KNOWLEDGE GAPS:

Let's Get Nursing Research Priorities Straight

11th Annual

Nursing Research
Evidence-Based Practice
Symposium

Thursday, November 7

2:30-3:00pm Registration, Poster Set Up

3:00-4:00pm Planning & Conducting Nursing Research: There's an App for That!
Sarah Manacek, MSN, RN

4:00-4:15pm Poster Set Up, Afternoon Break

4:15-5:15pm Turning your Dissertation into a Manuscript
Cheryl Tatano Beck, DNSc, CNM, FAAN

5:15-6:45pm Welcome, Reception, Poster Presentations

Friday, November 8

8:00-9:00am Registration, Posters, Continental Breakfast

9:00-9:15am Welcome, Introductions

9:15-10:15am Keynote Address - Developing a Program of Research: The Road Not Taken
Cheryl Tatano Beck, DNSc, CNM, FAAN

10:15-10:45am Morning Break; Posters

10:45-12:15pm Oral Presentations: A, B, C

12:15-1:15pm Lunch; Posters

1:15-2:15pm Oral Presentations: D, E

2:15-2:30pm Afternoon Break

2:30-3:00pm Oral Presentation: F, G

3:00-3:30pm Capstone Address

November 7-8, 2019

Hampton Inn
Colchester, Vermont

www.NursingResearchSym.org

Notes:

Continuing Education: This Continuing Nursing Education Activity was approved by the Northeast Multi-State Division, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation. This educational activity provides up to **7.0** nursing contact hours. The approval period of two years, October 16, 2021.

Activity No: 384-242-101119

Evaluations & Certificates of Completion: Please complete the online evaluation for the ORAL presentations in its entirety by day's end **Wednesday, November 13**. Certificates, including number of contact hours earned, will be emailed to those who complete their evaluations in this timely manner. The evaluation needs to be completed in one sitting. Certificates of Attendance with total earned contact hours will be emailed to attendees by **Friday, November 22**. To complete your evaluations, go to: **www.NursingResearchSym.org**

Poster Voting: In addition to the poster evaluation, you will have opportunity to vote for the best poster. Voting begins Thursday evening and concludes after lunch on Friday. The posters with the highest votes will be announced prior to the capstone address.

Welcome, Message from the Symposium Co-Chairs…

On behalf of this year's planning committee, thank you for joining us for the 11th Annual Nursing Research and Evidence-Based Practice Symposium. This year's theme, Knowledge Gaps: Let's Get Nursing Research Priorities Straight, was developed after the question was poised: Nurse researchers often find their niche topic, but how do they continue to make it relevant in a world full of research topics? We are fortunate to have keynoter Cheryl Tatano Beck, DNSc, CNM, FAAN with us to help us better understand how to develop a program of research - and continue to make that work relevant.

In its 11th year, the Symposium continues to showcase a sampling of the meaningful work that nurses in our region are investigating to improve healthcare outcomes. In keeping with the vision of the founder, Ann Laramee, the Symposium was one to bring a voice to nursing, at whatever level in which one practices; to showcase work from novice nurses to experts. It is with this vision that nurses learn and grow from each other. This work has had a huge hand in helping change the face of nursing outcomes through evidence-based practice, nursing research and quality improvement. As nurses, we encourage and enhance those around us to change the way in which we all practice. Whether you practice at the bedside, in a patient's home, in a clinic, or as an educator or nurse leader, the Symposium offers opportunities to network and learn about novel practice approaches. It allows the novice nurse researcher - as well as the expert to collaborate and share their work. The Symposium gives a voice to the hard work that we do. We continue to learn from each other, to grow with each other and initiate change by stimulating ideas and broadcasting ways in which we can affect patient outcomes in all areas of healthcare.

Special thanks to the planning committee for their time and efforts in creating this extraordinary annual event over the past year. We also extend a thank our devoted sponsors who, without their support, this experience could not happen. And last, a huge thank you to our dedicated Symposium director, Julie Basol, who keeps us on task and brings her expertise and wisdom to our team.

Jessica Sherman, DNP, MSN, RN-BC, PCCN-K
Program Co-Chair, 11th Annual Symposium
Jessica.Sherman@CVMC.org

Mary K Hill DNP, MSN, RN-BC, OCN, CHPN
Program Co-Chair, 11th Annual Symposium
Mary.Hill@VTC.edu

Program Planning Committee

- **JESSICA SHERMAN, DNP, MSN, RN-BC, PCCN–K**
  Program Co-Chair, 11th Annual Symposium
  Medical-Surgical Nurse Manager
  The University of Vermont Health Network
  Central Vermont Medical Center (CVMC)
- **Mary K. Hill, DNP, MSN, RN-BC, OCN, CHPN**
  Program Co-Chair, 11th Annual Symposium
  Associate Nursing Professor, Fanny Allen/Williston Campus
  Vermont Technical College
- **MARCIA BOSEK, DNSC, RN**
  Associate Professor, Department of Nursing
  College of Nursing & Health Sciences
  University of Vermont
- **TARA EBERE, BSN, RN**
  Director, Magnet Program
  The University of Vermont Health Network
  Champlain University Physicians Hospital (CVPH)
- **CARLYN HAAG, BMS, RN-BC, CCRN-K**
  Nursing Research and Clinical Practice Director
  The University of Vermont Health Network
  Champlain Valley Physicians Hospital (CVPH)
- **LINDA HAVEY, DNP, RNC-OB**
  Unit Manager, Birthing Center
  The University of Vermont Health Network
  Porter Medical Center
- **CAROL L. HODGES, MSN, RN-BC**
  Nursing Education Coordinator
  Northeastern Vermont Regional Hospital
- **RANDY KELLEY, DNP, RN, CCRN**
  Assistant Professor, Department of Nursing
  State University of New York College at Plattsburgh
- **ANN LARAMEE, MS, ANP-BC, ACNS-BC, CHFN, ACHPN, FHFSA**
  Nurse Practitioner, Palliative Care and Cardiology
  University of Vermont Medical Center
- **KAREN MCKENNY, BSN, RN**
  Nurse Educator
  University of Vermont Medical Center
- **SUZANNE MURDOCK, DNP, APRN, GNP-BC**
  Director, Nursing Outcomes, Practice, & Systems
  University of Vermont Medical Center
- **CHRISTINE ROVINSKI-WAGNER, MSN, APRN**
  National Transformational Coach Captain
  Veterans Health Administration,
  Office of Veterans Access to Care, Washington, DC
- **PAULETTE J. THABAULT, DNP, ANP-BC, JD, FAANP**
  Director and Professor, School of Nursing
  Norwich University
  Adult Nurse Practitioner
  Community Health Centers of Burlington

Developing a Program of Research: The Road Not Taken

Cheryl Tatano Beck, DNSc, CNM, FAAN
Distinguished Professor, School of Nursing
University of Connecticut

KEYNOTE

Dr. Cheryl Tatano Beck is a Distinguished Professor at the University of Connecticut, School of Nursing. She also has a joint appointment in the Department of Obstetrics and Gynecology at the School of Medicine. Her Bachelor of Science degree in Nursing is from Western Connecticut State University. She received her Master's degree in maternal-newborn nursing from Yale University. Cheryl is a certified nurse-midwife. She received her certificate in nurse-midwifery also from Yale University. Her Doctor of Nursing Science degree is from Boston University. She is a fellow in the American Academy of Nursing.

Dr. Beck has received numerous awards such as the Association of Women's Health, Obstetric, and Neonatal Nursing's Distinguished Professional Service Award, Eastern Nursing Research Society's Distinguished Researcher Award, the Distinguished Alumna Award from Yale University School of Nursing, the Centennial Award for Excellence from Western Connecticut State University, and the Connecticut Nurses' Association's (CNA) Diamond Jubilee Virginia A. Henderson Award for her contribution to nursing research and CNA's Mary Jane Williams Life Time Achievement Award. Cheryl also received the Sustained & Influential Leader Award from the Eastern Nursing Research Society and Outstanding Alumna Award from Western Connecticut State University.

Cheryl has focused her research efforts on developing a research program on postpartum mood and anxiety disorders. Based on the findings from her series of qualitative studies, Cheryl developed the Postpartum Depression Screening Scale (PDSS) which is published by Western Psychological Services. She is a prolific writer who has published over 150 journal articles and 20 book chapters. Cheryl is co-author with Dr. Denise Polit of the textbook, Nursing Research: Generating and Assessing Evidence for Nursing Practice. Editions of this text received both the 2007 and the 2011 American Journal of Nursing Book of the Year Award. Their Essentials of Nursing Research textbook won the 2013 AJN Book of the Year Award. Cheryl co-authored with Dr. Jeanne Driscoll Postpartum Mood and Anxiety Disorders: A Clinician's Guide which received the 2006 American Journal of Nursing Book of the Year Award. In addition Cheryl has published other books including *Traumatic Childbirth* and *The Routledge International Handbook of Qualitative Nursing Research*, *Developing a Program of Research in Nursing*, *Secondary Qualitative Data Analysis*, and *Writing in Nursing: A Brief Guide*.

Sponsors ~ special thanks for your support!

