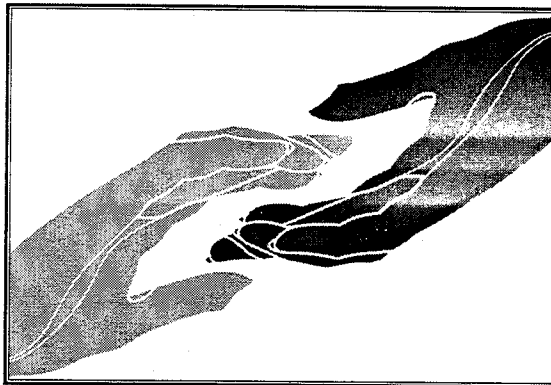


The Institute for Health Care Education and Capital Region Alliance
for Research and Research Utilization
presents

**The Sixth Annual
Research/Research Utilization
Conference**

PARTNERS IN CARE:

*Applying Best Practice to Enhance
Relationships in Health Care*



Friday October 4, 2002

7:15 AM – 2:30 PM



Education & Resource Center • 560 Hudson Street • Hartford, CT

***CONFERENCE
GOALS***

6th Annual Research / Research Utilization Conference

PARTNERS IN CARE: *Applying Best Practice to Enhance Relationships in Health Care*

Conference Goals

- 1. Provide a venue for dissemination of research findings to healthcare professionals.**
- 2. Through presentation of research efforts, illustrate ways in which utilization of research findings are improving clinical practice.**
- 3. Provide opportunities (through skill building/roundtable sessions) to enhance one's knowledge and the development of skill sets necessary for research utilization and research conduct.**

***CONFERENCE
SCHEDULE***

PROGRAM SCHEDULE

7:15 AM	Registration/Coffee & Danish Heublein Hall, ERC Lobby	11 AM	A) Concurrent Abstract Presentations The Effect of a Psychiatric Diagnosis on Health Care For Non-psychiatric Problems Beka Apostolidis, RN, BS, Hartford Hospital Brenda Armstrong, RN, BS John Dempsey Hospital Dawn Bernardo, APRN, MS, John Dempsey Hospital Michael Frakes, RN, BA, BSN, Hartford Hospital Steven Goldblatt, RN, MA ERC 216 Covert Bias in Evaluation of Associate Degree Nursing Students' Clinical Performance Joanne Anfinson, PhD, CS, RN, Professor Capital Community College, Hartford, CT ERC Room 216 Validating Math Competency for Medication Administration in Schools of Nursing in the United States Lynn Allchin, RN, PhD, Assistant Professor UCONN School of Nursing, Storrs, CT ERC Room 218 Acquired Mathematics Competencies of Beginning Baccalaureate Degree Nursing Students in the Northeastern Region of the Continental United States Daryle L. Brown, Ed.D, RN, Assistant Professor of Nursing, Pace University, Pleasantville, NY ERC Room 218
8:00 AM	Welcome Joan MacRae, RNC, MS Co-Chairperson, Planning Committee		
8:05 AM	Opening Remarks & Introduction of Keynote Speaker Laura Caramanica, RN, PhD Vice President, Nursing, Hartford Hospital		
8:15 AM	Keynote Address: Improving Care at the End of Life Dr. Betty R. Ferrell, PhD, FANN		
9:15 AM	Coffee Break-Heublein Hall Poster Exhibit Viewing-Formal Lounge Book Exhibit-ERC Lobby		
9:45 AM	A) Concurrent Abstract Presentations Growing Up in Pieces: Adolescents with Pervasive Developmental Disorder (PDD) Transitioning into Adulthood Geraldine Pearson, RN, CS, PhD, CNS Riverview Hospital for Children and Youth; Clinical Faculty, UCONN School of Nursing ERC 216 Lived Experience of Nausea in Persons with AIDS Elizabeth Anderson, PhD, APRN, Assistant Professor UCONN School of Nursing Margaret Spencer, MS, APRN, Trinity Hill Center, Hartford, CT ERC 216 Common Experiences Reported by Hospitalized Patients Karen Renstrom, RN, BS Nicole Adams, RN, BS Tara Bermen, RN, BS UCONN School of Nursing ERC 221 Postoperative Pain Communication Skills For Elders Deborah McDonald, RN, PhD, Assoc. Professor UCONN School of Nursing ERC 221	B) Skill Building Presentations Searching the Research Literature Arlene Freed, MLS, Senior Librarian Ellen MacNaughton, MLS, Medical Librarian Health Science Libraries, Hartford Hospital Room: In the Robinson Library C) Qualitative Research Roundtable Phenomenology Laura Mulka, MS, APRN, BC, OCN New Britain General Hospital AND Metasynthesis Joyce Fontana, RN, MSN Saint Joseph College Room; Heublein Hall	
	B) Skill Building Presentations: Searching the Research Literature Arlene Freed, MLS, Senior Librarian Ellen MacNaughton, MLS, Medical Librarian Health Science Libraries, Hartford Hospital Room: Robinson Library Computer Classroom Statistics: What Do You Need to Know Rose Maljanian, RN, MBA Director of Outcomes Research and Evaluation Ilene Staff, PhD, Senior Scientist Institute for Outcomes Research and Evaluation ERC Room 218	12:30 PM 1:15 PM 2:15-2:30 P	Buffet Luncheon/Poster Awards Heublein Hall and Informal Lounge Plenary Address Health Care Relationships: The New Frontier Sally S. Cohen, RN, PhD, FAAN Heublein Hall Summary, Evaluation, Book Giveaways Heublein Hall /Lobby
	C) Qualitative Research Roundtable Ethnography Barbara Bennett Jacobs, RN, MPH, MS Georgetown University AND Focus Groups' Dale Chiffer, RN, MSN Charlotte Steniger, RN, BSN Room: Heublein Hall		

***MAP OF EDUCATION &
RESOURCE CENTER***

Education & Resource Building

FIRST FLOOR



HUDSON STREET

LOBBY

Book Vendor

Registration

Mens Rest Room

Ladies Rest Room

Room 123

ENCLOSED GALLERY TO CORR

TRACED

Informal Lounge

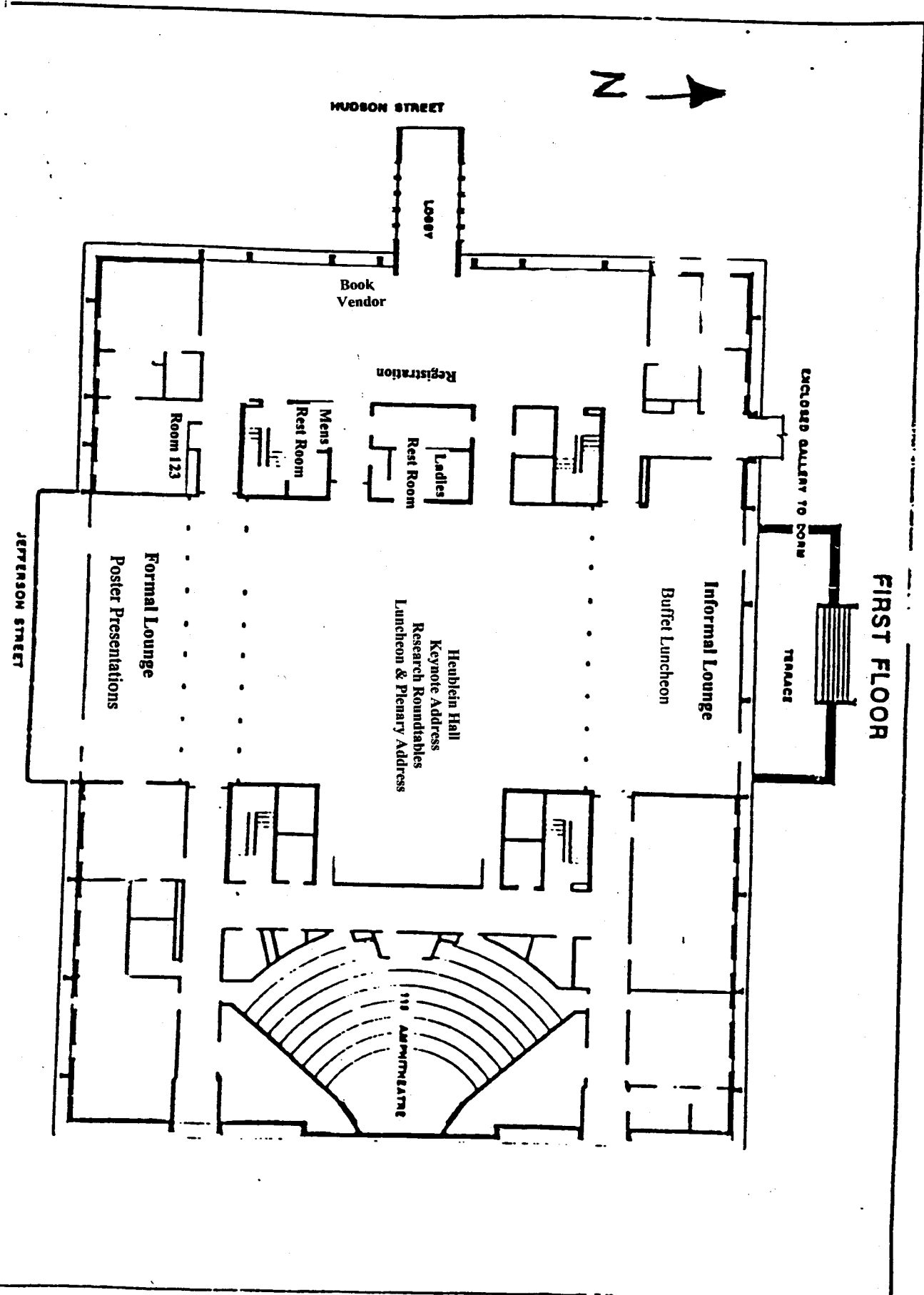
Buffet Luncheon

Heublein Hall
Keynote Address
Research Roundtables
Luncheon & Plenary Address

Formal Lounge
Poster Presentations

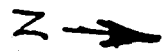
JEFFERSON STREET

118 AMPHITHEATRE



Education & Resource Building

SECOND FLOOR



HUDSON STREET

ENCLOSED BRIDGE TO CORAM

ASTOR STREET BRIDGE

JEFFERSON STREET

Nursing Education
Office
ERC 216
Concurrent Abstract Presentations
9:45-10:50 AM
11:00 AM - 12:20 PM

Mens
Rest Room
UPPER PORTION OF
ASSEMBLY HALL
Ladies
Rest Room

ERC 218
Skill Building Session
Statistics - 9:45 - 10:50 AM

ERC 221
Concurrent Abstract Presentations
9:45-10:50 AM

ENCLOSED BRIDGE TO BARNBY BLDG

Robinson Library
Skill Building Sessions
Searching Research Literature
9:45 AM and 11 AM

ACKNOWLEDGEMENTS

ACKNOWLEDGEMENTS

Sponsorship of Keynote Speaker, Betty Ferrell, RN, PhD, FAAN , provided by an educational grant courtesy of *Purdue Pharmaceutical L.P.*

