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The 2010 International Nursing Research Conference

Conference abstracts

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Contents

Keynote abstracts

Tuesday 11 May 2010

The evidence base in nursing practice: The potential impact of spearheading leading-edge nursing research on improving global health

Professor Alan Pearson, Executive Director, The Joanna Briggs Institute, Royal Adelaide Hospital/ Professor of Evidence Based Healthcare, The University of Adelaide, Australia

Abstract:

The evidence base for the broad field of health care has developed exponentially in the past thirty years. This is in part a result of the pressures on health services that come from increased demand for funds to maintain and develop health services; the formalisation of the concept and processes of evidence based healthcare; of the influx of more highly educated, energetic and rigorous clinicians and researchers into health care systems; and of the increased access to knowledge associated with globalisation.

What, though, of the evidence base for nursing practice? Although nurses and nursing are central in the provision of health services to people they feature rarely in high-level discussions on the generation and synthesis of knowledge/evidence, although we more frequently seen to have a legitimate role in the translation of evidence to practice. This latter reality may be a reflection of the way in which nurses and nursing are often seen as the "doing" or "application" part of the knowledge/action continuum of health care because of our interest in apparently simple, everyday aspects of health care.

In an era that is characterised by global concerns about the sustainability of health systems as they currently exist; and by increasing interest in generating and translating reliable and trustworthy evidence to underpin policy and practice, it is perhaps timely to take a long, hard, look at the current and potential role of nursing research and nursing science and to consider the actual and potential contribution of nurses and nursing scientists to building an evidence base through leading-edge nursing research that has a real and discernible impact on improving global health

That is not to say that we haven't already done this in the past. More than a decade ago at the 1999 International Nursing Research Conference in Edinburgh, Professor Alison Tierney asked where might nursing feature in a science museum or an encyclopaedia of science. Does nursing fit the conventional paradigm of discovery, the race for priority, the rush of scientific breakthrough? In her response to this paper, Rafferty (1999) – asserted that:

"...rarely do we hear of journalists talking of nursing at all, let alone in terms which suggest that the thin line between the sacred and the sublime is about to be crossed by nursing science. Such revelations are the stuff of Spielberg rather than nursing's version of 'science', which is more concerned with sacral sores than technological gimmickry and awesome inventions."

She goes on to ask "...do we have research that compares with the best in other fields or, if we think we do, are we in fact suffering from delusions of grandeur? What does our research showcase look like?"

If evidence based healthcare focuses on the need for all health professionals to use those interventions that are supported by the most up-to-date evidence or knowledge available, how can we, as nursing researchers and nursing scientists spearhead a dramatic increase the generation, synthesis and translation of knowledge and understandings about the experience of health and illness and the delivery of services to enhance the lives of people into action?

Wednesday 12 May 2010

Linking evidence into a ction: Piecing together a complicated jigsaw

Professor Jo Rycroft-Malone, Professor in Health Services and Implementation Research, Bangor University, Wales, UK

Abstract:

Our health care systems struggle to incorporate new knowledge into practice. Equally, practitioners find keeping apace of new research and incorporating that into new practices, challenging. Politically, there has been an emphasis and investment on 'pushing out' research evidence; evident in the creation and subsequent expansion of guideline development houses such as the Agency for Healthcare Quality (check), National Institute CS (NICS) in Australia, and the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom. It has only been relatively recently that these organisations have recognised that simply developing and publishing a guideline does not necessarily mean its recommendations get incorporated into local practice; it is much more complicated than that (Rycroft-Malone et al 2002, Dopson & Fitzgerald 2005, Nutley et al 2007)

During this presentation I plan to unpack some of the complexities involved in evidence use. Evidence use is usually a function of a number of interrelated factors including practitioners, teams, and contexts; factors that are difficult to disentangle. The themes that will be highlighted include evidence particularisation, context as mediator, theory use and development, impact, sustainability and intervention fidelity. These will be considered in relation to their implications for researching and evaluating implementation efforts.

References:

Rycroft-Malone J. , Kitson, A. Harvey, G. McCormack, B. Seers, K., Titchen, A. and Estabrooks, C. (2002) Ingredients for change: revisiting a conceptual framework. Quality and Safety in Health Care 11: 174-80

Dopson S. & Fitzgerald L (Eds) (2005) Knowledge to Action? Evidence-based health care in context, Oxford University Press: Oxford

Nutely, S. Walters I., Davies, H.T.O. (2007) Using evidence. How research can inform public services. Policy Press, Bristol, UK.

Thursday 13 May 2010

12.15

The realities of pursuing a clinical academic career in nursing – maintaining leading edge profiles in research and clinical practice

Christine Norton PhD MA RN, Professor of Clinical Nursing Innovation, Bucks New University & Imperial College Healthcare NHS Trust, Nurse Consultant (Bowel Control), St Mark's Hospital Harrow

Abstract:

The pursuit of a clinical academic career (CAC) has become something of a holy grail recently among nursing leaders. It is seen as a way of fixing several problems: the theory-practice gap; the low volume of nursing research; the apparent disconnect between academic research and clinical problems; and as a pathway in a modernised nursing career structure. Yet there are many unanswered questions. How many nurses and midwives actually want such a career? In the 2009 CAC fellowship call, from a national workforce of half a million in England there were 100 applications from nurses, midwives and allied health professionals (AHPs) and 5 awarded to nurses or midwives (4 London, 1 Manchester) and 10 AHPs. There were 22 applicants for the postdoctoral (Clinical Lectureship) awards and 6/10 awarded were nurses. This does not attest to a huge appetite for these posts, despite generous funding with salary back-fill. The average cost of those I was involved with was £300k+.

Are we going about this in the wrong way? Or do we need multiple strategies to address the various component problems? And what is the evidence base for any of the possibly available strategies? How do we prevent a clinical academic career from simply seeming like 2 jobs rather than one, and more trouble than it is worth? How do we ensure that this is a valued and rewarded career choice? Is it feasible to be "leading edge" in research and clinical practice. This paper will explore the key issues in this debate and give some examples, from a personal case history, of approaches which apparently do (and do not) work. There will inevitably be more questions than answers at this early stage of developing this as a national career pathway.

1.1 Maternity

1.1.1

How can maternity services be developed to effectively address maternal obesity? A qualitative study

Nicola Heslehurst, Health and Social Care Institute, Teesside University, UK

Co-authors: H Moore; J Rankin; L J Ells; J R Wilkinson; C D Summerbell

Abstract:

Background: Maternal obesity poses significant health implications for mothers and their babies. A study carried out in 2005-2006 across all NHS maternity units in North East England showed that care requirements for obese pregnant women did not match service provision (Heslehurst et al 2007).

Aim: To follow up from the previous study to identify developments in maternal obesity services, and health care practitioners' views on how maternity services need to be further developed to be more effective in the care of obese pregnant women.

Methods: Purposive sampling included 30 maternity unit health care practitioners with clinical experience of maternal obesity, representing each NHS Trust in the region that provides maternity services. Qualitative interviews and focus groups were carried out to identify views on the barriers, facilitators, advantages, and disadvantages of developing maternal obesity services, and how maternity services can be more effective in managing maternal obesity. Transcripts were analysed using thematic content analysis.

Results: Four dominant themes emerged: maternal obesity service development; psychosocial issues and maternal obesity services; information, evidence and training; and the way forward. The study identified that there has been a substantial improvement in the management of the health and safety aspects of maternal obesity over the last 3 years. However, more work needs to be done in respect of psychosocial issues, weight management, and public health aspects of maternal obesity.

Discussion of implications for practice: To meet the needs of obese pregnant women, maternity services need to consider the transition of care between pregnancy and the post natal period, improve communication between hospital and public health services, and to develop services that will engage pregnant women to address their obesity. Utilising the pregnancy period to engage pregnant women to address their obesity could also be a way of addressing obesity for the next generation.

Recommended reading:
Heslehurst, N., Lang, R., Rankin, J., Wilkinson, J. & Summerbell, C. Obesity in Pregnancy: A Study of the Impact of Maternal Obesity on NHS Maternity Services. BJOG: an International Journal of Obstetrics & Gynaecology. 2007, 114, 334-342.

1.1.2

A descriptive qualitative study exploring midwives' attitudes, knowledge and understanding whilst caring for obese pregnant women

Gillian Sedgewick, Women and Children, South Tees Hospitals NHS Trust, UK

Co-author: Susan Cleary

Abstract:

Background: Maternal obesity increases morbidity and mortality in both mother and infant and represents a significant burden on NHS resources. Obesity was directly linked to 52% of reported maternal deaths in the UK between 2003-2005 (CEMACH 2007, Heslehurst et al 2008, Zaninotto et al 2005). There is an urgent need to review practice whilst caring for obese women and to understand the challenges encountered by midwives when dealing with the public health issue of maternal obesity.

Aims:

• Examine midwives attitudes and knowledge whilst caring for obese pregnant women.

• Highlight areas for midwifery policy and guidelines development.

• Identify further topics for research in obesity.

Methods: A descriptive qualitative study was employed using in-depth semi-structured interviews with seven experienced midwives working within the acute hospital and community setting. Informants were recruited purposefully from within a large maternity unit in the North East of England. Burnards (1991) fourteen stages of systematic thematic content analysis were employed.

Results: Three major themes emerged from the data. 'Barriers to effective midwifery practice' highlights midwives feelings of embarrassment, midwives and women's relationships and stigmatisation associated with obesity. 'Evidence – based midwifery' discusses an absence of evidence based guidelines, the need for a multidisciplinary approach and risk assessment. 'Influence of service provision on midwifery practice' highlighted a lack of time to address issues and an absence of nutritional and physical education support. These categories were underpinned by issues related to communication, normalisation of obesity; student midwives experiences, breast-feeding, and wound care/infection rates.

Discussion and Conclusions: The findings of this research has led to service developments such guidelines including Maternal Body Mass Index Care Pathways, results have been disseminated within the hospital setting and student midwives as part of the midwifery curriculum. This study highlights the challenges midwives face when caring for obese pregnant women as they strive to promote safe effective care.

Recommended reading:
Confidential Enquiry into Maternal and Child Health (CEMACH) (2007) Why mothers die 2003-2005, London: RCOG

Heslehurst N., Lang R., Rankin J., Wilkinson J.R., Summerbell C.D. (2007) Obesity in pregnancy: a study of the impact of maternal obesity on NHS maternity services, BJOG 114:334-342

Zaninotto P., Wardle H., Stamatakis E., Mindaell J., Head J. (2005) Forecasting Obesity to 2010: Report to the Department of Health, London: Joint Health Surveys Unit, National Centre for Social Research, UCL.

1.1.3

Satisfaction and experiences of pregnant hypertensive women participating in a feasibility study of guided imagery effects on blood pressure

Faith Wight Moffatt, School of Nursing, Dalhousie University, Canada

Faith.Wight.Moffatt@dal.ca

Abstract:

Background: Hypertensive disorders of pregnancy are associated with maternal and perinatal health risk. Some studies have demonstrated blood pressure (BP) reduction from use of relaxation therapies, although previously study in pregnancy was limited. We undertook a RCT to determine the effects of guided imagery relaxation on BP and anxiety in hypertensive women during pregnancy, to answer feasibility questions for a larger trial.

Aims: This presentation will describe experiences with study participation, as reported by women in our study.

Methods: Pregnant women with hypertension (n= 69) were randomized to two daily periods of guided imagery or quiet rest, for four weeks or until delivery, whichever came first. Participants provided compliance data and evaluated guided imagery each week, and completed postpartum questionnaires about their satisfaction with study participation.

Results: 60 women completed at least one week in the study. Compliance with allocated group conditions was high. Most women were satisfied with their allocation; 83.3% would choose to be in the study again. A greater proportion (42.4%) indicated that the study reassured them, compared to 3.4% who felt it added to their worry. Of those in the Guided Imagery group providing ratings, more than 75% reported enjoyment and ease of use. Most indicated they would use it for future hypertension in pregnancy and for stress, and would recommend it to others.

Discussion: Our results suggest that Guided Imagery may moderate BP increases in pregnant women with hypertension. However, success of any clinical intervention requires a high degree of patient compliance and acceptability. Guided imagery was acceptable, based on reported use and intent to use it for future stress and hypertension.

Conclusions: Guided imagery can be used by hypertensive pregnant women to promote relaxation. Further research is required to determine whether it can improve physical and psychological health outcomes during pregnancy, birthing and postpartum.

Funding source:

10,001 – 50,000

1.1.4

Evaluating pathways of maternal care in NHS Scotland

Helen Cheyne, Reader, Nursing, Midwifery and Allied Health Professions Research Unit, University of Stirling, UK

Co-authors: P Abhyankar; C McCourt; K Niven

Abstract:

Background: UK health policy endorses normality in childbirth through midwife-managed care and evidence-based guidelines; however, implementation has been inconsistent. In Scotland, the Keeping Childbirth Natural and Dynamic (KCND) programme aims to implement this policy by introducing national pathways of normal maternity care. This study reports on phase I of the evaluation of KCND programme.

Objectives: Drawing on the principles of the realist framework, the evaluation focuses on understanding what works, how, for whom and in what circumstances. The aim of phase I is to explore propositions on what mechanisms the KCND programme introduces, into what contexts, and how these mechanisms do/do not generate outcomes into the pre-existing contexts.

Methods: Qualitative methods involving:

- Semi-structured interviews with programme developers and key national stakeholders
- Focus groups with local clinical champions
- Analysis of programme documents.

Results: Through implementation of care pathways, the programme aims to achieve high-quality, women-centred service, maximise normal birth experience, reduce unnecessary interventions, and support women's choice. The care pathways appear to trigger five key mechanisms to bring about these outcomes: ongoing risk assessment, risk-tailored care, standardisation of best practice, enhanced multi-professional collaboration, and women's involvement in their care. Contextual factors influencing the operation of these mechanisms are: practitioner motivation and behaviour, facilitation by clinical champions, stakeholder

engagement and organisational culture. However, the views and experiences of local champions were mixed; including lack of role clarity and sustainability, lack of local support, and lack of opportunity to inform programme direction.

Conclusions: KCND is a complex programme of work implemented in a complex healthcare system. It offers resources to enable practitioners to make change happen. The ways in which practitioners interpret and act upon the resources in different contexts are pivotal to the programme's effectiveness. The phase II involves case studies to test propositions about relationships among these contexts-mechanisms-outcomes.

Funding source:

UK – Health Service (National)

50,001 – 100,000

1.2   Quality of life

1.2.1

Quality of life in long-term conditions (ViPER)

Monique Lhussier, Community Health and Education Research Centre, Northumbria University, UK

Co-authors: S M Carr; C L Clarke

Abstract:

There is an increasing policy drive for nurses to encourage and operationalise self-management and collaborative partnerships with people with long-term conditions. Central to this is a development of understanding of the premises to a good quality of life. This presentation reports on a project in which the quality of life of people with Multiple Sclerosis (MS) was assessed. In parallel, the researchers examined the meaning attributed to the term in policy documentation such as the NSF for Long-Term conditions (2005) (Lhussier 2009).

It emerges that quality of life is premised upon an understanding of six oppositional pairs of:

- Life and death (because to talk about 'quality of life' is to assume a clear and fundamental difference between the two concepts)
- Health and disease (because people with long-term conditions are often assumed to have a poorer quality of life)
- Independence and dependence (because maintaining independence is one of the key aim of health care practice in long-term conditions)
- Empowerment and disempowerment (because patient empowerment is a key policy driver)
- Certainty and uncertainty (as the uncertainty of an illness trajectory impacts greatly on people's perception of their quality of life)
- Ability and disability (because disability is to be avoided for as long as possible in MS)

Drawing on the data collected, this presentation aims to expose and critique these six oppositional

pairs so that understanding of quality of life in long-term conditions can be enhanced and contextualised. Thus this presentation does not aim at solving definitional or measurement issues, but at engaging practitioners in critical thinking about such a key concept as quality of life. Such an engagement in questioning of pre-understandings is crucial for nursing practice to evolve and adapt to changing population needs, as the prevalence of long-term conditions continues to increase.

Recommended reading:

Department of Health (2005) The National Service Framework for Long-term Conditions. London, HMSO

Lhussier M (2009) Quality of life: Nomadological Insights – A Nomadic Exploration of Quality of Life in Long-Term Conditions. VDM Verlag. Saarbrucken.

Funding source:

No Funding

1.2.2

Social support and quality of life in Iranian hemodialysis patients

Forough Rafii, Faculty Member, Center for Nursing Care Research, Iran University of Medical Sciences, Iran

Co-author: Rambod Maasoumeh

Abstract:

Background: End stage renal disease and the resulted need for hemodialysis is a significant public health problem in both developed and developing countries. Despite improvement in the treatment measures, the level of health-related quality of life is much lower for these patients than for the general population. Religiosity and spirituality may have roles as coping mechanism for chronic illness. However, there are no published data about perceived social support and quality of life in Muslim HD patients.

Aim: To describe the relationship between perceived social support and quality of life in Muslim hemodialysis patients of Iran.

Design: A cross-sectional design was used. The setting was hemodialysis units affiliated to Iran University of Medical Sciences. 202 Muslim hemodialysis patients were selected by census during 2007.

Method: The Persian versions of 'Personal Resources Questionnaire 85' (PRQ-85) part II and the 'Ferrans and Powers quality of life Index – dialysis version' were used. The data were analyzed using chi-square non-parametric test, and Spearman's rho correlation coefficients. **Findings:** There were a statistically significant relationship between perceived social support and health/ functioning (r = 0.65, p≤0.05), socioeconomic (r = 0.67, p≤0.05), psychological/ spiritual (r = 0.63, p≤0.05), and family subscales of quality of life (r = 0.51, p≤0.05). Total quality of life was also significantly correlated with perceived social support (r= 0.72, p=0.00).

Conclusion: Perceived social support is associated with quality of life in Iranian hemodialysis patients. It is important to reflect on the impact of culture and religion of Iran on quality of life of hemodialysis patients and their perceived social support. Keywords: Quality of life, Perceived social support, Hemodialysis patient, Nursing, End Stage Renal Disease, Muslims.

Recommended reading:

Al-Arabi, S. (2006). Quality of life: subjective description of challenges to patients with end stage renal disease. Nephrology Nursing Journal, 33(3), pp 285-293.

Hemodialysis population and its relationship to satisfaction with medical care, satisfaction with life, and adherence. American Journal of Kidney Diseases, 44(3), pp 488-497.

Bloor, E.L., Sandler, S.R., Martin, C., Uchino, N.U. & Kinney, Y.A. (2006). Associations between emotional support and health related quality of life. Journal of Social and Clinical Psychology, 25(1), pp 96-116.

1.2.3

Exploring predictors of quality of life and patient self-management in peripheral arterial disease

Martyn Jones, School of Nursing and Midwifery, University of Dundee, UK

Co-authors: S Joice; C Johnstone; W Lauder; P Stonebridge

Abstract:

Background: Peripheral Arterial Disease (PAD) is a progressive ischaemic condition associated with leg pain, an inability to tolerate normal activity and reduced quality of life (QoL). UK prevalence ranges from 3%-20% ($\leftarrow$ 60-≥75 yrs) (Breek, J.C. et al, 2001). This study examined the demographic, clinical, and psychological factors associated with perceived QoL in PAD.

Methods: A consecutive cohort of patients (N= 203) attending local Intermittent Claudication clinics (GP referred) were invited to participate in this longitudinal survey. Patients included were suitable for conservative management not requiring immediate revascularisation. Measures included demographic, clinical (APBI-Ankle brachial pressure $\leftarrow$.95 indicating PAD; BMI, BP) psychological (Illness Perceptions, Quality of life, beliefs perceived loneliness and distress) and self management.

Findings: Ninety nine participants were recruited (49% response), 85 with APBI ≤.95. Participants were mainly male (n=64), retired (n=71). There were no PAD/no-PAD differences on demographic and clinical variables beyond ABPI. The no-PAD group reported stronger beliefs (M= 6.91) that treatment would help than PAD (M= 4.07) (t(66)=-

2.46, p=.016). Illness representations of consequence, emotion, identity and distress explained 65% of variance in QoL (F(4,75)=35.10 p =.001). Age and gender, APBI, loneliness, and concern were unrelated. Some 42 of the PAD group reported that they could neither prevent nor reduce their pain. Twenty-three participants reported they could prevent pain but only twenty-one described the activities they performed. At 9 months follow-up, 40 PAD respondents reported improved QoL, fewer symptoms, perceived less consequence and concern, showed greater understanding and self-management activities than previously.