GOLD SPONSORS

- The University of Vermont Health Network, Central Vermont Medical Center
- University of Vermont, Department of Nursing
- University of Vermont Medical Center, Nursing Education & Research Department

SILVER SPONSOR

- Vermont Technical College, Department of Nursing

BRONZE SPONSORS

- Norwich University, School of Nursing
- Rutland Regional Medical Center
- The University of Vermont Health Network: Home, Health & Hospice
- The University of Vermont Health Network, Champlain Valley Physicians Hospital
- Vermont Department of Health, Division of Maternal & Child Health
- White River Junction VA Medical Center, Veterans Education & Research Association of Northern New England

CONTRIBUTORS

- American Nurses Association - Vermont
- Northeastern Vermont Regional Hospital
- Omega Mu at-Large Chapter, Sigma
- Sigma Theta Tau – Kappa Tau Chapter, Sigma
- State University of New York College at Plattsburgh, Department of Nursing

Oral Presenter Lineup

ORAL PRESENTERS, see following pages for abstracts.

A The Lived Experience of Shutdowns for Adults on the Autism Spectrum
Laura Lewis, PhD, RN
Assistant Professor
University of Vermont
[Nursing Research]

B Delphi Study Identifies Core Components of Nurse Competency Framework
Susan Boyer, MEd, DNP, RN-BC
Executive Director
Vermont Nurses in Partnership
[Nursing Research]

C Lessons from New Zealand: Nurses' Role in Dementia Diagnosis and Care
Mary Val Palumbo, DNP, APRN, GNP-BC
Nurse Practitioner/Professor,
College of Nursing & Health Sciences
University of Vermont
[Nursing Research]

D POD Nursing: A Team-Based Approach to Quality Care
Jessica Sherman, DNP, MSN, RN-BC, PCCN-K
Nurse Manager, Medical-Surgical
University of Vermont Health Network,
Central Vermont Medical Center
[Quality Improvement]

E Preparing Frontline Nurse Leaders for Peer Review: An Evidence-Based Practice Project
Suzanne Murdock, DNP, APRN, GNP-BC
Director, Nursing Outcomes, Practice and Systems
University of Vermont Medical Center
[Evidence-Based Practice]

F Restraint Minimization to Improve Veteran Safety & Satisfaction
Renee Sylvies, RN, MSN, CEN
Clinical Nurse Educator, Emergency Department
VHA Buffalo Health Care System
[Quality Improvement]

G Is Your Nursing Practice Evidence Based?
Marcia Bosek, DNSc, RN
Associate Professor,
College of Nursing & Health Sciences
University of Vermont
[Nursing Research]

Notes:

The Lived Experience of Shutdowns for Adults on the Autism Spectrum

Laura Foran Lewis & Kailey Stevens

Purpose & Background: An autistic meltdown is an event in which an individual on the autism spectrum loses control of behavior in response to an overwhelming situation. Meltdowns are typically characterized by intense verbal and/or physical reactions such as screaming, crying, or kicking, but anecdotal evidence and gray literature suggest that many adults experience autistic catatonia, or "shutdowns," instead of meltdowns in response to stress. There is limited research on autistic shutdowns, and no studies have explored this phenomenon from the perspective of those who have lived it. The purpose of this study was to explore the experience of having an autistic shutdown.

Methods: In this descriptive phenomenology, a purposive sample of 33 adults who had experienced an autistic shutdown were recruited via online message boards and forums to participate in asynchronous online interviews. Responses were analyzed using Colaizzi's (1978) method. Interview transcripts were read and significant statements were extracted. Meanings for each statement were formulated and clustered to identify themes from the data. Themes informed an exhaustive description and fundamental structure of the phenomenon, which were shared with nine participants for feedback and verification of findings.

Results: Eight themes emerged from the data. Participants described *precipitating social and/or sensory stressors*, such as bright lights or attending a party, that led up to the shutdown experience. They described *intense negative feelings* like sadness and fear that escalated as stressors increased. Eventually this negativity reached a *threshold where they felt they lost control*, marking the start of the shutdown. During the shutdown itself, participants described an *inability to respond to surroundings*, often reporting a loss of ability to move or speak. They also experienced a *desire to escape* from the situation and a *focus on meeting basic needs and survival*. Ultimately the shutdown would end with *removal from the stressful situation*, either by physically moving away or by the stressors being eliminated. Participants described a *recovery period* of exhaustion following shutdowns that lasted from hours to days.

Discussion/Conclusions: Shutdowns are undesirable responses to stress that affect the wellbeing and safety of those experiencing them. Due to the loss of control and perceived immobility during shutdowns, participants described an inability to remove themselves from potentially dangerous situations. Understanding the shutdown experience offers nurses the opportunity to guide individuals on the spectrum and their loved ones on ways to support, intervene, and potentially even prevent shutdowns. For example, by identifying precipitating stressors and feelings associated with shutdowns, participants described a window of opportunity to take action prior to the threshold when they lost control. Loved ones should be guided to assist in removing sensory and social stressors when witnessing a shutdown.

Next Steps: Future studies should explore the use of an educational approach to assist individuals on the autism spectrum in identifying early signs of shutdowns and strategizing ways to remove stressors prior to reaching the shutdown threshold as a potential means to prevent these events.

Delphi Study Identifies Core Components of Nurse Competency Framework

Susan Boyer, MEd, DNP, RN-BC

Purpose and Background: This study sought to determine expert consensus on, and prioritize, core Nurse Competency Program components that apply across the continuum of transition to initial practice, new specialty practice, a new role, or within general nursing orientation.

When working to update and optimize the transition program for transition to specialty in a major tertiary care center, the literature review found no synthesis of current nurse competency models, objectives, and components to inform program development (van Rooyen, et al, 2018). This identified a knowledge gap, as work in the agency introduced several concepts that were unfamiliar to the nurse leadership team. A limited leadership survey was completed as part of data collection for the project (Boyer, et al, 2017), then the team developed a modified Delphi Study to seek consensus of expert opinion on optimal and necessary program components.

Methods: The modified Delphi Study plan received a letter of exemption after IRB review by *Integ Review IRB*. The plan involved survey procedures for data collection and use of a *research advisory team* for data management, study fidelity, review of modifications, and to ensure an audit trail for study progression (Avella, 2016; McPherson, et al, 2018). Ayre and Scally's (2014, p. 85) table of exact values for content validity ratio validated a minimum sample size of 50 with at least 65% agreement on importance. The initial list of program components evolved from the leadership survey completed in the prior specialty residency project. Then three rounds of Delphi surveys identified, expanded upon, clarified, merged and then ranked core components within a nurse competency or transition program. The study recruited *a purposive participant sample* that draws on expert practitioners in the field of nurse competency validation. Participants were recruited via cyber-communications and professional networks to gain feedback from multiple geographic regions, specialties, and practice levels. Demographic info allowed data sorting based on participant background and experience. The study facilitator managed and modified the list of core elements with research advisory team oversight.

Results: The final Delphi round obtained responses from 118 Nurse Leaders with competency or transition program experience. Optimal framework factors were identified within 20 specific elements for Nurse Competency Program delivery with clarifying examples or rationale for each. The final round of survey responses ranked the importance of components and added to the clarifying comments. Quantitative data analysis resulted in greater than 80% agreement on importance of all 20 core program elements, with the majority ranking 91% or higher.

Discussion/Conclusions: This modified Delphi Study established consensus on core components for a nurse competency program while offering a suitable process for data collection within professional practice. Programs for on-boarding and transition to specialty practice require evaluation for efficacy due to the complexity and high acuity environment in which care providers engage experiential learning. The Delphi Study process delineated a list of 20 elements required for an optimal program, along with rationale and further explanation of each.

Identify Next Steps: Dissemination of this work includes solicitation of further research studies. The identified list of program components forms the foundation for an evaluation tool to be used for competency program assessment. This session supports two considerations; 1) sharing core program components as identified; while also 2) discussing potential applications of Delphi methodology for supporting professional development challenges and data needs.

Lessons from New Zealand: Nurses' Role in Dementia Diagnosis and Care

Mary Val Palumbo DNP, APRN, GNP B-C; Betty Rambur PhD, RN, FAAN;

Lori McKenna MSW, LICSW

Purpose & Background: Primary care in Vermont (VT) is experiencing an important transition from fee-for-service to outcomes-based healthcare. A healthcare workforce with skills in chronic disease management is needed to assure quality care; however, this has been slow to become a reality, particularly regarding the care and management of persons with Alzheimer's disease (AD), and their family caregivers. It is estimated that 17,000 Vermonters will have AD by 2025 (Alzheimer's Association, 2019), representing an increase of 30%. Because of this, and the projected increase in the population over the age of 65 in VT, primary care for Vermonters with AD and their family caregivers critically deserves more attention. International exemplars hold promise for analysis and selective adoption across the globe (Hallberg et al., 2013). One such model, New Zealand's (NZ) Health Pathway for Cognitive Impairment and Dementia Care, is a community/person/family centered model with essential nursing roles. The purpose of this study was to describe the model, including its policy, practice and workforce implications.

Methods: The study setting was the two largest cities in NZ, Auckland and Wellington. A qualitative descriptive design (Sandelowski, 2000, 2010) using semi-structured interviews was used. Critical case purposive sampling of primary care offices and the Ministry of Health was undertaken, followed by snowball sampling. Sixteen interviews spanning 20 minutes to one hour were conducted. Five general practitioners, two nurse practitioners, five nurses, one psycho-geriatrician, two case managers, four social workers, two family carers, and four employees of the New Zealand Ministry of Health were interviewed. The interviews were audio-recorded and transcribed verbatim. Qualitative content analysis was used and the Guba and Lincoln (1994) approach to quality employed.