Sponsorship of Plenary Speaker, Sally Cohen, RN, PhD, FAAN, provided by and educational grant courtesy of *Johnson & Johnson.*

Book Exhibit and Book Raffle courtesy of Anthony Cantore, Elsevier Sciences, Publisher

Special thanks to members of the Conference Planning Committee:

Janice Bartis, RN, MSN, Dawn Beland, RN, MSN, Cindy Belonick, APRN, Pamela Burris, RN, MSN, Laura Caramanica, RN, PhD, Janice Lamb, RN, MSN, Joan MacRae, RN, MS, Peg Moynihan, RN, MS, Amy Schroder, RN, MSN, Lynn Satherlie, RN, MPH – Hartford Hospital

Sally Strange, RN, MSN – Connecticut Children's Medical Center – Hartford, CT

Ann Cinotti, RN, MSN – UCONN Health Center, Farmington, CT

Kathleen Stolzenberger, RN, MS, Karen Levine, RN, MSN – Middlesex Hospital

Cindy Russo, RN, MS – MidState Medical Center – Meriden, CT

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Anne Durkin, RN, PhD – Quinnipiac University – Hamden, CT

Virginia Knowlden, RN, PhD – Saint Joseph College – West Hartford, CT

Barbara Aronson, RN, MSN – Southern CT State University – New Haven, CT

Deborah Dillon McDonald, RN, PhD – University of Connecticut, Storrs, CT

Karen Breda, RN, PhD – University of Hartford – West Hartford, CT

CONTACT HOURS: 5.3 CHs will be awarded to participants attending full day conference and handing in evaluation form. For those unable to attend entire day, individual contact hours will be awarded for Keynote Address and Plenary Address.

Hartford hospital is an approved provider of continuing nursing education by the Connecticut Nurses' Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Contact hour approval does not imply ANCC Commission on Accreditation/CNA or Hartford Hospital endorsement of any commercial products displayed in conjunction with this conference.

Book Exhibit Open

7:30-8:00 AM

9:15-9:45 AM

12:30-1:15 PM

**Come visit with Anthony Cantore,
from Elsevier Science and browse
through the research textbooks on
display.**

6th Annual Research/Research Utilization Conference
PARTNERS IN CARE: Applying Best Practice
To Enhance Relationships in Health Care

BOOK VENDOR DISPLAY

Anthony Cantore, Clinical Sales Representative from Elsevier Sciences Publishers, will be set up in the ERC Lobby with a display of various journals, textbooks and multimedia relating to research utilization and the research process. Samples of publication from W.B. Saunders, C.V. Mosby, Churchill Livingstone and Harcourt Brace will be on display.

Several publications will be given away as door prizes at the end of today's conference. Make sure to fill out your raffle ticket and drop it off in the box at the registration table before we break for lunch.

Stop by the display during the times listed below and check out the diversity of publications available to assist health care professionals in the conduct, dissemination and utilization of research.

9:15-9:45 AM

12:15-1:15 PM

***KEYNOTE
ADDRESS***

Slide 1

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Improving Care at the End of Life

Betty R. Ferrell, PhD, FAAN

Slide 2

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Objectives

- 1. Describe the current national mandate for improved end of life care.**
- 2. Recognize the importance of professional education in end of life care.**
- 3. Identify strategies for education and practice for better care of the terminally ill.**

Slide 3

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Palliative Care - Definition

“Palliative care seeks to prevent, relieve, reduce or soothe the symptoms of disease or disorder without effecting a cure...Palliative care in this broad sense is not restricted to those who are dying or those enrolled in hospice programs...It attends closely to the emotional, spiritual, and practical needs and goals of patients and those close to them.”

Institute of Medicine 1998

Slide 4

The Mandate for Improved End of Life Care

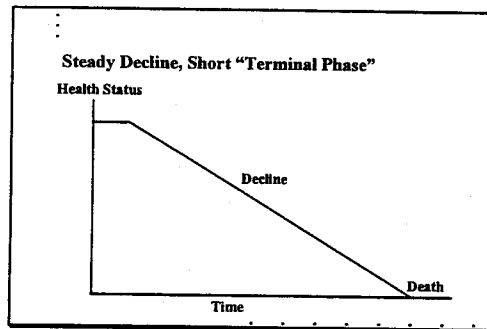
- Social Demands
- Critical Research Findings
- The Assisted Suicide Debate

Slide 5

The Mandate for Improved End of Life Care

Social Demands

Slide 6

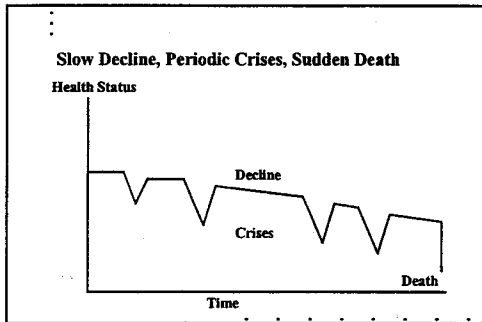


Slide 7

Protracted Life - Threatening Illness

- >90%
- predictable steady decline with a relatively short "terminal" phase (cancer)
- slow decline punctuated by periodic crises (CHF, emphysema, Alzheimer's type dementia)

Slide 8



Slide 9

- 2.2 million deaths/year in the U.S.
- 1 in 8 Americans is > 65 years.
- Nearly half of all medical expenses are incurred in the last 6 months of an individual's life
- 80% of deaths occur in hospitals
- The median stay in hospice is 36 days; the mean is 17 days.

Slide 10

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Role of Hospice, Palliative Care

- Median length of stay declining
- 36 days in 1995
 - 16% died < 7 days of admission
- 20 days in 1998

Slide 11

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Role of Hospice, Palliative Care

- Hospice started in US in 1970's
- Percentage of total US deaths in Hospice
- 11% in 1993
- 17% in 1995

Slide 12

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The Mandate for Improved End of Life Care

Critical Research Findings

Slide 13

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National data on the experience of dying in 5 tertiary care teaching hospitals

The SUPPORT Study

- Controlled trial to improve care of seriously ill patients
- Multicenter study funded by RWJ
- 9000 patients with life threatening illness, 50% died within 6 months of entry

JAMA 1995; 274:1591-98

Slide 14

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SUPPORT: Phase I Observational Study

Determine objective measures of quality of death:

- Presence and timing of written DNR
- MD awareness of DNR preferences
- Number of 'undesirable' days
- Pain levels
- Costs of care

Slide 15

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SUPPORT: Phase I Results

- 46% of DNR orders written within 2 days of death
- Of patients preferring DNR, <50% of their MDs were aware of their wishes
- 38% of those who died spent > 10 days in ICU
- Half of patients had moderate-severe pain >50% of last 3 days of life

Slide 16

Pain data from SUPPORT	
% of 5176 patients reporting moderate to severe pain between days 8-12 of hospitalization	
colon cancer	60%
liver failure	60%
lung cancer	57%
MOSF + cancer	53%
MOSF + sepsis	52%
COPD	44%
CHF	43%
Desbiens & Wu. JAGS 2000; 48: S183-186.	

Slide 17

Family caregivers and the SUPPORT study	
Patient needed large amount of family caregiving: 34%	
Lost most family savings:	31%
Lost major source of income:	29%
Major life change in family:	20%
Other family illness from stress:	12%
<i>At least one of the above</i>	55%

Slide 18

The Mandate for Improved End of Life Care

The Assisted Suicide Debate

Slide 19

Issues Regarding Assisted Suicide

- Individual Good vs Social Good
- Duty to Die
- Distraction from the Goals of Palliative Care
- Autonomy
- Separation of Roles of Health Care Providers
- Impact on Family Members

Slide 20

Issues Regarding Assisted Suicide

- Slippery Slope
- Issues of Control
- Suicide as "Prevention"
- Omission vs Commission
- Autonomy/Duty of the Health Care Providers

Slide 21

RWJ Project/Strengthening Nursing Education
Project Goals:

1. Review texts used in nursing schools for end-of-life (EOL) content.
2. Improve EOL content in the national nursing license exam.
3. Work with key nursing organizations (NCSBN, AACN, NLNAC) for improved EOL care.

Slide 22

Summary of Content of Texts N=50

Category	# Txts	% Txts	# pgs	# EOL pgs	# chps	# EOL chps
AIDS/HIV	1	2	526	20	16	0
Assmnt/Dx	3	6	1783	15.3	80	0
Communication	2	4	767	38	35	0
Community/HH	4	8	3108	21.3	116	0
Crit Care	4	8	4116	80.8	181	2
ER	2	4	1006	14.5	69	1
Ethics/Legal	5	10	2018	143	88	4
Fundamentals	3	6	4353	114.9	140	3

Slide 23

Summary of Content of Texts N=50

Category	# Txts	% Txts	# pgs	# EOL pgs	# chps	# EOL chps
Gerontology	3	6	2515	84.8	72	2
Med-Surg	5	10	9969	146.3	298	2
Onc	2	4	3264	107.5	149	7
Pt Ed	2	4	636	8.0	26	0
Peds	3	6	2599	33.5	70.0	2
Pharmacology	4	8	3476	22.0	236	0
Psychiatric	3	6	2886	35.3	127	1
Nursing Review	4	8	2661	17.0	47	0
TOTAL	50	100	45,638	901.9	1750	24 (1.4%)

Slide 24

Frequency of Occurrence of End-of-Life (EOL) Care Dilemmas

Dilemmas	Very Common	Somewhat Common	Not Common
Use of advance directives	37%	32%	31%
Preserving patient choices	23%	48%	29%
Uncertainty about prognosis	13%	44%	43%
Fear of causing death by giving pain medication	11%	34%	55%
Discontinuing life-sustaining therapies	11%	48%	41%
Withholding/withdrawing nutrition/hydration	8%	42%	50%

Forrell et al. ONE 27(3), 2898

Slide 25

Frequency of Occurrence of End-of-Life (EOL) Care Dilemmas, cont.

Dilemmas	Very Common	Somewhat Common	Not Common
Legal issues of EOL	7%	39%	54%
Requests for assisted suicide	1%	6%	93%
Requests for euthanasia	1%	6%	93%

N = 2,333

Ferrell et al. ONE 27(3), 2000

Slide 26

Barriers to EOL Care

Barriers to EOL Care	Severe Barrier	Somewhat of Barrier	Not a Barrier
Influence of managed care	25%	52%	23%
Lack of continuity of care	23%	54%	23%
Family members' avoidance of death	19%	73%	8%
Professionals' personal discomfort with death	17%	56%	27%
Knowledge by healthcare providers	15%	57%	28%
Patient/families' fears of addiction	12%	63%	25%

N = 2,333

Ferrell et al. ONE 27(3), 2000

Slide 27

Barriers to EOL Care, cont.