Discussion: QoL was predicted more by the way the individual represented their illness and the distress they perceived, than by clinical or demographic variables. Many patients had discovered self-management activities that prevented and reduced their pain. Improvements in QoL at nine month follow-up were associated with a better understanding of PAD and increased self management activities.

Recommended reading:

Breek, J.C. et al, 2001. Quality of life in patients with intermittent claudication using the World Health Organisation (WHO) questionnaire. European Journal of Vascular & Endovascular Surgery, 21(2), pp. 118-22

Treat-Jacobson, et al., 2002. A Patient-derived Perspective of Health-related Quality of Life With Peripheral Arterial Disease. Journal of Nursing Scholarship, 34(1), pp. 55-60

Leventhal H, Nerenz DR, Steele DS. (1984) Illness representations and coping with health threats. In: Baum A, Taylor SE, Singer JE, (Eds.), Handbook of psychology and health (pp219 – 52). Hillsdale, (NJ): Erlbaum.

1.2.4

Service quality in intensive care assessed by patients using the SERVQUAL scale

Maria Angeles Margall, University of Navarra, Spain

Co-authors: R Goñi; M C Asiain; E Regaira; M Sola; M Del Barrio

Abstract:

Background: Patient assessment of the quality of the service they receive is important for the implementation of strategies to improve care quality.

Aims:

• To assess care service by means of the analysis of the difference between what Intensive Care Unit patients expected and what they perceived.

• To analyse whether there is a relationship between the care service as assessed by the patients and the socio-demographic variables.

Methods: A total of 142 conscious and oriented ICU patients were prospectively studied 24 hours after being discharged from the ICU, they were given the service quality measurement scale SERVQUAL, as adapted to a hospital environment by Babakus and Mangold (1992). This scale measures service quality based on the difference in the scores for the expectations and perceptions of the patients; positive scores show that the patients' perceptions exceed their expectations. The scale has five dimensions: Tangibles, Reliability, Responsiveness, Assurance and Empathy. It is made up of 15 items for perceptions and the same number for expectations, and has five degrees of response (1 strongly disagree – 5 strongly agree). Babakus and Mangold offered good validity and reliability for the scale; in this study the Cronbach's was 0.931 for perceptions and 0.970 for expectations, and the gap score between perceptions and expectations was 0.939.

Results: The mean score for perceptions (67.50) was higher than that for expectations (61.64). The mean gap score between perceptions and expectations for the total SERVQUAL scale was 5.86. It was also positive for each of the dimensions: Tangibles=1.55, Reliability=0.74, Responsiveness=1.26, Assurance=1.44, Empathy=0.87. No statistically significant associations were found between the service quality assessed by the patients and the socio-demographic variables.

Conclusions: The health care service perceived by the patients in the ICU exceeded their expectations, and bore no relation to socio-demographic characteristics.

Recommended reading:

Babakus, E., Mangold, W.G. (1992). Adapting the SERVQUAL Scale to Hospital Services: An Empirical Investigation. Health Services Research, 26(6), 767-786.

Parasuraman, A., Zeithaml, V.A., Berry, L.L. (1985). A Conceptual Model of Service Quality and Its Implications for Future Research. Journal of Marketing, 49, 41-50.

Chou, S.M., Chen, T.F., Woodard, B., Yen, M.F. (2005). Using SERVQUAL to evaluate quality disconfirmation of nursing service in Taiwan. Journal of Nursing Research, 13(2),75-84.

1.3 Efficiency

1.3.1

Learning and impact from 'The Productive Ward' programme in England

Jill Maben, National Nursing Research Unit, Kings College London, UK

Co authors: Elizabeth Morrow, Peter Griffiths, Glenn Robert, Simon Jones, Victoria Wood

Abstract:

Background: In a challenging economic climate the imperative for health care providers is to improve both the efficiency and quality of service provision. 'The Productive Ward: Releasing Time to Care' programme, which is based on the principles of Lean Thinking, has been rapidly and widely implemented across the National Health Service in England. The aim of this paper is to examine this national quality improvement programme from several stakeholder perspectives in order to capture lessons for future initiatives in the healthcare sector.

Methods: The programme was explored from the perspective of three key stakeholder groups using in-depth interviews with 15 national and regional stakeholders, a national web-based survey of 150 frontline staff, and case studies of implementation within five NHS hospitals (interviews with 58 staff).

Findings: The Productive Ward programme has been well received as a very valuable initiative by both senior and frontline staff in English hospitals. Staff reported many examples of operational efficiencies at a local level, including more time for better care, better organised wards and cost savings. Improvements in staff skills, teamworking, communication, ownership of change and satisfaction were also outcomes that were valued by staff.

Conclusions: The Productive Ward programme has deliberately framed Lean Thinking in a way that is perceived very positively by staff working at different levels of the health system. Whilst the perception of commercial 'productivity' initiatives and the language of Lean may act as barriers to engaging healthcare staff, Lean principles have been successfully translated, packaged and supported through the Productive Ward programme. As part of the programme, healthcare staff and their organisations are making use of Lean techniques as they strive to improve both service efficiency and the quality of patient care.

1.3.2

Delivering person centred care through 'the productive ward'?

Christine Boomer, Research Fellow, School of Nursing /Institute of Nursing Research, University of Ulster, UK

Co-author: Bernadette Gribben

Abstract:

Background: This presentation will report on the evaluation studies from 2 of the participating Trusts in the Northern Ireland regional pilot of the Productive Ward

Published literature indicates an immediate impact from the PW 'release of time to care'; it is less transparent how this time is utilised. It is important that we evaluate the impact initiatives have on meeting the reform agenda and ultimately in providing quality person centred cultures and person centred care practices.

Aims:

• Pilot implementation in each Trust

• Explore the impact on person centred care

Methods: Service evaluation – utilising the practice development principles (collaboration, inclusivity and participation)

- PW key performance measures

- Person-centred Nursing/Caring Index (Slater and McCormack, 2006/2007)

- Focus groups

- Interviews with ward managers

Findings: Changes in Survey data.

- Enthused staff with 'Quick wins'.

- Contribution to person-centred practice.

- Personal/professional development of individuals.

- Useful 'diagnostic tools' to examine practice.

- Requires expert facilitation and considerable investment at ward level.

- Un-registered staff can take a leading role in development.

Discussion: The 'releasing time to care' banner of the PW has the implicit intention of person – centred practice. However, it is quite process driven and requires expert facilitation to enable the values, behaviours and attributes of staff to be explored regarding their impact on person-centred practice. PW enables staff to explore current practices, 'quick wins' can help foster enthusiasm and motivate staff, and can be viewed as a 'way in' to commence development activity focusing on cultural issues impacting on person-centred practice.

Conclusion: The PW captures the motivation of staff and increases team communication and effectiveness, empowers staff to take ownership of their wards and take action for improvement. Early indications are that it has an impact on person centeredness. Further evaluation is required in this area.

Recommended reading:

McCormack B, McCance T, Slater P, McCormick J, McArdle C, Dewing J (2008) Person-Centred Outcomes and Cultural Change IN Manley K, McCormack B, Wilson V (Eds) International Practice Development in Nursing and Healthcare, Blackwell Publishing, Oxford.

NHS Scotland.(2008) HNS Scotland Releasing Time to Care Evaluation, July-December 2008.

1.3.3

An evaluation of releasing time to care in trusts within one strategic health authority

Sarah Starr, Programme Lead 'Productive Ward: Releasing Time to Care', Nursing Directorate, NHS East of England, UK

Co-authors: D Kelly; M Spencer

*sarah.starr@eoe.nhs.uk*

Abstract:

The NHS spends £17 billion per year on in-patient care, much of which is delivered by nurses (DH, 2003). Variation in patient satisfaction with ward based care is well-documented and exists alongside evidence of staff dissatisfaction with the care environment its effect and its effect on patient experience (Maben et al, 2007). In response to this, the NHS Institute launched the Releasing Time to Care (RTTC) programme in April 2008. The main focus of this programme is to engage frontline staff, mainly nurses, in implementing and defining the service changes they wish to see on their ward and for their patients. One SHA funded training and local facilitators in all 36 trusts with in patient beds. This evaluation reviews that implementation & its future sustainability.

Aims:

• To evaluate the impact of the Productive Ward on patient experience

• To evaluate the ways in which an increase in direct care time can lead to increased patient satisfaction & experience

• To assess ways in which the programme can be sustained and supported in future.

Methods: A mixed-methods evaluation was adopted. Data were collected regarding implementation plans & progress between April and October 2009. Case studies were conducted with three trusts. Semi-structured interviews were held with key stakeholders and frontline staff. Data were analysed using a Diffusion of Innovation framework (Greenhalgh et al, 2005).

Results: Findings showed an increase in the percentage (20-35%) of direct care time. Further improvements in ward organisation and care processes were achieved. However direct outcomes for improved patient experience were difficult to
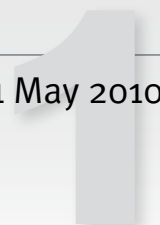
measure. The study highlighted the need to adopt more relevant metrics to measure improvements attributable to this programme. Recommendations were made on how to sustain and support the impact from this Lean service improvement initiative.

Recommended reading:

Department of Health (2003): Delivering the NHS Plan: Expenditure Report 1 April 2003. DH London.

Maben J., Latter, S. and Macleod Clark J. (2007): The challenges of maintaining ideals and standards in professional practice: evidence from a longitudinal qualitative study: Nursing Inquiry, 14, 2, pp 99-113.

Greenhalgh, T., Robert, G., Bate, P., McFarlane, F. & Kyrikiadou, O (2005) Diffusion of Innovations in Health Services Organisations. A systematic literature review. Report for the NHS SDO Programme. Oxford: Blackwell Publishing

Funding source:

UK – Research Council

50,001 – 100,000

1.3.4

Nurse staffing and quality of care in UK general practice: Cross sectional study using routinely collected data

Peter Griffiths, Director, Nursing Research Unit, Florence Nightingale School of Nursing & Midwifery, King's College London, UK

Co-authors: Mark Ashworth; Simon Jones; Jill Maben; Trevor Murrells; Dalia Dawoud

Abstract:

Objectives: To determine the association between the level of nurse staffing in general practice and the quality of clinical care as measured by the Quality Outcomes Framework (QOF).

Design: Cross sectional analysis of routine data.

Setting: English General Practice in 2005/6.

Methods: QOF data from 7456 general practices were linked with a database of practice characteristics, nurse staffing data, and census derived data on population characteristics and measures of population density. Multi-level modelling explored the relationship between QOF performance, the number of patients per whole time equivalent nurses and organisational factors.

Main outcome measures: The outcome measures were achievement of quality of care for eight clinical areas as rated by the QOF and reported achievement of ten clinical outcome indicators derived from it.

Results: A high level of nurse staffing (fewer patients per full time equivalent practice employed nurse) was significantly associated with better performance in 4/8 clinical areas of the QOF (COPD, CHD, Diabetes and Hypertension, p=0.004 to p $\leftarrow$ 0.0001) and in 4/10 clinical outcome indicators (diabetes HbA1C ≤ 7.4%, HbA1C ≤ 10% and total cholesterol ≤193mg/dl and stroke total cholesterol ≤193mg/dl p=0.0057 to p $\leftarrow$ 0.0001). We will also report the results of further modelling exploring the effect of other dimensions of organisational 'effectiveness', derived from the QOF including human resource factors.

Conclusions: Practices which employ more nurses perform better in a number of clinical areas measured by the Quality and Outcomes Framework. This improved performance includes better intermediate clinical outcomes suggesting real patient benefit may be associated with using nurses to deliver care to meet QOF targets.

1.4 Critical care

1.4.1

Family presence during resuscitation and/or invasive procedures in a hospital setting: The lived experience of patients, family members' and health care practitioners

Susan Hulme, Staff Nurse on Haematology Unit, North Tees Hospital, UK

Co-author: J Bettany-Saltikov

Abstract:

Background: The concept of family witnessed resuscitation (FWR) has become a controversial issue globally. Previous systematic reviews have focused primarily on quantitative measures. **Aims:** The aims of this systematic review were to identify the perceptions of FWR and/or invasive procedures (IP) from the perspectives of patients', family members' and health care practitioners (HCP's).

Criteria for considering studies in the review: Qualitative studies that evaluated the perceptions of the following populations toward FWR / IP were included as follows; Adult patients ---}18 years undergoing either cardiopulmonary resuscitation or invasive procedures; family members and HCP's involved in FWR within a hospital setting.

Systematic Search Strategy: A comprehensive search was conducted on twelve key databases for papers published between 1966 – till December 2007. These included Amed, British Nursing Index, CINAHL, Medline, Proquest amongst others. Hand searching, scanning reference lists and contacting authors of relevant studies was pursued.

Methods: All studies meeting inclusion criteria were selected by initially reading the title and abstract followed by reading the full text of each paper. Following this, the appraisal of methodological quality and data extraction for each included paper was conducted.

Results: Opposing views emerged from patients', their families and HCP's. Witnessing FWR greatly reassured family members that everything medically possible had been done for their loved one and patients' felt greatly comforted by family presence during resuscitation. Conversely however, HCP's felt 'invaded' by observation.

Discussion and Conclusions: All persons' involved in FWR should adopt a holistic perspective of patient and family member(s) requests during essential care delivery to their loved ones. Professionals' insight into this phenomenon is fundamental so as to identify if appropriate counselling / communication is needed. Implementation of set protocols is warranted; as is further research for the enhancement of FWR.

Recommended reading:

MacLean, S, L., Guzzetta, C, E., White, C., Fontaine, D., Eichhorn, D, J., Meyers, T, A. and Desy, P. (2003) "Family Presence During Cardiopulmonary Resuscitation and Invasive Procedures: Practices of Critical Care and Emergency Nurses'. Journal of Emer

Boudreaux, E, D., Francis, J, L. and Loyacano, T. (2002) "Family Presence During Invasive Procedures and Resuscitation in the Emergency Department: A Critical Review and Suggestions for Future Research", Annals of Emergency medicine, Vol 30, No 2, pp 193-

Madden, E. and Condon, C. (2007) "Emergency Nurses' Current Practices and Understanding of Family Presence During CPR", Journal of Emergency Nursing, Vol 33, No 5, pp 433-440.

Funding source:

No Funding

1.4.2

User experiences of critical care discharge: A meta-synthesis of qualitative research

Suzanne Bench, Florence Nightingale School of Nursing and Midwifery, King's College, London, UK

Abstract:

Background: Discharge from critical care to a general ward is stressful for patients, relatives and healthcare staff. Effective and timely information, based on patient need is a key factor affecting psycho-social well being in the early post critical care period (NICE, 2007; NICE, 2009). Little robust evidence exists, however, of the incorporation of user views in the design of discharge support strategies for this population group.

Aim: This aim of this paper is to present and discuss (in relation to discharge support), the findings of a meta-synthesis of qualitative data, focusing on users' perceptions of factors affecting critical illness recovery during the first month after critical care discharge.

Method: Qualitative primary research published in English between 1990-2009 was identified using online databases: CINAHL, MEDLINE, EMBASE, British Nursing Index, CDSR, ACP Journal Club, Cochrane library, Social Policy and Practice and PsycInfo. Adult studies, focusing on discharge

experiences from intensive care or high dependency care to a general ward were retrieved. Methodological appraisal of ten studies was conducted using a published framework. Findings of these studies were used to inform the review.

Results: Five key themes emerged: physical and psychological symptoms; making progress; the need to know; safety and security.

Discussion: Findings from this meta-synthesis suggest that patients and their families have a desire for more control over their recovery. This desire is, however, countered by a need to feel safe and protected, culminating in an expression of dependence on healthcare staff. Any effective information support strategy needs to take account of these findings.

Conclusions: This meta-synthesis provides insight into the user experience of critical care discharge. Findings will be used to inform the development of a more effective information support strategy for critical care patients and their families upon discharge to the general ward.

Recommended reading:

Coulter A, Ellis J (2006) Patient focused interventions; a review of the evidence. London, The Health Foundation.

NICE (2007) Acutely ill patients in hospital; recognition and response to acute illness in adults in hospital. National Institute for Health and Clinical Excellence. Available online at: www.nice.org.uk. Accessed 21/09/2009.

NICE (2009) Rehabilitation after critical illness. National Institute for Health and Clinical Excellence. Available online at: www.nice.org.uk. Accessed 21/09/2009.

Funding source:

No Funding

1.4.3

Family-centred care: A way to connect patients, families and nurses in critical care: A qualitative study using telephone interviews

Marion Mitchell, Griffith University, Australia
Co-author: Wendy Chaboyer

Abstract:

Background: Family-Centred Care is a model of care that incorporates both family members and the patient as the focus for care. Its effectiveness has predominantly been examined in paediatric settings. For decades, research has identified that family members of critically ill adult patients need to be physically close to their relatives, however, it is not usual practice to include family members in patient care activities in Australia.

Aims: This study sought to describe families' experiences of providing fundamental physical care to their critically ill relatives with the bed-side nurses' support.

Methods: Semi-structured telephone interviews were conducted with ten family members in late 2007. The interviews were analyzed using content analysis where data were grouped around central, recurrent ideas. A purposeful sample of family members who had performed care for their sick relative was drawn from a critical care unit in a large Australian hospital.

Findings and Discussion: The family members were very positive about their participation in their relatives' care. They felt well supported by the bed side nurse and were able to individualise the care they gave. Family members felt useful and they considered their provision of care improved communication with the nurses together with facilitating close physical and emotional contact with their relative. Three main themes emerged in relation to the family members' perceptions of providing fundamental care to their sick relative. They included: (1) 'Enacting Care'; (2) 'Connecting with Sick Relatives' and (3) 'Partnering with Nurses'. Connecting emotionally was important and providing physical care supported this connection.

Conclusions: This partnership approach successfully incorporated family members into the daily care of their sick relative and connected patients, families and nurses in a critical care unit within a Family-Centred Care model. The study adds to the knowledge of the benefits of family/nurse partnering within adult critical care areas.

Funding source:

No Funding

1.4.4

Critical care discharge information strategies: A focus group study involving patients, relatives and healthcare professionals

Suzanne Bench, Florence Nightingale School of Nursing and Midwifery, King's College, London, UK

Abstract:

Background: Discharge from critical care to a general ward is a stressful time for patients, relatives and healthcare staff. Effective and timely information delivery is a key factor affecting psycho-social well being in the early post critical care recovery period, and the development and evaluation of more effective strategies is recommended (NICE, 2007; NICE, 2009). Effective health information should be based on patients' needs (Coulter and Ellis, 2006). Little evidence exists, however, of user involvement in the design of information strategies for this population group.

Aim: To explore the user perception of critical care discharge information.

Objectives: To elicit the views of patients, families and health care professionals with regard to:

• The most effective methods of information delivery

• Information content

• Benefits and limitations of existing strategies

• Resource implications

Method: Commencing August 2009, six audio-recorded focus group interviews were held, two for each stakeholder group (patients/families; nurses; other healthcare professionals) (n=26). Participants were primarily recruited from a single NHS Trust. Additionally, ex critical care patients, and their families across England were recruited via the internet. Data collection is currently ongoing; this will terminate in December 2009 or before if data saturation is reached.

Results: Interim analysis conducted at the end of each focus group interview reveals some consistency between participant views and previously conducted research. Following transcription of all data, it will undergo qualitative thematic analysis, assisted by the computer software programme NVIVO 7.

Discussion: Findings will be discussed with reference to a meta-synthesis of qualitative research conducted by the author.

Conclusion: This study provides important information, which will be used to inform the development of more effective information strategies to support the adult critical care patient and their family when they are discharged to the ward.

Recommended reading:

Coulter A, Ellis J (2006) Patient focused interventions; a review of the evidence. London, The Health Foundation.

NICE (2007) Acutely ill patients in hospital; recognition and response to acute illness in adults in hospital. National Institute for Health and Clinical Excellence. Available online at: www.nice.org.uk. Accessed 21/09/2009.

NICE (2009) Rehabilitation after critical illness. National Institute for Health and Clinical Excellence. Available online at: www.nice.org.uk. Accessed 21/09/2009.

Funding source:

No Funding

1.5 Research methods

1.5.1

Research in a virtual world: How technology can assist research activity?