Results: The findings informed a thematic illustration of the pathway, that will be presented, highlighting six main themes and describing the nurses' role in each: 1. National standards create a progressive pathway; 2. Standards include making the diagnosis and assessing caregiving support; 3. The burden of care is eased by education, cultural sensitivity, and respite; 4. Adaptive teamwork enhances access to care and assures person/family centered care delivery; 5. Home is the preferred setting; and 6. Workforce rewards and challenges are present.

Discussion Conclusions: The use of a "dementia care pathway" provides nurses and other healthcare professionals, patients, and families with structure and resources that are necessary to proactively monitor individuals and provide optimal care from dementia diagnosis to end-of-life.

Next Steps: Lessons learned from this research will help inform a new design for dementia diagnosis and care that will be centered in primary care practices in Vermont. Adequate knowledge, resources, and support will be necessary in order to implement an evidence based practice dementia care model.

POD Nursing- A Team-Based Approach to Quality Care

Jessica Sherman, Lacey Clark, Brian Plante, Erin Burrell, Paige Picard

Purpose & Background: A three hallway, 38-bed medical-surgical unit in a community hospital transitioned from random patient assignment development to a geographically located team-based approach known as POD Nursing. The purpose of POD Nursing were to make it easier to match assignments between nurses, allow for easier bedside shift report handoff, improve the team's satisfaction, improve patient safety by reducing falls, and ultimately improve patient satisfaction.

Methods: The leadership team on the unit started by developing a Likert scale (Strongly Disagree, Disagree, Agree, Strongly Agree) Pre-Survey via Survey Monkey that asked: "Our assignments create efficiency in my work flow", "The assignments help ensure good team work among coworkers", and "The assignments allow me to safely care for my patients". There was one open-ended question asking for feedback on patient assignments. The leadership team then educated staff on the POD Nursing design and recruited Champions to help in implementation. The three hallways were turned into four PODs (9-10 patients/POD). Two to three RNs and 1 LNA were assigned to each POD. The team was instructed to chart in their POD so that they could always visualize their call bells. Go live was in January of 2019. Data was collected on Falls/1000 patient days and call bell volume in comparison with total in and out-patient days from August through April. This was done to compare historical data to current data of the POD Nursing implementation. A Post-Survey via Survey Monkey was sent to the team in May 2019 asking the same 3 questions along with an open-ended asking for comments or concerns related to POD Nursing assignments.

Results: Forty-eight (48/100) staff members responded to the Pre-Survey. 52% of the team "disagreed-strongly disagreed" that the assignments created efficiency in workflow, 54% "disagreed-strongly disagreed" that the assignments ensured good teamwork, and 46% "disagreed-strongly disagreed" the assignments allowed for safe care. The open-ended concerns from the staff were that the assignments felt "random", "unsafe", created "wasted time" searching for team members across the unit, and promoted "poor teamwork". Fifty-one (51/100) staff members responded to the Post-Survey. 78% "agree-strongly agreed" that the assignments created efficiency in workflow, 71% "agreed-strongly agreed" that the assignments ensured good teamwork, and 84% "agreed-strongly agreed" the assignments allowed for safe care. The open-ended comments/concerns from the staff discussed some inconsistency in the RNs and LNAs being assigned to strictly one POD and not crossing into other PODs, patient acuity needs to be considered when assignment is made, "having patients in close proximity of one another is good for safe and timely care", and patient care is "easier and more effective" within a POD model.
The average falls/1000 patient days rate for the months of August through December was 4.79. Since the POD Nursing design began, the average has decreased to 4.27 (January through March). The medical-surgical unit received higher in and out-patient volumes January '19 -March '19 than had been seen August '18-December '18; however, the call bell volume notably decreased each month January through March.

Discussion/Conclusions: POD Nursing is making a positive impact on care delivery and staff satisfaction. The nursing staff shared in the Post-Survey feeling the assignments in the POD Nursing model creates improved safety and efficiency in patient care, as well as a teamwork driven work environment. There is still improvement to be made on developing assignments consistently within a POD as well as considering patient acuity. The data demonstrates that improvements have been made in falls and call bell volume by the RN and LNA being geographically located near their patient assignment.

Next Steps: Continue to share data progress and review Post-Survey results with the team. Further education with the relief charge nurses on assignment creation within the POD Nursing model. Continue to collect falls/1000 patient days and call bell volume data. Make modifications as needed and evaluate.

Preparing Frontline Nurse Leaders for Peer Review: An Evidence-Based Practice Project

Suzanne Murdock, DNP, APRN, GNP-BC

Introduction: Nurse peer review (NPR) is defined by the ANA as "the process by which practicing registered nurses systematically assess, monitor, and make judgements about the quality of nursing care provided by peers as measured against professional standards." NPR can measure the quality of nursing practice against established standards, identify strengths and weaknesses in practice, and identify knowledge gaps. Studies of NPR focus on clinical nurse attitudes and knowledge after educational intervention and implementation barriers, but do not provide robust information on how to promote adoption. A literature review provided evidence that frontline nurse leaders (FLNL) can positively influence adoption of new practices such as NPR if they feel confident in demonstrating new skills needed. As transformational leaders, FLNL are expected to coach and support their staff, but there is little formal guidance offered on how best to do this. The project organization plans to implement peer review for all nurses in the coming year.

Purpose: To engage FLNLs in a program designed to improve confidence in and perceptions of NPR and prepare them to support staff in future NPR implementation. The project introduced Kamishibai or K-cards, which will be used with the clinical NPR process.

Methods: The Research Protections Office's online assessment indicated the project is not research. FLNLs were invited to attend a presentation on NPR and watched a video demonstration of the process. Later, they were paired with a FLNL and participated in role specific K-card based NPR on their units. They completed pre and post-assessments of confidence in and perceptions of the NPR process, which were paired for analysis with participant created unique identifiers. The outcome of interest was FLNL confidence in and perceptions of NPR processes. Completion of the assessments was considered consent for participation and FLNLs could drop out of the project at any time.

Results: 43 FLNL were invited, 26 attended training and 17 participated in NPR. Paired *t*-Tests showed statistically significant improvements in both confidence in implementation of NPR and perceptions of NPR for the 17 participants. Greatest improvement in confidence was in explaining K-cards (118%), explaining NPR principles (69%), identifying FLNL importance in success with NPR implementation (68%), and techniques to provide NPR (72%). The greatest positive change in NPR perceptions included giving feedback on quality of care (27%), comfort giving or receiving feedback (both 15%), and receiving feedback on unit's quality of care (15%).

Discussion: NPR education with an opportunity to practice in "real life" improved the confidence of FLNL in NPR best practice and perceptions, which may help FLNL roll out NPR to staff. Having confidence in their knowledge may enable FLNL to respond more effectively to staff questions. Anecdotally, FLNL identified knowledge gaps in key practices that should be addressed. Limitations included the lack of valid tools for assessing FLNL's NPR confidence and increased patient census during the project, limiting participation of many FLNL.

Next Steps: After completing the roll out of the project to remaining FLNLs, the process will be brought to clinical nurses and licensed nursing assistants on inpatient units through the organization's Professional Governance structure.

Restraint Minimization to Improve Veteran Safety & Satisfaction

Carol Ann J. Hayes, EdD, MSN
Kristin Kowalske, MSN
Michelle Alt, EdD

Purpose & Background:

Physical restraint in a hospital is undesirable, albeit common. It entails the use of devices to restrict patient's freedom of movement preventing them from disrupting medical treatment or causing harm to themselves or others. Joint Commission Standards 01.03.03 & 03.05.07, call for clinically justified restraint only "when warranted by patient behavior that threatens the physical safety of patient, staff, or other". Healthcare providers should first try other methods to safely control a patient and use restraints only when other means are ineffective. The literature suggests that using physical restraints is often associated with undesirable physical and mental outcomes, such as pressure ulcers, urinary retentions, fear, anger, anxiety, and self-esteem. The objectives of this quality improvement project were to reduce restraint episodes and hours, through the research of alternatives to restraint and staff education to reduce hours of necessary restraint within one healthcare system.

Methods:

A multidisciplinary team reviewed local policy and evidenced based practice. A multifaceted intervention plan was implemented including non-restraint alternatives such as mittens, new clinical education aimed at bringing awareness to the contraindications of restraints and new alternatives to restraints, and more timely provider order re-assessments.

Results:

Over a two-year period, non-violent restraint episodes in the medical-surgical unit decrease by 87%, violent restraint episodes (behavioral) decreased by 33% and the intensive care unit restraint episodes decreased by 93%. Of episodes that did require restraint in the above wards, the hours of restraint decreased 91%, 84.7%, and 93% respectively.

Conclusion:

Results show that the intervention of restraint educational programs and the addition of alternative choices for restraints, safely decreases restraint use and improves patient satisfaction. Local policy was revised to reflect practice changes.

Next Steps:

Sustainment through an audit committee and diffusion via regional VHA Quality Improvement Forum.

Is Your Nursing Practice Evidence Based?

Marcia Bosek DNSc, RN

Purpose/Background: Evidence-based practice (EBP) is the standard of care for nursing practice. Although most nurses hold positive attitudes about EBP, a disconnect appears to exist between their beliefs and clinical implementation. The purpose of this study is to describe how confident registered nurses are about their ability to implement EBP into their nursing care.

Methods: A descriptive non-experimental survey design was used. The Evidence-Based Practice Self-Efficacy Scale (EBPSES) (Cronbach's $\alpha > 0.94$) with demographic questions was disseminated electronically to a population of 1200 registered nurses after gaining IRB approval.

