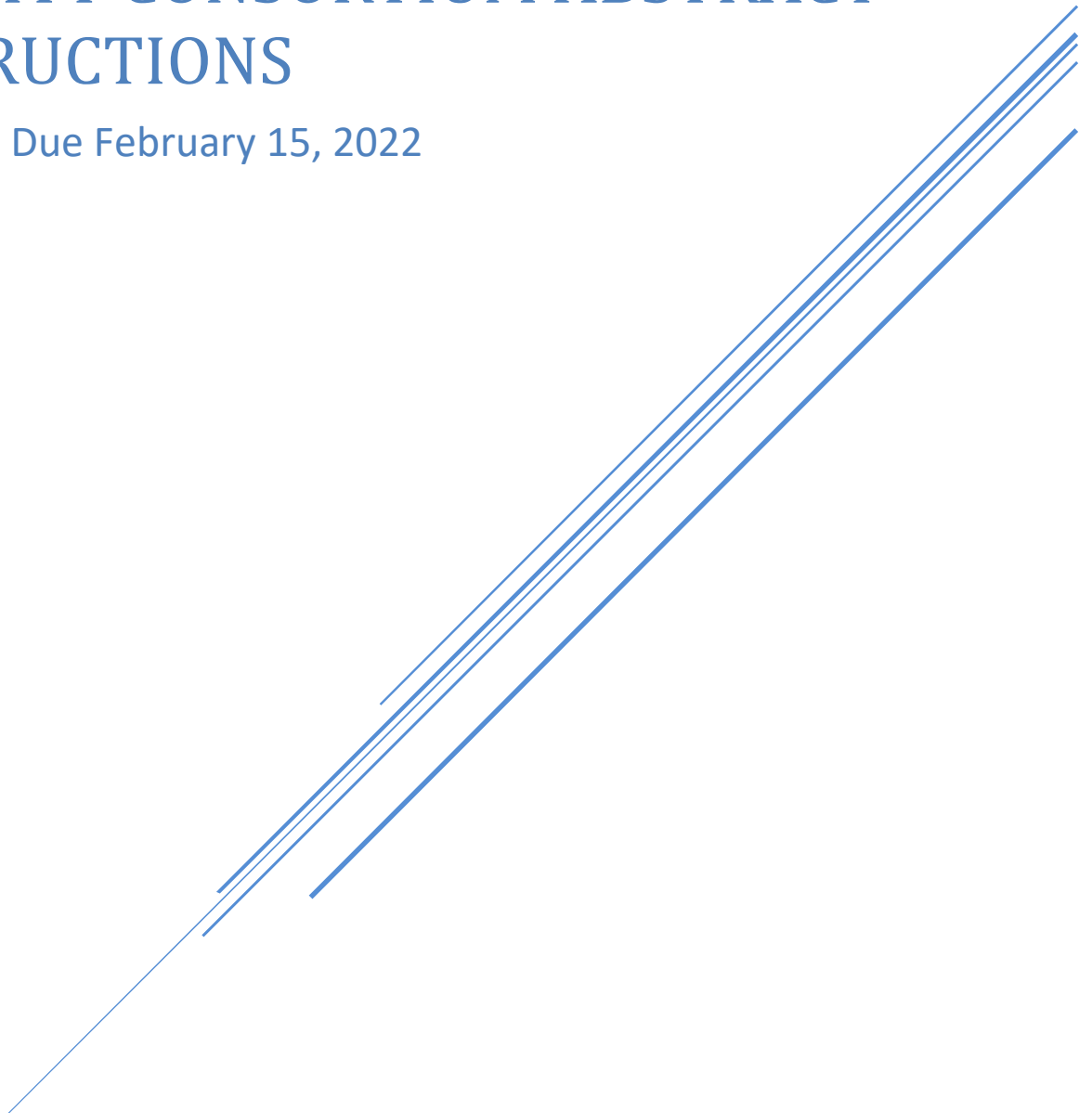




OREGON NURSING RESEARCH & QUALITY CONSORTIUM ABSTRACT INSTRUCTIONS

Abstracts Due February 15, 2022



ABSTRACT Instructions

Thank you for your interest in submitting an Abstract for the Oregon Nursing Research & Quality Consortium (ONRQC). You are welcomed to submit a research or a quality improvement abstract. Perhaps you even submitted in 2020 when we canceled the conference. Please consider resubmission, adding the most current outcomes. Thank you.

Instructions:

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 clinical inquiry that resulted in a quality improvement project or nursing research study

- 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

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

(See below for examples of abstracts describing research and quality projects).

SAMPLE ABSTRACT: Research Example

ABSTRACT TITLE: Does the Coping Assessment for Laboring Moms (CALM© Scale) Enhance Perception of Nursing Presence?

Problem: Traditional assessment using the 0-10 pain scale is an inadequate method of assessing the specific pain that laboring women experience (Roberts, et al. 2010; Lowe, 2002). The desire was to create a more effective method to assess women's ability to cope during labor.

Background/Evidence: The CALM© Scale was developed from a literature review of pain/coping tools. This coping scale was designed to include assessment of facial, behavioral, psychosocial, vocalization, and verbal expressions.

Aim/Objectives: The following hypothesis was tested: If nurses use the CALM© Scale with intuitive nursing support, compared to the 0-10 pain scale, women's perception of nursing presence will be enhanced. The emphasis being on improving women's comfort, confidence, and control during the childbirth experience.

Methods/Strategy: Using a comparative design, the two scales were evaluated in a birth center at a regional community hospital. Two groups of 40 women were consented to be involved in the study. The first group was evaluated using the 0-10 scale and the second using the CALM© Scale. Both completed the 29-item Positive Presence Index (PPI) to share perceptions of nursing presence, within 24 hours of delivery.

Results: PPI scores were 137.89 (SD 76.31) and 165.42 (SD 59.01) in the 0-10 (n=39) and CALM© (n=43) groups, respectively. While differences in total PPI scores approached significance between groups ($t=7.63$, $p=.08$), four items were significantly higher ($p<.05$) in the CALM© group. These items were '*knowing what would work best for me*', '*having a comforting touch*', '*taking care of everything so I could concentrate*', and '*understanding what I was saying*'. Pain and CALM© scores were also positively correlated ($R=.86$, $p=.001$).

Recommendations:: Although the perception of nursing presence was higher with the CALM© Scale, it was not statistically significant. Further research is needed to discern the efficacy of the CALM© Scale with a larger, more diverse population.

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.