Carol Haigh, Professor in Nursing, Manchester Metropolitan University, UK
Co-author: M Wakeman

Abstract:

It is difficult to imagine any single development, within the last decade, that has impacted upon nurse research to the extent that the surge of digital learning technology has. Pod casting, social networking sites, document sharing and all of the opportunities offered by the second generation

of web design that allow for information sharing, known as web 2.0, have expanded the horizons of the nurse researcher beyond their host organisation to the whole of the global community. Nurse researchers are becoming more aware of the opportunities that web 2.0 offers and are slowly moving into the world of cyber collaboration.

The purpose of this practically focussed session is to show case the technological collaboration opportunities that are freely available to complement the research process. The presentation will demonstrate web sites that facilitate multi-user document creation and editing. The use of free meeting manager and communication programmes will be explored with the emphasis upon the role that such programmes play in research study steering committees. The role and use of social networking sites as data collection methods will be explored and the use of virtual environments as strategies for the provision of 'safe' research environments will be critiqued. In addition, the ethical and copyright issues surrounding some of these approaches will be discussed. Nursing research continues to develop and evolve and is, increasingly, moving towards multi-sited, multi-disciplinary research partnerships. Exploiting the organisational and collaborative platforms offered by Web 2.0 is the next great challenge for researchers

Recommended reading:

Haigh, C Jones, N (2005) An overview of the ethics of cyber-space research and the implication for nurse educators. Nurse Education Today 25(1) 3-8

Higher Education Funding Council. (2008) Copyright Exceptions and Web 2.0 Overview Paper. Available at www.web2rights.org.uk (Accessed 13/08/09)

Waskul,D (1996) Ethics of online Research: considerations for the study of computer mediated interaction. Available at http://venus.soci.niu. edu/~jthomas/ethics/tis/go.dennis (Accessed 18/08/2009)

Funding source:

No Funding

1.5.2

A matrix approach to managing your data

Camille Cronin, Lecturer, School of Health and Human Sciences, University of Essex, UK

Abstract:

What do you do with your data? Where do you put it? How do you intend to use it? These are all questions that need to be addressed in terms of managing a research project.

In this study a longitudinal case study design (Yin 2003) conducted over a two year period (2006-2008) was used to explore 5 students on work placements. As part of vocational practice, learning environments (hospitals, nursing homes, nurseries) were observed. Through interviews

critical learning incidents were examined as well as students' learning journals and course materials

Over the course of the two years, fieldwork was managed and data collected. It is here the matrix approach came to fruition. Over time as each student placement was explored a vast amount of data was collected from each observation, interview and journal per student per placement. The matrix approach contributed to the display and interpretation of data. As a strategy it manages large amounts of data over long time frames. It manages the handling of in-depth analysis, advances knowledge and enhances the development of evidence in qualitative research. It shows the trail of collection and shows clearly what you are working with.

This presentation will show why the matrix approach is useful and how easy it is to apply. While it is an aid to data management over prolonged periods, recording methods of data collection, it is limited as it does not draw conclusions. Ultimately its value lies (as in this study) in its integrity involving multiple analytical strategies. Through the triangulation of data and methods this enhances the trustworthiness of the study and its findings.

Combined with thematic analysis and critical reflexivity, the matrix approach provides the infrastructure for knowledge building and meaning making. Such a strategy can only benefit and strengthen the research process.

Recommended reading:

Yin R, K (2003) Case Study **Research:** Design and Methods. London: Sage Publications.

Funding source:

No Funding

1.5.3

Challenges of using participant observation

Liz Tutton, Senior Research Fellow, RCN Research Institute, School of Health and Social Sciences, Warwick University, UK

Abstract:

Participant observation is a useful research method/methodology for finding out what people do and how they make sense of the world. In practice it is fraught with difficulties and hence often not considered as a feasible choice when considering a research design. This paper will consider practical and theoretical issues of using participant observation drawing on the findings from three discrete studies. Each study used a different method of participant observation: taking on the role of clinical support worker; sitting in a hospital bay; and shadowing staff. Three elements will be considered; i) ethical, ii) emotional, and iii) the nature of the evidence gained.

i) In participant observation gaining consent by written, verbal or proxy means is a constant struggle particularly in acute areas where staff and patients

are constantly changing. Nurse researchers often have privileged access to private areas and use this data, but identifying the boundaries between the role of nurse and that of researcher can be difficult.

ii) Being part of a health environment is often an emotional experience due to the nature of suffering and closeness to poor care. How this data is used within the body of the work is variable and open to debate.

iii) Integrating participant observation with other sources of data is often challenging. Sometimes the value of participant observation as a tool for examining health care practice can often be lost and priority given to other sources of evidence such as interview data.

To conclude participant observation has great utility for uncovering embedded health care practices and in doing so contributes to knowledge, and influences policy and practice. This paper highlights some of the practical difficulties and debates in the use of participant observation and suggests ways to support its use in practice.

Recommended reading:

Baillie, L. (2007) The impact of urological conditions on patients' dignity. International Journal of Urological Nursing, Vol 1, No 1, pp 27-35.

Dixon-Woods M., Suokas, A., Pitchforth, E., & Tarrant, C. (2009) An ethnographic study of classifying and accounting for risk at the sharp end of medical wards. Social Science and Medicine, Vol 69, pp 362-369.

Tutton, E., Seers, K., Langstaff, D. (2008) Professional nursing culture on a trauma unit: experiences of patients and staff. Journal of Advanced Nursing, Vol 61, No 2, pp 145-153.

Funding source:

No Funding

1.5.4

Methodological reflections: The challenges of maintaining an inductive approach and managing bias in a longitudinal Interpretative Phenomenological Analysis (IPA) study

Sherrill Snelgrove, Lecturer, School of Health Science, Swansea University, UK

Abstract:

The distinguishing characteristic of longitudinal research is that the sample is investigated more than once (Shaughnessy et al. 2009). An IPA study of patients with Chronic low back pain (CLBP) over three years highlighted the challenges of maintaining an inductive and unbiased approach in a longitudinal, interview study.

A main aim of phenomenological research is to gain access to the participants' experiences relatively unhampered by a priori frameworks, biases

and presuppositions (Willig 2008). Therefore a focal task for the phenomenological researcher is to keep the analyses free from potential, distorting preconceptions; thus preventing the phenomenon from 'showing itself as itself' in a Heideggarian sense. This means that in order to achieve a close representation of the participants' experiences, the researcher has to 'bracket out' or withhold any pre-conceptions, assumptions and judgements, whilst also recognising access to the participants experiences are dependent upon the researcher's own conceptions (Smith 1996).

Whilst there is much written about the management of researchers conceptions in lengthy participant observational studies, there is very little documentation about how the researchers conceptions are managed in longitudinal, phenomenological, interview studies where there is also repeated contact.

The focus of this paper is upon the strategies used to maintain an open mind where accruing knowledge and implicit theorising arising from previous interviews threatened to jeopardise the integrity of later interviews. In keeping with a reflexive approach, there were opportunities to reflexively evaluate and address these preconceptions that helped inform the researcher's management of these issues. The strategies are outlined and the efficacy of a reflexive approach discussed.

This paper critically addresses well established, phenomenological rhetoric that has implications for generating methodological knowledge for nursing research.

Recommended reading:

Shaunessy, J.J., Zechmeister, E.B., Zechmeister, J.S. (2008) Research Methods in Psychology. (8th Ed). New York: McGraw – Hill Higher Education.

Willig, C. (2008) Introducing Qualitative Research in Psychology (2nd Ed). U.K: McGraw – Hill Higher Education.

Smith, J. and Eatough, V. (2006) Interpretative Phenomenological Analysis. Ch. 16. In Breakwell, G.M., Hammond, S., Fife – Shaw, C. and Smith, J.A. (2006) Research Methods in Psychology (3rd ed). London: Sage publications.

Funding source:

1.6   Sexual health

1.6.1

Decision-making in men who seek help in relation to a sexually transmitted infection (STI)

Paula Walls, School of Nursing, University of Ulster, UK

Abstract:

Decision-making in men who seek help in relation to a sexually transmitted infection (STI)

The control of STIs is now recognized as a global health priority (WHO, 2006) and the United Kingdom continues to have the highest rate of STIs in Europe (HPA, 2008). A delay in seeking treatment is potentially a factor in increasing the transmission of infections to others, and in increasing the risk of complications to the individual (WHO, 2006). Evidence suggests men are more likely to delay seeking help for an STI, therefore, understanding decision-making and the help seeking behaviour of men is important if STI control programmes are to be effective (WHO, 2006).

The findings of a grounded theory study of decision-making in men who seek for an STI will be presented to highlight:

• The stages that men go through in making the decision to seek help,

• The factors that influence decision-making, and;

• The implications for nursing practice.

A purposive and theoretical sample of 31 men and eight contacts was accessed via Brook N.I, and two Genito-Urinary Medicine Clinics in Northern Ireland.

Participants were interviewed between 2008-2009 using in-depth face-to-face interviews. Data collection and analysis were simultaneous combining coding and constant comparison of incidents, which informed further sampling and data collection.

A substantive theory was generated which highlights the complex, and often protracted nature of decision-making in men who seek help for an STI. This theory offers a unique insight into a hitherto little understood area with potential practical application. Decision-making emerged as a five stage iterative process comprising acknowledgement, recognition, interpretation, rationalisation and negotiation.

The rate at which men progress in their decision-making varies, and most men delay seeking help at some point. The factors that can influence male decision-making will be presented, and the implications for nursing practice highlighted.

Recommended reading:

Health Protection Agency. (HPA)(2008) Diagnoses and the rates of selected STIs seen at GUM clinics, United Kingdom: 2001-2007. London, HPA. Available online http;//www.hpa.org.uk, accessed 17/10/09

World Health Organisation, (2006). Aids and sexually transmitted disease: Vulnerable and risk groups. Geneva, WHO. Available online: – http://www.emro.who.int/asd/programmereas-Risk-groups.htm. 09/10/09.

Funding source:

1.6.2

Factors that limit women's ability to practice safer sex: A feminist perspective

Leah East, School of Nursing and Midwifery, University of Western Sydney, Australia

Co-authors: D Jackson; L O'Brien; K Peters

Abstract:

Background: Sexually transmitted infections (STIs) are widespread throughout the world and carry significant physical and emotional consequences. Though a number of public health campaigns have promoted safer sex strategies, prevalence of STIs among young women continues to increase.

Aim: This study aimed to identify factors that limit women's ability to practice safer sex, through exploring young women's stories of having an STI.

Methods: This research used a qualitative feminist methodology. Stories were collected in 2007 via online conversational interactions with ten women, and were thematically analysed using a feminist narrative technique.

Results: Findings from this study revealed that although all the women in this study were vulnerable to STIs through participating in risk activities, they did not believe themselves to be at risk due to perceptions they held about women who contract these infections. Further, the women's affection for their male partners led to the belief that these men were not a sexual risk nor a possible source of STIs, which superseded their risk perceptions. The women also revealed experiencing considerable barriers when attempting to negotiate the use of condoms, and difficulties in adequately protecting themselves when engaging in unplanned sexual activity.

Discussion: Findings suggest a need for health professionals to help young women to develop skills in negotiating safer sexual encounters.

Conclusion: Recognition of the factors that limit women's ability to practice safer sex and the perceived invulnerability to STIs among young women can guide healthcare education and promote the development of public health campaigns. Safer sex education needs to incorporate strategies to empower young women to practice safer sex and should aim to dismantle the perceived invulnerability to STIs held by some young women.

Funding source:

1.6.3

Discussing sexual and relationship health issues with young people within an acute paediatric setting

Erica Pritchard, Sister/Research Nurse, Alder Hey Childrens NHS Foundation Trust, UK
Co-authors: L Bray; C Sanders; J McKenna
erica.pritchard@yahoo.co.uk

Abstract:

Background: Research shows increasing rates of sexually acquired infections and teenage pregnancies within young people (Horseman 2005). Often relationship issues are not addressed by healthcare professionals due to a lack of confidence, education and feelings of embarrassment. Current literature within this field focuses on primary care and school settings (Metcalfe 2004) with little conducted within acute care.

Aim: To explore the discussion of sexual and relationship health with young people.

Method: Mixed method approach.

Questionnaires were distributed to young people aged 14 or over and their parents within an acute paediatric trust to gather data on what, if any, information they would like regarding sexual or relationship health whilst in hospital. 100 questionnaires were distributed with a 70% response rate.

Seven semi structured focus groups were held with multi-disciplinary team members to explore barriers and enablers relating to discussing sexual and relationship issues with young people.

Results: Questionnaires – Young people identified that they wanted information and wanted to raise questions, but described being too embarrassed to ask or felt that it was not the right environment. Parents felt the hospital was an appropriate place to discuss sexual and relationship health and should be covered as part of holistic care.

Focus Groups – Staff identified topics that they would and would not feel comfortable discussing with young people and this was affected by their personal upbringing, gender, age, professional role and experience talking about these issues. All felt they would benefit from training in discussing sexual and relationship health to improve knowledge and confidence.

Conclusion: The data highlighted that the acute trust has a role in providing sexual and relationship information and staff require further training in order to deal with this need. This research aims to inform the design of training opportunities which will be subsequently evaluated.

Recommended reading:

Metcalfe, T. (2004) Sexual Health; Meeting Adolescents Needs. Nursing Standard, vol 18, no 46, pp 40-43

Horseman, W. (2005) Sexuality in the Hospital Setting. Paediatric Nursing, vol 17, no 8, pp 27-29

1.6.4

Nurses as 'street level bureaucrats': An exploration of provider-initiated routine HIV testing in Nairobi, Kenya

Catrin Evans, Lecturer, School of Nursing, Midwifery and Physiotherapy, University of Nottingham, UK
Co-authors: E Ndirangu

Abstract:

Background: The policy of routine 'provider-initiated testing' (PITC) for HIV aims to radically increase numbers of people tested. PITC implementation in sub-Saharan Africa is controversial however, with concern over whether/how informed consent, privacy and confidentiality will be upheld in under-resourced health care settings (Evans & Ndirangu, 2009). Consequently, rigorous global policy guidelines have been produced to ensure good practice (WHO/UNAIDS 2007).

Quantitative research from Kenya demonstrates PITC's efficacy in increasing testing uptake, however qualitative evidence on the implementation process is lacking.

Research Aim and Methods: This study aimed to explore PITC implementation from a nursing perspective. Fifteen qualitative interviews and two focus groups were conducted in 2008 with nurses working in Government health facilities in Nairobi. Data were analysed thematically.

Results: Nurses clearly understood the ethical principles underlying HIV testing guidelines. However most participants recounted instances where the principles of confidentiality and informed consent had been breached â " usually in situations where nurses had grave concern for a patient's or third party's well being. Nurses employed a range of creative communication strategies that resulted in 'coded disclosure'. Nurses' actions were also strongly shaped by a sense disempowerment in the workplace and in PITC policy making.

Conclusions: On one level, the study findings give cause for concern, confirming fears of poor practice in HIV testing. However, this paper draws upon Lipsky's (1980) concept of the 'street level bureaucrat' to argue that global standardised guidelines will necessarily undergo processes of local interpretation and translation by actors on the front lines of policy implementation. Nurses' actions represent a response to acute ethical dilemmas in cultural and health system contexts very different to those of the West.

The findings suggest that clinical supervision and involvement of nurses in PITC service development are required to support the development of context-specific good practice in PITC.

Recommended reading:

Evans, C & Ndirangu, E, 2009. The nursing implications of routine provider-initiated HIV testing and counselling in sub-Saharan Africa: A critical review of new policy guidance from WHO/UNAIDS. International Journal of Nursing Studies, 6(5), 723-731.

W.H.O./UNAIDS. (2007). Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities. Geneva: World Health Organisation.

Lipsky, M. (1980). Street Level Bureaucracy: Dilemmas of the Individual in Public Service, New York, Russell Sage

1.7   Violence

1.7.1

actors affecting Israeli nurses' reports of violence perpetrated against them

Merav Ben Natan, Lecturer Pat Mattews Academic School of Nursing and Nursing Department Tel Aviv University, Hillel Yaffe Medical Center, Israel
meraav@hy.health.gov.il

Abstract:

Aims and objectives: The aim was to examine whether the guiding conceptual model, constructed of the variables: assailant traits, victim traits and type of violence, succeeds in predicting nurses' decision to report violence perpetrated against them in the workplace.

Background: Violence against nurses in the workplace is universal. The proportion of nurses subjected to violence worldwide ranges from 82%-98.5%. Violence has negative implications for nurses, their patients and the medical facility. Nonetheless, violent incidents are only infrequently reported (20%-25%) even though reporting is required by Israel's Ministry of Health.

Design: Quantitative correlational design.

Method: Data was gathered with a structured questionnaire, constructed specifically for the current research and based on the literature review and research model. The research population was sampled by convenience sampling and consisted of nurses from general hospitals in northern and central Israel.

Results: The research consisted of 220 nurses, of whom nearly 72% (n=158) had experienced violent incidents over the past year, mainly verbal abuse perpetrated by patients' relatives. Only 26.6% (n=42) reported violent incidents in written form. Most reports were submitted to the nurse in charge of the department. Correlations were found between assailant traits (identity and mental state) and victim traits (sociodemographic characteristics and attitudes on and perceptions of reporting) – and intention and actual report. Nurses' normative beliefs regarding reporting violence had the greatest effect on intention to report.

Conclusions: The conceptual model, excluding type of violence, succeeded in predicting intention to report of violence by affected nurses, and signifi-

cant others were found to have the greatest effect on intention to report.

1.7.2

Emergency nurses fostering resilience: Resisting the negative sequelae of violence

Lauretta Luck, School of Nursing and Midwifery, University of Western Sydney, Australia
Co-author: D Jackson

Abstract:

Background: Emergency Department (ED) nurses experience high levels of violence in the workplace. The literature reports the sequelae of workplace violence is multifactorial, ranging from intra and inter personal consequences, occupational health and safety issues through to fiscal and institutional costs.

Aims: The purpose of the study was to extend the current knowledge about the phenomena of violence towards ED nurses when the agent of violence was the patient, their family or friends. This paper will present one of the findings from a larger study (see Luck, Jackson, & Usher, 2007, 2008; 2009). Specifically, it will discuss the personal strategies that ED nurses' used during their routine nursing practice when there was a violent event or potential for violence, and the initial consequences of violent events for those nurses.

Methods: A mixed methods instrumental case study design was used. Data were collected in 2006 via 290 hours of participant observation, 16 semi-structured and 13 unstructured open ended interviews, organisational documents and researcher journal. Data were analysed thematically using NVivo 2 software and via descriptive statistics.

Results: Narratives and observational data analysis established that the Emergency nurses resisted the potential negative personal and work related effects of violence in their workplace. The ED nurses displayed the qualities of hardiness and stamina and informally used validating and debriefing strategies, thereby fostering resilience to violence.

Conclusions: Findings from this study offer new insights into how ED nurses engaged in an active process of developing resilience and hardiness as individuals, and as a team, to resist the negative sequelae of violence. Further, the preferred mechanisms for support included informal, spontaneous peer support. These findings have not been previously revealed and can inform organisational support strategies for ED nurses who experience violence.

Recommended reading:

Luck, L., Jackson, D., & Usher, K. (2007). STAMP: components of observable behaviour that indicate potential for patient violence in emergency departments. Journal of Advanced Nursing, 59(1), 11-19.

Luck, L., Jackson, D., & Usher, K. (2008). Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. Journal of Clinical Nursing, 17(8), 1071-1078.

Luck, L., Jackson, D., & Usher, K. (2009). Conveying caring: nurse attributes to avert violence in the ED. International Journal of Nursing Practice, 15(3), 205-212.

1.7.3

Psycho-social factors affecting elders' maltreatment in long-term care facilities

Merav Ben Natan, Lecturer, Pat Mattews Academic School of Nursing and Nursing Department Tel Aviv University, Hillel Yaffe Medical Centre, Israel
meraav@hy.health.gov.il

Abstract:

Study Purpose: The purpose of the current study was to examine and analyze the major variables affecting elders' maltreatment in nursing home residents. The study was based on two theoretical paradigms (Theoretical model for predicting causes of maltreatment elderly residents developed by Pillemer (1988) and the Theory of Reasoned Action developed by Ajzen & Fishbein, 1980) for understanding decisions made by staff to mistreat older nursing home residents.

Methods: The research population consisted of staff of 22 nursing homes in Israel. Six hundred questionnaires were distributed to these facilities and 510 were completed and returned.

Results: The findings indicate that slightly more than half of the staff sampled reported abuse of elderly residents over the past year, involving one or more of types of maltreatment. The total number of various types of maltreatment reported was 513. About two-thirds of the cases were incidents of neglect. 70% of the respondents reported that they had been present at incidents in which another staff member abused an elderly resident in one or more types of maltreatment, while in such situations mental abuse and mental neglect were the most prevalent forms of maltreatment.