Results: Ninety-seven nurses started the survey, however only forty-nine nurses (90% female, 78% Bachelors prepared, 67% worked full-time) completed the survey. Four (9%) subjects noted having an EBP mentor at work. Fourteen subjects (29%) had participated in an EBP project. Subjects were most confident ($\bar{x} > 90\%$) about their ability to routinely ask questions about their practice. Subjects were least confident ($\bar{x} < 60\%$) about their ability to (1) organize the necessary support and procedures to make a nursing practice change based on evidence and (2) activate the process to implement an evidence-based practice change.

Discussion/Conclusion: It is unclear whether the 50% non-completion rate is related to the EBPSES tool (was it perceived as being too hard?) or the subjects' EBP skills. Confidence in asking clinical questions reflects the first step in the EBP process. Further investigation is needed to understand the disconnect between the ability to identify evidence and resources, and their ability to implement EBP change in the clinical setting.

Next Steps: Further research is needed to understand the educational and clinical facilitators and barriers that influence a nurse's confidence and ability to implement EBP change.

Poster Presenters

POSTER PRESENTERS, see following pages for abstracts.

1 Structured Interdisciplinary Rounding Tool in Moderate Sized Rural Hospital Decreases Patient Length of Stay
Kathleen Boyd, MSN, RN, RN-BC, CCM, NE-BC
Rutland Regional Medical Center
[Evidence-Based Practice]

2 Infection Control Standards of Central Venous Catheters
Douglas Sutton, MSN; Sammy Pham, MD; Jenny Chen, MPH; Heidi Sutton, MSN, Joseph Shields, MD; Christopher Morris, MD; Geoffrey Scriver, MD; Anant Bhave, MD
University of Vermont Medical Center
[Quality Improvement]

3 Professional Development: NLN Core Competency III and Assessing the Behavioral Intentions of Nurse Educators to Assess and Evaluate Pre-licensure Nursing Students
Karen Cote, MSN, RN-BC;
Vermont Technical College
[Nursing Research]

4 An Intraprofessional Approach to Identify and Address Social Determinates of Health in a Community Hospital Setting: a Roadmap to Successful Recovery
Samantha Helinski, MSN, RN, CWOCN, CCCTM;
Jennifer Wasilauskas, MSN, RN, CNOR, ONC;
Karyn Brower, LMSW
Rutland Regional Medical Center
[Quality Improvement]

5 Bringing Preop Care to the Patient on the Inpatient Unit
Julie Dufresne, BSN, RN, CAPA
University of Vermont Medical Center
[Quality Improvement]

6 Ultra Rapid Opioid Detoxification vs. Conventional Detoxification in Relation to Sobriety at 6 Months
Mary Jane McMahon, BSN, RN, CCRN-CSC
University of Vermont Medical Center
[Evidence-Based Practice]

7 Do Patients With a History of Intravenous Drug Use (IVDU) Requiring Long Term Antibiotics Require a Prolonged Hospitalization?
Christina Bushey, RN, VA-BC
University of Vermont Health Network,
Champlain Valley Physicians Hospital
[Evidence-Based Practice]

8 The Effect of Dance Therapy on Mobility in Patients with Parkinson's Disease
Anya Hoagland, BSN, SN; Shakirah Mukandekezi, SN
Norwich University
[Evidence-Based Practice]

9 Does Aromatherapy Make Good Scents for Oncology Patients?
Stephanie Rettew, BSN, RN, OCN
Staff RN
University of Vermont Medical Center
[Quality Improvement]

10 Insulin Pumps and the Bedside Nurse: Do We Know What We Need to Know
Elizabeth Lawliss, BS, BSN RN, RN-BC, CMSRN
The University of Vermont Health Network,
Champlain Valley Physicians Hospital
[Evidence-Based Practice]

11 The Prevalence of Post-Intensive Care Syndrome (PICS) in a Community Hospital
Emily Reding, BSN, RN, CCRN
The University of Vermont Health Network,
Champlain Valley Physicians Hospital
[Nursing Research]

12 Acute Care Nurse Practitioner as a Hospitalist: Role Description
Laura Cohen, DNP, ACNP-BC, ANP-BC, MSN
Rutland Regional Medical Center
[Quality Improvement]

13 Efficacy of Standardized Patients in Simulation: An ADN Students' Perspective
Nicole Dragoon, MSN, RN, OCN
University of Vermont Medical Center
[Quality Improvement]

14 Psychobiotic Utilization in the Treatment of Anxiety and Depression
Benjamin Brown, SN
Jess Webber, SN
Norwich University
[Evidence-Based Practice]

15 Effects of Reducing Weight Bias and Stigma in Healthcare Settings on Health Outcomes for Patients with Obesity: A Review of the Literature
Paulette Thabault, DNP, APRN, JD, FAANP
Amy Blair, RN
Norwich University
[Evidence-Based Practice]

16 Putting the Squeeze on LE Edema
Christine Rovinski-Wagner, MSN, ARNP
Kathryn Karg Gutierrez, BSN, RN
Veterans Administration Medical Center, WRJ
[Quality Improvement]

17 Using a Nursing Executive Assessment Tool to Enhance Nurse Leaders Self-Efficacy
Carolyn Stannard-Carlo, RN, MS, DNP Student
Vermont Technical College
[Quality Improvement]

Structured Interdisciplinary Rounding Tool in Moderate Sized Rural Hospital Decreases Patient Length of Stay

Kathleen M. Boyd, MSN, RN, RN-BC, CCM, NE-BC

Purpose: The purpose of this study was to demonstrate the benefits of a structured and scripted Interdisciplinary Rounding process and tool in driving positive patient outcomes including decreased length of stay and improved team communication.

Background: Effective patient care communication and collaboration are essential to positive patient outcomes, e.g., decreased length of stay, and prevent adverse events related to miscommunication, e.g., medication error during a patient's acute hospital stay. According to The Joint Commission (TJC) approximately 65% of sentinel events occurs as a result of communication breakdown (Cornell, Townsend-Gervis, Vardaman, Yates, 2014). To ensure superior outcomes the vision of the Rural Hospital is to be the best community hospital in New England, and the intent is to do so through superior preventative, collaborative, and integrated care. Prior to 2017 interdisciplinary rounding did not occur on the inpatient units. Rounding consisted of a physician, and the case manager, who would see patients daily. Rounding times varied and multi-disciplinary communication was fragmented, inconsistent, and did not include all members of the patient's care team. According to Terra (2015) a structured communication process which includes a tool that covers essential topics which contribute to care planning is key to a successful multi-disciplinary rounding process.

Methods: An integrative literature review was conducted to determine the best approach to ensure a successful change project. A strength, weaknesses, threats, and opportunities (SWOT) analysis was conducted at the start of the project and individuals were identified who would be critical in overcoming the weaknesses and threats. Stakeholders were identified and a timeline was developed. Using a combination of formative and summative assessments outcome metrics were displayed using a balanced scorecard.

Results: Through the use of a scripted and structured rounding process and tool the average length of stay for the adult population decreased from 4.13 days to 4.04 days. Additionally, care/orders were clarified 79% of the time thereby decreasing risk of error.

Discussion: Utilizing a structured multi-disciplinary rounding process and scripted tool has many benefits, including decreased length of stay and improved multi-disciplinary communication. Additional benefits include staff engagement and improved relationships.

Next Steps: Continued monitoring is paramount to ensuring the success of the project. Additionally, a re-evaluation of the script is warranted to make sure Organizational change initiatives, e.g., Do Not Resuscitate bracelet are captured on the script to foster superior outcomes.

Infection Control Standards of Central Venous Catheters

Sammy Pham, MD, Douglas Sutton, MSN, Jenny Chen, MPH, Heidi Sutton, MSN,
Joseph Shields, MD, Christopher Morris, MD, Geoffrey Scriver, MD, Anant Bhave, MD

Background:

There has been a growing concern in the IR practice regarding rising central venous catheter (CVC) infection rates. Infections continue to remain one the main complications of CVC, with catheter-related bloodstream infections occurring between 3-8% of inserted catheters in the US. This study aims to investigate the impact of introducing new infection control practices on CVC infection rates in an outpatient setting.

Methods:

We looked at data on 3,820 chest ports placed between 2003 and 2017 at our outpatient facility. For our analysis we considered central blood stream infection, localized infection, septicemia, septic shock, and non-healing margins as infections related to chest port removal. From 2003-2008 there was a steady increase of post-procedural CVC infections, reaching annual infection rates up to 3.9%. In alignment with CDC and SIR recommendations we adopted additional infection control standards to deal with these rising infection rates. The actions we took were: 1.) adoption of the AORN guidelines for sterile field and tray preparation, 2.) development of technologist competency training for standardization of sterile field and tray preparation, 3.) standardizing education and training required by the technologist staff on sterile field and tray preparation, and 4.) changing our skin disinfection solution from betadine to 2% chlorhexidine solution.

Results:

Following the implementation of these standards we observed a steady decline in CVC infection rates between 2008 and 2014 with infection rates dropping as low as 0.88% in 2014. However, we noticed the trend in CVC infections began to rise again (2015-2017). We reinvestigated the process to discover that infections were likely occurring as a result of care and maintenance after insertion. When monitoring trends in infection occurrence we observed patients becoming infected within a 10 to 14 day window after insertion. This new data motivated the adoption of additional sterilization practices in our facility, the disinfection of the nares and chest before CVC procedures.

