2012). Uncovering middle managers' role in healthcare innovation implementation. *Implementation Science*, *7*(1), 1.

Gifford, W., Lefebre, N., & Davies, B. (2014). An Organizational Intervention to Influence Evidence-Informed Decision Making in Home Health Nursing. *Journal of Nursing Administration*, *44*(7/8), 395-402.

Stetler, C. B., Ritchie, J. A., Rycroft-Malone, J., & Charns, M. P. (2014). Leadership for evidence-based practice: strategic and functional behaviors for institutionalizing EBP. *Worldviews on Evidence-Based Nursing*, *11*(4), 219-226.

Contact

claytonshuman@gmail.com