Barriers to EOL Care, cont.	Severe Barrier	Somewhat of Barrier	Not a Barrier
Increased use of unlicensed personnel	11%	28%	61%
Legal restrictions in prescribing pain medications	11%	36%	53%
Cultural factors influencing EOL care	10%	64%	26%
Avoidance of dying patients	10%	39%	51%
Professionals' fear of causing addiction	10%	34%	56%
Patients' avoidance of death	8%	70%	22%

N = 2,333

Ferrell et al. ONE 27(3), 2000

Slide 28

Adequacy of Basic Nursing Education	Not Adequate	Somewhat Adequate	Very Adequate
Pain management at EOL	71%	21%	8%
Overall content about EOL care	62%	31%	7%
Role/needs of family caregivers in EOL care	61%	31%	8%
Other symptom management	59%	32%	9%
Grief/bereavement	58%	34%	8%
Understanding the goals of palliative care	57%	33%	10%
Ethical issues of EOL care	56%	34%	10%

Ferrell et al. ONF 27(3), 2000.

Slide 29

Adequacy of Basic Nursing Education, Cont.	Not Adequate	Somewhat Adequate	Very Adequate
Care of patients at time of death	52%	36%	12%
Communication with patients/families at EOL	52%	37%	11%

N = 2333

Ferrell et al. ONF 27(3), 2000.

Slide 30

End of Life Care
 or
“Brink of Death” Care?

Slide 31

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Field MJ, Cassel CK. (Eds.): Approaching death: Improving care at the end of life (Report of the Institute of Medicine Task Force). Washington, DC: National Academy Press, 1997.

Slide 32

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End of Life Nursing Education Consortium (ELNEC)
**Robert Wood Johnson Foundation
Funded Project
2000-2003**

Slide 33

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Purpose
To provide a comprehensive national effort to improve end of life care by nurses.

Slide 34

Investigators

Geraldine Bednash, PhD, FAAN
Anne Rhome, MPH, RN
American Association of Colleges of Nursing

Betty Ferrell, PhD, FAAN
Marcia Grant, DNSc, FAAN
City of Hope National Medical Center

Slide 35

Consultants

Patrick Coyne, RN, MSN, CS, CHPN
Medical College of Virginia Hospitals
Virginia Commonwealth University

Kathy Egan, MA, BSN, CHPN
The Hospice Institute of the Florida Suncoast

Judy Paice, PhD, RN, FAAN
Northwestern Memorial Hospital

Joan Panke, BSN, RN
NYU Palliative Care Nurse Practitioner Program

Slide 36

Project Directors

Frances Weed, MSN, RN
American Association of Colleges of Nursing

Rose Virani, RNC, BSN, MHA, OCN
City of Hope National Medical Center

Slide 37

Affiliated Organizations

American Medical Association, EPEC Program
American Nurses Association
Hospice and Palliative Nurses Association
National Council of State Boards of Nursing, Inc.
National Hospice and Palliative Care Organization
National Organization for Associate Degree Nursing
Oncology Nursing Certification Corporation
Oncology Nursing Society
PDIA Consortium of Specialty Nursing Groups
Veterans Administration Health Systems

Slide 38

ELNEC Curriculum

Modules

1. Nursing Care at the End of Life
2. Pain Management
3. Symptom Management
4. Cultural Considerations in EOL Care
5. Ethical/Legal Issues
6. Communication
7. Grief, Loss, Bereavement
8. Preparation and Care for the Time of Death
9. Achieving Quality of Life at the End of Life

Slide 39

Courses

- 8 courses sponsored by COH/AACN
- 5 regional courses sponsored through Last Acts

Slide 40

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The Importance of "Being With"

Slide 41

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"I awoke that morning with a huge stapled wound in the center of my abdomen. Every inch of me hurt. Most of all my heart hurt with the knowledge that I had cancer. The nurse who came to bathe me was an older woman. Her hands were strong, her touch firm. As she washed my battered body, she cleansed away some fear and uncertainty and left calm and quiet in their places.

Slide 42

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The drains, the tubes, the staples didn't deter her from seeing me as a frightened, hurt human being. I don't know if she said much, but her hands spoke volumes."

The Octopus and Me by Susan G. Jaquette, BA, MATS. AJN, April 2000

Slide 43

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Non-Abandonment

Slide 44

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Pass Me the Blue

A little girl died today. She was 7 years old, liked cheese pizza, frozen yogurt, and macaroni, and loved dancing to Broadway hits. Her favorite color was purple although she had reconsidered and announced it to be "lavender". And like other 7 year-olds, she was quite wise about what really matters.

Pamela Hinds, RN, PhD, DS; J of Ped Onc Nsg, 11(2), 1994

Slide 45

⋮

Pass Me the Blue

She was first diagnosed with acute lymphocytic leukemia when she was an infant; she had a first relapse when she was 5 and a second relapse several months ago. Shortly after her first relapse, we were coloring together and sharing the same package of crayons.

Pamela Hinds, RN, PhD, DS; J of Ped Onc Nsg, 11(2), 1994

Slide 46

Pass Me the Blue
"Pass me the yellow," she said. I did.
"Do you think I'm going to die?" she asked. I swallowed.
"This is serious," I said. "But I'm concentrating on you getting well again."
Pamela Hinds, RN, PhD, DS; J of Ped Onc Nsg, 11(2), 1994

Slide 47

Pass Me the Blue
"Pass me red," she commanded. I did.
"I figured out it's serious," she said,
"And I'm thinking the same thing you are. But if I die, will you be there?"
"Yes, for sure," I said.
"O.K., good," she said. "Pass me the blue."
Pamela Hinds, RN, PhD, DS; J of Ped Onc Nsg, 11(2), 1994

Slide 48

We estimate that it will cost \$1.4 million per year to provide universal access to hospice for terminally ill Oregonians who remain uninsured. Ironically, those for and against Oregon's assisted suicide initiative spent a total of \$4.6 million in advertising for the intensely debated November 1997 election to retain or eliminate Oregon's assisted suicide law. That is enough money to fund access to hospice for every dying Oregonian for 3 years.

Slide 49

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If so much money can be found to fight battles over differing moral views, it seems reasonable to expect that, as a society, we can agree to fund access to high-level end-of-life care, including hospice care for all terminally ill Americans, thereby ensuring a *true* choice about end-of-life treatment.

-Susan Tolle, MD (1998)
Oregon Health Sciences University

Slide 50

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Eliminating Death, Disease by Disease

The tacit message of the research agenda is that if death itself cannot be eliminated - no one is so bold as to claim that it can - then at least all the diseases that cause death can be done away with. As William Haseltine, chairman and chief executive officer of Human Genome Sciences, has put it, "Death is a series of preventable diseases."

-Callahan, 2000

Slide 51

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Eliminating Death, Disease by Disease

From this perspective, the researcher is like a sharpshooter who will pick off the enemy one by one: cancer, then heart disease, then diabetes, then AIDS, then Alzheimer's disease, and so on. The human-genome effort, the latest contender in the battle against death, will supposedly get to the genetic bottom of things, radically improving the aim of the sharpshooter.

-Callahan, 2000

Slide 52

For every birth, someone long ago happened to notice, there is one death. We cannot and will not change that fact. But we can change the way people are cared for at the end of life, and we can substantially reduce the burden of illness. It is not, after all, death that people seem to fear the most, and certainly not in old age, but a life poorly lived. Something can be done about that. -Callahan, 2000

Slide 53

“Too Many Words. . .
Let Them Just See What We Do.”
-Mother Teresa

Slide 54

City of Hope Pain Resource Center
(COHPRC)
Ph: 626/359-8111, x 63829
Website: <http://prc.coh.org>

***PLENARY
ADDRESS***

***CONCURRENT
ABSTRACT
PRESENTATIONS***

"GROWING UP IN PIECES": ADOLESCENTS WITH PERVASIVE DEVELOPMENTAL DISORDER (PDD) TRANSITIONING INTO ADULTHOOD
AUTHOR: GERALDINE S. PEARSON, RN, CS, PHD

Purpose and Rationale: The purpose of this descriptive study was to ascertain the experience of adolescents with PDD who have transitioned into a supervised apartment setting associated with an adult mental health services provider. In this study, adulthood was arbitrarily defined as the point an individual turns age 18. All of the participants in this research had been diagnosed during childhood or adolescence with PDD. This was a requirement for entry into this structured apartment program.

Research Questions: The central research questions and directive emerged from the experiences I have had with children and adolescents with PDD. These questions were: What is the lived experience of adolescents with PDD who have transitioned into a supervised apartment setting with an associated adult services model of care? How do participants perceive their current functioning and the process of their transition into independent living in The Special Populations Project, one step in the developmental transition to adulthood?

Synthesis of Review of Literature: Transition into adulthood is a developmental outcome of late adolescence. The transition to an independent living situation, for all adolescents, represents a normalizing task towards adulthood. For some adolescents with Pervasive Developmental Disorder (PDD) transition to independent living occurs against a back-drop of impaired social relatedness, lengthy out-of-home placements, limited family support, and limited financial resources. Meleis and Trangenstein's (1994) concept of transitions as a central concept of nursing was used to guide the study.

Method/Procedures: Descriptive qualitative research methodology was used to analyze data. Purposive sampling was used to recruit participants. Ten individuals volunteered to participate in a face-to-face interview that occurred in their apartments. A semi-structured interview was used to gather data around living environment, presentation of self, personal history, and relationships with others. The predominant request posed to participants was: "Tell me about something that has happened in the last few months that helped you understand that you were growing up and becoming more independent in your living". Thematic analysis then occurred with all interview data.

Results: This research resulted in a number of themes. Descriptions of the growing-up event were clustered around issues of increasing independence, clarification of relationship with mother, and accountability. Other identified themes included unrealistic goals for the future and poor physical health. The predominant and unexpected theme from all participant interviews involved chronic sorrow. Participants were sad about their life situations, what they were missing, and what they lacked in social relationships. This study described the life situations of ten impaired participants involved in a structured independent living situation within a community.

Discussion/Application to Practice: This study resulted in numerous nursing implications. The co-morbid physical and mental health needs presented by participants was immense. As nurses we need to be aware of the quality of life issues around managing a severely impaired population attempting to live within a community. The presence of chronic sorrow undoubtedly influenced functioning and also seemed to need ongoing intervention. On another level, the research illustrated the merger between clinician and researcher in conducting the interviews and reporting the interview data.

Ref: Meleis, A. I. & Trangenstein, P. A. (1994). Facilitating transitions : Redefinition of the nursing mission. *Nursing Outlook*, 42, 255-259.

LIVED EXPERIENCE OF NAUSEA IN PERSONS WITH AIDS

Elizabeth H. Anderson, PhD., APRN, University of Connecticut School of Nursing
Margaret H. Spencer, MS, APRN, Trinity Hill Care Center

Purpose & Rationale: Purpose was to describe the lived experience of nausea in persons with AIDS. With HIV/AIDS, 95% adherence to antiretroviral drug regimens is necessary for viral suppression and prevention of mutant strains. Persons with AIDS often experience nausea that impacts medication adherence, eating, and living a normal life. Understanding how nausea influences the life of a person with AIDS is essential for quality nursing care.

Research Question: What is the lived experience of nausea in persons with AIDS?