Discussion:

In this retrospective single center review, the introduction of several infection control guidelines has helped decrease rising CVC infection rates. However, we recognize that quality improvement is an ongoing exercise and we continue to monitor causes of CVC infections and stay up to date on infection control best practices.

Next steps:

The data collection will need to continue and determine the effectiveness of the changes in the disinfection process is significant. The current thinking is to monitor the addition of the nares and chest disinfection prior to the procedure.

Professional Development: NLN Core Competency III and Assessing the Intentions of Nurse Educators to Assess and Evaluate Pre-licensure Nursing Students

Karen Cote, MSN, RN-BC

Purpose and Background: Within their scope of practice, nurse educators must remain competent in eight National League of Nursing (NLN) Nurse Educator Core Competencies. The focus of this presentation will be on core competency III: the use of assessment and evaluation strategies. The literature demonstrating the number of faculty who are deficient in this competency is overwhelming and can place the safety of the public in harm's way by allowing an unsafe nursing student to enter professional nursing practice. The purpose of this study was to determine if there was a change in the behavioral intentions of nurse educators in assessing and evaluating their current body of nursing students after the participation in a professional development session.

Methods: The instrument utilized in this study was the Continuing Professional Development (CPD) Reaction Questionnaire. This is a 12 item questionnaire adapted to meet the objectives of the session and assesses the impact of a continuing professional development session has on the behavioral intentions of healthcare professionals. Participants (n=4) are asked to complete the questionnaire prior to the session and immediately after the session.

Results: Results were compiled, analyzed, and interpreted using Minitab statistical software. A 2 sample paired t-test was ran to determine if there was difference in the means of each session. As a whole, it was demonstrated that there was an increase in the behavioral intentions to assess and evaluate pre- licensure nursing students after attending this professional development session.

Discussion/Conclusion: Prior to the session, current behavioral intentions of Nurse Educators were inconsistent. The reasons for the inconsistencies were unknown as the tool utilized did not capture this data. This study did not discuss how it would be determined that nurse educators would be following through on stated intentions. This project demonstrates the importance for continued professional development of today's nurse faculty. With a lack of education in this core competency, educators can be allowing unsafe nursing students to enter the workforce, placing the welfare of the public in harm's way.

Next Steps: Due to the small sample size in one region of the author's state, it is recommended to implement this professional development session to a larger group of nurse educators in a larger region to determine if the study is valid and reliable. Lastly, further research is needed to determine how a lack of knowledge in any of the NLN Nurse Educator Core Competencies can impact student readiness for practice, patient outcomes, and violations within the Code of Ethics for Nurses.

An Intraprofessional Approach to Identify and Address Social Determinates of Health in a Community Hospital Setting: a Roadmap to Successful Recovery

Samantha Helinski, MSN, RN, CWOCN, CCCTM ,
Jennifer Wasilauskas, MSN, RN, CNOR, ONC, Karyn Brower, LMSW

Purpose & Background: The purpose of this study is to identify evidence based practice (EBP) predictive tools to assess for and address the needs of patients coming into the hospital electively for orthopaedic procedures and urgent circumstances; including multiple comorbidities impacted by social determinates of health. The goal to proactively screen patients for these needs and deploy resources was identified by the Orthopaedic RN Clinical Liaison and the Transitional Care RN and MSW Liaisons to positively influence health and our community. Historically, unscreened patients may not have all social determinate needs addressed which led to unmet needs impacting recovery negatively which led to poorer outcomes, and readmissions.

Rationale and Significance: In 2018 CMS removed knees from the inpatient only list of elective orthopaedic procedures. Following was the need to prepare patients and their care teams for rapid throughput with proactively planning for discharge prior to procedure. Similarly, non-elective hospital discharges needed screening to assess outside influences negatively influencing health; mitigating social determinates and setting up patients for improved supports at discharge.

Methods: A systematic literature search was done to evaluate tools to for populations identified. The Orthopaedic elective surgery provider's evaluated patient's needs preoperatively. Retrospective case studies identified the predictive qualities of tools to calculate patient needs and reduce untoward outcomes such as infection and readmission. The tools identified were the Charlson Co Morbidity Index (1987) and the Risk Assessment and Prediction Tool (2001) and were adapted to form the JIPT (2018) tool. Transitional Care adopted a screening tool, the Psychosocial Community Care Plan (PSCP) Assessment (Blue Print for Health, 2017). This combines questions from multiple EBP tools the Patient Health Questionnaire, the Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences, the Hunger Vital Sign, Columbia Suicide Severity Rating Scale, and the Hurt, Insult, Threaten, and Scream.

Results: Optimizing patients prior to surgery, the institution responded to CMS guidelines and increased volume while maintaining the expected or better standard of care. Transitional Care was able to implement a standardized tool for screening patients early to improve outcomes.

Discussion/Conclusions: Implementation of the JIPT and PSCP provides standardized tools by proactively screening patients early in their encounter establishing a robust plan of care, reducing duplication, avoidable reasons for health disparity, length of stay, and readmission.

Next Steps: Discuss opportunities for greater patient centered care coordination to reduce gaps in transitions of care to help facilitate aging in place and a healthier community.

Bringing Preop Care to the Patient on the Inpatient Unit

Julie Dufresne, BSN, RN, CAPA

Background: Issues identified with the practice of bringing patients from the inpatient unit to a surgical admissions area, prior to entering the operating room, inspired staff to embark on an improvement initiative to bring preop care to the patient on the inpatient unit. These issues included interruptions to continuity of care (multiple transitions of care/handoffs), inability to maintain same level of care/services as on the inpatient unit, patient/family satisfaction, Preop staff satisfaction, Preop space constraints, and throughput issues impacting outpatient flow.

Purpose: The Purpose of this evidence based practice project was to examine the practice of bringing preop care to the patient on the inpatient unit and its' effect on: continuity of care, level of care, patient and family satisfaction, staff satisfaction, and throughput/flow.

Methods: A review of the literature was completed using the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed and Ovid Medline (1946 to present) and grey literature searches of Google Scholar using the following terms: Patient flow, capacity management, queuing analysis in health care, variability management, coordination of care, care transitions and handoffs, and duplicating care/services.
Forty-five articles were reviewed and thirteen articles were selected for appraisal using the JHNEBP model. One article was appraised to be at Evidence Level III and the remaining twelve articles at Evidence Level V.

Results: No articles were found directly addressing bringing Preop care to the inpatient unit. The closest parallel process found in the literature, from a 1987 article, a new concept at the time, described bringing physical therapy to the patient on the inpatient unit versus bring the inpatient to the physical therapy gym. Relevant articles found addressed theories of throughput such as; Lean methodology, Six sigma methodology, and Variability (natural vs. artificial) methodology. Other articles addressed benefits of limiting care transitions/handoffs, patients receiving care in the appropriate setting, patient focused care, patient satisfaction, and staff satisfaction.

Discussion/Conclusions: Translation of the findings from the literature review supported the proposed benefits of bringing preop care to the patient on the inpatient unit. As a result, Preoperative Services staff have decided to continue with the practice change, working with stakeholders, establishing guidelines, and driving positive change. Throughput times, patient and staff satisfaction will be monitored to determine the impact of full implementations.

Ultra Rapid Opioid Detoxification vs Conventional Detoxification in Relation to Sobriety at 6 Months

Mary Jane McMahon, BSN, RN, CCRN-CSC

Purpose & Background: As the opioid epidemic continues to surge, claiming and diminishing more and more lives, all options for improvement should be considered. Currently 130 people die each day from drug overdoses in the United States. In some states, there have been up to a 12-fold increase in hospital admissions due to drug induced infective endocarditis and up to a 13-fold increase in drug use-associated valve surgery. One option for improving the negative impact of opioid misuse is the use of anesthesia to support detoxification of substance abusers and promote earlier engagement in rehabilitation. The goal of this evidence-based practice project was to determine if anesthesia induced rapid opioid detoxification was of benefit to improve outcomes for substance abusers as measured by sobriety at 6 months.

Methods: A review of the literature was conducted using The Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Google Scholar, Ovid, and NIH using the search words opioid detoxification, rapid opioid detoxification, and ultra-rapid anesthesia induced opioid detoxification. 33 articles were found and evaluated. 12 articles were analyzed using the Johns Hopkins Nursing Evidence-Based Practice model and results were synthesized to determine effectiveness. Of these, two were Level IB, three were level IIA, one Level II B, two were Level III A/B, two were Level III B, and II were Level IV B.

Results: The studies found were very limited and dated. Findings from studies in the late 1990's and early 2000's seem to have led to an avoidance of anesthesia-induced rapid opioid detoxification as a study intervention. The drawbacks found were the expense of the intervention and the risk of adverse outcomes. The benefits found were full detoxification and the ability to enter a maintenance program sooner. There have been no new studies on the topic since 2014. The more recent studies tended to be incomplete and did not reflect new treatments available to mitigate side effects and prevent the adverse outcomes.

Discussion/Conclusions: More study of the intervention is needed using newly available symptom management techniques and encompassing newer sobriety successes as compared to slower detoxification techniques that often do not support the patient in achieving the maintenance phase of recovery.

Next Steps: As a result of this project, there has been more discussion with interested practitioners regarding the safety and effectiveness of ultra-rapid opioid detoxification. Several anesthesiologists involved in critical care rotations feel this service should be offered as an adjunct to the management of patients with substance use disorders in critical care. Grant funding would need to be obtained to support further research in this area and more discussion with interested parties should continue.