The findings show that staff attributes, i.e., the degree of emotional burnout and resident traits, i.e., their cognitive status impact physical and mental abuse; while institutional features, i.e., staff turnover rate and staff characteristics; their level of emotional fatigue; impact physical and mental neglect. Finally, resident traits, i.e., their dementia, are the most significant variable influencing the total number of maltreatment cases.

Conclusions: This is the first study that examines elder maltreatment in the long term care population in Israel. The research findings lead to an expanded and improved research model for assistant nurses planning to prevent the phenomenon.

1.8 Education

1.8.1

Learning in nurse practitioners (LiNP): An investigation of workplace learning

Debra Sharu, Senior Lecturer, Nurse Practitioner Program, Health and Social Care, University of Cumbria, UK

Abstract:

This discussion will draw upon findings from Learning in Nurse Practitioners (LiNP), a longitudinal investigation of workplace learning of primary care Advanced Nurse Practitioners. The research explores the first year of practice in the ANP's new position and addresses three central questions:

• What is being learned?

• How is it being learned?

• What factors affect the level and direction of learning in newly qualified ANPs?

The introduction will include a brief discussion on the background, aims and methodology. The primary focus will be on the findings of the first question, What is being learned, the resulting typology and the shape of learning trajectories that is unique to ANPs.

Based on the premise that the majority of learning at this stage takes place at work, both formally and informally, evidence was collected by a series of interviews and observations over approximately one year. This involved two initial pilot studies, preliminary interviews of 14 ANPs, then further interviews and observational visits to the participant's respective places of employment. Face to face and telephone interviews with managers and facilitators were also undertaken. All observations and discussions were transcribed and analysed using a Nud*ist (N6) computer research package. Categories and themes derived from findings of an ESRC investigation conducted by the University of Sussex (Eraut, M 2006), were adapted to form a final theoretical framework that addressed the three central questions.

Of particular note was the recognition of learning trajectory patterns that were central in fostering ANP development. Being able to depict an individual's current position as points along this 'learning curve' can show what particular support is required at different stages of learning, may flag up why some low points occur and can illustrate how contextual and organisational factors can alter the range and quality of acquired skills.
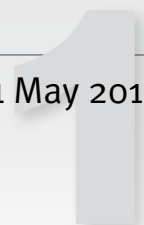
Recommended reading:

Eraut, M. (2006), Early Career learning at Work: Project LiNEA Final Research Report for ESRC/TLRP University of Sussex.

1.8.2

Peer teaching in practice: Final year students teaching vital signs to novice students

Lisa McKenna, School of Nursing and Midwifery, Monash University, Australia
Co-author: J French
lisa.mckenna@med.monash.edu.au

Abstract:

Background: According to the Australian Nursing and Midwifery Competency Standards (2008), registered nurses are required to undertake teaching as part of their professional responsibilities. However, many express reluctance and feeling unprepared. With this in mind, a semester-long unit was designed to equip final year students with knowledge and skills to enable them to teach, assess and evaluate workplace education. As part of the unit's assessment, students participate in teaching either TPR or BP with first year students in clinical laboratories, developing and implementing a relevant teaching plan with one or two novices.

Aim: The study sought to explore the impact of an education unit incorporating peer teaching in the undergraduate curriculum on final and first year nursing students.

Methods: The Peer Teaching Experience Questionnaire (PTEQ) (adapted from Iwasiw & Goldenberg, 1993) was administered to senior students and Clinical Teaching Preference Questionnaire (CTPQ) (Iwasiw & Goldenberg, 1993) to junior students. In addition, focus groups were conducted to explore any issues arising in greater depth.

Results: Final year students reported increased confidence in their knowledge and teaching ability, promoted reflection on their own learning and found the experience rewarding overall. Similarly, first year students reported enjoying the experience, collaboration with their senior peers, and less anxiety in performing skills than if supervised by an academic. Overall, final year students recognised more strongly that teaching was a part of nurses' roles than the first year students. Qualitative data suggested some inconsistency in teaching, creating anxiety while peer assessment was intimidating for some. Junior students appreciated the smaller learning groups than normal. Senior students suggested there should be more similar experiences in the course.

Discussion and Conclusion: Evaluation data indicates a successful and extremely worthwhile experience with many benefits. In addition, it supports the need for unit offerings supporting peer teaching in undergraduate nursing.

Recommended reading:

Australian Nursing and Midwifery Council (2008) National Competency Standards for the Registered Nurse. ANMC: Canberra.

Iwasiw, C. & Goldenberg, D. (1993) Peer teaching among nursing students in the clinical area: effects on student learning. Journal of Advanced Nursing, Vol 18, no 4, pp 659-68.

1.8.3

Real world or out of this world? An evaluation of the effectiveness of simulation in teaching blood pressure measurement

Karen Ousey, Divisional Head Acute and Critical Care, Nursing and Health Studies, University of Huddersfield, UK
Co-author: M Bland

Abstract:

Introduction: The use of stimulation, in the form of clinical skills labs, has been widely used in undergraduate nursing programmes for decades, yet little is known about the effectiveness of this educational strategy. The School of Nursing, Universal College of Learning, New Zealand, and the Department of Nursing and Health Studies, University of Huddersfield, England, have collaborated to evaluate the usefulness of simulation within their respective undergraduate nursing programmes. One clinical skill, blood pressure measurement, was selected as the focus for this study.

Methods: A mixed method approach for data collection was used. Anonymous surveys were distributed to 140 year one student nurses from both institutions before and after their first clinical placement, and also to their clinical lecturers and clinical preceptors.

Results: Preliminary data analysis suggests that students had limited knowledge about how to measure blood pressures prior to the simulation sessions. Following the simulation they felt prepared to undertake the skill in clinical practice but only with supervision. Interestingly mentors and clinical preceptors were confident in the student's ability to monitor blood pressures unsupervised.

Discussion: Roberts (2000); Wong and Chung (2002) associated the use of simulation with higher order thinking, inclusive of concepts such as problem solving, decision making and diagnostic reasoning; whilst Haigh (2007) discussed the value of simulation to the students as being associated to the knowing 'why' and the inclusion of peers in the process for discussion purposes. The data collected suggests that mentors believed

the students' cognitive and problem solving abilities were sufficiently developed to perform the procedure safely following the simulated clinical experience; yet the students did not consider their skills were sufficiently developed to undertake monitoring without supervision.

Recommended reading:

Haigh J. (2007). Expansive learning in the university setting: The case for simulated clinical experience. Nurse Education In Practice 7, 95-102.

Roberts, J. D. (2000). Problem-solving skills of senior student nurses: An exploratory study using simulation. International Journal of Nursing Studies 37, 135-143.

Wong, T.K.S., & Chung, J. W. Y. (2002). Diagnostic reasoning processes using patient simulation in different learning environments. Journal of Clinical Nursing, 11(1), 65-72.

1.8.4

Patient safety in nursing education: Results from a multi-site UK study

Alison Steven, School of Health, Community and Education Studies, Northumbria University, UK
Co-authors: P Smith; C Magnusson; J Lawrence; P Pearson

Abstract:

Background: Education, formal or informal, is 'key' to how nurses think, talk and write about keeping patients safe. Little is known about how 'patient safety' is incorporated into nursing education, or where and how nurses learn about patient safety. These data are part of a multi-site study exploring patient safety education across four health professions in the UK (Pearson, Steven et al 2009).

Aims: To study the formal and informal ways pre-qualification students from healthcare professions learn about Patient Safety.

Methods: Multi-method study drawing on educational theory (Eraut 1994) and illuminative evaluation. During 2006-2008 curricula of four nursing programmes were explored followed by two in-depth case studies. Data included curriculum and NHS documents (n=15), interviews with curriculum leads (n=4) and NHS leads (n=4), observations in academic (n= 6) and practice settings (n= 4), focus groups with staff (n=12), students (n=24) and patients (n=6). Analysis was iterative and ongoing throughout the study.

Results: Patient safety was not clearly visible in curriculum documents. Definitions of patient safety differed between the organisations, educators, staff and students.

Tensions exist between a 'no blame' culture and performance management. Students have few

opportunities to learn about organisational strategies and systems.

Students reported tensions relating to learning safe practice, role models and relationships with staff.

Discussion and Conclusions: Differing definitions and conceptualisations were found which need to be explored further as they influence education and practice. Links between the organisational context and pre registration education need to be strengthened. Relationships with practice mentors were crucial to learning but students noted a power imbalance as mentors assessed placements (Smith et al 2009). There is a need for effective role models in practice: the development training of practitioners in relation to patient safety is therefore crucial. Further research is needed in order to understand the complex relationships involved.

Recommended reading:

Pearson P, Steven A on behalf of the Patient Safety Education Study Group (2009) Patient safety in health care professional educational curricula: examining the learning experience, HMSO

Eraut, M. (1994), Developing Professional Knowledge and Competence, London, Falmer Press.

Smith P, Pearson PH and Ross F (2009) Emotions at Work: What is the link to patient and staff safety? Implications for nurse managers in the NHS, Journal of Nursing Management 17, 230-237

Funding source:

UK – Health Service (National)

100,001 – 500,000

1.9 Miscellaneous

1.9.1

Developing nursing capacity through doctoral study in UK universities: An investigation of international students' learning experiences

Catrin Evans, Lecturer, School of Nursing, Midwifery and Physiotherapy, University of Nottingham, UK

Co-author: K Stevenson

Abstract:

Background: The global advancement of nursing is dependent upon creating a cadre of professionals who are educated to doctoral level, who can subsequently build the evidence base for nursing and teach future generations (Ketefian 2008). Given that only 32 countries offer doctoral programmes, many nurses seek doctoral study overseas. The UK is currently a popular destination country and 20% of the total number of its doctoral nursing students are 'international' (Evans & Stevenson, 2009).

Objective: In a rapidly changing context of doctoral programme provision (Park 2007), this study sought to investigate the learning expectations and experiences of overseas doctoral nursing students in the UK.

Methods: Semi-structured qualitative interviews were conducted in 2008/09 with 17 international doctoral nursing students (representing nine countries) from six different schools of nursing across the U.K. Data were analysed thematically. All were enrolled on 'traditional' PhD programmes and 88% (n=15) planned to work in higher education institutions upon graduation.

Results: Students identified a range of social, linguistic and academic transitions that defined PhD study in the UK. The emphasis on unstructured self-directed study, being exposed to new epistemologies and the encouragement of critical analysis were all areas that students grappled with but came to appreciate over time. The nature of the supervision relationship and the academic environment were the most critical factors that influenced the learning experience. Almost all students had expected a more structured start to the PhD process. Many students expressed a strong desire for the development of links with UK clinical practice to be an integral part of their learning experience.

Conclusions: Doctoral programmes need to ensure that structures are in place to support international students at different stages of their doctoral journey. An international version of the professional doctorate may be a way forward in meeting the needs of future global leaders.

Recommended reading:

Ketefian, S. (2008). Doctoral education in the context of international development strategies. International Journal of Nursing Studies, 45, 1401-1402.

Evans, C and Stevenson, K. (2009). The learning experiences of international doctoral students with particular reference to nursing students: a literature review. International Journal of Nursing Studies, doi.10.1016/j.ijnurstu.2009.05.025

Park, C. (2007). Redefining the Doctorate. London: Higher Education Academy, http://www.heacademy.ac.uk/

Funding source:

UK – Higher Education Institution

10,001 – 50,000

1.9.2

Magnetic resonance imaging, knee arthroscopy and clinical decision-making: A descriptive study

Gayle Maffulli, Trials Manager/Research Nurse, Centre for Sports and Exercise Medicine, Queen Mary University, UK

Co-authors: S Derrett; G Walley; S Bridgman; P Richards; N Maffulli

g.walley@keele.ac.uk

Abstract:

Objectives: A randomised controlled trial (RCT) showed magnetic resonance imaging for patients waiting for knee arthroscopy did not reduce the number of arthroscopies. Our study aimed to identify decisions made by orthopaedic surgeons about whether patients on a waiting list should proceed to arthroscopy, and to describe surgeons' decisions.

Methods: Five surgeons were asked to Think Aloud (TA) as they made their decisions for 12 patients from the original RCT. Audio-tapes of the decision-making were transcribed for analysis.

Results: For five patients, surgeons agreed about proceeding with arthroscopy, although reasoning differed. In no cases did surgeons agree about not proceeding to arthroscopy. Agreement was more likely in patients with clinically diagnosed meniscal abnormality, and less likely in patients with osteoarthritis.

Conclusions: Surgeons' decisions were influenced by patient wishes. For some patients, the decision to proceed with arthroscopy was based solely on clinical diagnosis; MRI may not be advantageous in these cases. Surgeons disagreed more often than they agreed about the decision to proceed with arthroscopy, particularly when OA was diagnosed. This has implications for decision-making in the current NHS patient choice environment. Patients may choose a treatment provider from a list of available providers at time of original clinical assessment and diagnosis. The treating surgeon does not necessarily re-examine the patient until the day of surgery. Given the variation between surgeons about the merits of proceeding with arthroscopy, surgeons may end up in the invidious position of providing surgery to patients whom they do not believe will benefit from arthroscopy.

Funding source:

UK – Higher Education Institution

1,000 – 10,000
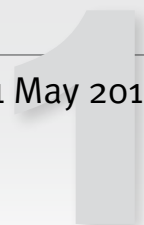
1.9.3

The merits of interviewing couples separately in a Heideggerian hermeneutic study on sexuality and intimacy

Bridget Taylor, Senior Lecturer & PhD Student, School of Health & Social Care, Oxford Brookes University, UK

Abstract:

Introduction: Heideggerian hermeneutic phenomenology seeks to understand how people interpret their place in their world (Benner, 1994). The person whose body has changed as a result of illness is challenged to develop a new 'ready to hand' (Heidegger, 2007) mode of engaging in the world, to make sense of their situation in the context of their relationships.

When considering the experiences of both patients and partners of patients, it is important to weigh-up the pros and cons of interviewing patients and their partners separately. For this PhD study, exploring the meaning of sexuality and intimacy in life-limiting illness, a decision was made to interview couples separately.

Content: This presentation discusses the merits of interviewing couples separately, drawing upon extracts from interviews with patients and their partners to illustrate the different ways that individuals make sense of their shared experiences as a couple; in adapting to their current situation and in anticipation of their future. These extracts are presented in the context of Heideggerian philosophy.

The implications for other research involving more than one person from the same family will be considered and recommendations made.

Conclusion: Whether patients and their partners are interviewed together or separately, different data will be generated. In this UK study, there have been clear advantages in interviewing individuals separately in trying to understand how individuals living with a life-limiting illness make sense of this personal aspect of their lives.

Recommended reading:

Benner P (Ed.) (1994) Interpretive Phenomenology: Embodiment, Caring and Ethics in Health & Illness. Sage Publications: London.

Heidegger M (2007) Being and Time (29th edition) (Translated by Maquarrie J & Robinson E). Blackwell Publishing: Oxford. (Original work published 1927).

2.1 Maternity and depression

2.1.1

Personal resources: Identifying sources of self-efficacy in parenting support

Karen Whittaker, Senior Lecturer, School of Nursing and Caring Sciences, University of Central Lancashire, UK

Co-author: S Cowley

Abstract:

Background: Parenting training/support is a key component of wealthier nations' intervention strategies for improving life chances (WHO 2002). Measurement of self-efficacy as a predictor of competence is often used as a parenting programme outcome variable (Sanders and Woolley 2005).

Aims: the study was a theory driven realistic evaluation of parenting support. Drawing on Bandura's (1977) theory of self-efficacy, it aimed to identify evidence of 'what works for whom in what circumstances, within a UK parenting programme'.

Methods: Permission was obtained from an NHS Local Research Ethics Committee and an advisory group of practitioners and parents provided ongoing guidance and commentary. A mixed methods approach to data collection was employed. This involved (1) validating and administering a questionnaire survey (incorporating Parenting Self-Agency Measure (PSAM) and subscales from the Self-Efficacy for Parenting Tasks Index (SEPTI) as outcome measures) of adults accessing formal parenting support over a 10 month period (n=168) and (2) a qualitative study of 18 purposively selected individual and collective case studies (mothers (n=38), fathers (n=2) and practitioners (n=21)). In-depth qualitative interviewing and methods of participant observation were used to study cases. Quantitative data were analysed using SPSS. Qualitative data were thematically analysed to identify evidence of the context, mechanism and outcome combinations pertinent to parents' parenting service experiences and exposure to self-efficacy sources.

Results: Survey data suggest that parents' tiredness influenced their sense of self-efficacy. Case study data illustrate how parents mainly drew strength from other parents attending groups.

Discussion: This will explore how health visitors (public health nurses) could carefully use interpersonal skills when facilitating community parenting groups/training so that parents can recognise and make use of sources of self-efficacy.

Conclusions: To strengthen parenting programme outcomes, strategies should include sufficient training of practitioners in understanding sources of self-efficacy, the use of interpersonal skills and community group facilitation processes.

Recommended reading:

Bandura A (1977) Social Learning Theory. New Jersey: Prentice Hall.

Sanders MR, Woolley ML (2005) The relationship between maternal self-efficacy and parenting practices: implications for parent training. Child:Care, Health & Development 31(1): 65-73.

WHO (2002) World Report on Violence and health. Available: http://www.who.int/violence_injury_prevention/en/ [Accessed 26/10/09].

2.1.2

First-time mothers: Maternal parental self-efficacy and postnatal depression

Patricia Leahy-Warren, Senior Lecturer, School of Nursing and Midwifery, University College Cork, Ireland

Co-author: Geraldine McCarthy, P Corcoran

Abstract:

Aim: This paper reports on a study on first-time mothers' perceived maternal parental self-efficacy at birth and six weeks; prevalence of postnatal depression at six weeks and the relationships between these variables.

Background: Maternal parental self-efficacy is a necessary component for successful parenting and important for mothers' sense of well-being and thus low levels may contribute to risk of depression. Little research evidence exists on the relationship between maternal parental self-efficacy and postnatal depression for first-time mothers in the first six weeks post child birth.

Design: A quantitative correlational prospective repeated measures design was used. Conceptual framework for the study is based on Bandura's self-efficacy theory.

Instruments: The Perceived Maternal Parental Self-Efficacy Scale and the Edinburgh Postnatal Depression Scale

Sample and Participation: Five hundred and twelve mothers completed and returned the first questionnaire at birth and 410 mothers at six weeks.

Findings: At birth, mothers reported an overall study sample mean self-efficacy score of 62.5 (SD = 8.0) indicating high levels of self-efficacy. At six weeks, mothers reported overall study sample mean self-efficacy score of 65.9 (SD = 8.2), which was higher than at birth indicating an increase over the first six weeks post delivery. This finding supports Bandura's theory, experiential learning increase self-efficacy, which was statistically significant ($p < 0.001$). Prevalence of postnatal depression was 13% at 6 weeks. The hypothesis there was a statistically significant relationship between maternal parental self-efficacy at 6 weeks and postnatal depression at 6 weeks (Chi-square = 18.26, df=2, $p < 0.001$) was supported.

Conclusion: Levels of maternal parental self-efficacy significantly increased over the six-week postnatal period. Nurses and midwives need to be aware of the significance of maternal parental self-efficacy in positively influencing maternal well-being. Universal assessments of maternal parental self-efficacy and postnatal depression are recommended to identify at risk mothers and develop individualised interventions.

Recommended reading:

Barnes, C. R., & Adamson-Macedo, E. (2007). Perceived Maternal Parenting Self-Efficacy (PMP S-E) tool: development and validation with mothers of hospitalized preterm neonates Journal of Advanced Nursing, 60(5), 550-560.

Cox, J., Holden, J., & Sagovsky, R. (1987). Detection of postnatal depression – development of the 10-item Edinburgh Postnatal Depression scale. British Journal of Psychiatry, 150, 782-786.

Bandura, A. (1997). Self-efficacy: The Exercise of Control. New York: Freeman & Co.

2.1.3

Are health visting postnatal depression services equitable?

Palo Almond, School of Health Sciences, University of Southampton, UK

Abstract:

A qualitative case study examined factors affecting equity in provision and access to postnatal depression services delivered by health visitors (public health nurses) in one primary care trust in the south of England, UK. Postnatal depression is a major public health problem world-wide. It affects the mothers', her husband's and baby's health in a number of adverse ways.