Review of Literature: In a 13 city study in France, physicians recognized nausea in HIV-infected persons only 39% of the time. In the U.S., nurses underestimated the frequency and severity of symptoms in newly admitted AIDS patients. Nausea was accurately detected 27% of the time. No study described the lived experience of nausea in persons with AIDS.

Methods/Procedures: Design was phenomenological. A purposive sample of 48 men and women with AIDS were interviewed. Average age was 42 ($SD = 8.3$) years with mean CD4 count of 156 ($SD = 169$) and Viral Load of 153,451 ($SD = 92,366$). Mean time from HIV diagnosis to interview was 106 ($SD = 63.2$) months. Participants were asked to respond to the following statement, "Please describe your experience of nausea including your physical symptoms, thoughts, feelings, perceptions, and its meaning in your life." Bracketing past experience, one researcher experienced in phenomenology conducted all interviews until saturation was achieved. Using Colaizzi's Phenomenological method, transcripts were tape recorded verbatim and read several times. Significant phrases/sentences were identified and meanings formulated then clustered into themes. Results were integrated into an exhaustive description. Application of credibility, auditability, and fittingness ensured methodological rigor.

Results: From 48 transcripts, 221 significant statements were extracted. Three themes emerged: Swimming Against the Current, Caught in a Riptide, and Navigating Turbulent Waters. Water was the unifying symbol in this study because it varies from streams that are easy to navigate to oceans that ravage ships. It is a force that exerts power through waves and tides and like nausea comes and goes. A riptide or strong undertow can pull a swimmer into great depths against his will. Continuous small drops of water can erode rock. Likewise, nausea over time can erode the human spirit. It takes great mental physical, and psychological fortitude to swim in or navigate a boat in a raging sea. So also patients exhibited great courage in taking medications that caused nausea.

Discussion/Application to Practice: Nausea can be an overwhelming physical and psychological symptom that impacts the human spirit. Feelings of fear, anxiety, worry, hopelessness and helplessness were dominant. Persons with AIDS persistently and creatively struggled to manage nausea in order to take prescribed medications, eat, and live as near a normal life as possible. Some persons persisted in taking medications despite years of nausea. Nurses have the unique opportunity to assess nausea in persons with AIDS and to recommend ways to manage these symptoms. Helping patients manage nausea may be key to medication adherence and reducing psychosocial stress.

Common Experiences Reported by Hospitalized Patients
Deborah Dillon McDonald, Karen Renstrom, Nicole Adams,
Tara Bernen, Gloria Kascak & Kristen Salisbury

Purpose & Rationale: Identifying the concrete experiences common to hospitalized patients might help people cope more effectively during their hospital stay.

Research Question: What concrete, objective experiences do the majority of adults experience during an inpatient hospital stay?

Conceptual Base: The Self-Regulation Theory of Coping suggests that providing people with concrete, objective information prior to a procedure allows them to develop a mental image of the event and cope more effectively. The basic components of the concrete objective aspects of a healthcare event include physical sensations and symptoms, causes of the sensations and symptoms, time, and the surrounding environment.

Design and Sample: A descriptive survey design was used. The sample consisted of 86 randomly sampled adults who had been hospitalized during the past five years. The reasons for the hospital stay included 39.3% elective surgery, 28.6% medical, 16.7% childbirth, 10.7% non-elective surgery, 2.4% trauma, and 2.4% mental health.

Procedure: The Hospital Experience Survey was developed and pilot tested by the authors. The survey consisted of four open-ended questions measuring the major dimensions identified by Johnson (1999) for describing concrete objective experiences. Six trained interviewers used a computer-generated list of random Connecticut telephone numbers to interview the anonymous participants. Responses were hand recorded by the interviewers. Content analysis was used to examine the concrete objective experiences described by the participants. Pairs of trained raters independently analyzed the responses and then compared their results.

Results: Pain was the only common concrete sensation described by the majority of participants (n=52; 60.5%). One woman described her pain as if "someone stabbed me in the stomach." The remaining commonly reported sensations included immobility (18.6%), fatigue (14.0%), cardiac symptoms (14.0%), dyspnea (12.8%), nausea (11.6%), insomnia (7.0%), and confusion (5.8%). A total of 36 different sensations were described, reflecting a wide range of sensations from dry mouth to shivering. Participants easily identified causes, but few common causes existed. One participant described the cause of her sleeplessness as "It was never night...the hospital does not sleep." The most common response to how the hospital environment affected their hospital stay was that the hospital room was good (26.7%). Negative comments included having to share the room with another patient (10.5%), noisy environment (8.1%), and too many people (7.0%). One participant said his roommate coughed quite a bit and "I was concerned I would get sick from him." Twenty-one respondents (24.4%) stated that time passed slowly, while 15 (17.4%) stated that time passed quickly. Nine (10.5%) people remarked about having to wait. A 36 year-old with heat exhaustion stated, "It took them two hours to even get an IV started on me...that is frustrating and they didn't even look busy."

Discussion/Application to Practice: Pain was the only sensation described by more than 50% of the participants. The experience of being hospitalized appears to be highly individual. Interview excerpts provide compelling descriptions of individual hospital experiences. Excerpts from the interviews may help sensitize nurses to the impact that pain, noise, roommates, family presence, waiting, and other factors might have for hospitalized patients, making it possible for nurses to support patients with an even more positive hospital experience.

Postoperative Pain Communication Skills for Elders

Deborah Dillon McDonald, PhD, RN

Sheila Maloney, RN, MS, CS

Purpose: The purpose of this study was to test the effect of a pain communication intervention on elders' ability to communicate their pain and obtain pain relief after surgery.

Research Question: Do elders who are taught pain communication skills and basic pain management information experience less postoperative pain than elders taught only pain management information or elders not taught any additional information?

Framework: The intervention was based upon Communication Accommodation Theory (CAT) that describes specific communication skills helpful in managing a conversation.

Methods: A posttest-only experimental design was used to compare three groups: (a) elders receiving standard preoperative teaching, and viewing the pain management film and the pain communication film; (b) elders receiving standard preoperative teaching and viewing the pain management film; and (c) elders receiving only the standard preoperative teaching. The two films were professionally developed for the study, reviewed by an expert, and tested with a focus group of elders prior to use. CAT guided development of the pain communication film. Content for the pain management film was based on prior work by Ferrell, Rhiner & Ferrell (1993). Forty-one elders undergoing a single total knee replacement at two different hospitals were randomly assigned to one of the three conditions. All of the elders had attended a preoperative total joint replacement class (standard preoperative teaching) provided by the hospital, as part of their preparation for surgery. Elders in the two film conditions also received a colorful tri-folded handout summarizing the content of the film(s) they viewed. Average daily postoperative pain was measured with the Short Form McGill Pain Questionnaire on postoperative day 1, and 2, and 1 and 7 days after discharge by a research assistant blind to the condition. Two pain dimensions were measured, pain intensity (100 mm VAS) and sensory dimensions of pain (0 - 33 scale).

Results: Significant group differences emerged for the first postoperative day, $F(4,76)=2.96$, $p < .025$. Post hoc analysis with the Scheffe' test revealed that elders in the treatment group reported significantly less sensory pain than elders in the control condition with film, $M = 3.6$ ($SD=2.48$) and $M=8.7$ ($SD= 7.19$), respectively, $F(2, 38) = 4.21$, $p < .023$. The VAS pain intensity scores were $M=47.0$ ($SD=29.24$), $M= 41.1$ ($SD=23.16$) and $M = 31.7$ ($SD= 18.60$) for the control no film, control with film and treatment group, respectively.

Discussion/Application to Practice: A significant difference in the sensory dimension of pain emerged between elders in the treatment group and elders in the control condition with film. The pain intensity differences, although not statistically significant, suggest a clinically significant difference between the treatment and control groups, with treatment group elders reporting a pain intensity in the mild range and elders in the two control groups reporting a slightly higher pain intensity in the moderate range. The sensory and pain intensity results together suggest that teaching elders specific pain communication skills along with basic pain information before surgery might result in greater pain relief during the early postoperative period when pain tends to be most intense. Further refinement of the film intervention is needed so that greater pain relief might be obtained beyond the first postoperative day. Nurses and physicians can assist elders to use pain communication skills, for example by teaching them to describe the pain sensation in their own words, use a pain intensity rating scale, prioritize the pain topic when pain is a problem, and ask for clarification when they do not understand their pain management. Elders who effectively communicate their pain may be more likely to obtain greater postoperative pain relief.

The Effect of Psychiatric Diagnosis on Healthcare for Non-psychiatric Problems
Deborah Dillon McDonald, Beka Apostolidis, Brenda Armstrong,
Dawn Bernardo, Michael Frakes & Stephen Goldblatt

Purpose: The purpose of this study was to test how knowledge of a patients' psychiatric diagnosis might affect nursing care during an acute medical problem.

Hypotheses: Nurses in the psychiatric patient condition: (1) estimate a lower probability that the patient is experiencing a myocardial infarction; (2) estimate less time for nursing care; (3) delegate more patient care activities to ancillary staff; and (4) are less likely to identify additional ambiguous symptoms as evidence of a myocardial infarction, than nurses in the two control conditions.

Framework: Implicit Personality Theory suggests that people might unconsciously rely on external cues and stereotype people. Psychiatric medication revealed in a patient history might cause nurses to unconsciously stereotype the patient.

Methods: Sixty medical surgical registered nurses were randomly assigned to one of three conditions in this posttest only experiment. A pilot study was done to test the procedure and measures prior to the full study. All of the nurses read a brief patient vignette describing a man admitted to their floor from the emergency department with a possible myocardial infarction (MI). Nurses in control group #1 read the basic patient information about the patients' condition. Nurses in the control group #2 read this information, and that the person was on a common anti-anxiety medication. Nurses in the psychiatric patient group read the same basic information and that the person was on a list of medications used to treat schizophrenia. After reading the vignette the nurses estimated the probability that the person was having a MI. The nurses then estimated the time they would need to carry out each of 14 nursing actions relevant to the clinical situation. They also indicated whether they would carry out the actions themselves or delegate to ancillary staff. The final page described the patient with a sudden increase in anxiety. The nurses wrote how they would respond to this situation, and their responses were content analyzed by pairs of independent raters.

Results: Nurses in the psychiatric patient group estimated the probability that the patient was experiencing a MI at 35.0%, compared to nurses in control group #1 and control group #2 who estimated (50.6%) and (49.5%), respectively, $F(2,56)=3.21$, $p < .05$, effect size, .10. There were no significant differences between the groups for the time estimated for nursing actions or for delegation of activities. More nurses in control group #1 (78.9%) responded to the patient's increased anxiety as if it might be symptoms of an MI than did the nurses in the psychiatric patient group (45.5%), $\chi^2(1)=4.81$, $p < .03$.