Do Patients With a History of Intravenous Drug Use (IVDU) Requiring Long Term Antibiotics Require a Prolonged Hospitalization?

Christina Bushey, RN VA-BC Felis Scholar

Purpose & Background: With the incidence of IVDU growing, more patients are being admitted to the hospital with infections. Cellulitis, osteomyelitis, and endocarditis are commonly associated infections. These infections often require long term parenteral antibiotic therapy (LTPAT), which can range from 2-8 weeks. These patients often have poor peripheral venous access, requiring a long-term catheter be placed in the form of midline or peripherally inserted central catheter (PICC). Providers are reluctant to send a person with an IVDU history home with an intravenous (IV) line in place for liability reasons and fear of misuse. Often these patients are kept in the hospital until they have completed the IV therapy portion of their treatment regimen. Once patients are no longer considered acutely ill, a decision about how to safely continue antibiotic therapy (outpatient vs. inpatient) has to be made. These patients occupy acute care beds and utilize facility resources. Additionally, this patient population has higher rates of leaving against medical advice (AMA) largely due to restrictions from leaving nursing units and unwelcomed surveillance.

Methods: A literature review was conducted using CINAHL and PubMed. Significant keywords used for literature review included best practices, IVDU, LTPAT, and outpatient antibiotic therapy. The literature review yielded 17 articles. Common themes were identified, and 9 articles were used for this research project. The most common theme identified was utilization of a risk stratification tool. Every patient admitted with a history of IVDU should have a risk stratification when it has been identified that the patient requires LTPAT. Stratification consisted of low, medium and high risk for relapse and discharge locations were based on this tool. High risk patients were those with IVDU within the last 6 months and would remain in hospital or sub-acute rehab for LTPAT. Medium risk included those with no active use within the past year and were discharged home requiring daily visits to an infusion clinic. Low risk were patients with no active drug use within past two years and were discharged home for self-administration of antibiotic therapy.

Results: Results suggested that a risk stratification tool was helpful in treating patients with a history of IVDU requiring LTPAT. Successful completion of therapy was achieved in 72-100% of these patients. Two articles discussed an increased prevalence of leaving AMA. These articles revealed AMA rates as high as 42%, supporting the premise that many IVDU patients leave AMA.

Discussion/Conclusion: With implementation of a risk stratification tool and discharge location based on that assessment, patients with a history of IVDU who require LTPAT can achieve favorable treatment outcomes. Additionally, more research is necessary to evaluate risk stratification and other factors influencing AMA in IVDU.

The Effect of Dance Therapy on Mobility in Patients with Parkinson's Disease

Anya Hoagland, SN and Shakirah Mukandekezi, SN
Faculty Advisor Llynne C. Kiernan, DNP, MSN, RN-BC

Purpose: To analyze dance as an alternative therapy for patient diagnosed with Parkinson's Disease that is both cost effective and combats not only the physical symptoms but cognitive as well.

Background: Parkinson's Disease (PD) is a neurodegenerative disorder that causes symptoms primarily in the older adult population including gait and balance problems, tremors and cognitive impairments. The prevalence of this disease has been on the rise since 1978 and interventions to slow the disease process have been known to be quite expensive. Dance is an alternative method of therapy that helps patients on a holistic level. As dance therapy continues to emerge as a method of PD therapy, it has been proven to be more cost effective as well as improve quality of life.

Methods: The literature review includes studies that used a number of surveys as tools to assess PD patients pre and post dance therapy. These tools include the Unified Parkinson's Disease Rating Scale, Timed Up and Go Test, Freezing of Gait Questionnaire, Berg Balance Scale, and Physical Activity Scale for the Elderly for physical assessment as well as the Trail Making Test and Frontal Assessment Battery for cognitive assessment.

Results: Through conducted studies and analyzing data it can be concluded that dance is an effective therapy for PD patients. The majority of patients report they enjoyed participating in dance therapy and it improved their quality of life.

Discussion/Conclusions: Complications that result from Parkinson's Disease can be debilitating and impair patient's ability to perform activities of daily living (ADL). Dance therapy is an intervention that not only improves quality of life for PD patients but also encourages older adult exercise and an improvement in mood. It is a potential cost-effective outlet that continues to keep holistic patient care in mind.

Next Steps: More research needs to be done about the long-term effects of dance therapy as well as analyzing the different genres of dance. As more research continues to emerge, health care providers, can provide patients with effective nonpharmacologic options such as dance therapy to treat their PD.

Does Aromatherapy Make Good Scents for Oncology Patients?

Stephanie Rettew, RN, BSN, OCN

Purpose: Oncology patients are using more complementary and integrative medicine methods to combat symptoms. Aromatherapy is often brought into the hospital by the patient but nurses know little about its purpose, application, and effectiveness. The purpose of this project was to evaluate the evidence of aromatherapy effectiveness on cancer related symptoms of nausea, anxiety and quality of sleep.

Background: The use of complementary and integrative therapies for symptom management is prevalent among oncology patients. An estimated 65% of cancer patients use some form of integrative therapy. However, as nurses and medical providers we have limited knowledge of their overall effectiveness. Aromatherapy is the therapeutic use of essential oils to promote physical and psychological well-being. Aromatherapy can be used in 3 different ways, direct inhalation, indirect inhalation and secondary with massage. Safety testing on essential oils shows very few side effects or risks when they are used as directed. Anxiety, nausea and sleep problems are common side effects of cancer and cancer related treatments. (Reilly, 2013) To improve these symptoms, patients often use medications that may be sedating, increase fall risk, as well as contribute to other side effects such as constipation. Therefore, alternative treatments that minimize these common symptoms and side effects are needed.

Methods: Using the John Hopkins Evidenced Based Practice Model 142 articles were reviewed, 34 articles were critically appraised, and 12 were selected for this review. Articles greater than 10 years old were excluded. Articles that addressed aromatherapy with massage were discarded. Electronic databases utilized were: CINAHL, PUB MED, Google Scholar and cancer.gov. Key words used included: aromatherapy, cancer, nausea, anxiety, and sleep.

Results: Overall, the use of aromatherapy in cancer patients show some positive effects. Aromatherapy provides a general feeling of well-being and comfort. Of the 12 studies evaluated, 8 showed significant improvement in at least one cancer related symptom of anxiety, sleep, or nausea. All of the studies reported low or no adverse effects from the use of aromatherapy.

Discussion/Conclusion: Due to its low-risk, ease of use and potential benefits, the clinical use of aromatherapy is a feasible non-pharmacological intervention for nurses to offer to patients. Limited sample size, differing cancer populations, and varying demographics limit the generalizability of these results. Larger more rigorous studies are needed for further conclusions.

Next Steps: Create a Quality Improvement project on inpatient oncology using the Institute for Healthcare Improvements(IHI) four phases of a quality improvement project PLAN, DO, STUDY, ACT. Bring aromatherapy to the inpatient oncology units as a nurse led symptom management intervention. Review current status of aromatherapy policy (May, 2019, policy is being evaluated and worked on). Create an education program that incorporates written materials, staff meeting, and safety huddles to review project. Create pre-post implementation surveys for nurses. Evaluate effectiveness of rollout based on survey information.

Insulin Pumps and the Bedside Nurse: Do We Know What We Need to Know

Elizabeth Lawliss, BS, BSN RN, RN-BC, CMSRN

Purpose and Background: An increasing number of inpatient diabetics utilize insulin pumps to manage their blood glucose with limited resources and varying levels of education and understanding. Complicating this issue are the multiple insulin pump models, limited resources and varying practices that exist pertaining to the use of an insulin pump during the inpatient stay. Additionally, many facilities do not have a designated endocrinology team or an inpatient diabetic educator. This review of literature focused on the evidence pertaining to practices related to inpatients using insulin pumps and nurses caring for these patients. The American Diabetes Association advocates for patients to maintain their insulin pumps when hospitalized (Kannan, Satra, Calogeras, Lock, & Lansang, 2014). This research topic was to help identify how patients and nurses can be supported as insulin pump technology advances in inpatient diabetic care.

Methods: A review of the literature was completed using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed databases. Key words utilized were: hospital, acute care and noncritical, continuous subcutaneous insulin infusion (CSII), insulin pump, self-manage, continuous glucose monitoring, and multiple daily injections. The outcome research was glycemic control, hemoglobin A1C, capillary blood glucose. Exclusion terms were pediatric, critical, and strictly outpatient. Eleven articles were appraised, five articles were excluded being lower than level three on the John Hopkins Nursing Evidence-Based Practice Model, unrelatedness to strictly inpatients, and irrelevance to insulin pumps. A total of six articles were evaluated to answer the clinical question.

Results: Evidence from this research found that there was no statistical difference in glycemic control among patients who maintained their insulin pumps versus those who did not. Findings in the literature with statistical evidence 1) teaching inpatient diabetics on signs and symptoms of hypoglycemia could decrease occurrences of hypoglycemia as an inpatient. 2) providing nurse education on insulin pumps to increase compacity and knowledge of insulin pumps provides bedside nurses with more confidence and could help facilitate inpatients keeping their pumps during their stay.

Discussion/Conclusion: No definitive conclusion could be made based on this the review. Studies on adult inpatients with insulin pumps does not appear to be well represented in the literature (Kannan, Satra, Calogeras, Lock, & Lansang, 2014).

