Call for Abstracts - Extended!

3rd Annual Conference:

Inquiry in Action: Tools for Success

Conference Objectives:

1. *Learn techniques for clinical inquiry*
2. *Discover applications of clinical inquiry relevant to your practice*
3. *Identify ethical issues evolving in clinical inquiry*

OregonNursingResearchAndQuality.org

Monday, April 23, 2012

Salem Hospital
Wedel Conference Center - Building B
665 Winter St SE
Salem, OR 97301

Please send us an abstract if you have completed:

Research Study
Quality Improvement Projects
Evidence-Based Practice Project

Mark your calendar!
Your Abstract must be received before

7AM, Friday January 6, 2012

POSTERS & PODIUMS 2012

April 23, 2012

ABSTRACT SUBMISSION FORM

Please Note--Due to limits of program presentation time & poster presentation space, not every abstract may be accepted for presentation. Also, selection for poster or podium presentation is based on the needs of the conference and is not a measure of merit of the abstract or the project. Following review of all abstracts, you will be notified by *February 1, 2012*

Presenters must register and submit the registration fee in order to present their poster. Presenters are responsible for setting up and taking down posters at designated times. Outstanding poster and podium presentations will be acknowledged with awards selected on basis of on-site judging (criteria provided upon notification of acceptance).

Title of Abstract			
Category	☐ **QUALITY**	☐ **EVIDENCE-BASED PRACTICE**	☐ **RESEARCH**
Presenter, including credentials			
Other Authors:			
Employer:			
Employer address:			
CONTACT AUTHOR OR PROJECT REPRESENTATIVE			
Name:			
Address:			
Email:			
Work Phone:		**Home Phone:**	
Other Phone:			

Please ask a Site Coordinator to review your abstract and advise you if you have questions.

Abstract Reviewers and Site Coordinators

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***NOTE: Site Coordinators are prepared to assist you in completing your abstract and preparing your presentation. Plan enough time to give your Site Coordinator a chance to review each abstract prior to your submission.**

ABSTRACT Instructions:

DO NOT PLACE NAMES ON ABSTRACT PAGE or other identifying material in the abstract

Title:

- Make as brief as possible indicating the nature of the presentation
- Omit abbreviations in the title; you may use them in the text

Body:

- Content of the abstract should be related to a nursing practice concern from the vantage point of a quality/performance improvement, evidence-based practice or nursing research project
- Abstract should be 300 words maximum (excluding title)
- Microsoft Word format – submit electronically please.
- Use 12 point font, single-spaced, with 1 inch margins.
- NO graphs, tables or references included in the abstract
- Please include headings such as ***'problem statement, 'background/evidence', 'method/strategy', 'results', 'recommendations'*** or ***'lessons learned'*** as appropriate for your topic.
    - Keep all the headings to the left.
    - As above and in examples, highlight and use italics
- Abstract Submission form (or other page separate from the Abstract Page) must list all authors' names and include:
    - The presenter's name with an asterisk *
    - Full corresponding author contact information

Send your abstract electronically by 7 AM Friday, January 6, 2012 to:
Mary.waldo@providence.org

Questions? Please call Mary Waldo at (503) 216-2297

(See below for examples of abstracts describing a research, quality or, EBP project).

SAMPLE ABSTRACT: Research Example

ABSTRACT TITLE**:** Comparison of Blood Pressure Readings Using Manual and Automated BP Devices in Patients with Atrial Fibrillation

Purpose: The purpose of this study is to compare the accuracy of blood pressure (BP) readings taken with an automated and manual BP device in patients with irregular heart rates.

Background: The use of automated machines to in-directly measure BP is common in the acute care setting. A number of factors other than BP can affect the accuracy of the automated BP reading. There is limited data on its accuracy in populations with cardiac dysrhythmias, or irregular heart rates.

Research Hypotheses: In patients requiring BP measurement, there will be no difference in: 1) systolic and diastolic BP readings obtained with manual and automated BP devices; and 2) BP readings obtained with a manual or automated BP device in patients with different cardiac rhythms.

Methodology: A prospective, comparative design was used with a convenience sample of adult patients who met the inclusion criteria. Patients had their BP taken once with an automated and manual BP device during a normally scheduled BP measurement time.