Discussion/Application to Practice: The presence of psychiatric medications caused nurses reading the vignette to respond differently than nurses reading the control vignettes. The nurses estimated a lower probability that the patient was experiencing an MI and were less likely to respond to possible symptoms of a MI. Psychiatric patients with a diagnosis of rule out MI might be at risk for an inadequate response if they develop symptoms of an evolving infarction. Nurses who are aware of the potential to unconsciously stereotype medical patients with psychiatric

E-mail: beka001@aol.com
badauph@aol.com
dnhx4@hotmail.com
mafrakes@aol.com
stevergoldblatt@myeastern.com

Covert Bias in Evaluation of Associate Degree Nursing Students' Clinical Performance

Author: Joanne Anfinson Phd, CS, RN

Purpose and Rationale: Nursing education programs rely on nurse educators to evaluate the performance of students during clinical affiliations. The purpose of this study was to determine whether covert bias exists in the evaluative judgments of Associate Degree nurse educators. It is possible that ethnic minorities are being excluded from the profession if academically capable minority students do not graduate because of covert bias. If this is the case increasing faculty awareness may ultimately increase the numbers of ethnic minority students graduating from ADN programs.

Research Question: Do faculty grading practices differ based on the ethnic/racial background of the student?

Synthesis of review of the literature: A review of the literature revealed studies which focus on (a) minority students' perception of their educational program (Kirkland, 1998; Langston Moss, 1997; Lena, Jackonen, & Wilson, 1996; Tucker-Allen, 1991), (b) nursing students' perceptions regarding the clinical learning experience (Anfinson, 1993, Streubert, 1989, Windsor, 1987), (c) clinical evaluation (Haskins & Rose St Prix, 1997; Stewart, 1991; Easterling, 1989; Wigton, 1980).

Methods/Procedures. A convenience sample of 109 Associate Degree nurse educators from the New England area was selected. The subjects were all female (107 white, 1 black, and 1 other), mean number of years as nursing faculty 18.18 years (range of 1-36). Four female Associate Degree nursing students (1 white, 1 Hispanic, 1 Asian, and 1 black) were videotaped reciting identical scripts about a patient's status. Each subject was randomly assigned to one of four groups and read a case study about the patient, viewed a videotape, and rated the student's presentation on a form developed by the researcher adapted from a tool developed by Haskins and Rose-St Prix, 1997.

Results. The black, Asian and Hispanic students received higher ratings than the white student on attendance behaviors, accuracy, nonjudgmental statements, focuses on topic, communication of significant information and thoroughness. The Asian student received higher ratings than the black, Hispanic, and white student on attendance behaviors, nonjudgmental statements, objectivity focuses on topic, accuracy, and overall rating. The Hispanic student received the lowest rating on overall rating and the Asian student received the highest overall rating.

Discussion/Application to practice: Although in 9 of the 10 categories the ANOVA fails to reject the hypothesis that faculty grading practices do not differ based on ethnic/racial background of the student, there are noted differences in the students' ratings. The white student consistently received the lower ratings, despite reciting the identical script recited by the black, Asian, and Hispanic students indicating the white student may have been treated differently based on her personal style. The results of this study indicate that nursing faculty in the New England area are somewhat prepared to work with students of different racial or ethnic backgrounds. The study shows that there is a need for selected faculty to gain insight into their relationships and their attitude toward minority students and how these attitudes may be influencing student evaluation.

VALIDATING MATH COMPETENCY FOR MEDICATION ADMINISTRATION IN SCHOOLS OF NURSING IN THE UNITED STATES

John McNulty, RN, MS, BC
E. Carol Polifroni, RN, EdD, CNAA
Lynn M. Allchin, RN, PhD

Purpose & Rationale: The ability to both accurately calculate medication dosages and safely administer medications are essential nursing skills in the delivery of safe therapeutic patient care. A study conducted by the authors in Spring 2001 using Connecticut Schools of Nursing demonstrated significant issues with student's mathematical ability for medication administration. There was no clear standard in the 2001 study or in the literature related to what constitutes math competency validation. The purpose of this current study was to assess and describe current teaching and validation practices used in Schools of Nursing related to math competency for medication administration of nursing students in the United States.

Research Question: What are the current teaching and validation practices used in Schools of Nursing related to math competency for medication administration of nursing students in the United States.

Synthesis of Review of Literature: Several research teams have studied math competency for medication administration. Each team found students unable to pass the math competency exam. Ptaszynski & Silver (1981) had no student score over 80% and most scored below 70%. Bindler & Bayne (1984) tested students over a five-year period and had between 9-38% of each group tested score below 70%. Blais & Bath (1991) had 89% of the students score below 90%. Worrell & Hodson's (1989) review of accredited nursing programs in the US identified that 82% of the schools reporting found students deficient in math skills.

Methods/Procedures: Using the NLN four geographic regions, a randomized sample of 600 schools with proportionate representation of diploma, associate, and baccalaureate programs received a researcher-designed survey. The return rate was 54%.

Results: Initial data analysis yielded results remarkably similar to the data from the CT only sample. There is no standard used throughout the nation for math validation. Admission requirements in regard to mathematical competency differ from school to school with any relationship to passing scores on math validation assessments. Less than 20% of the students throughout the nation pass the math competency assessments with scores greater than 90%.

Discussion/Application: Mathematical validation for medication administration remains an issue. National data indicates the problem with limited math skills is widespread. An intervention needs to be designed and the authors are working with high school teachers to design such an activity. Further research will continue until a solution is found.

Acquired Mathematic Competencies of Beginning Baccalaureate Degree Nursing Students in the Northeastern Region of the Continental United States

Author: Daryle L. Brown, Ed.D., R.N.

Synthesis: literature review

According to some educators, mathematics is becoming less important to nurses and nursing curricula should reflect this. With unit dosages, use of calculators, and pharmacy preparations of medications, some question why nursing curricula should contain any mathematics. However, administration of medications is complex and multifaceted and nursing graduates must be able to consistently calculate medication dosages correctly. Although mathematic calculation is only one step in this process, it is an essential one, with potentially critical outcomes for patients.

A newly graduated registered nurse... was asked to give $\frac{1}{8}$ grain of morphine to a small, gravely ill elderly woman. Reasoning that if $4 + 4 = 8$, then $\frac{1}{4} + \frac{1}{4}$ must equal $\frac{1}{8}$, the nurse gave two $\frac{1}{4}$ grain ampules of morphine, which so depressed the patient's respirations that she nearly died.

Purpose/Research Question: What are the acquired mathematic competencies of beginning baccalaureate degree nursing students in the northeastern region of the continental United States?

Method/Procedures: This study was designed to determine baccalaureate nursing students' mathematic competencies. Participants were 230 beginning baccalaureate students from 11 National League for Nursing accredited programs in the Northeastern United States.

Subjects were invited to participate in the study by taking an anonymous test. Students who signed a consent form were administered the Computational Arithmetic Test adapted from the Cooperative Guidance and Placement Program of the College Board (CGP) (KR-20 = .88).

Results: The mean test score was 76.3%. Because 75% is passing for most colleges, students appeared mathematically prepared. When the mean of individual test items was examined, problems became evident. At least 70% of the students correctly calculated answers to all but one item involving addition, subtraction, multiplication, and division of whole numbers. When items dealt with fractions, decimals, or percents, correct responses ranged from 38.3% to 91.7%: 9 items had a correct response rate < 70%, and 3 had a correct response rate < 50%. These three items involved changing a fraction to a decimal, changing a decimal to a fraction, and dividing mixed numbers, common calculations in medication administration.

Discussion/application: Medication administration demands the ability to calculate dosages correctly. Nurse educators should not assume students have the mathematic skills needed for medication calculation. To ensure safe medication administration, faculty must actively help students become mathematically competent by analyzing SAT mathematic scores for incoming students, requiring entering students to take University placement tests in mathematics and providing remediation if needed, administering a mathematics skills test every semester, requiring students to seek remediation if needed, assigning one faculty member to work consistently with these students and, monitoring student drug dosage calculation skills throughout the curriculum.

***POSTER
PRESENTATIONS***

POSTER CRITERIA FOR AWARDS

We welcome your participation in selecting outstanding poster presentations for recognition awards. First, second and third place ribbons will be awarded to posters judged to be worthy of merit. During the 9:15-9:45 AM break, conference participants should:

1. Review all poster stations located in the Formal Lounge area. *Poster tables will be numbered.*
2. After reviewing all poster stations, use the poster criteria described below to choose the *ONE* poster that you felt best meets the awards criteria. Circle rank score for chosen poster.
3. For the poster you choose, assign the poster number (number on the table) on this form.
4. Fold the form in half and place in the labeled box on the Registration Table by 10:00 AM. *All voting must be completed by 10:00 AM as box will be removed for tabulating at that time.*
5. Ribbons will be awarded by the Awards Committee. Winners will be acknowledged at 2:15 PM, in the Heublein Hall, immediately following completion of the Plenary Address.

POSTER CRITERIA FOR AWARDS

POSTER # _____ Scale: 1=Poor 2=Fair 3=Good 4=Very Good 5= Excellent

CRITERIA	RANK				
1. Poster is attractive and draws attention (good use of color, pictures, graphs, etc.)	1	2	3	4	5
2. Important descriptors included in presentation.	1	2	3	4	5
3. Statistical findings & analysis included and was easy to understand (if N/A, delete this item)	1	2	3	4	5
4. The presentation "flows" from the study hypothesis (research question) to design, implementation, results and conclusions, in an organized fashion.	1	2	3	4	5
5. Implications for change in practice evident.	1	2	3	4	5
6. Viewer is able to grasp the total message in 5 minutes or less.	1	2	3	4	5

NOTE: All completed ballots for poster awards must be in ballot box by 10:00 AM. Please remember to only vote for ONE poster. Thank you.

**PARTNERS IN CARE: Applying
Best Practice to Enhance Relationships in Health Care**

**POSTER PRESENTATIONS
9:15-9:45 AM, ERC Formal Lounge**

Development of the Short-term Antibiotic Scale: Qualitative Study for Item Generation.

Barbara Aronson, MSN, CS, Assistant Professor, Southern CT State University, New Haven, CT.

What Would it Mean to Owners to Have Their Pet(s) Visit in the Hospital: A Qualitative Study. Lynn Allchin, RN, PhD, Assistant Professor, UCONN School of Nursing, Storrs, CT. and Laura Scarpa, RN, Lawrence & Memorial Hospital, New London, CT.

Comfort Levels of Nursing Students and Faculty Regarding Clinical Assignment to a Patient with AIDS. Anne Durkin, PhD, RN, BC, Assistant Professor, Quinnipiac University, Hamden, CT.

Negotiating Health Care with a Managed Care Corporation when Benefits Have Been Denied. Carol Williams, DNSc, RN, Associate Professor, Central CT State University, New Britain, CT and Judith Pollmann, RN, Eastern Kentucky University Department of Nursing.

Evaluation of a Volunteer Program for Frail Hospitalized Elders. Christine Waszynski, RNC, MS, APRN, Hartford Hospital, Hartford, CT.

Self-medication Practices in Patients Taking Levo-thyroxine. Ruth Michel, Undergraduate Honors Scholar and Patricia Neafsey, PhD, RD, Associate Professor, University of CT School of Nursing, Storrs, CT.

A Comprehensive Model-Education and health Care Delivery (CM-EHCD). Carole Mensing, RN, MA, CDE, CNS, UCONN Health Center, Farmington, CT.