Next Steps: To translate into practice the two main findings: 1) increase education on hypoglycemia signs and symptoms to inpatients and 2) provide evidence-based practice education on insulin pump use to bedside nursing staff.

The Prevalence of Post-Intensive Care Syndrome (PICS) in a Community Hospital

Emily Reding, BSN, RN, BA, Cayla Ventre, RN

Purpose: To identify the prevalence of PICS experienced by patients in a small, 300-bed community hospital post-ICU discharge. The study focused on identifying which ICU patients were at a higher risk for PICS.

Background: Technological advancement in critical care medicine has significantly increased survival rates of ICU patients. However, survivorship does not always improve quality of life. One-third of ICU survivors experience a collection of symptoms known as PICS. PICS involves the development or worsening of cognition, mental, and physical impairments that persist beyond the acute hospitalization. Of these survivors, 40% have depression, 60% have anxiety, and 40% have cognitive deficits comparable to moderate traumatic brain injuries (Rawal, Sankalp, & Kumar, 2017). Despite the prevalence of serious complications, there is limited awareness. Early screening and increased awareness of PICS may help to identify at risk individuals and allow for targeted interventions.

Methods: Self-report survey data was gathered at one month, three months, six months, and one-year post-ICU discharge using a validated tool called the PTSS-14 (Post -Traumatic Stress Syndrome) Intensive Care Screening Tool. The PTSS-14 focuses on a subset of PICS symptoms focusing on mental and emotional health. A comprehensive PICS tool was not yet available.

Results: A total of 49 participants were enrolled in this study. Exclusion criteria included patients less than 18 years old, unable to give informed consent, and an ICU stay < 24 hours. Preliminary data suggests that females were more likely than males to have higher PTSS scores than males and both the 1-month and 3-month mark. Participants with prior history of anxiety and depression were also more likely to have higher PTSS scores than those that did not. Only one participant scored positive for delirium and had the highest PTSS score of the sample. Conclusions: There is a cohort of our ICU population that is still suffering from symptoms of PTSS up to three months after discharge from the ICU. Despite limitations relating to our sample size, there is a significant number of patients experiencing PICS which healthcare providers are obliged to address.

Next Steps: Limitations of this study include small sample-size and challenges recruiting participants. 141 participants were excluded based on inclusion criteria. A follow-up interventional study will involve a two-part intervention. PICS education will be provided to patients and clinicians in addition to a new intervention-the introduction of patient journaling to assist in reality-orientation and to document their hospitalization.

Acute Care Nurse Practitioner as a Hospitalist: Role Description

Laura Cohen, DNP, ACNP-BC, ANP-BC, MSN

Purpose: To describe the role of the Acute Care Nurse Practitioner on a Hospitalist Team

Background and Growth: There is an increased need for Hospitalist providers due to the developing Hospitalist movement. This has lead to expanding NP roles on the team. Traditionally viewed as a role for physicians, NP's have been identified as meeting the needs of hospitalized patients, achieving the financial needs of the hospital, while also improving outcomes. Currently there are fewer physicians entering the workforce (Bryant,2018). The NP has been identified in the literature as a practitioner who could serve in this provider role thus shortening the gap for needed providers (Kleinpell et al,2008).

Methods: A review of articles from 1995 -2016 places ACNPs in teaching, community, rural, and military hospitals. Kleinpell surveyed ACNPS over a period of 5 years, revealing over 50 practice settings. A small sampling of practice settings within the hospital include adult and pediatric cardiac surgery, neonatal ICUS, oncology general surgery, and neurosurgery. (Rosenthal and Guerrasio,2016). In 2006, Becker et al published results from a single survey of 77 ACNPS in which 34 primary practices were identified. In these 2 articles, the largest reported practice areas were cardiac ICUS, surgical ICUS and step-down telemetry and cardiology floors. In 2015, the American Association of Nurse Practitioners reported an estimated 220,000 NPS practicing in the United States (American Association of Nurse Practitioners [AANP],2016). Of these providers 7.7% were acute care nurse practitioners who were practicing in hospital settings, an estimated 50% of licensed APNS held some type of hospital privilege (AANP,2016). However, the NP role in the hospital was not clearly identified.

Results: The literature on hospitalist medicine discusses characteristics of hospitalists that are similar if not identical to those of the ACNP. The Acute Care Nurse Practitioner Competencies state that the ACNP "diagnose acute and chronic conditions that may result in rapid physiologic deterioration or life-threatening events…works collaboratively with a variety of health professionals… [and] promotes efficient use of resources and provision of quality care to achieve optimal cost-effective outcomes. In addition to similar characteristics, hospitalists and ACNPs also share much of the same core curriculum. These overlapping philosophies allow the ACNP to function well in the role of the hospitalist.

Conclusion: The role of the ACNP as hospitalist is gaining more acceptance within the health care setting, like that of the hospitalist itself. Past and current curriculum prepares ACNPs for working within the inpatient environment. The addition of ACNPs to hospitalist teams and their integration in a collaborative healthcare model is supported by hospital medicine groups (Kleinpell, et al,2008). Studies have focused on outcomes with the integration of NP roles. Research demonstrates that a hospitalist directed care service that utilized NPs had a lower median length of stay and lower median hospital charges (P= less than 0.0001) compared to patients cared for by a traditional internal medicine resident-based service (Kleinpell, et al,2008).

Future: Hospitalist medicine offers growing opportunities for NPs to provide inpatient care throughout multiple areas of the hospital. The expanding NP role improves integration in a collaborative healthcare model. (Society of Hospital Medicine,2018). Ongoing research of successful models of care utilizing NPs on the hospitalist team, as well as research identifying outcomes will more than likely promote the use of NPs in this evolving area of practice.

Efficacy of Standardized Patients in Simulation: An ADN Students' Perspective

Nicole Dragoon, MSN, RN, OCN

Purpose & Background:

The purpose of this study evaluated ADN students, at a college in New England, preferences to using a Standardized Patient (SP) in a simulated experience compared to prior experience with High Fidelity Simulation. The study also determined if using a SP was an effecting teaching/learning methodology.

Methods:

A simulation scenario was developed utilizing a SP and The International Nursing Association for Clinical Simulation and Learning (INACSL) standards. Using the INACSL standards for knowledge, skills, and attitude as a guide objectives were evaluated with a standardized checklist. Students received a short assignment to prepare for the experience two days prior to simulation. On the day of they participated in pre-briefing, the simulated experience in randomly selected roles, and in debriefing using the Promoting Excellence And Reflective Learning in Simulation (PEARLS) standardized debriefing model. A Likert scale questionnaire was developed to evaluate perceptions related to the simulated experience and its effectiveness as a teaching/learning methodology. The questionnaire also included open-ended questions to find themes on how the student perceived HFS compared to their perception of a SP simulated experience.

Results:

The results showed that students strongly agreed that using a SP in a simulated experience was an effective teaching/learning methodology. On the Likert scale used, 1 represented strongly agrees and 5 strongly disagrees. The averages for each question was 1.28, 1.46, 1.75, and 1.53.

Discussion/Conclusion

The students indicated that learning was enhanced by feeling better prepared for clinical and feeling more comfortable during the SP simulation compared to their previous experiences with HFS. Having a small sample size of students and not running the scenario twice using both SP and HFS were identified as limitations.

Next Steps:

Simulation program development should consider using more SPs and technology to enhance SP scenarios such as RFID tag systems and the ability to display all vital signs on the monitor. Further comparative studies should be conducted with a larger sample size and using the same scenario, HFS versus SP simulation to validate or disprove these findings.

Psychobiotic Utilization in the Treatment of Anxiety and Depression

Jesse Webber & Benjamin Brown

Purpose & Background:
To identify a relationship between the microbes residing in the gut and the effects it has upon mood disorders such as depression and anxiety. The microbiome, that is the microorganisms in a particular environment such as the human body, is composed of over one thousand different species and contributes to the stability and diversity of the three million microbial genes found in the human gut (Maloney, Desbonnet, Clarke, Dinan, Cryan, 2014). Current treatment modalities to improve mood disorders such as anxiety and depression target relief from symptoms and not curing the actual disease.

Methods:
This literature review included studies that were conducted on both humans and laboratory mice. Different species of mice, which varied in gut microbes were compared and observed for signs and symptoms of mood disorders. Utilizing scales such as the Becks Depression Inventory human studies were able to compare the levels of depression in participants who consumed probiotics.

Results:
There was a strong correlation to the laboratory mice levels of depression and the number of microbes residing the gut (Lyte, Procotor, Phillips, Wannemuehler, 2018). In human studies, the level of depression was found to decrease significantly with the consumption of probiotics (Appleton, 2018).

Discussion/Conclusions:
Through testing, researchers have identified the gut-brain axis and have begun illuminating alternative treatment opportunities for individuals suffering severe and debilitating chronic illnesses such as depression and anxiety.

Next Steps:
The next steps are to continue exploration of health benefits associated to the gut brain axis, healthy microbiomes, and their association to chronic illnesses such as depression and anxiety disorders.

Effects of Reducing Weight Bias and Stigma in Hhealthcare Settings on Health Outcomes for Patients with Obesity: A Review of the Literature

Paulette J. Thabault, DNP, ANP-BC, JD, FAANP and Amy Blair, RN

Purpose & Background: Obesity is a Public Health Global Crisis with an estimated 500 million adults worldwide with obesity and 2 of 3 United States adults overweight (BMI $\geq$ 25) or with obesity (BMI $\geq$ 30), and 1 out of 3 adults with obesity. Childhood obesity is similarly rising at alarming rates. Obesity focused treatment is inadequate and compounded by social effects of obesity including weight bias and stigma. The purpose of this review of the literature, was to examine the prevalence of weight bias and stigma, identify associated health outcomes and describe healthcare interventions, including nursing implications for reducing weight bias and stigma to improve health care for adults with obesity.