Results: Differences between automated and manual methods of BP determination ranged from -30 to 23 mm Hg for systolic and -15 to 21 mm Hg for diastolic BP. ANOVA found that the type of ECG rhythm (NSR, paced, AFib) had no significant effect on the blood pressures differences between the automated and manual methods for either systolic ($F_{2, 135} = 1.433$, p=.245) or diastolic ($F_{2, 135} = .251$, p=.779) blood pressures. Student's t Test found a significant difference between manual and automated systolic ($t_{135} = 3.54$, p=.001) and diastolic ($t_{135} = 3.52$, p=.001) blood pressures.

Conclusions: Blood pressures obtained with an automatic BP device were significantly different than blood pressures obtained with the manual technique. The type of ECG rhythm did not effect the BP differences with the two methods.

SAMPLE ABSTRACT: Quality Improvement Example

ABSTRACT TITLE: Implementing hourly rounding as a cognitive tool for nursing interventions

Background: While there is evidence that hourly rounding has reduced falls and hospital-acquired pressure ulcers, this nursing intervention has been difficult to implement and sustain. Our initial attempts at hourly rounding included a detailed checklist that consumed so much of the hour; staff quickly abandoned this practice of hourly rounding.

Purpose: The purpose of this presentation is to describe how we used principles of implementation science to study, redesign, and reintroduce rounding activities.

Methods: Implementation science is the systematic investigation of methods, interventions, and variables that influence the adoption of evidence-based health care practices by individuals and organizations. Interviews with unit leaders suggested the staff perception of rounding as a task-focused activity contributed to its failure. We redesigned our hourly rounding program as a cognitive intervention to organize workflow and emphasize patient safety by meeting common patient needs in a proactive and consistent manner. Rounding isn't about 'going' in the room, but rather assuring that critical elements are addressed when the nurse is already in the room. We intentionally did not develop any documentation elements specific to rounding, but requested nurses document care as it is provided. Hourly rounding was re-introduced with broad institutional support.

Results: Evaluating the process and outcomes of rounding is complex. Timely and complete documentation of activities related to rounding serves as an indirect measure for compliance. Documentation of patient activity (turns and ambulation) increased. We have opportunities to improve manager validation that rounding occurs regularly. Patient outcomes of interest, including fall rate, pressure ulcers rate, and 'responsiveness' items on the HCAHPS survey, will be presented.

Conclusion: Implementation science, with careful attention to the evidence, the context, and the facilitation, served as a useful framework to reengage staff and leaders in rounding.

SAMPLE ABSTRACT: Evidence-based Practice Example

ABSTRACT TITLE: Development and Implementation of an Evidence-Based Protocol for Management of Hypoglycemia

Purpose: The purpose of this project was to implement an evidence-based hypoglycemia protocol in a tertiary care, Magnet designated teaching center.
Synthesis of the Evidence: In 2008, the American Diabetes Association reported that 17.5 million people in the United States have a diabetes diagnosis. Diabetic patients have increased use of inpatient services and are at higher risk for complications. Barriers identified in achieving adequate glycemic control include: 1) healthcare professionals' fear of hypoglycemia, and 2) nursing time required to follow protocols. The Institute for Healthcare Improvement recommends protocol use as a method to optimize abilities of healthcare providers and reduce errors. Consequences of hypoglycemia can be life threatening, develop rapidly and can occur at any time in diabetics. Since the identified causes are difficult to predict, a standardized treatment protocol can ensure safe, effective treatment of hypoglycemia.
Proposed Change in Practice: Develop an evidence-based protocol that: 1) can be used across multiple clinical areas, and 2) is easy to implement at the point of care.
Implementing Strategies: First, we established a hypoglycemia definition and determined the areas of use. The existing protocol was then evaluated and modifications were made to reflect the current evidence base. Standardized documentation was developed and a one-page treatment algorithm was created to support ease of use at the point of care. Once all components were approved through a multi-step organizational approval process, staff education occurred.
Evaluation: We evaluated rates of severe hypoglycemia (CBG <40 mg/dL) as a measure of protocol effectiveness and safety. Rates in the medical-surgical setting ranged from 0.0% to 0.70% pre-implementation and 0% to 0.23% post-implementation. This decline from baseline suggests that implementation of our hypoglycemia protocol is an effective strategy to appropriately manage hypoglycemic episodes.