Trust documents were gathered. 16 health visitors were observed doing 21 home visits to antenatal and postnatal women where they planned to discuss, assess or treat women for postnatal depression. 20 semi-structured interviews were conducted with health visitors, nine with Bengali women (most via interpreters), 12 with English women, and nine with managers and other personnel. Ritchie and Spencer's Framework Analysis method was used to conduct analysis of documents and interviews.

The trust had taken several steps to provide equitable health care. A policy had been written enabling all health visitors to be trained in detecting and managing postnatal depression. Support groups for women with postnatal depression had been provided to improve access. However, some women were still not being assessed, particularly Bangladeshi women. Health visitors were not culturally competent. Whilst professional interpreters were available they were rarely used, translated patient information was unavailable. Bangladeshi women were not referred to support groups.

Recommendations: A thorough analysis of population demography is needed to ensure policy is culturally relevant. Training must include knowledge and skills to enable cultural competence. Research is needed on levels of inequity in the British health visiting postnatal depression services.

2.2 Gastrointestinal nursing

2.2.1

Enhancing the quality of oral nutrition support to hospitalised patients through the Knowledge to Action cycle

Kate Gerrish, Professor of Nursing, Centre for Health and Social Research, Sheffield Hallam University & Sheffield Teaching Hospitals NHS Trust, UK

Co-authors: S Laker; E Cotton; M McAlindon; I Ilott; K Bray; C Soreny. S Shearstone

Abstract:

Background: Risk of malnutrition / malnutrition among hospitalised patients with long-term conditions is a widespread problem leading to adverse health outcomes (Ferreira 2009). There is evidence to suggest that under-nutrition delays recovery, and lowers resistance to medical complications, with links observed between under-nutrition and lengthened hospital stay, morbidity and mortality (NICE 2006). Despite efforts targeted at improving the nutritional status of patients and the quality of nutrition support in hospitals, under-nutrition remains widespread among in-patients.

Aim: To enhance the quality of oral nutrition support provided by the multi-disciplinary team to adult patients with long-term conditions through the implementation of a malnutrition screening tool (MUST+) and associated care guidelines.

This study forms part of the knowledge translation activity of NIHR CLAHRC South Yorkshire.

Methods: The Knowledge to Action cycle (Graham et al 2006) provided a framework for trialling and evaluating two interventions designed to facilitate the uptake of MUST+ and care guidelines in a large teaching hospital. The interventions comprised:

• Ward-based nutrition champions

• Facilitation of the multi-disciplinary team by a dietitian

A multi-disciplinary action research approach was used to implement the two interventions. Baseline data were collected in September 2009 from 6 evaluation wards by means of observation, a survey of the multi-disciplinary team members' knowledge, attitudes and perceived barriers to nutrition support and organisational audit data. Baseline data were subsequently fed back to nutrition champions, the dietitian and ward teams to assist them in further developing nutrition support. Subsequent data collection which focuses on the 'user' experience of patients, carers and the multi-disciplinary team included observation, interviews followed by further feedback.

Findings: This paper reports on survey and observational data and the outcome of the first action research cycle.

Conclusions: A critique of the Knowledge to Action cycle as a means of facilitating knowledge translation will be presented.

Recommended reading:

Graham I, Logan J, Harrison M, Straus S, et al (2006) Lost in knowledge translation: Time for a map? The Journal of Continuing Education in the Health Professions, 26: 13-24

NICE (2006) Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition. London, NICE

Ferreira I, Brooks D, Lacasse Y et al (2009) Nutritional supplementation for stable chronic obstructive pulmonary disease. The Cochrane Collaboration. Oxford, Wiley

2.2.2

Safe and effective laparoscopic entry technique in the obese woman undergoing gynaecological laparoscopy: A systematic review

Sarah Carter, Gynaecology, South Tees Hospitals NHS Trust, UK

Co-author: J Bettany-Saltikov

Abstract:

Background: Laparoscopy, a minimally invasive surgical procedure, is used in gynaecology to enable pelvic and abdominal organs to be examined under direct vision. Approximately 250 000 women in the UK undergo some form of laparoscopic surgery each year. The prediction that twenty-eight per cent of females will be obese by 2015 (Foresight, 2007) will result in gynaecological laparoscopy in this group of women becoming more common. Over half of major complications associated with laparoscopy are related to the initial entry into the peritoneal cavity (Jansen et al., 1997, p599). The role of surgical care practitioner demands the knowledge and skills to perform safe entry.

Objectives: To identify the safest and/or most effective laparoscopic entry technique in the obese woman undergoing gynaecological laparoscopy.

Search Methods: The following data bases were searched: Cochrane Library, the online Aggressive Research Intelligence Facility, TRIP (Turning Research into Practice), MEDLINE, EMBASE and CINAHL. Reference lists and hand searching.

Selection Criteria:

• Study participants included women:

• Adult, undergoing gynaecological laparoscopic surgery; diagnostic, operative or a mixture of both.

• BMI 25.0.

• With or without previous abdominal surgery.

Main Results: Seven studies involving 461 obese women were included. Differences in sample size, complexity of operations, surgeon expertise and range of BMI were identified within the data. Based on successful entry, the Alignment of the Umbilical axis maneuver prior to the open/Hasson technique (Pelosi and Pelosi, 1998) was the most effective with a 100% success rate. The least successful was the sub-costal route with a 91% success rate. Complications were related to the complexity of procedure, and not entry technique.

Conclusion: Results suggest that Alignment of the Umbilical Axis, prior to the open/Hasson entry, is superior to other techniques. However, generalisation from these findings should be viewed with caution due to heterogeneity within the included studies.

Recommended reading:

Foresight Report 2nd edition (2007): Tackling Obesities: Future Choices: Modelling Future Trends in Obesity and their Impact on Health. Government Office for Science [Online] http://www.foresight.gov.uk/Obesity/14.pdf [accessed; April 8th 2009].

Jansen FW, Kapiteyn K, Trimbos-Kemper T, Hermans, J, and Trimbos JB. (1997) Complications of laparoscopy: a prospective multicentre observational study. British Journal Obstetrics & Gynaecology Vol 104, No.5, pp 595-600.

Pelosi, III, M.A. and Pelosi, M.A. (1998) Alignment of the umbilical axis: An effective manoeuvre for laparoscopic entry in the obese patient. Obstetrics & Gynecology, Vol.92, No.5, pp 869-872.

2.2.3

Nurse-led group education for patients with gastro-oesophageal reflux disease in primary care: Findings from a pilot study

Lesley Dibley, Research Fellow, Florence Nightingale School of Nursing and Midwifery, Kings College, London, UK

Co-authors: C Norton; R Jones

Abstract:

Background: Up to 50% of patients with gastro-oesophageal reflux disease (GORD) have persistent symptoms despite taking proton pump inhibitors (PPIs) regularly. No previous UK study has tested a behavioural change intervention to help patients to improve their symptoms.

2

Aims: To determine whether a primary care nurse-led intervention to address patient behaviours which promote GORD symptoms (based on a previous literature review (ref)) results in symptom improvement, increased sense of control and reduced requirement for prescribed medication.

Methods: A group programme (four x 1.5 hours) focussing on diet and stress was delivered to patients on regular PPI prescriptions with reflux symptom recruited in three GP practices. Pre and post intervention data included the Brief Illness Perception Questionnaire (BIPQ), and the GORD Impact Scale (GIS).

Results: 42 subjects (m19, f 23) aged 31-86 years took part. There was significant improvement in the BIPQ (p<0.001) and GIS (p<0.008) at three months post-intervention compared to pre-treatment. Patients also reported benefits including understanding relevant anatomy and physiology, learning behavioural techniques to change eating patterns and manage stress, identifying actual and potential triggers, and developing and executing action plans. No reduction in PPI use was seen. Greatest improvements were demonstrated in the patient's sense of control, perception of symptoms and understanding of reflux.

Discussion: Patients with persistent reflux symptoms can be challenging to manage, often remaining symptomatic despite long-term PPI prescriptions and additional over the counter medicines. The behavioural change intervention for GORD enhanced self-management and led to perceived symptom improvement and sense of control at three months. With targeted support, patients are able to change behaviours and lifestyle to improve health status. Follow-up at 12 months is planned.

Conclusion: A nurse-led behavioural intervention, alongside medical management, could improve symptom control for patients with persistent reflux symptoms and warrants further evaluation.

Recommended reading:

Lorig K (2001) Patient Education: A Practical Approach Sage: Thousand Oaks

Barlow J, Wright C, Sheasby J, Turner A, Hainsworth J (2002) Self-management approaches for people with chronic conditions: a review Patient Education and Counseling 48 (2): 177-187.

Mason J & Hungin APS (2005) Review article: gastro-oesophageal reflux disease: the health economic implications Alimentary Pharmacology & Therapeutics 22 (Suppl.1): 20 – 31.

2.3 Methods

2.3.1

Meeting the challenge of identifying and conducting clinically relevant projects in a large teaching hospital

Irene Mabbott, Learning and Development Department, Sheffield Teaching Hospitals NHS Foundation Trust, UK

Co-authors: Judith Palfreyman; Jeanette Roberts, Nana Theodourou, Claire Smith

Abstract:

Although basing practice on evidence is seen as the gold standard encouraging staff to engage in this activity can be difficult and time consuming (McGeehan et al, 2009). One initiative that has been established for a number of years within our local Trust is a clinician led group called the Evidence based Council. This group seeks to share best practice and address common issues that affect the whole five site organisation. Projects undertaken by the Council start as informal discussions during the regular meetings. If there is a consensus that it is a shared problem then the next step is to establish a subgroup of interested members who will plan the project and identify the relevant links within the Trust. To date ten areas have been examined by council members. Examples include promoting a good nights sleep, breaking bad news, intravenous access and the use of natural laxatives. So far three projects have secured funding, five articles have been published in peer reviewed journals and two are currently ongoing. Other projects have been incorporated into local guidelines and have made significant changes to clinical practice within the Trust (Ryton et al, 2007).

The Evidence Based Council has a distinctive way of harnessing the enthusiasm of its members and linking the ideas and discussions to the wider organisation. In this way, realistic projects can get the impetus needed to get started and be maintained in today's NHS (Palfreyman et al, 2003).

This paper will illustrate the challenges and rewards associated with developing and sustaining small scale clinically relevant projects within the hospital environment. Examples of projects will be provided to illustrate the development pathway from the initial idea to the final closure of the project.

Recommended reading:

McGeehan, B, Debbage, S, Gilsenan, I, Jennings, A, Jennings, C, Laker, S, Thompson, S, & Beastall, H, (2009) Supporting clinical innovation: An organisation wide approach to practice based development, Practice Development in Health Care, Vol. 8, No. 1.

Palfreyman S, Tod A & Doyle J (2003) Learning from experience: Promoting evidence based practice, Practice Development in Health Care, Vol. 2, No. 2, pp87-98.

Ryton, B, Grant, V, Little, A, & Gilsenan, I, (2007) Step to it: A toolkit for evidence based practice, Practice Development in Health Care, 6(4) pp213-20

2.3.2

Multi-disciplinary research and user involvement – What is the added-value to nursing research?

Charlotte Clarke, Community, Health and Education Studies Research Centre, Northumbria University, UK

Abstract:

Background: Multi-disciplinary research and user involvement was highlighted by the RAE2008 as a strength of sucessful nursing research submissions. It is therefore, appropriate to explore some of the boundaries of multi-disciplinary research in which users are involved and ask in what ways nursing and patient care can benefit from this.

Research: This presentation will draw on the experiences of two very diverse multi-disciplinary research groupings.

Enabling environments – modelling wellbeing of older people. This research network is funded by the MRC and draws together nursing, social gerontology, psychology, computing, medicine and mathmatical physics.

Information use in dementia care. This post-structuralist research project is funded by NIHR Research for Patient Benefit programme and brings together nursing, speech & language therapy, psychology and disability studies.

Conclusion: Multi-disciplinary research in which users are involved is challenging, not least in learning to use each others' language, but by focussing on the needs of patients, it brings new theoretical and methodological foci which add to the breadth and depth of research ascribed to nursing. It demands clear leadership and project management, but contributes to nurses being at the cutting edge of research and clinical practices.

2.3.3

Promoting research collaborations: The work of the Infectious Disease Research Network

Michael Head, Research Dept of Infection and Population Health, University College London, UK

Abstract:

Objectives: The Infectious Disease Research Network (IDRN) provides an innovative infrastructure that promotes multi-disciplinary collaborations, provides information on funding opportunities, organizes training events, and acts as a forum for encouraging high quality basic and translational infectious disease research.

Methods: We achieve this by several methods. These include running of research strategy

workshops to identify priority research topics and providing support to groups who are focussed on a specific research question. Support may include arranging further meetings, identifying extra collaborators and assisting with the financial projections for the project. We also run training events, and have various electronic resources, such as current funding and training bulletins, and an online researchers database.

We have also launched a student placement programme, that is actively working as a link between the scientific and medical student community and research institutions.

Results and outcomes: IDRN research outcomes include Flu-Watch (household cohort study on transmission of influenza), National Intestinal Infectious Disease Study (looking at diarrhoeal illness in the community) and a Medical Research Council fellowship looking at community-acquired MRSA. See http://www.idrn.org/research.php for a complete list.

We have also successfully been involved in many multi-disciplinary collaborations, a key example being the scabies project that is currently running and is a collaboration between nurses, epidemiologists and dermatologists. We will present details of this and other nursing-related collaborations as examples of our work.

Conclusions: The IDRN provides a model of how a small administrative infrastructure, with academic input from Network members, can initiate and support a wide range of collaborations, training events and information resources, ultimately leading to better collaborative research.

2.4   Attrition

2.4.1

I wasn't going to just pick up a pen for an easy life: Assessing nursing students on the borderline of achievement in practice

Simon Cassidy, Nurse Education Centre, Bro Morgannwg NHS Trust, UK

Co-author: F Murphy

Abstract:

Background: Mentors are accountable for their decision-making when assessing the competence of nursing students. However, there is little research which explores the complex range of subjective feelings mentors experience when assessing students on the borderline of achievement in clinical practice.

Aim: To explore mentors' experience of assessing nursing students who are on the borderline of achievement in clinical practice.

Methods: Drawing on the broad characteristics of qualitative enquiry, in-depth semi-structured interviews were conducted with a purposive sample of 20 registered nurse mentors who had experienced assessing a student on the borderline of achievement in clinical practice. Data were collected in 2009.

Results: Mentors feeling a sense of duty to 'step up' and take accountability for their decision making was an important finding. Addressing concerns about students' motivation and capacity for learning in clinical practice were set against considerable emotional intensity attached to the process of assessment. Significantly, whilst mentors embraced the mentoring role, the extent of this investment was underestimated.

Discussion: Mentors felt torn between nurturing a sense of hopefulness that students would achieve whilst battling personal reservations about their own worth as assessors. It will be suggested that these contradictions have a connection to the concepts of emotional labour (Hochschild 2003) and communities of practice (Wenger 1998).

Conclusion: Previous work has highlighted the potential for mentors to give failing students the benefit of the doubt in clinical practice (Duffy 2003). Critically, this study suggests it is not so much mentors' willingness to accept accountability that is in question as the immediacy of support they might require in these circumstances. This finding may help mentors contextualise their individual decision-making in terms of a community of assessors.

Recommended reading:

Duffy, K. (2003) Failing students: a qualitative study of factors that influence the decisions regarding assessment of students' competence in practice. London.

Hochschild AR (2003) The Managed Heart. Commercialization of Human Feeling. University of California Press. Berkeley.

Wenger, E. (1998) Communities of Practice. Learning Meaning and Identity (6th ed). Cambridge University Press. Cambridge (1998).

2.4.2

Should I stay or should I go? An exploration of student nurses' reasons for continuing with their studies

Jane Wray, FHSC, University of Hull, UK
Co-authors: D Barrett; J Aspland

Abstract:

Student attrition is estimated at 25% across the sector (Waters 2006) and students exit a programme for a number of reasons; some may fail to meet academic standards (Anionwu et al 2005)

others choose to leave because of personal or family difficulties (Glossop 2001).

This paper presents findings of a project that sought to explore with continuing students whether they have considered leaving the programme and what factors influenced their decision to stay.

594 questionnaires were handed out to all continuing students from 5 pre-registration nursing cohorts. The questionnaire comprised statements with a Likert type response scale (1= strongly agree, 4= strongly disagree) and space for qualitative comments. Data was analysed using SPSS (v 16) and NVivo (v 8).

195 completed questionnaires were received (33% response rate). 102 students (52.3%) had considered leaving the programme but had chosen to stay. The factors that most influenced students to stay were: the desire to be a nurse, the support received from family, fellow students and support staff, and personal attributes such as a determination to succeed.

Preliminary analysis to date has revealed that students who had considered leaving were more likely to state that "I have struggled financially during the programme" when compared with the rest of the cohort and this was statistically significant. The programme overall was rated highly, particularly academic and pastoral support. The lowest rated item was "the programme is family friendly".

Whilst studies of attrition have traditionally focused on the reason why students leave programmes, this project sought to explore those 'pull' factors that facilitate student retention.

Recommended reading:

Anionwu, E., J. Mulholland, et al. (2005). Diversity, Attrition and Transition into Nursing: The DATING Project Final Report, Thames Valley University.

Glossop, C. (2001). "Student nurse attrition from pre-registration courses: investigating methodological issues." Nurse Education Today 21: 170-180.

Waters, A. (2006). "Government data on attrition rates unreliable, experts claim." Nursing Standard 20(47): 12.

2.4.3

Developing an attrition risk prediction tool

Peter Norrie, School of Nursing and Midwifery, De Montfort University, UK
Co-author: J Fowler

Abstract:

Attrition of student nurses is an international problem which has been shown to be complex and difficult to solve. It is certainly a significant problem within the United Kingdom (DH 2006). This

paper discusses a mixed methods research project carried out at De Montfort University, Leicester, to explore and identify the factors involved and to initiate remedial action.

The research phase involved qualitative investigation of lecturers and students (n= 35), aiming to identify why students were at risk of leaving their nursing and midwifery programmes. The quantitative phase involved a cross sectional survey of students (n= 605) seeking to relate likelihood of attrition to a range of published variables. Multiple regression was used to produce a parsimonious model of risk factors.

The main findings confirm the concept of a multifactorial problem. Both sets were incorporated into the production of an attrition risk tool which identifies a range of categories shown to impact on the likelihood of the student completing their studies. These are:

• Non standard academic entry

• Very young students

• Little experience of the practice of nursing and midwifery

• Having significant family commitments, including caring for children and partner or parent

• Having learning difficulties

• History of casual sickness or lateness

• Poor module results

• Lack of financial support

• Additional paid work

• Presence of additional life events

The final phase of the project involved bringing these factors together into one risk assessment tool. This is now in use and the second part of the presentation will outline how it may be implemented to support the student and personal tutor in managing the student experience. Finally, the research and tool have now been published and the latter is now available for wider use (Fowler and Norrie 2009)

Recommended reading:

Fowler, J. Norrie, P. (2009) Developing an attrition risk prediction tool, British Journal of Nursing, vol 18, no 19, pp 1194-1200

Department of Health (2006) Managing Attrition Rates for Student Nurses and Midwives, TSO, London

2.5   Infection control

2.5.1

An evaluation of the impact of a national educational programme for health care workers to ensure good practice in preventing healthcare associated infections

Colin Macduff, Reader, Nursing, Robert Gordon University, UK

Co-author: F Baguley

Abstract:

Background: Healthcare associated infections (HAIs) are an internationally recognised patient safety challenge. Although this has led to several major educational initiatives within the UK, there has been little evaluation of impact. This paper contributes to knowledge of policy and practice by reporting research into the impact of the NHS Education for Scotland Cleanliness Champion Programme (CCP).

Aims: The enacted research aimed to:

Explore perceived changes in infection control and prevention behaviours of staff undertaking the CCP, and to gather any related evidence of change in clinical practice.

Identify factors which facilitate and factors which inhibit the implementation of change in practice following CCP completion.

Methods: This mixed method research involved: documentary analysis; questionnaires to a range of key contacts and managers in 18 Health Boards (response = 136/348; 39%); a census survey of all those known to have completed the programme between 2003 and mid 2008 (response = 1387/5,400; 26%); 42 interviews with Cleanliness Champions (CCs), clinical colleagues and other colleagues with organisational management or infection control remits; and five site visits.

Findings: Participants saw the CCP as impacting positively on CCs': awareness and knowledge of infection prevention and control; hand hygiene practice; and practice in relation to equipment and environmental aspects. Related improvements to some colleagues' awareness, knowledge and behaviours in these aspects were also reported. These changes are best thought of as proximal, positive and practical in nature. Individual CC motivation and peer support were the key facilitating factors.