Methods: Researchers identified studies published in CINAHL, NCBI and PubMed databases using key words weight bias, weight stigma, overweight, obesity, health care professionals, nurses, nursing students, physicians, weight loss, education and interventions. The initial search generate 30 studies, with 12 studies meeting inclusion criteria of qualitative studies or systematic reviews within 5 years addressing health care provider (nurses and physicians) weight bias.

Results: Patients with obesity report weight bias and stigmatization as important factors in decisions to avoid health care services. Interventions to reduce weight bias in health care and stigma include provider education programs that challenge weight controllability beliefs and provide information about obesity as a complex chronic disease. Multifaceted programs may be most effective.

Discussion/Conclusions: Health care providers including nurses are in the best position to improve care and outcomes for patients with obesity by identifying and overcoming their own weight based biases and approaching obesity as a chronic disease. Individualized evidence based interventions provided with compassion will improve health care services.

Next Steps: Disseminating research findings about the negative impact of weight bias and stigma through publications and education programs are among the next steps for improving care and outcomes of patients with obesity. Further research to determine the most effective education strategies to reduce weight bias will also be helpful.

Putting the Squeeze on LE Edema

Kathryn Karg Gutierrez, BSN, RN
Christine Rovinski-Wagner, MSN, ARNP

Purpose & Background: Literature universally supports compression therapy for the treatment of edema related to chronic venous insufficiency (Ratliff et al, 2016). Patients who have had ulcers and adhered to compression therapy had a 4% recurrence of ulcers versus the 79% recurrence of ulcers for those who did not adhere to compression therapy (Health Quality Ontario, 2019). Some compression is better than no compression and a range in types of compression systems is acceptable depending on the range of patient characteristics, including patient tolerance (Australian Wound Management Association Inc. and New Zealand Wound Care Society, 2011). The purpose of this study was to examine patient compliance and outcomes associated with the Juxtalite compression therapy which is easier to apply due to its design.

Methods: Over a 12-month period, 29 patients, diagnosed with lower extremity edema and not compliant or unable to use compression socks related to their difficulty in donning, doffing or discomfort, were fitted and trained on the use of juxtalites. Four had history of ulcerations prior to getting fitted for the juxtalites and one had an issue of capillaritis.

Results: At the completion of the 12-month period, 16 of the 29 patients were successfully contacted to determine their current compliance with compression therapy. Patients who adhered to compression therapy for lower extremity edema experienced many of its intended benefits. 16/16 (100%) report noticing a decrease in lower extremity edema. 3/4 (75%) had resolution of their ulcers. One patient continues to have issues with ulcers. 14/16 (88%) did not develop lower extremity ulcers. One patient experienced an ulcer after using the juxtalites when the patient had a gap in compression therapy related to a back injury. 1/1 (100%) had complete resolution of capillaritis symptoms. 16/16 (100%) are still doing some form of compression therapy.

Discussion/Conclusions: Most of the patients have continued using compression therapy over a sustained period. All but one experienced improvement in lower extremity health status. Many of the patients shared that family members who were unable to assist with donning compression sock found assisting with juxtalites easier. Spouses or family members were encouraged to be at the initial appointments to assist with application and learn the process. This may have helped with compliance.

Next Steps: The results have led to the formulation of a quality improvement team that is examining a revision of patient education for patients requiring daily compression with inclusion of potential barriers and solutions, standardization of patient follow-up schedule, and greater inclusion of family members or caregivers.

Using a Nurse Executive Assessment Tool to Enhance Nurse Leaders Self-Efficacy

Carolyn Stannard-Carlo RN, MS

Purpose & Background: The aim of this quality improvement (QI) project was to improve the nurse leader's self-efficacy pre and post-intervention mean stem scores for the use of the American Organization of Nurse Executives (AONE) evidence-based assessment tool for succession planning at Southwestern Vermont Medical Center (SVMC). The PICOT question for this QI project was : For nurse leaders in the director role at Southwestern Vermont Medical Center (SVMC) in Bennington, Vermont does the implementation of the American Organization of Nurse Executives (AONE) Competencies Assessment Tool improve self-efficacy in the use of the AONE evidence-based assessment tool for succession planning over 8 to 10 weeks?.

SMVC currently selects nurse leaders based on clinical expertise. Such practices can cause a gap in leadership, potentially decreasing the organization's revenue while diminishing outcomes. Studies showed that implementation of a planned succession activity that identifies potential talent for leadership development positively affected finances and patient outcomes (Titzer, Phillips, Tooley, Hall, & Shirey, 2013; Titzer, Shirey, & Hauck, 2014). Another study demonstrated enhancing a nurse leader's self-efficacy lead to effective application of evidence-based (EB) practice (Cziraki, Read, Spence Laschinger, and Wong 2017). Thus creating an opportunity for SVMC nurse leaders to improve in the use of an EB assessment tool for succession planning.

Methods: The sample was convenient and purposive of nurse leaders (n=7) in the director role at the mesosystem-level. The Evidence-based Nursing Practice Self-Efficacy Scale was administered pre and post-intervention. The intervention included education about succession planning, self-efficacy, and AONE Competencies Assessment Tool and training for proper tool utilization. A two-tailed t-test with unequal variances tested the data. Supporting conceptual frameworks included Albert Bandura's Theory of Self-Efficacy and Lippitt's Change Theory.

Results: No questions showed a significant difference in the pre and post self-efficacy mean stem scores. However, five items (29.4%) showed a positive trend with lower p-values for mean stem scores.

Discussion/Conclusion: Self-efficacy is a modifiable factor for evidence-based practice (EBP). Improving a nurse's self-efficacy for EB tool application will positively affect an organization's succession planning efforts for inventorying internal talent for leadership development.

Next Steps: To re-test the survey questions using a larger data set to determine if the positive trend differences are truly due to statistical significance.

Notes:

Symposium Agenda

Thursday, November 7

2:30-3:00pm Registration, Poster Set Up

3:00-4:00pm

Planning & Conducting Nursing Research: There's an App for That!
Sarah Manacek, MSN, RN
Lecturer, Clinical Instructor, School of Nursing
Norwich University
Northfield, Vermont

4:00-4:15pm *Afternoon Break, Poster Set up*

4:15-5:15pm

Turning Your Dissertation into a Manuscript
Cheryl Tatano Beck, DNSc, CNM, FAAN

5:15-6:45pm **Reception, Poster Presentations, Honor the Nurse, Welcome Remarks:**
Jessica Sherman, DNP, MSN, RN-BC, PCCN-K
Mary Hill, DNP, MSN, RN-BC, OCN, CHPN
Program Co-Chairs, 11th Annual Symposium

Thursday Evening's Poster Reception is FREE and open to the public.

Friday, November 8

8:00-9:00am Registration; Cont. Breakfast; Posters

9:00-9:15am Welcoming Remarks

9:15-10:15am

Keynote Address

Developing a Program of Research: The Road Not Taken
Cheryl Tatano Beck, DNSc, CNM, FAAN

10:15-10:45am Posters, Morning Break

10:45-12:15am

Oral Presentations - A, B, C

A The Lived Experience of Shutdowns for Adults on the Autism Spectrum
Laura Lewis, PhD, RN
Assistant Professor, College of Nursing & Health Sciences
University of Vermont
Burlington, VT

B Delphi Study Identifies Core Components of Nurse Competency Framework
Susan Boyer, MEd, DNP, RN-BC
Executive Director
Vermont Nurses in Partnership
Perkinsville, VT

C Lessons from New Zealand: Nurses' Role in Dementia Diagnosis and Care
Mary Val Palumbo, DNP, APRN, GNP-BC
Nurse Practitioner/Professor,
College of Nursing & Health Sciences
University of Vermont
Burlington, VT

12:15-1:15pm Lunch; Posters

1:15-2:15pm

Oral Presentations - D, E

D POD Nursing: A Team-Based Approach to Quality Care
Jessica Sherman, DNP, MSN, RN-BC, PCCN-K
Nurse Manager, Medical-Surgical
University of Vermont Health Network,
Central Vermont Medical Center
Berlin, VT

E Preparing Frontline Nurse Leaders for Peer Review: An Evidence-Based Practice Project
Suzanne Murdock, DNP, APRN, GNP-BC
Director, Nursing Outcomes, Practice and Systems
University of Vermont Medical Center
Burlington, VT

2:15-2:30pm Afternoon Break

2:30-3:30pm

Oral Presentations - F, G

F Restraint Minimization to Improve Veteran Safety & Satisfaction
Renee Sylvies, RN, MSN, CEN
Clinical Nurse Educator, Emergency Department
VHA Buffalo Health Care System
Buffalo, NY

G Is Your Nursing Practice Evidence-Based?
Marcia Bosek, DNSc, RN
Associate Professor, College of Nursing & Health Sciences
University of Vermont
Burlington, VT

3:30-4:00pm

Capstone Address/Wrap Up
Mary K. Hill, DNP, MSN, RN-BC, OCN, CHPN
Jessica Sherman, DNP, MSN, RN-BC, PCCN-K