Care Map Interventions vs. Traditional Home Care Visits for Managed Care and Medicare Clients with CHF. Carol Williams, DNSc, RN, Associate Professor, Central CT State University, and Mary Thompson, RN, MS, Cardiac Clinical Specialist, VNA of Central Massachusetts.

Strengthening Shared Governance: A Baseline Study of RN Perceptions of the Distribution of Authority. Kathleen Stolzenberger, RN, MS, Director of Program Development and Karen Levine, RN, MSN, Director of Pregnancy & Birth Center, Middlesex Hospital, Middletown, CT.

The Effect of a Specialized RN Intervention Designed to Maximize Patient-Provider Relationships on Adherence to Anti-depressant Medications. Rose Maljanian, RN, MBA, Louise Reagan, APRN, Cathy Yavinsky, Nurse Director, Hartford Hospital, Hartford, CT.

Development of the Short-term Antibiotic Scale: Qualitative Study for Item Generation

Author: Barbara S. Aronson MSN, CS, APRN, PhD(c)

Purpose, Rationale, Research Question: Most people have difficulty taking their medications as directed even in a short course of treatment. Non-adherence to antibiotic regimens decreases treatment benefit and adds to the occurrence of antibiotic resistance. Understanding medication adherence from a patient's point of view is the first step in the process of designing effective nursing interventions to promote improved adherence in patients prescribed short-term antibiotics. The specific purposes of this qualitative study are to: identify patterns of medication taking behavior, factors that influenced adherence, and attitudes and beliefs about short-term antibiotic therapy in adults recovering from an acute infectious illness. Themes generated from this study, supported by previous adherence research will be used to conceptualize short-term medication adherence and to generate items for an instrument that will be used to predict the likelihood of adherence in clinical practice.

Synthesis of Review of Literature: A literature review can provide the basis for question formation in qualitative interviews. While it is often difficult to predict adherence, some patterns of non-adherent antibiotic taking have been identified in the literature. They include: failure to have the prescription filled, omission of doses, errors of dosage, errors in the time of drug administrations, and premature discontinuation of the drug. Other factors associated with non-adherence include: multiple drug therapy, complexity of dosing, frequency of administration, forgetfulness, the duration of therapy, and the presence of adverse effects. Patients are also less likely to be adherent when their initial symptoms resolve or improve, or if symptoms were never present. Other factors that may be associated with non-adherence include an inadequate patient-provider relationship, socioeconomic status, age, or inadequate financial resources. Patients may also be incapable of being adherent due to a poor understanding of the importance of therapy or the prescription instructions.

Method/Procedures: Approximately 8-10 adult, English-speaking patients will be recruited from an outpatient medical clinic at Hartford Hospital and invited to participate in the in-depth interviews in they meet inclusion criteria and are willing to sign a consent form. Data will be collected through semi-structured interviews and include open ended questions and cues based on known predictors of antibiotic non-adherence cited in the literature. Questions and cues will be modified as successive interviews are completed to explore new themes or concepts as they emerge. The interviews will be audio-taped and transcribed verbatim. The constant comparative method of analysis will be used to analyze the interview data and to generate themes that will be later integrated into items during the next phase of the instrument development process.

Results: This study is currently in progress

Discussion/Application to Practice: This qualitative study is the first step of a projected program of research aimed at the development and testing of an instrument that will be used to predict the likelihood of short-term antibiotic adherence. Based on responses to the instrument, nurses will be able to tailor their interventions to more effectively promote adherence for patients prescribed antibiotics, with the ultimate goal of enhancing treatment efficacy and reducing the occurrence of antibiotic resistance.

Abstract Title:

**What It Would Mean to Owners to Have Their Pet(s) Visit in the Hospital:
A Qualitative Study**

Author(s): Laura E. Scarpa (GN to RN), Lynn Allchin, RN, PhD.

Purpose & Rationale: It is important to explore with potential patients what it would mean to have their pet visit in the hospital. Personal pet visitation may be an important intervention that can be used to promote the health of pet owning patients.

Research Question: The research question was: What is the meaning of potentially having personal pet visitation in the acute care setting?

Synthesis of Review of Literature: Human-animal interactions are gaining recognition as a valuable relationship, and the components that make up this intricate relationship have been broken down and examined. Psychosocial, social, behavioral, and physical aspects of the human/animal bond have been explored. The benefits of human-animal interactions are many including enhancing human well-being and improving cardiovascular health. However, research on personal pet visitation in the hospital is limited.

Methods/Procedures: The research was conducted by the descriptive phenomenological method. Sixty-one pet owners, from a Southeastern Connecticut veterinary clinic, 18 years of age and older, voluntarily wrote answers to a survey question, "What would it mean to you to have your pet visit you if you were hospitalized?". The participants descriptive were analyzed using Giorgi's methodology.

Results: Three themes emerged from the data: Pets enhance the well being of their owners; pets are family; and concerns for the pets. A majority of the data supported that pets enhance the well being of their owners by bringing joy, comfort, and love to their lives. Parallel to enhancing the well being of their owners many people consider pets as part of their family. Participants suggested that a pet visit would be comparable to a family member visiting them in the hospital. Also emerged concerns for the pets, which covered concern for the pet in the absence of their owner, as well as concern about bringing a pet to the hospital.

Discussion/Application to Practice: Pets are important to people. They benefit people's lives immeasurably and their owners recognize this. The simple response to the research questions, "It would be wonderful" or "It would mean everything," shows that pets are truly a significant part of their owner's life and they are needed in times of stress and illness, such as when would be hospitalized. It is important that nurses and other health care professionals are aware of the potential benefits and the role that companion animals can have in promoting human health. Nurses can take an active role in advocating for pet visitation and enhancing pet owners well-being.

Comfort Levels of Nursing Students and Faculty Regarding Clinical Assignment to a Patient with AIDS

Purpose & Rationale: The purpose of this study was to examine the comfort levels of nursing students and faculty regarding clinical assignment to a patient with AIDS and to determine whether or not demographic variables predict students' comfort levels.

Research Questions: (1) What is the comfort level of nursing students, as measured by Form A of the Nursing Care Comfort Scale (Williams, Benedict, & Pearson, 1992), with respect to anticipating clinical assignment to a patient with AIDS? (2) What is the comfort level of clinical nursing faculty, as measured by Form A of the Nursing Care Comfort Scale (Williams et al., 1992), with respect to anticipating the supervision of a nursing student assigned to a patient with AIDS? (3) As assessed by multiple regression analysis, do the variables of age, education and experience reliably predict the comfort levels of nursing students with respect to anticipating clinical assignment to a patient with AIDS?

Synthesis of Review of Literature: A literature review reveals conflicting findings regarding students' reactions to caring for persons with AIDS. Some data show that nursing students have fear (Cornelius, 1999; Morgan & Grubb, 1999) and prejudice (Stewart, 2001) regarding caring for persons with HIV. Other findings suggest that nursing students do not consider themselves to be at great risk of contracting AIDS from caring for persons with the disease (Cole, 1996), and that students have positive attitudes toward caring for patients with HIV/AIDS (Ward, 1998). Little research has been conducted to investigate the responses of nursing faculty toward patients with AIDS.

Method/Procedures: This descriptive correlational study was carried out from July 17, 1999 through October 31, 1999. Nonrandom samples of nursing students ($n=122$) and faculty ($n=28$) were drawn from three baccalaureate programs in the northeast. Participants were asked to complete and anonymously submit a biographic questionnaire and the Nursing Care Comfort Scale. Participation was voluntary. Returning the completed questionnaires constituted consent to participate. Data analysis included descriptive statistics and multiple regression analysis.

Results: The answers to the research questions are as follows: (1) the mean comfort level of nursing students was 3.79 (1-lowest, 5-highest), $SD=0.90$; (2) the mean comfort level of clinical nursing faculty was 4.47, $SD=0.78$; (3) none of the independent variables was found to be a reliable predictor of comfort level for students.

Discussion/Application to Practice: Findings show that nursing students were less comfortable anticipating the care of a patient with AIDS than were faculty members anticipating the supervision of this care. Students may benefit from additional preparation and support before caring for patients with AIDS. Faculty members should not make assumptions about students' comfort levels regarding care of a patient with AIDS based on age, education or experience. Educators might consider devoting time during clinical conferences to discussion of the comfort levels students experience in response to anticipating or delivering care to a patient with AIDS.

Negotiating Health Care with a Managed Care Corporation when Benefits have been Denied

Carol G. Williams, D.N.Sc., R.N., Central Connecticut State University, Dep't of Nursing

Judith Pollmann, Ph.D., R. N., Eastern Kentucky University, Dep't of Nursing

This presentation explores theoretical concepts underlying negotiating care with a Managed Care Corporation when benefits have been denied. Storytelling is advanced as a method of experiential learning to change people's attitudes toward a situation/issue to enhance cognitive understanding. The story to be told is that of a colleague who has been diagnosed and treated for inflammatory ductal carcinoma of the breast. Critical thinking and analysis of concepts used as the story unfolded will be described through the qualitative research approach of storytelling. Hermeneutics is from Heidegger's Philosophy of Science. The Hermeneutic approach is a method of research which incorporates storytelling. This is a research method that asks the question, "What's going on here?". The qualitative approach of storytelling includes Observing, Listening, Writing, and Journaling. Journaling is for the purpose of conveying the complexity, depth, sensitivity, sadness and joy of the lived experience. Storytelling is useful in raising the consciousness of society often resulting in political action, as exemplified by numerous motion pictures, such as, One Flew Over the Cuckoo's Nest, And the Band Played On, Philadelphia, and A Civil Action. These examples dealt with such contemporary concerns as the need for psychiatric reform, AIDS incidence and discrimination, and giving voice to disenfranchised people experiencing death and disease from environmental pollution. The rationale behind this research is to share with professionals how Hermeneutics and Community Health Nursing theory along with experience enabled a team of nurses to negotiate with a Managed Care Corporation to change their decision in denying an autologous stem cell transplant. Only 2% of denials for services are ever reversed.. The decision in this situation was reversed within 30 hours.

E-mail: cgwnest@Juno.com

Evaluation of a Volunteer Program for Frail Hospitalized Elders

PURPOSE AND RATIONALE: Older hospitalized adults are at risk for many complications which often lead to poor medical and functional outcomes. Delirium occurs in 15-60% of hospitalized elderly and is associated with increased mortality, morbidity, extended hospital stays, delayed rehabilitation, increased rate of nursing home placement and hospital readmission. Persons with delirium display a variety of behaviors which put them at risk for significant sequelae such as restlessness leading to falls and injuries, disorientation and misinterpretation of the environment leading to disruption of medical devices required for treatment often resulting in chemical and physical restraint, urinary incontinence leading to skin breakdown and falls, inability to feed self leading to malnutrition. Delirium requires increased staff time to provide for care needs and supervision. Clearly, from a care and cost perspective, there is a need to investigate strategies to prevent, minimize and manage delirium.

RESEARCH QUESTION: Will implementation of a volunteer program to provide appropriate stimulation and distraction opportunities to high risk elderly prevent or minimize delirium and related sequelae?