Discussion: The programme's enablement of small scale changes around individual practice is clearly useful, but Health Boards typically struggle to develop the potential wider benefits accruing from large numbers of CCs.

Conclusion: The CCP is considered a valuable programme but fuller integration of the CC role into local infection control planning and practice could realise greater benefits.

Recommended reading:

Macduff, C., Baguley, F; Gass, J; Tuckwell, M and West B (2009) An Evaluation of the Impact of the NHS Education for Scotland Cleanliness Champions Programme on Clinical Practice. Aberdeen: Robert Gordon University and Edinburgh: NHS Education for Scotlan

Kerr, J., Phillips, G., Gillies, E and Mires, G. (2009) Challenges of transferring hand hygiene skills to clinical practice – medical students' perceptions of the impact of a self directed programme. International Journal of Clinical Skills 3

2.5.2

Validation of methods for sampling contamination of uniforms

Allyson Lipp, Health, Sport and Science, University of Glamorgan, UK

Co-author: G Lusardi

Abstract:

Aim: The aim of this study was to validate a method for sampling microorganism contamination of Health Care Workers' uniforms.

Methods: In a laboratory, a calculated number of microorganisms used for European standard testing were added to 10cm x 10cm samples of sterile polyester-cotton uniforms using wet and dry inoculation techniques. Four sampling methods were tested: Casella Slit Lamp Sampler, Satorius MD 8 Airscan, a swabbing system and a Carpet Sampling Kit. They were compared to the reference method of 'stomaching', which provided a baseline recovery efficiency. Colony forming units were then recorded at high and low level of inoculum.

Results: The carpet sampler showed the highest average recoveries of the four methods in comparison to 'stomaching' when inoculated dry. Swabbing was found to be an inefficient recovery method. Poor retrieval of organisms was found for all sampling methods when the inoculum was applied wet.

Discussion/implications for practice: The carpet sampler was most effective at microorganism retrieval in the laboratory compared to other methods. The carpet sampler requires less equipment and its capacity to test large numbers more quickly is greater compared to other methods. The stomaching method remains the gold standard, however in practice this would involve destroying the uniform and is thus impractical. Evidence of poor retrieval of inoculum applied wet may have implications for practice if organisms bind to certain fabrics.

Conclusions: This research shows that nurses can drive cutting-edge microbiological research. The validated tool will be used to assess bacterial

contamination of uniforms in practice in future research.

Recommended reading:

DH. (2007). Uniforms and Workwear: an evidence base for developing local policy. London: Department of Health

2.6 Incontinence

2.6.1

The effectiveness of sterile versus non-sterile urinary catheter insertion at reducing the incidence of catheter associated urinary tract infection

Fiona Bezzina, Orthopaedics, County Durham and Darlington NHS Foundation Trust, UK

Co-authors: J Bettany-Saltikov

Abstract:

Background: Approximately 15% to 25% of all hospital patients undergo urinary catheterisation; either to accurately monitor urine output, to treat urinary retention or for investigative purposes. However, urinary catheterisation places the patient at a significant risk of acquiring a urinary tract infection. Guidelines by both the Royal College of Nurses (RCN, 2008) and the National Institute for Health and Clinical Excellence (NIHCE, 2003) emphasise the use of aseptic technique at catheter insertion in order to prevent catheter associated urinary tract infections.

Objectives: The aim of this review was to evaluate the effectiveness of strict sterile versus non-sterile urinary catheter insertion at reducing the incidence of catheter associated urinary tract infection (CAUTI).

Search Strategy: The following data bases were searched: The Cochrane Library, the online Aggressive Research Intelligence Facility, Turning Research into Practice. AMED, MEDLINE, EMBASE and CINAHL. Reference lists and hand searching was also carried out.

Criteria for Considering Studies in Review: Study participants included adults needing urinary catheterisation in any setting. The primary outcome of interest was the incidence rates of CAUTI in the intervention and the control groups.

Methods of Review and Data Extraction: Methodological quality of the selected studies was assessed using the McMaster University Critical Review Form for Quantitative Studies.

Results: Eight research articles (six randomised controlled trials and two Cohort studies were included. Study results suggested that there was no significant difference in infection rate using either sterile or non-sterile insertion techniques.

The evidence provided needs to be considered with caution given the small number of studies and the poor methodological quality found.

Discussion: In conclusion, since the current evidence is lacking in validity, suggestions are presented for future research in terms of better design in order to avoid the methodological flaws of the existing studies.

Recommended reading:

National Institute for Health and Clinical Excellence (2003) Infection control Prevention of healthcare-associated infection in primary and community care.National Institute for Clinical Excellence: London. [online] www.nice.org.uk. (accessed 25th June 2)

The Royal Collage of Nursing (2008) Catheter Care, RCN guidelines for nurses.Published by the Royal College of Nurses: London [RCN online] www.rcn. org.uk/direct(accessed on 19th June 2008).

2.6.2

Critical exploration of nursing practice in patients with post stroke urinary incontinence

Ronalda Agnew, School of Health, Glasgow Caledonian University, UK

Co-authors: J Booth; J Brown; C McVey

Abstract:

It is widely recognised that nurses are responsible for bladder rehabilitation following stroke (Burton, 2003). Evidence suggests that nurses are more inclined to contain incontinence rather than actively promote continence (Booth et al 2009, Dingwall, McLafferty 2006,). However no studies have investigated whether nurses ever intend to promote urinary continence from the outset and whether this intention translates into practice. The aim of the study is to critically explore and explain the factors that influence stroke nurses in the management of bladder function in stroke patients.

The two stage design involves a postal survey and a case study. The Theory of Planned Behaviour (Ajzen, 1988) is the conceptual framework. In developing the questionnaire for Stage 1, an elicitation study was undertaken to agree a definition of 'continence promotion' and to elicit nurse's salient beliefs that could facilitate or create barriers to promoting continence in stroke patients. This work forms the focus of the presentation.

Three groups of registered nurses participated. Nominal group technique was used to explore nursing activities associated with managing urinary incontinence and promoting continence. The findings were coupled with a 7 stage elicitation study with thematic analysis resulting in a list of activities associated with promoting continence, the 'behavioural category' and a definition

for 'promoting continence' for use throughout the mixed methods study.

This study has produced a definition which can be used in practice to understand clearly what nurses mean when they say that they 'promote continence' and factors which could be used to support active rather that reactive continence care.

Recommended reading:

Burton,C. 2003. Therapeutic nursing in stroke rehabilitation: a systematic review, Clinical Effectiveness in Nursing, vol7, no. 2-4, pp124-133

Booth,J.; Kumlien,S.; Zang,Y.; Gustafsson,B.; Tolson,D. 2009. Rehabilitation nurses practices in relation to urinary incontinence following stroke: a cross-cultural comparison. Journal of clinical nursing, vol18, no.7, pp1049-1058

Ajzen, I. 1988. Attitudes, personality, and behavior. Open University Press: Milton Keynes.

2.6.3

Exploring issues and solutions in promoting continence and managing incontinence with people with dementia living at home and their family carers

Vari Drennan, Professor of Health Policy & Service Delivery, Faculty of Health and Social Care Sciences, Kingston University and St. George's, University of London, UK

Co-author: L Cole

v.drennan@sgul.kingston.ac.uk

Abstract:

Background: Toileting difficulties and incontinence problems are embarrassing, stressful and significant in the decision to the move to a care home. Current evidence based guidance for supporting people with dementia does not include incontinence and conversely national guidance on aspects of incontinence excludes people with dementia. Consequently, there is little to inform practitioners when supporting people, with dementia and these problems, living at home, and their family carers. Recent UK strategies for dementia emphasis the need for person centred care and support of family carers. This presentation reports on one phase of the EVIDEM-C study which EVIDEM-C is a nested study with in the NIHR funded programme of research.

Aim: To explore the range of toileting and incontinence problems and solutions as perceived from the perspectives of the person with dementia and their family carers.

Method: This a qualitative study within the interpretative tradition, using semi-structured interviews. Participants are people with dementia living in their own homes and family carers recruited through voluntary organisations, Admiral Nurses,

multi-disciplinary community mental health teams and general practice. Interviews have been transcribed and thematically analysed.

Results: A wide range of problems and solutions were identified. These included managing distress and preserving dignity while trying to find acceptable and appropriate solutions, environmental challenges (outside and inside the home) in locating and using toilets, accessing local sources of information and expertise, financial consequences for the individual and carers, access to publicly funded appropriate containment products and the threat to maintaining continence when the person was admitted to hospital or care home.

Discussion and Conclusion: The presentation discusses the relevance of the findings for the nursing practice in the community and specialist continence services, examines issues of relevance for commissioners of service and indicates how this phase is used in the next stages of the research.

Recommended reading:

Thomas P., Ingrand P., Lalloue F., Hazif-Thomas C., Billon R., Vieban F., Clement J. P, (2004) Reasons of informal caregivers for institutionalizing dementia patients previously living at home: the Pixel study. International Journal of Geriatric Psychiatry.

National Collaborating Centre for Mental Health (2007) Dementia: The NICE-SCIE guideline on supporting people with dementia and their carers in health and social care. London: The Royal College of Psychiatrists and the British Psychological Society.

Department of Health. (2009) Living Well with Dementia: a National Dementia Strategy. London the Stationary Office.

Funding source:

2.7   Mental health

2.7.1

The experience of mental health first aid instructors' programme delivery

Julia Terry, School of Health Science, Swansea University, UK

Abstract:

Background: Mental health literacy among the public is often poor, with stigmatising attitudes persisting. People frequently encounter others experiencing mental distress in the workplace, in their families and communities and may be ill equipped to provide appropriate support. 'Mental Health First Aid' (MHFA) is a 12 hour mental health awareness programme that seeks to address this, by training people in the knowledge and skills needed to engage with someone experiencing mental health problems. Research relating to the MHFA programme has centred around the impact on course attendees. There is a paucity of research surrounding the delivering of mental health training programmes. This study sought to identify the views and experiences of instructors delivering the MHFA programme in Wales.

Aims:

• To explore instructors' views and experiences of delivering MHFA

• To identify from their perspective, the benefits and challenges of MHFA

• To compare the findings in the light of the national context for the delivery of MHFA programmes

Method: A qualitative descriptive study design was used, with 14 MHFA instructors participating in semi-structured interviews. Transcripts were analysed to identify key themes.

Results: Participants were motivated to deliver the MHFA programme and viewed the course as having potential to influence people's knowledge about mental health. Instructors with necessary prerequisite skills and appropriate support, experienced enjoyment and self development, and with essential components of a national infrastructure had a positive experience of delivering the MHFA programme. Conversely, instructors who perceived a lack of support, an undefined infrastructure and lacked prerequisite skills, experienced anxiety, frustration and logistical difficulties in course delivery, leading to a negative experience.

Conclusion: Universal mental health training programmes aimed at a wide public audience must put in place a clear infrastructure to train, support and monitor those delivering them, for the programme rollout to be effortless and effective.

Recommended reading:

Kitchener, B., Jorm, A. (2008) 'Mental health first aid: an international programme for early intervention' Early Intervention in Psychiatry,2008:2,55-61

Scottish Development Centre for Mental Health (2004) ' Evaluation of Mental Health First Aid Pilot Project in Scotland January – June 2004' Scottish Executive Available at: http://www.wellscotland.info/research-papers.html#smhfa Last accessed: 21/7/2

Stevenson, R, Elvy, N (2007) 'Evaluation of Scotland's Mental Health First Aid' Edinburgh: NHS Health Scotland

Funding source:

2.7.2

Unfulfilled expectations: A narrative study of individuals' experiences of being a patient on an acute psychiatric inpatient ward in Scotland

Rosie Stenhouse, Nursing Studies, University of Edinburgh, UK

Abstract:

Within the existing research base, few studies focus on the patient's experience of acute psychiatric inpatient care, and none of these is set in Scotland. Those that do, indicate that the patient experience of acute psychiatric inpatient care is often negative.

This study examines people's experiences of being a patient on an acute psychiatric inpatient ward in Scotland.

The theoretical perspective of this study conceptualises experience as represented in narrative form, thus the data take the form of narratives. Thirteen participants were recruited through the acute ward. Each participant participated in two unstructured interviews focussed on gathering narratives of their experience. Data analysis was holistic, guided by Gee's (1991) socio-linguistic theories. This holistic analysis culminated in the presentation of each participant's narrative in poetic form.

From the holistic analysis I identified three themes – help, safety and power – that were evident in the analyses of all participants' interviews. The theme of help represents participants' expectations that they will receive help on the ward, and their experiences of trying to get this help. Safety represents participants' expectations pertaining to the ward's function in keeping them safe, their experience of threat and strategies to keep safe. The theme of power represents participants' experiences of power relations within the acute ward. I conclude that participants' experiences of being a patient on the ward are characterised by feelings of frustration, concerns about safety, and the perceived need to focus on self-presentation as they attempt to reach their desired goal of discharge.

Findings offer insights into the patient experience that are helpful for those delivering and planning acute mental health services.

Recommended reading:

Gee J.P. (1991)

Funding source:

2.7.3

Perceptions and views of self neglect: A client-centered perspective

Mary Rose Day, College Lecturer, School of Nursing and Midwifery, University College Cork, Ireland
Co-author: G McCarthy
mr.day@ucc.ie

Abstract:

Introduction: Ageing populations and chronic illness increases vulnerability of older people for self-neglect. It is characterized by an inability to meet one's own basic needs and is an increasingly common problem which can be intentional or unintentional. A large number of referrals received by Adult Protection Services in Ireland are categorized as self-neglect. Self-neglect is a serious public health issue yet many adults who self-neglect are found to be indifferent to their situation.

Aim: To observe and describe the living circumstances of people who are deemed self-neglectful by senior case workers for Adult Protective Services in Ireland. To detail their life stories.

Methods: An exploratory descriptive research design was used. A purposive sample of eight older adults participated in guided interviews which were tape recorded, transcribed and thematically analyzed. Home environments were also observed.

Results: The complexity and diversity of circumstances in which people lived their lives will be portrayed in this presentation and exemplar case studies will be presented. In addition the major themes that emerged will be presented: Early life experiences and lifestyle, Disconnectivity: isolation and loneliness, vulnerability, frugality and service refusal.

Conclusion: The observed living circumstances (personal care, environment) of individuals varied and depicted elements of squalor, hoarding, neglect, chaos, frugality and old world living. Life stories depicted helplessness, fear, isolation, loss and disconnection with communities and families. Some participants were content in their environments while others disapproved or refused interventions and support. To date few studies have included the voice and personal perspective of people who self-neglect. Self-neglect accounts for a large numbers of referrals to Adult Protection Services. This study provided insight into the lives and perspectives of self-neglecting older adults. These findings will support professionals across health and social care settings in developing policy and best practice to identify and support self-neglecting clients in the community.

Recommended reading:

Day, M. R. & Leahy-Warren, P. (2008) Self-Neglect 1: Recognising Features and Risk Factors Nursing Times 104, 24 26-27

2.8　　Education

2.8.1

Reflections on the nursing role in rehabilitation: Enhancement in practice

Mari Carmen Portillo, Department of Adult Nursing, University of Navarra, Spain
mportillo@unav.es

Abstract:

Background: Although neurological patients and relatives experience emotional and social changes at acute and chronic stages, most rehabilitation programmes do not deal with non-physical needs or do not involve nurses, leading to a poor definition and specialisation of the nursing role.

Aims: To explore the nurses' role in neurological rehabilitation and identify some strategies for the enhancement of rehabilitation services.

Methods: This was a cyclic action research project which took place in two neurological wards of a highly specialised hospital in Spain and lasted 30 months (completed in 2006). An individualised nurse led social rehabilitation programme was planned, implemented and evaluated. The nursing role in rehabilitation and the quality of care were explored with 37 nurses, and 40 neurological patients and 40 relatives (convenience sampling). Multiple triangulation of data from semi-structured interviews and participant observations with all participants took place. Content (QSR NUDIST Vivo (v.2.0)) and statistical (SPSS v. 13.0) analyses were developed.

Results: Most data showed that holistic care was not developed in the nursing wards because of the lack of time, knowledge and experience, the poor definition of the nursing role, and the ineffective communication with users mainly. To overcome this, some enhancing strategies were proposed and studied in-depth: the promotion of acceptance/adaptation of the disease through nursing verbal and written education, the reinforcement of the discharge planning, and the planning of emotional and social choices and resources based on the assessment of individual needs and possibilities and support at home.

Discussion and Conclusions: Nursing professionals are in a privileged position to deal with neurological patients' and carers' holistic needs. Several attributes of the advanced nursing role in rehabilitation and some changes of nursing practice have been identified and proposed to deal with non-physical aspects of care and highlight the nursing contribution in rehabilitation teams.

Recommended reading:

Bakas, T., Austin, J.K., Jessup, S.L., Williams, L.S. & Oberst, M.T. (2004): Time and Difficulty of tasks provided by family caregivers of stroke survivors: Journal of Neuroscience Nursing, 36, 95-106.

Grant, J.S., Elliott, T.R., Weaver, M., Glandon, G.L., Raper, J.L. & Giger, J.N. (2006): Social support, social problem-solving abilities, and adjustment of family caregivers of stroke survivors: Archives of Physical Medicine Rehabilitation, 87, 343

Lewin, K. (1946): Action Research and minority problems: Journal of Social Issues, 2, 34-46.

2.8.2

Education for practice: Are university health care courses 'fit for practice' in preparing staff for their health service roles?

Antonia Beringer, Research Fellow, Faculty of Health and Life Sciences, University of the West of England, UK
Co-authors: L Donovan; S Scott; M Tuckey

Abstract:

Background: As competition for students increases and deregulation of commissioning means health authorities can choose from a wider range of educational providers, it is important that health care courses prepare practitioners who are 'fit for practice' for their NHS roles. This study evaluates the effectiveness of educational programmes in meeting the needs of this changing healthcare workforce and their health service employers.

Method: A two stage mixed methodology was adopted using on – line questionnaires and telephone interviews (June – October 2009) to gather a range of quantitative and qualitative data from healthcare practitioners and service managers (n= 99). The practitioners included those at assistant, specialist and advanced levels of practice who had undertaken a range of short courses and full degree programmes at a UK university.

Results: Whilst we have just begun analyzing data from this extensive study, preliminary findings indicate a number of key differences and similarities between perceptions of practitioners and service managers about how well courses prepare staff for their health service roles. Differences are apparent between the reasons for doing a course, the level of support needed and the work duties staff are able to undertake following completion. Variation in experience between courses is reported. Similarities are apparent in the increased levels of confidence after course completion, rated by both groups.

Discussion: These preliminary results suggest a gap in understanding between university, practitioners and service providers about what skills and abilities specific courses offer and, linked to this, the lack of opportunities to make best use of new skills in the workplace.

Application to practice: Clarity about the outcomes of courses, in terms of skills and competencies being offered, will enable practitioners to chose the most appropriate course and service managers

to match the requirements of the workplace to the aptitude of specific practitioners.

Recommended reading:

Department of Health (2004) The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process, DoH, London. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090843 (accessed

Girot, E.A. & Rickaby, C.E. (2008): Education for new role development: the Community Matron in England: Journal of Advanced Nursing, 64,1, pp 38-48, doi: 10.1111/j.1365-2648.2008.04749.x

Rattray, J. & Jones, M.C. (2007): Essential elements of questionnaire design and development: Journal of Clinical Nursing, 16, pp 234-243

Funding source:

2.8.3

Is history taking a dying skill?

Lisa McKenna, School of Nursing and Midwifery, Monash University, Australia
Co-author: J French
lisa.mckenna@med.monash.edu.au

Abstract:

Introduction: History taking is a vital and important component of patient assessment in nursing practice. Nurses with sound interviewing skills identify priorities for care (Roberts, 2004) and need for referral to other health professionals (Beck, 2007). Verbal and non verbal cues from patients provide triggers for nurses to follow-up with appropriate questions to fully explore key aspects during a health assessment and develop appropriate plans for care. This skill, however, is a difficult one for students to learn and develop.

Aim: To explore the value of video feedback, facilitated review and debriefing following a simulated patient experience to enhance final year nursing students' history taking and assessment skills.

Methods: Scenarios with a number of predetermined cues imbedded within were developed, based upon specific and commonly encountered situations. Actors were employed as simulated patients from who the students then took a history while being videotaped.