SYNTHESIS OF REVIEW OF THE LITERATURE: The literature has described a positive effect of selected interventions with older adults in a variety of settings to decrease cognitive and functional decline. Innouye et al (1999 & 2000) designed a hospital based program that selected patients with at least one of six risk factors and implemented selected targeted interventions by an interdisciplinary team. They demonstrated a decrease in cognitive and functional decline, with a reduced overall hospital cost of \$1500 per patient. This program did not evaluate the effect of each intervention toward the outcome of decreased cognitive and functional decline. This study at Hartford Hospital is designed to investigate the effect of an individualized cognitive activity program on cognitive function and related sequelae in hospitalized older adults identified at high risk for delirium.

METHOD/PROCEDURE: 240 patients will be enrolled in the study; 120 from an orthopedic unit and 120 from a cardiology unit. Patients on each of the two units will be randomized to the intervention or control group. Persons in the intervention unit receive visits from a volunteer twice daily, who will conduct the individualized activity program. Each patient's cognitive status is assessed by the APRN upon admission and discharge and by the RN/PCA team every shift. Cognitive status of patients in the intervention group is also assessed by the volunteer at each visit. Tools used include the Folstein Mini Mental State Exam, The Confusion Assessment Method and the Clock Test. All charts are also reviewed for evidence of falls, injuries, medical restraints, psychotropic drugs, sitters, weight loss, iatrogenic consequences, length of stay and discharge destination. Three months after discharge, patients are contacted for a current address.

The design of this study is for two between group factors (floor and intervention) and one within group factor (time). The primary analysis will focus on the differences between the intervention and control group in delirium, falls, length of stay, psychotropic or anxiolytic drug use, sitter time, and will be performed using a Chi-square or t-test

depending on the variable type. A secondary analysis will assess subgroup differences for type of admission (floor).

RESULTS: Not yet available. Study is in process.

DISCUSSION/APPLICATION TO PRACTICE: Results will identify if a volunteer program that provides individualized activity programs for high risk hospitalized seniors can prevent or minimize delirium and its sequelae.

Self-Medication Practices in Patients Taking Levo-thyroxine

**Ruth Michel, Undergraduate Honors Scholar
Patricia Neafsey, PhD, RD, Associate Professor
University of Connecticut School of Nursing, Storrs, CT
Email: ruth.michel@uconn.edu**

Background:

Hypothyroidism affects 13 million people in the United States and is especially common in women. It is a condition in which the thyroid gland is under active and does not produce enough thyroid hormone. Fatigue, hair loss, weight gain, and muscle cramps can result. Fortunately, hypothyroidism can be treated with a daily dose of a prescription medication called levo-thyroxine sodium (Levoxyl, Synthroid or Unithroid). This drug is the 3rd most commonly prescribed drug in the United States.

Patients treated for hypothyroidism are at greater risk for osteoporosis, and are often encouraged to take calcium supplement, such as calcium carbonate. Calcium supplementation is the most common type of nutritional supplementation used in the United States, and is especially important for post-menopausal women. However, recent studies have demonstrated that taking calcium within four hours of levo-thyroxine may decrease absorption of levo-thyroxine in the body. Iron and magnesium supplements may also cause this interaction. A review of the information provided to most patients taking these two drugs suggested that many were probably unaware of this important interaction.

Objective and Methods:

The objective of this study was to determine how common it is for patients to take levo-thyroxine with nutritional supplements, especially calcium. A sample of 45 patients taking levo-thyroxine (mean age 51, n=38 women) responded to posters at local pharmacies announcing the study. They completed a telephone interview about their self-medication practices.

Results and Discussion:

Preliminary results show that over 80% of people taking a calcium supplement (n=21) were taking it within four hours of levo-thyroxine. 75% of people taking a multivitamin (n=23) also reported taking it within four hours of the levo-thyroxine.

These results suggest that a significant number of patients who are being treated for hypothyroidism may be self-medicating with calcium and/or multivitamins and may be uninformed about the interaction. This information is important to nursing, because nurses and nurse practitioners are essential to health teaching and should be made aware of this interaction.

A Comprehensive Model-Education and Health Care Delivery (CM-EHCD)

Carol Mensing, RN, MA, CDE, Clinical Nurse Specialist
UCONN Medical Center, Farmington, CT
mensing@nso.uhc.edu

Purpose and Rationale: Practitioners rely on models, resources to assist in successful, quality program implementation. Collaboration between four key players-*Patients, Provider/Clinicians, Administration and Community*- enhance this model's innovative approach. This poster introduces and describes an innovative comprehensive model (CM) for educational programming and health care, education delivery in the ambulatory or inpatient setting. Presented, is a diabetes-programming model successfully implemented in a variety of community settings, and replicated in chronic disease programs. Improved patient outcomes in evidence-based or best practice have been demonstrated.

Research Question(s): Will the use of the *Comprehensive Model: Education and Health Care Delivery (CM-EHCD)* achieve recognition and support timely implementation of a quality, comprehensive chronic disease program for better patient care?

Synthesis of Review of Literature: Only three models located in the literature were found to offer a strong support for several component parts to this model; none were reflective of this model's infrastructure. The Psychology Model (Peek-Heinrich), the Health Care Delivery Model (Nelson), and the Public Health Model (Johnson, Robert Wood). Each represent strong, replicable and operational models for their target audiences; each served to strengthen though not duplicate, the CM-EHCD approach. The original model is a synthesis of nursing theory (Fawcett, et al), the three above mentioned models, and CQI and business literature (Drucker, Berwick).

Methods/Procedures: The model has been successfully implemented in three of four communities. Developed in the early 80's as a diabetes program model, driven by standards for diabetes education, it has broadened to include a variety of chronic disease programs, including: CHF, HIV, Anticoagulation Therapy, etc. Each program utilizing the four axes and flow diagram including the component parts of: *Patients Educational programming, Provider/Clinician Education and Standard Care Delivery, Administrative Champion, and Community Interaction.*

Initial outcomes reflect accountabilities in patient care, administrative support, practitioner and community practices. Patient indicators have been studied (A1C changes, DQIP indicators measured) as well as patient, provider (onsite as well as community referral) satisfaction. Formative evaluation has been completed – the model changed from a vertical to horizontal. Pilot phase refined the model for practical implementation. Formal monitoring is currently underway, involving process and fidelity monitoring.

Results: Patient outcomes show significant decreases in A1C levels (-2.72), with an overall average decrease (-1.13). A1C testing annually has been increased to 100% of IMA patients reviewed. 73% of the patients seen by the diabetes education program team received eye exams, vs. 47% of patients not seen for education. Provider satisfaction is rated high achieving. Administration embraced the model, evidenced by its use with the Outpatient Anticoagulation Therapy and Outpatient Case Management Programs.

Discussion/Application to Practice: For all intent and purpose, this model broadens to support any type of health care program; i.e. topic specific or chronic disease. As represented here, it is repeatable, clinically and educationally operational, and a dependable, feasible Health Care implementation design, in readiness for any clinician, educator, practitioner to implement.

Care Maps™ Interventions vx. Traditional Home Care Visits for Managed Care & Medicare Clients with CHF

Carol G. Williams, D.N.Sc., R. N., Department of Nursing, Central Connecticut State University

Mary Thompson, M. S. , R. N., Cardiac Clinical Specialist, VNA of Central MA

This evaluation research was conducted to determine what types of visits and Care Maps™ are related to better functional status, quality of life, satisfaction with care, lower costs, and adoption of self-care behaviors. A quasi-experimental design with retrospective and prospective aspects was used. The sample was divided into 2 control groups and 2 experimental groups. Experimental group one of Medicare clients received care as designated by Care Maps™ (VNA First). Managed Care Plan (MCP) clients (group 2) received care according to revised CareMaps™ which condensed nursing care for each visit to correspond with the number of allowable visits for clients of a MCP. The control group received traditional care a year prior to use of CareMaps™. Experimental groups were compared for satisfaction with care, functional status, quality of life, self-care, rehospitalizations, and cost of care. Quality of life was also used as an independent variable to determine its relationship to self-care behaviors. Control group comparisons are limited to costs and functional status. Chart review was used for data collection for the control group; chart review and interview were the methods of data collection for the experimental groups. Results from comparisons of all subjects for changes in functional status from admission to discharge using paired t-tests will be reported; differences in functional status and costs across groups will be reported based on ANOVA. Independent t-test findings will be reported for group differences in quality of life and rehospitalizations.

Strengthening Shared Governance: A Baseline Study for RN Perceptions of the Distribution of Authority

Karen Levine, MSN, RN, Director, Pregnancy & Birth Center
Kathleen Stolzenberger, MS, RN, Director, Program Development
Middlesex Hospital, Middletown, CT
Karen_Levine@midhosp.org or Kathleen_Stolzenberger@midhosp.org

PURPOSE & RATIONALE: During the past two decades, over 1000 hospital nursing departments have made efforts to strengthen the practice climate by creating nursing council structures as the forum for shared decision making. However, research indicates that many organizations fall short of fully integrating shared governance because they fail to pay sufficient attention to developing clear and appropriate processes for decision making. Specifically, nurse leaders need to insure that decisions impacting professional practice are made by the right people with the appropriate authority to make autonomous or shared decisions. The purpose of this study is to establish a baseline description of hospital nurses' perceptions of the actual and ideal distribution of authority for decisions impacting nursing practice.

RESEARCH QUESTIONS: what are the perceptions of hospital nurses regarding the actual and ideal distribution of authority for decisions impacting nursing practice?
Is there a difference in perceptions of the distribution of authority among staff nurses, managers and administrators?

SYNTHESIS - LITERATURE REVIEW: Numerous studies cite the positive and significant effects of shared governance models on nurse satisfaction, autonomy, accountability, professionalism and retention. Consensus is that incorporating nurses into hospital policy setting as "empowered partners" (Porter-O'Grady, 1995, p. 21) and supporting their participation, power, and influence in matters regarding practice (Havens, 1992, 1996; Aydelotte, 1983; Begun, 1985; Kaluzny and Shortell, 1994) promotes anew organizational culture that capitalizes on nursing expertise in shaping decisions that promote high quality patient care. However, experts caution nurse leaders that transformation of the practice culture is an evolutionary process requiring three to five years to fully integrate the principles of empowerment, partnership, accountability, and equity that underlie the processes of shared decision making (Porter-O'Grady, 1996; Havens & mills, 1992). Current research recommendations include a call to clarify the definition, distribution, and extend of nurse decision making in acute care hospitals and to take strategic steps to strengthen shared governance by assessing, educating involving, and evaluating staff regarding practice decision making (Laschinger & Havens, 1994; Havens, 1996; Porter-O'Grady, 1996; Spooner, Keenan & Card, 1997).

METHODS & PROCEDURES: This is a single site survey of a random sample of 200 registered nurses at every level of employment at an acute care hospital in Connecticut. The survey used was the Haven's Distribution of Authority Scale with reported validity and reliability (Havens, XXX). **Sample size was determined.....(Add informed consent plans).**
Responses were coded by job level. Data were analyzed using descriptive statistics.