Following interviews with simulated patients, video-recordings were reviewed with each student and a lecturer to highlight missed cues or ways in which questioning could be further developed. All video-recordings were then analysed by the research team to explore cue identification. Finally, a focus group was held with participants to elicit detailed views of the experience.

Results: Findings from the focus group suggested that the students found it a valuable exercise and they previously lacked understanding of the
importance of many aspects, such as lifestyle, on planning patient care. Many reported never having had the opportunity in clinical placement to undertake a full history. Analysis of the video tapes demonstrated commonly missed social cues and a failure to fully explore possible health ramifications.

Discussion: The study raises questions about whether history taking is being poorly developed in undergraduate students, implications for practice and how it can be more effectively interwoven into curricula.

Recommended reading:

Beck, A. (2007) Nurse-led pre-operative assessment for elective surgical patients. Nursing Standard Vol 21, no 51, pp 35-38.

Roberts, J.D. (2004) Senior student nurses information seeking skills: A comparative study. Nurse Education Today, vol 24, pp 211-218.

Funding source:

3.1.	Care delivery

3.1.1

Effective preadmission and preparation of day surgery patients

Marilyn Richardson-Tench, School of Nursing and Midwifery, Victoria University, Australia

Co-author: J Rabach

Abstract:

Background: Of concern to the Day Surgery Special Interest Group (DSSIG) is the variation in patient preparation prior to surgery. Many day surgery centres have implemented a system of undertaking preadmission assessments a week or more in advance of surgery. Alternative preadmission interventions include telephone screening and preadmission clinics. Although it is generally considered that preadmission care is beneficial, there are no evidence based Best Practice Guidelines (BPG) for patients undergoing day surgery in Australia.

Aim: To evaluate which preadmission care intervention is more effective in enhancing the physical and emotional preparedness for patients undergoing cataract surgery as a day patient: preadmission telephone screening or preadmission clinics.

To inform the development of BPG for patients undergoing cataract surgery as a day patient

Method: A low risk pilot study using questionnaires and interviews was undertaken to evaluate which preadmission care intervention is more effective in enhancing the physical and emotional preparedness for patients undergoing cataract surgery as a day patient: preadmission telephone screening or preadmission clinic.

Sample size: 50 participants undergoing cataract surgery participated in the research consisting of two groups: Twenty-five patients undergoing preoperative preparation face to face education; twenty-five patients undergoing preoperative preparation by telephone.

Data analysis: Data is currently being analysed using descriptive statistics; comparisons of study outcomes by chi-square analysis using categorical [odds ratio with 95% CI] and continuous [Mann-Whitney-U tests] tests using SPSS. Answers to open ended questions is being subjected to content analysis.

Results: Initial results indicate there is no significant difference between preadmission telephone screening or preadmission clinic for physical and emotional preparedness of patients undergoing cataract surgery as a day patient.

This paper will present the completed data analysis as well as a discussion and conclusions on the results of the study.

Recommended reading:

Richardson-Tench, M., Pearson, A., & Cairns, M. (2005)

Pearson, A., Richardson, M., Peels, S., & Cairns, M. (2004)

3.1.2

Exploring issues in the use of grading practice

Morag Gray, Associate Dean (Academic Development), Faculty of Health, Life and Social Sciences, Edinburgh Napier University, UK

Co-author: J Donaldson

m.gray@napier.ac.uk

Abstract:

Background: There has been growing interest in the grading of student nurses' practice particularly since the NMC required the grading of midwifery practice. Grading practice involves making a decision based on the assessment of performance which allows recognition of merit or excellence beyond awarding a mere pass (Andre 2000; Hill et al., 2006).

Aims: The aim of the paper is to present findings from a commissioned systematic literature review which explored the issues arising from the use of grading practice.

Method: Literature was collected following a systematic search and spanned across 14 professional groups. In total a 119 articles were reviewed following application of exclusion criteria. Of these, the majority were quantitative in nature (n=66); followed by descriptive accounts or opinion based (n=28); literature reviews (n=19) and qualitative (n=6).

Results: Some of the documented challenges such as time availability, consistency and accountability of assessors are not specific to only grading practice. Four specific challenges when grading practice arose from the systematic literature review and these will form the basis of this presentation.

Discussion: The review of the literature presented specific challenges of grade inflation; grading tools; Rubrics; and Training for assessors / mentors. Grade inflation is a well-documented problem and there suggested methods (although not fully evaluated) from the literature to control this will be discussed. If nursing is to use grading within practice, there are a number of training requirements suggested by the literature for mentors and these will also be discussed.

Conclusion: If grading of practice is adopted, we recommend that consideration is given to the following: The development, testing and use of rubrics for both formative and summative assessment; use of a multi-method approach to assessment; and training and updating sessions for assessors.

Recommended reading:

Andre, K. (2000) "Grading student clinical practice performance: the Australian perspective." Nurse Education Today 20(8): 672-679.

Hill, L. H., J. C. Delafuente, et al. (2006) "Development of a competency-based assessment process for advanced pharmacy practice experiences." Am J Pharm Educ 70(1): 1

NMC (2009) "Standards of proficiency for pre-registration midwifery education". London, NMC

3.1.3

Hospitalisation means being in a constant waiting position

Mette Spliid Ludvigsen, Clinical Researcher in Nursing, Department of Renal Medicine C, Aarhus University Hospital, Denmark

Co-authors: B D Pedersen; M B Risør

Abstract:

The aim of this presentation is to explore the theme "Being in a constant waiting position" derived from an ethnographic study and part of a PhD dissertation entitled "Patient life in hospital" (Ludvigsen 2009). It was based on an ethnographic design (Hammersley & Atkinson 2000), using participant observations and qualitative interviews, over a period of 18 months in 2003-2005 in a gastroenterological department at a university hospital in a Denmark. Nine males and nine females were selected for qualitative interviews. Analysis and interpretation were conducted at three levels: naïve analysis, structured analysis and critical interpretation and discussion (Ricoeur 1976).

The results shows that time is passed waiting; patients talk to fellow patients and through these encounters they process information and prepare themselves for decisions about treatment and care. Generally, patients cope with waiting using a strategy on how to pass time. This could explain why patients sometimes appreciate the company of fellow patients. However, there are some dilemmas and time is characterised by uncertainty and patients are kept in suspension.

The results in this study partly confirm previous research on waiting. Though, as this study introduces time as phenomenological time, the study highlights that waiting is not always a negative experience. When patients experience waiting time as phenomenological time they have the possibility to develop and build up informal and often short-lived relationships with fellow patients. Waiting can be a necessity for patients to come to terms with what is going to happen during their hospitalisation and should thus not always be avoided.

Obviously, patients should not be exposed to prolonged waiting during hospitalisation. However, waiting time may be advantageous for patients. When designing hospital wards the aspect of phenomenological time should be considered to provide patients with physical space for not only solitude but also for spending time with fellow patients.

Recommended reading:

Hammersley, M. & Atkinson, P. 2000, Ethnography. principles in practice, 2. ed., reprint. edn, Routledge, London.

Ludvigsen, M. S. 2009, Patient life in hospital: a qualitative study of informal relationships between hospitalised patients: PhD dissertation Department of Nursing Science, University of Aarhus, Aarhus.

Ricoeur, P. 1976, Interpretation theory: discourse and the surplus of meaning Texas Christian University Press, Fort Worth, TX.

Funding source:

3.1.4

How do Australian nurses contribute to surveillance in an acute hospital setting?

Jacqueline Jones, Associate Professor, College of Nursing, University of Colorado Denver, United States

Abstract:

Background: Nursing surveillance describes the processes of ongoing observation including vigilant watching for physiological or behavioral changes during interactions with patients or whilst at a distance. It has cumulative, temporal and contextual aspects and is a collective effort of interventions delivered by multiple nurses over time, as well as interventions by individual nurses (Kutney-Lee, Lake & Aiken 2009).

Aims: This presentation explores nursing surveillance through the findings of an observational study of nursing activity conducted in the major tertiary level cardiothoracic referral hospital for Queensland, the largest such unit in Australia.

Methods: The aim of this multi-method study was to describe the activities undertaken by regulated and unregulated nursing staff across three wards (medical, surgical and sub acute) in a 550 bed public hospital. Two weeks of randomized timed activities were collected over a nine week period using a structured observation tool. A mini-ethnographic approach to observation supplemented the descriptive and frequency data obtained through work sampling.

Results: All nurses on each ward gave consent and were observed in this study (n=92). Age (mean 42, SD 10.2) and gender (male = 8.2%) of nurses within the sample were comparable to state demographics. Total nursing experience ranged from new graduate, to 45 years. Experience on the ward under study ranged from less than one year to 15 years. 32,609 episodes of 10 minute observations were collected using work sampling technique.

Discussion: What nurses are doing 'at the bedside or beyond' and the way in which they perform 'surveillance' as individuals, as a workgroup and as a unit to facilitate safe patient outcomes has contextual factors to consider such as the geographical layout of the ward, the pace and cultural dimensions of the nursing unit.

Conclusion: Understanding 'effective' surveillance requires exploration of the proximity of nurses to patients for safety.

Recommended reading:

Kutney-Lee, A., Lake,E.T., Aiken L.H. (2009) Development of the hospital nurse surveillance capacity profile, Research in Nursing & Health, 32, 2, pp 217-228

Funding source:

3.2 Children and young people

3.2.1

Shared decision making with families in the specialist children's asthma clinic: The impact of parents' approaches to their children's participation in decision making

Sharon Fleming, Head of Research in Nursing, Nursing Research, Royal Brompton and Harefield NHS Foundation Trust, UK

Abstract:

Background: Discussion papers suggest that child-adult relations at home may impact on the level of involvement attained by children in the hospital clinic (James and Prout 1996; Gabe et. al 2004). However, little empirical research has been undertaken on how the experience of decision making at home for children with moderate to severe asthma impacts on their involvement in decision making in the hospital clinic.

Aims: To present findings from an ethnographic study on the involvement of children in their consultations in a paediatric clinic.

Methods: 50 clinic sessions were observed and field notes taken. The clinic consultations of 20 children (aged 7 to 11 years) with asthma were observed and audio-recorded. Subsequently, the same 20 children and their parents (n=20) were interviewed, as well as 14 health care professionals and clinic workers.

Results: Social worlds theory (Strauss 1978) allowed analysis of the meeting of families' and doctors' social worlds in the clinic arena. Despite the culture of the 'new' NHS based on patient partnership and choice, some children had minimal involvement in their care. The level of decision making achieved by children in the hospital clinic seemed to be influenced by whether their parents' approaches to children's decision making at home was protectionist, pragmatist or democratic. Children's preferences for 'silence' also played a part. Children's involvement in the clinic worked best when the parent, child and doctor wanted involvement and children were enabled to participate, because of the doctor's communication ability and the carer's pragmatist or democratic approach to decision making.

Discussion: These findings highlight that shared decision making is a problematic concept in relation to children. This presentation shows how children's experiences of decision making within family social worlds has implications for interaction in the contemporary heath care setting. The choice of children to participate or not needs to be added to the partnership discourse.

Recommended reading:

Gabe J., Olumide G. and Bury M. (2004). 'It takes three to tango': a framework for understanding patient partnership in paediatric clinics. Social Science and Medicine 59, 1071-1079.

James A. and Prout A. (1996) Strategies and structures: towards a new perspective on children's experiences of family life. In J. Brannen and M. O'Brien (eds) Children in Families: Research and Policy. pp. 41-52. Routledge Falmer: London.

Strauss A. (1978) A social world perspective. In N. Denzin (ed.) Studies in Symbolic Interaction Vol 1, 119-128. JAI Press: Greenwich, CT.

Funding source:

3.2.2

Parents' experience of a cleft lip and palate service: Evaluation of a service innovation

Gillian McCorkell, Western Health and Social Care Trust, UK

Co-authors: Vivien Coates; Cathy McCarron; Sylvia Blair

Abstract:

Background: Cleft of the lip or palate is the most frequent birth defect in the UK and has the potential to be facially disfiguring and distressing (Watson, 2001). In 1995 a liaison nurse service was developed and is a service that is unique to this Health &Social Care Trust in Northern Ireland (NI).

Aims: To determine if the support and information provided by the Cleft Lip and Palate Liaison Nurse Team (CLAPLNT) was appropriate and beneficial to the families of children who have had this condition.

Objectives:

• Explore service users' opinions

• Clarify the most valued information and support from diagnosis and over time

• Identify weaknesses in the service & suggest solutions

• Explore parents' experiences of learning to cope with a baby/ child with a cleft lip and palate

Methods: A retrospective survey of families' experiences was undertaken using a qualitative approach. Semi-structured interviews were conducted with 20 families who had received the service between 2000-2008. The interviews were

conducted on an individual basis, in patients' homes and clinics with families' consent, by a research nurse not part of the usual CLAPLNT. The interviews were digitally recorded, transcribed and content analysis conducted.

Results: The following themes were identified:

- Initial Reaction
- Information and support provided in hospital and on discharge by CLAPNT
- Deficiency in service
- Advice by surgeon and advice by CLAPNT prior to surgery
- Support most valued

Conclusion: This was an innovative service and while anecdotal evidence indicated that the service was of great help to parents it had never been formally evaluated. This approach, seeking patients/ families views has provided evidence that the service is of value and the details of the interviews give insights into parents' needs and how they were met. The results will inform future service development.

Recommended reading:

Watson A.C.H. (2001) Embryology, aeitiologyand incidence. In Watson A.C.H, Sell D.A.,Grunwell P.(eds) Management of cleft lip and palate.London: Whurr, 2001

Funding source:

UK – Research Charity/Foundation

1,000 – 10,000

3.2.3

Children with single ventricle anatomy (SVA): Understanding the experiences of adolescent survivors and their families

Helen Gardner, Lecturer, Nursing and Physiotherapy, University of Birmingham, UK

Abstract:

SVA refers to a single functional ventricle regardless of the underlying anatomy, with a common mixing chamber, pumping both systemic and pulmonary circulations. Treatment involves staged, palliative surgical procedures, commencing in the neonatal period and involving protracted periods of recovery in specialist units. Because of the high risk nature of the treatment and unique and complex anatomy, these children and their families provide specific challenges and require frequent contact with health services throughout their lives. The impact on the child and family therefore warrants investigation.

Aims:

- To investigate how children and young people understand the vicarious decisions made on their behalf as their own awareness develops.

- To understand children and young people's perceptions of 'healthcare choices'

- To contribute to the advancement of models of care for adolescents with SVA and their families.

Ethical approval was gained and consent procedures followed. Data were collected using semi-structured interviews, using open-ended questions informed by an extensive scoping exercise carried out prior to commencing the research. 38 interviews were carried out with 17 participants (children living with SVA, their siblings and parents) over three data collection points between May 2006 and April 2008. With participants permission interviews were audiotaped and transcribed verbatim.

Data were analysed using grounded theory procedures, specifically a situation-centred approach to grounded theory developed by Clarke (2005). Situational analysis is described by Clarke (2005) an attempt to regenerate grounded theory using Strauss's social worlds/arenas/negotiations framework (Strauss, 1987), underpinned by constructivist framings (Charmaz, 2006). The situation-centred focus was achieved through mapping of issues focused around difference and variation. Initial findings indicate key areas of concern are around: support and coping; maintaining normal life; family relationships; general health; education; self-image and the future.

Recommended reading:

Charmaz, K. (2006) Constructing grounded theory: a practical guide through qualitative analysis. London, Sage Publicaions.

Clarke, A. E. (2005) Situational analysis: grounded theory after the postmodern turn. Thousand Oaks, Sage.

Strauss, A. L. (1987) Qualitative analysis for social scientists. Cambridge, Cambridge University Press.

Funding source:

No Funding

3.2.4

Symptoms and diagnosis of cancer: A narrative study of the experiences of young people

Daniel Kelly, Middlesex University, UK
Co-authors: S Pearce; F Gibson; O B Eden; A Glaser; L Hooker; J Whelan

Abstract:

Background: The difficulties in ensuring prompt diagnosis, referral and treatment of cancer in young people are thought to be a contributing factor for poorer outcomes when compared to younger or older age groups. There is very little research concerning the period leading up to a diagnosis for teenagers and young adults.

Aims: This study aimed to understand the pre-diagnostic and diagnostic phase of cancer in young people as close as possible to the experience itself.

Methods: 24 young people between the ages of 16 and 24, who were between two to four months from first diagnosis with a solid tumour, were recruited to the study from four principal centres in England. Narrative interviews were undertaken as well as analysis of medical notes. Data were analysed to examine how accounts were constructed and connected to broader contextual issues concerning cancer and this age group, diagnostic timelines and entry into specialist care.

Findings: Shared themes within these narratives shaped a group narrative and an emerging conceptual framework. This included the individual's perception of, and meaning given to symptoms; the impact of others in determining the identification of a threat within symptoms; the negotiation of generalist health care and then entry into specialist care. A narrative of delay was evident in some stories.

Discussion: The time before diagnosis was revealed to be complex and multidimensional with a range of factors contributing to the overall experience. This paper will focus primarily on symptom-based issues with the aim of sharing the young peoples' accounts of embodied experiences before diagnosis.

Conclusions: This study offers new insights into the experiences of young people from first symptoms to a diagnosis of cancer. These will have implications for developments in practice, policy and research; with the ultimate aim of preventing or minimising diagnostic delay for this patient group.

Recommended reading:

Pearce S (2009) Policy and practice in teenage and young adult care in England: looking to the future. European Journal of Oncology Nursing. 13: 149-153.

Kelly D. & Gibson F. (eds) (2008) Cancer Care for Adolescents and Young Adults. Oxford: Wiley-Blackwell Publishers.

Bury M (1982) Chronic illness as biographical disruption. Sociology of Health & Illness. 4: 167-182.

Funding source:

UK – Research Charity/Foundation

50,001 – 100,000

3.3   Clinical issues

3.3.1

Public health nursing in the workplace: CVD risk assessments for employees (ViPER)

Pat Watson, Centre for Health & Social Evaluation, Teesside University, UK
Co-author: N Oswald

Abstract:

Background: Cardiovascular disease (CVD) is the largest cause of premature death in the United Kingdom (UK) (Fleming et al 2005). The UK Department of Health (DH) is introducing primary prevention for CVD as 'NHS Health Checks' (DH (2008) Putting Prevention First: Vascular Checks, Risk

Assessment and Management DH). It is imperative to introduce the check equitably. An innovative programme has been introduced on Teesside by which nurses offer employees CVD risk assessments during work hours in workplaces.

Aims:

- To assess the prevalence of unrecognised CVD risk among people in work.
- To identify characteristics of employees taking up the offer of workplace assessments.
- To assess the benefits of placing nurses in the workplace environment.

Methods: We report on the feasibility of workplace CVD assessment, its uptake by working people, and the prevalence of risk factors for CVD. Methods included:

- Postal questionnaires
- Interviews
- Analysis of the PCT dataset of participants

Results: A total of 2,461 people completed the CVD assessments.

273 (11%) were assessed at above 20% risk.

29% men (177/609) were at high risk compared with 5% women (96/1852).

53% of all participants were referred to their GP for further intervention.

Employers engaged well and released staff.

The programme was successful in attracting employees and found a high level of unrecognized CVD risk.

Discussion: Our discussion will focus on the importance and practicality of such roles for nurses with a public health remit.

Conclusions: Since the process of workplace assessments was acceptable to employers and to the workforce, this is a valuable role for nurses. It has the potential to enhance the population benefit of CVD risk assessment.

Recommended reading:

Fleming, M, Eynon, C, Reilly, M & Green, L (2005) Mending Hearts: Inequality and Inequity in Coronary Heart Disease County Durham & Tees Valley 1993-2003. County Durham and Tees Valley Public Health Network

Department of Health (2008) Putting Prevention First: Vascular Checks, Risk Assessment and Management. DH

Funding source:

10,001 – 50,000

3.3.2

Including older patient's perception of their readiness for going home from hospital

Alice Coffey, Nursing and Midwifery, University College Cork, Ireland

Co-author: Geraldine McCarthy

Abstract:

Background: Going home from hospital is a transition for patient and family (Weiss et al, 2007). Readiness for discharge focused on medical stability (Effraimsson et al, 2003) and home support (Schaefer et al, 1990) but unmet needs persist (McKeown, 2007). Importantly readiness can be perceived differently by health professionals, family and patients (Weiss et al, 2007. Congdon, 1994). Measures at discharge include patient's functional ability, availability of home support and adequate discharge information. Nevertheless post discharge recovery can prove complex for older patients (Bull, 1992) and no previous empirical research measured their perspectives of their readiness at discharge.