RESULTS: Results demonstrate aggregate findings based on the total RN sample and variations across positions. Findings illustrate differences between perceptions of actual and ideal distribution of authority.

DISCUSSION/APPLICATION TO PRACTICE: Significant differences exist between actual and ideal distribution of authority in the total sample and among RN job levels. Findings will be used to: 1/ guide further literature review; 2/ develop plans to further educate staff about shared governance and the nature of decision making; 3/ establish consensus on appropriate authority/venues for decision making at this site; 4/ identify priorities/strategies for strengthening shared decision making; 5/ evaluate progress toward implementation of a mature shared governance model.

Aydelotte, M. (1983). Professional nursing: the drive for governance. In N. Chaska (Ed). The Nursing Profession: a Time to Speak. (pp.830-842). New York: McGraw-Hill Book Company.

Begun, J. (1985). Managing with professionals in a changing health care environment. Medical Care Review. 42(1), 3-10.

Havens, D.S. (1996). Is governance being shared? XXX

Havens, D.S. & Mills, M.E. (1992). Staff nurse empowerment: Current status and future projections. Nursing Administration Quarterly, 16(3), 58-64.

Kaluzny, A. & Shortell, S. (1994). Creating and managing the future. In S. Shortell & A. Kaluzny (Eds). Health Care Management: Organizational Design and Behavior. (3rd ed.). Albany, NY: Delmar Publishers, Inc.

Laschinger, H.S. & Havens, D.S. (1996) Staff nurse work empowerment and perceived control over nursing practice: conditions for work effectiveness. Journal of Nursing Administration, 26(9), 27-35.

Porter-O'Grady, T. (1994). Whole systems shared governance: creating the seamless organization. Nursing Economics, 12(4), 187-195.

Porter-O'Grady, T. (1996). A mature shared governance system: more structure than substance. Journal of Nursing Administration, 26(2), 14-19.

Spooner, S.H., Keenan, R., & Card, M. (1997). Determining if shared leadership is being practiced: evaluation and methodology. Nursing Administration Quarterly, 22(1), 47-56.

Title: The Effect of a Specialized RN intervention designed to Maximize Patient- Provider Relationships on Adherence to Anti-depressant Medications

Principal Investigator: Rose Maljanian, Director

Co-Principal Investigators: Louise Reagan, APRN
Cathy Yavinsky, Nurse Director
Hartford Hospital, Hartford, CT

Project Coordinator: Cynthia O'Brien, RN Adv.

Abstract:

Depression affects nearly 25% of patients in urban Primary care practices. Only 40-50% of patients adhere to their prescribed medications. This study tests the following hypothesis: patients who receive an additional RN intervention focused on relationship and self management skills building will have:

- 1) better rates of adherence to anti-depressives
- 2) greater satisfaction with care and improvement in symptoms.

Within the framework of King's model for goal attainment, each nurse/patient interaction will be based on a mutual participation model where both are equal partners, working together to establish goals; the patient is an active participant in decisions and uses his own experience to provide cues for treatment. The nurse acts as facilitator as well as educator.

SKILL BUILDING SESSIONS

**9:45-10:50 am Searching the Research Literature
Robinson Library- ERC 3rd floor**

**9:45-10:50 am Statistics: What Do You Need to Know
ERC Room 218**

**11:00 am-12:20 pm Searching the Research Literature
Robinson Library – ERC 3rd floor**

RESEARCH ROUNDTABLE SESSIONS

- | | |
|--------------------------|--|
| 9:45-10:15 am | Ethnography
ERC Heublein Hall |
| 10:20-10:50 am | Focus Groups
ERC Heublein Hall |
| 11:00-11:35 am | Phenomenology
ERC Heublein Hall |
| 11:40 am-12:20 pm | Metasynthesis
ERC Heublein Hall |

EVALUATION FORMS

- 1. Keynote & Plenary Addresses**
- 2. Concurrent Abstract Presentations**
 - 9:45 AM Speakers**
 - 11:00 AM Speakers**
- 3. Skill Building Sessions**
 - Searching the Research Literature**
 - Statistics: What You Need to Know**
- 4. Research Roundtables**
 - Ethnography / Focus Groups**
 - Phenomenology / Metasynthesis**



EVALUATION FORM
DIVISION OF NURSING EDUCATION & RESEARCH
CONTINUING EDUCATION

TITLE OF COURSE: IMPROVING CARE AT END OF LIFE

DATE: OCTOBER 4, 2002

CE CODE 014-669A

- POSITION: Please fill in the bubble that corresponds with your job title.**
- | | | | |
|--------------------------------------|--|--|--|
| <input type="radio"/> RN | <input type="radio"/> ND/NM | <input type="radio"/> RESPIRATORY | <input type="radio"/> OFFICE CLERK |
| <input type="radio"/> LPN | <input type="radio"/> CLINICAL COORDINATOR | <input type="radio"/> PHARMACIST | <input type="radio"/> ADM. ASSISTANT |
| <input type="radio"/> NURSE EDUCATOR | <input type="radio"/> PCA/PSA/PAA | <input type="radio"/> DIETICIAN | <input type="radio"/> SUPERVISOR/MANAGER |
| <input type="radio"/> CNS/NP/APRN | <input type="radio"/> SOCIAL WORKER | <input type="radio"/> SECURITY OFFICER | <input type="radio"/> OTHER |

EDUCATION DESIGN: Please rank the following items with this numerical scale.

- ⓪ Not Applicable ① Strongly Agree ② Agree ③ Disagree ④ Strongly Disagree

Question 1: To what extent was the speaker(s) knowledgeable, organized and effective in presentation?

1. Speaker	BETTY FERRELL, RN, PhD	⓪	①	②	③	④
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EDUCATION DESIGN: Please rank the following items with this numerical scale.

- ⓪ Not Applicable ① Strongly Agree ② Agree ③ Disagree ④ Strongly Disagree

Question 2: To what extent were you able to meet the following Objectives?

NOTE: ↓ Fill in bubbles completely

1)	Describe the current national mandate for improved end of life care.	⓪	①	②	③	④
2)	Identify the importance of professional education in end of life care.	⓪	①	②	③	④
3)	Identify strategies for education/practice to improve care for the terminally ill.	⓪	①	②	③	④
4)	Did the objectives relate to the purpose/goal(s) of this educational activity? Purpose/Goal: Enhance care provider knowledge of end of life care issues for application to practice setting.	⓪	①	②	③	④

Place comments on back of form.



EVALUATION FORM
DIVISION OF NURSING EDUCATION & RESEARCH
CONTINUING EDUCATION

TITLE OF COURSE: HEALTH CARE RELATIONSHIPS: THE NEW FRONTIER

DATE: OCTOBER 4, 2002

CE CODE 014-669B

POSITION: Please fill in the bubble that corresponds with your job title.

- | | | | |
|--------------------------------------|--|--|--|
| <input type="radio"/> RN | <input type="radio"/> ND/NM | <input type="radio"/> RESPIRATORY | <input type="radio"/> OFFICE CLERK |
| <input type="radio"/> LPN | <input type="radio"/> CLINICAL COORDINATOR | <input type="radio"/> PHARMACIST | <input type="radio"/> ADM. ASSISTANT |
| <input type="radio"/> NURSE EDUCATOR | <input type="radio"/> PCA/PSA/PAA | <input type="radio"/> DIETICIAN | <input type="radio"/> SUPERVISOR/MANAGER |
| <input type="radio"/> CNS/NP/APRN | <input type="radio"/> SOCIAL WORKER | <input type="radio"/> SECURITY OFFICER | <input type="radio"/> OTHER |

EDUCATION DESIGN: Please rank the following items with this numerical scale.

- ⓪ Not Applicable ① Strongly Agree ② Agree ③ Disagree ④ Strongly Disagree

Question 1: To what extent was the speaker(s) knowledgeable, organized and effective in presentation?

1. Speaker	SALLY COHEN, RN, PhD, FAAN	⓪	①	②	③	④
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EDUCATION DESIGN: Please rank the following items with this numerical scale.

- ⓪ Not Applicable ① Strongly Agree ② Agree ③ Disagree ④ Strongly Disagree

Question 2: To what extent were you able to meet the following Objectives?

NOTE: ↓ Fill in bubbles completely

1)	Describe how nurses have contributed to the knowledge base of patient-clinician relationships.	⓪	①	②	③	④
2)	Identify gaps in research regarding patient-clinician relationships.	⓪	①	②	③	④
3)	Identify difficulties in researching adherence as an outcome of patient-clinician relationships.	⓪	①	②	③	④
4)	Identify major themes of an innovative framework for understanding healthcare relationships.	⓪	①	②	③	④
5)	Identify areas for future nursing research that emanate from this framework.	⓪	①	②	③	④
6)	Identify challenges in research dissemination related to this project.	⓪	①	②	③	④
7)	Did the objectives relate to the purpose/goal(s) of the education activity? Purpose/Goal: Demonstrate the contribution of research to the enhancement of patient-clinician relationships.	⓪	①	②	③	④

SAVE THE DATE

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Conference**

October 10, 2003

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7th Annual Research/Research Utilization Conference- October 10, 2003

***Theme: Prevention of Infectious Diseases: The
Public Health Nurse in All of Us***

Keynote Speaker: Elaine Larson, RN, PhD, FAAN, CIC

Dr. Elaine Larson is currently the Professor of Pharmaceutical and Therapeutic Research and Associate Dean for Research at the Columbia University School of Nursing. She also holds an appointment as Professor of Epidemiology within the Joseph Mailman School of Public Health at Columbia University.

From 1992-1998, she was Dean, Georgetown University School of Nursing and Associate Director of Nursing, Georgetown Hospital. Before going to Georgetown, she was the Nutting Professor of Clinical Nursing and Director of the Center for Research at the Johns Hopkins University School of Nursing. There she directed a postdoctoral program in infection prevention. Dr. Larson received a baccalaureate in nursing, masters of arts in nursing and microbiology, and doctorate in epidemiology from the University of Washington. She was a Robert Wood Johnson Clinical Nurse Scholar at the University of Pennsylvania.

Dr. Larson has served as a member of the NIH Study Section on HIV Infection, as the President of the Certification Board for Infection Control, as a member of nine journal editorial boards, an AHC scholar in Academic Administration & Health Policy, and as Director and then a trustee for the APIC Research Foundation. She has served on the President's Committee for Gulf War Veterans' Illnesses, the Board of Scientific Counselors, and National Center for Infectious Diseases, CDC, and was a member and then Chair of the CDC's Healthcare Infection Control Practices Advisory Committee (HICPAC), 1992-2000. She is currently a member of the Board of Directors, National Foundation for Infectious Diseases.

Dr. Larson has been Editor of the American Journal of Infection Control since 1994. She has published more than 200 journal articles, four books and a number of book chapters in the areas of infection prevention, epidemiology and clinical research, and has served as a consultant in infection control and nursing in international settings such as Kuwait, Jordan, Singapore, Japan, Australia, Ghana, Peru, Brazil, Spain, Portugal, France and Egypt.