Aim: To examine the readiness of older people at discharge from acute hospital to home.

Method: A quantitative descriptive and correlational design guided by Meleis' theory of transitions (Shumacher and Meleis, 1994). Data were collected from a 335 patients over 65 years on the day of discharge from acute medical wards at a university hospital in Ireland. Research variables and measures included Readiness for Discharge (RHDS, Weiss et al 2006), Physical function (Barthel Index), Cognitive function (MMSE), patient characteristics, hospitalization factors and home supports measured by researcher developed questionnaire. Descriptive and inferential statistics were employed using SPSS version 15.

Results: Data analysis demonstrated that certain patient characteristics, hospitalisation factors and home supports were statistically associated with older people's perception of their readiness for discharge.

Discussion: Findings agree that readiness for discharge can be perceived differently by older patients (Weiss et al, 2006. Congdon, 1994). Consistent with transitions theory this perception can be influenced by their hospitalisation and identifiable conditions at discharge.

Conclusion: These findings support the assessment of older patients' perception of their readiness for discharge not only in order to include the patient in their own discharge but also to inform discharge planning.

Recommended reading:

Effraimsson,E., Rasmussen,B.H., Gilje, F.,Sandman, P.(2003) Expressions of powerlessness in discharge planning. Journal of Clinical Nursing 12, (5), pp 707-716

Mc Keown, F (2007) The experiences of older people on discharge from hospital following

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assessment by the public health nurse. Journal of Clinical Nursing 16(3) PP.469-476

Weiss, M., Piacentine, L.B., Ancona, J., Gresser, S., Toman, S and Vega-Stromberg, T (2007) Perceived Readiness for Hosp.ital Discharge in Adult Medical – Surgical Patients. Clinical Nurse Specialist 21(1), pp 31-42.

3.3.3

Helping and hindering factors to nursing work in primary care

Fiona Ross, Dean, Faculty of Health and Social Care Sciences, Kingston University and St. George's, University of London, UK

Co-authors: S Christian; S J Redfern

Abstract:

The organisational structures and systems governing primary and community care are changing radically in response to policy imperatives to improve outcomes, quality of care, value for money and patient access to services. However, little is known about the impact of these changes on the professional experience at the sharp end of care delivery.

This paper draws on interview data with nurses from a case study evaluation of the professional response to different modes of governance and incentives in the context of long-term conditions. The study, which reported in 2009, was conducted by a multidisciplinary team, working with local health and social care sectors in three case study sites. In depth interviews with health and social care professionals were informed by vignettes developed by the service user reference group to explore views on team performance, incentives and the experience of managing ambiguity and complexity in care delivery in the context of organisational change and new partnerships. Using an agreed coding framework containing Atlas ti micro codes emergent themes were identified for each site, followed by a cross case analysis. For this paper we have re-analysed the site reports from the perspective of nursing with a view to offering understanding of how nurses' experience and make sense of the helping and hindering factors affecting how their care meets patient expectations within the context of change.

The paper will discuss the emerging major themes: the impact of service re-organisation on partnerships, teamwork and colleagueship; responding to target-led culture; managing the risk-safety balance; service user involvement; continuity of care; job satisfaction, morale, time and resources. The paper will conclude with some messages for policy on ways in which existing workplace cultures can support the development of a patient-centred nursing contribution in primary care.

3.3.4

Partnering in primary healthcare in New Zealand: Clients' and practitioners' experience of the Flinders Programme in the management of long-term conditions

Dianne Roy, Senior Lecturer, Department of Nursing, Unitec, New Zealand

Co-authors: F Mahony; M Horsburgh; J Bycroft; D Miller

Abstract:

Background: The Flinders Programme (FHBHRU) provides healthcare teams with a tool for assessing self-management capacity and facilitating care planning for people with long-term conditions (LTC) in line with client/family values and priorities. This is significant for people with LTCs. Nurses need to be cognisant of techniques to work effectively with clients living with LTC (Macdonald et al., 2008).

Aim: This mixed method feasibility study assessed the acceptability and usefulness of the Flinders Programme when utilised by primary healthcare nurses working with people with a LTC.

Methods: 20 general practices in New Zealand were enrolled, with recruitment of 80 clients with LTCs (randomly selected from practice registries). The study compared a group of clients who received assessment and care planning with nurses using the Flinders Programme (intervention group) to a group who received 'usual care' (control group). Outcome measures were collected via client-partic- ipant questionnaires at the commencement of the study and at 6 months.

Qualitative data, collected between October 2008 and September 2009, focused on the experiences of intervention group clients and practice nurses as they partnered to develop self-management capacity. Qualitative data were analysed themati- cally using Thorne's (2008) interpretive processes. This analysis will be presented.

Results and Discussion: Clients and nurses described 'time' as a key factor. Paradoxically time was both an enabler and a barrier to successful use of the programme. 'Being-listened-to' was an important for clients, with the Flinders programme being 'a catalyst-for-change' in the lives of many.

Conclusions: The Flinders Programme provides an evidence-based generic set of tools to systemati- cally assess self management capacity and collab- oratively identify issues, goals and a management plan for people with LTCs. In NZ while implemen- tation is to date limited, there are benefits of the approach in terms of greater understanding of self- management, collaborative care and effective strat- egies to support behaviour change.

3.4 Outcome measures

3.4.1

Telephone interviewer interrater reliability for a national study of nurse practitioner patient outcomes

Glenn Gardner, School of Nursing, Midwifery and Nutrition, James Cook University, Australia

Co-authors: T Polga; A Gardner; S Middleton; P Della

Abstract:

Aim: The purpose of this nested study was to develop and implement a process to establish interrater reliability for a team undertaking telephone interviews for one phase of a national project exploring the profile, practice and patient outcomes of Australian nurse practitioners (the Australian Nurse Practitioner Project). This phase as explored nurse practitioner related patient outcomes. The training package also needed to be suitable for future use by nurse practitioners and their clinical teams undertaking their own patient outcome evaluations.

Methods: A comparative, cross-sectional study was undertaken. The four-part patient outcome survey tool, previously devised and tested by the chief investigators, included two well validated instruments as well as other specifically developed closed and short answer questions. The interview- ers were experienced clinical nurses with limited research or telephone interviewing experience. The training package was based on active and adult learning principles. Interviewer reliability was tested using a scenario specifically developed to evaluate a range of interviewer skills. Reliabil- ity was calculated both as a total percentage (to assess interrater reliability) and on an individual basis for each interviewer against a gold standard set of responses using the Kappa statistic.

Results: A training and assessment package was developed comprising a formal overview of the survey instrument and the principles of interrater reliability; two practice sessions incorporating peer review processes and a formal assessment of rater reliability. Overall interrater reliability was 92%. Testing each interviewer against the gold standard yielded Kappa values between 0.918 and 0.959.

Discussion: When well validated survey instru- ments are used by telephone interviewers who have received appropriate training, interrater reli- ability is high. Additional outcomes of this nested study were a range of professional development opportunities for novice interviewers including survey methods, assessment of patient outcomes and the nurse practitioner role.

3.4.2

Are the patient reported outcome measures (PROMs) used for venous ulceration suitable for use in economic evaluations of their treatments?

Simon Palfreyman, Research Nurse, Sheffield Vascular Institute, Sheffield Teaching Hospitals NHS Foundation Trust, UK

Co-authors: J E Brazier; P Shackley

Abstract:

Background: Venous leg ulcers have a negative impact on quality of life which can be measured using patient reported outcome (PROM) ques- tionnaires. One class of these, preference-based questionnaires, have a value for each of the health states they describe on a zero to one scale (zero equals death and one equals full health). This can be used to calculate quality adjusted life years (QALYs) which are used to determine the effective- ness of interventions.

Aim: To undertake a systematic literature review in order to assess the extent to which the current PROM questionnaires could be use in economic evaluations of interventions related to venous ulceration.

Methods: Studies were sought that used PROMs to evaluate the impact of venous ulceration on quality of life. A total of 14 electronic bibliographic databases and 11 Internet sources were searched. Data were extracted regarding the type of PROM used, the sample, number of items and domains, and the psychometric performance of the instru- ment.

Results: Fourteen studies, using seven different PROMs were identified. There were variations in the length (range 6 to 83 questions) number of levels (range 2 to 7). None of these were preference-based and therefore suitable for use in economic evalua- tions. Little detail was reported in the majority of studies regarding key aspects of their psychomet- ric performance. In addition, none of them, in their current form, were deemed suitable for conversion into a preference-based instrument.

Discussion: All of the PROMs identified in the review had limitations regarding their applicability for venous ulcer patients and use in economic eval- uations. A number of the PROMs, although admin-

istered to venous ulcer patients, were developed for a breadth of conditions.

Conclusions: There is a need to develop a HRQoL questionnaire for venous ulcers which has the necessary properties to allow it to be used in economic evaluations.

Recommended reading:

Brazier J & Dixon S (1995) The use of condition specific outcome measures in economic appraisal. Health Economics 4, 255-64.

Neumann PJ, Goldie SJ & Weinstein MC (2000) Preference-based measures in economic evaluation in health care. Annual Review of Public Health Vol, 587-611.

Persoon A, Heinen MM, van d, V, de R, Kerkhof-Peter CM & van Achterberg T (2004) Leg ulcers: a review of their impact on daily life. Journal of Clinical Nursing 13, 341-354.

3.4.3

Development and validation of a tool for differentiating advanced practice nursing roles

Glenn Gardner, Professor of Clinical Nursing, School of Nursing and Midifery, Queensland University of Technology, Australia
Co-authors: A Chang; C Duffield
ge.gardner@qut.edu.au

Abstract:

Background: In a health service context where service demands often outstrip available resources, nursing is well placed to provide innovative advanced practice service models to meet community needs. However within the nursing profession and the broader health industry there is no common understanding of the concept of advanced practice nursing (APN)[1]. Whilst the nurse practitioner role is becoming standardised and defined in many countries, this is not so for other levels and types of APN roles.

Aims: To test and validate a tool for measuring the dimensions of practice of APN providing an operational framework to optimise use of APN roles in health service planning.

Methods: In 2008 a state wide survey of a random, stratified sample of 1592 nurses across all grades of seniority was conducted in Queensland, Australia using the 'APN Role Delineation Tool'. This tool, originally developed in the USA from the Strong Model[2], was modified in a qualitative scoping study[3].

Results: With a 42% response rate, the overall mean extent to which all nurses in the sample carried out the 41 APN activities was 2.19 (SD=.69) out of a possible score ranging from 0-4 and there were significant differences according to grade of

nurse in the mean score for total APN activity. The validity of the tool was demonstrated, with factor analysis confirming the domains of APN practice and a good level of reliability attained. Additional support for the tool's validity was the ability of the tool to distinguish among nurses according to grade, position and level of education.

Conclusion: The initial validation of the APN Role Delineation tool provides the means for measuring the extent to which nurses perform APN activities. The validity and reliability of this tool also provides confidence in the findings giving an important baseline for comparison in future studies.

Recommended reading:

Ruel, J. (2009) Advanced practice nursing: A principle-based concept analysis. Journal of the American Academy of Nurse Practitioners, 21, 384-392.

Ackerman, M., Norsen, I., Martin, B., Wiedrich, J. & Kitzman H. (1996) Development of a model of advanced practice. American Journal of Critical Care, 5, 68-73.

Gardner, G., Gardner, A. & Duffield, C. (2006): Making nursing work: breaking through the role confusion of advanced practice nursing: Journal of Advanced Nursing, 57, 382-391.

3.4.4

Development of a violence assessment tool for nurses in the ED

Lauretta Luck, School of Nursing and Midwifery, University of Western Sydney, Australia
Co-authors: L Wilkes; S Mohan; D Jackson
Lauretta.Luck@uws.edu.au

Abstract:

Background: Violence against nurses is well documented in the literature. Despite the need to reduce violence towards nurses, there are no validated assessment tools routinely used by Emergency Department (ED) nurses to predict the potential for violence.

Aims: This paper reports the first phase of a project that builds on the work of Luck, Jackson and Usher (2007, 2008, 2009) to develop and test the construct and predictive validity and reliability of a violence assessment tool to be used in the ED.

Methods: In 2008, three rounds of Delphi were used to send a violence assessment tool to an expert panel (n=23). Response rates varied from 100% to 47.8% across the three Phases. All data were entered into SPSS software and analysed.

In Phase 1, a 37 item assessment tool was developed. Participants were asked to indicate whether they agreed or not with the inclusion of each cue by ticking 'yes' or 'no'. Frequency analyses were undertaken.

Following reduction of the tool, both Phase 2 and 3 used five point Likert scales. In Phase 2 (27 cues) the scale ranged from 1 'least important' to 5 indicating 'most important'. Phase 3 (17 cues) used a scale where 1 was 'not important' and 5 indicated 'extremely important'. Phase 2 and 3 responses for each cue were tallied and frequencies tabulated. The mean response (rating) for each cue and the corresponding standard deviations were calculated and tabulated.

Results: 37 cues, constituting a violence assessment tool, were reduced to 17 cues by an expert panel.

Conclusions: The final 17 cue violence assessment tool developed in this study is an easy to use, quick and efficient way for nurses to assess the potential risk of violent behaviour.

Recommended reading:

Luck, L., Jackson, D., & Usher, K. (2007). STAMP: components of observable behaviour that indicate potential for patient violence in emergency departments. Journal of Advanced Nursing, 59(1), 11-19.

Luck, L., Jackson, D., & Usher, K. (2008). Innocent or culpable? Meanings that emergency department nurses ascribe to individual acts of violence. Journal of Clinical Nursing, 17(8), 1071-1078.

Luck, L., Jackson, D., & Usher, K. (2009). Conveying caring: nurse attributes to avert violence in the ED. International Journal of Nursing Practice, 15(3), 205-212.

3.5 Workforce roles

3.5.1

Work stress and well being in oncology settings: A multidisciplinary study of health care professionals

Martyn Jones, School of Nursing and Midwifery, University of Dundee, UK
Co-author: M Wells

Abstract:

Background: High levels of work related stress are reported by staff working in oncology settings (Ekedahl & Wengstrom, 2007; Fenga, 2007). This may arise from practitioner perceptions of high demand and lack of control in the clinical area (Karasek, 1979). This study investigated the associations between staff perceptions of the work environment, psychological well-being, job satisfaction and performance related to patient safety.

Methods: This questionnaire study combined quantitative and qualitative assessment in a cohort sample of multidisciplinary staff (N=85) working in a cancer centre in the East of Scotland. Ethical approval was granted by local LREC.

Results: Response rate was 50.6% (N=85). Older, female and nursing and support staff were more likely to provide data. Sickness absence exceeded the 5% rates seen in the NHS. Turnover intention rates were consistent with the NHS Survey (Health Care Commission, 2009). Support staff reported the lowest levels of job satisfaction and managerial support. Radiographers reported the highest level of job satisfaction, co-worker support and managerial support. Nurses perceived lower decision latitude and job satisfaction than AHPs or Doctors. Nursing staff, Doctors and AHP perceptions of the work environment placed them in the Active Learning Quadrant of the Demand/Control model. In general, perceptions of decisional control and reward were protective of job satisfaction, particularly when work was perceived to be increasingly demanding or effortful. Co-worker support was associated with perceptions of reduced effort, greater reward and increased satisfaction. Managerial support was also associated with greater control beliefs. Some 51% of significant clinical incidents facing staff in the last month related to high clinical demand and a lack of control.

Discussion: The development and introduction of multi-level strategies to reduce demand and improve control perceptions may be warranted in this setting. Such interventions should target improvements in managerial support, individual self and colleague management skills.

Recommended reading:

Health Care Commission (2009) National NHS staff survey 2008: summary of key findings. Healthcare Commission, London.

Ekedahl M. & Wengstrom Y. (2007): Nurses in cancer care-Stress when encountering existential issues. European Journal of Oncology Nursing 11, 228-237.

Karasek R.A. (1979): Job Demands, Job Decision Latitude and Mental Strain: Implications for Job Redesign. Administrative Science Quarterly 24, 285-308.

Funding source:

1,000 – 10,000

3.5.2

Evaluation of the physician assistant (anaesthesia) practitioner project

Morag Gray, Associate Dean (Academic Development), Faculty of Health, Life and Social Sciences, Edinburgh Napier University, UK
Co-author: Jayne Donaldson
m.gray@napier.ac.uk

Abstract:

The new role of Anaesthetic Practitioner (AP) was established in England using the National Anaesthesia Practitioner Curriculum Framework (Department of Health 2005), and is now being adopted in Scotland.

Aims:

Evaluate the education (in Scotland) of Physician Assistant (Anaesthesia) students from selection to graduation.

Evaluate the impact and perceived impact of implementing this new role on existing members of the theatre team, the public and wider staff within the NHS in Scotland.

A number of approaches to evaluation were adopted that were student; programme; institutional and stakeholder orientated. The methodology consisted of a longitudinal design using a comparative case study approach since the evaluation was inextricably bound within the environment in which both study and practice takes place. The sample included students from the first two cohorts (n=23); course team members (n=9); clinical tutors / supervisors and Consultant Anaesthetists (n=24); and members of the theatre team (n=25). To gain different perspectives and understandings in order to capture the complexity of the experiences and improve validity of findings, a combination of data collection methods were used (documentary analysis; face to face interviews; focus group interviews and telephone interviews. Ethical approval and access were obtained from MREC and R&D in five participating Health Boards.

Data were analysed using the constant comparative method (Glaser and Strauss, 1967). Emergent concepts from one setting (and from the variety of sources) influenced the data collection and purposive sampling in the next setting. Thus data collection and analysis ran concurrently and capitalised on the cumulative and iterative nature of the propositions.

This paper will provide an overview of the findings which will be discussed under the themes of Coping with Academic Aspects of the Course; Resistance to acceptance?; Learning from and in practice; Expectations of the role.

Recommended reading:

Department of Health (2005) Anaesthesia Practitioner Curriculum Framework. DoH, NHS Modernisation Agency

Glaser, B.G., Strauss, A.L. (1967) The discovery of grounded theory. Chicago, Aldine

Funding source:

UK – Professional Education Regulating Body

10,001 – 50,000

3.5.3

The New Zealand Organisation of Nurses 2009 Employment Survey

Leonie Walker, Researcher, New Zealand Nurses Organisation, New Zealand Nurses Organisation, New Zealand

Abstract:

Introduction: The NZNO 2009 Employment Survey, based on the Royal College of Nurses Employment survey, was sent to a 5% (approximately 2000) computer-generated random sample of members of the New Zealand Organisation of Nurses. The objective of the survey was to provide baseline statistical data on the employment conditions, working arrangements and job quality of New Zealand's nursing workforce.

Results: 805 responses were received. Excluding returned changed address notifications, this equates to a 40% response rate. Respondents were broadly representative of the membership.

Employment – All aspects of the employment of NZ nursing workforce were described and analysed, and the differences between working as a nurse in New Zealand and in the UK explored.

Views of nursing – New Zealand's nurses are positive about nursing as a career, job security, career progression and the quality of care they provide. They are less positive about access to training, choice of working hours and the extent of bullying. They were least happy about workload and pay – especially compared to other professionals.

When compared to the UK RCN survey, New Zealand nurses are generally more positive – this might reflect wider cultural and employment differences.

Conclusion: A sound base line has been established from which to be able to measure changes over time. Recommendations can be produced related to the major sources of dissatisfaction or poor morale in the workplace.

Changes to more flexible working practices, return to work programmes and better access to PDRP are needed to accommodate nurses with families who would otherwise be excluded from the workplace, exacerbating shortages. Given the high rate of migration between the UK and New Zealand, understanding the similarities and differences between the work environment and culture is particularly important.

Funding source:

£—1,000

3.5.4

Understanding the impact of ward-based assistant practitioner roles on service delivery and the workforce in acute NHS (hospital) Trusts

Karen Spilsbury, Senior Research Fellow, Health Sciences, University of York, UK
Co-authors: J Adamson; K Atkin; R Carr-Hill; D McCaughan; H McKenna; A Wakefield; M West

Abstract:

Background: The last decade has witnessed significant growth in nursing assistant workforce numbers and their scope of practice. An important assistant worker development in the United Kingdom (UK) is the Assistant Practitioner (AP) role. APs are 'higher

level' support workers, introduced to complement the work of registered professionals.

Aims: We are conducting the first national evaluation of this role to understand how its introduction into ward-based nursing teams in UK acute hospital settings is impacting on the organisation, management and quality of patient care.

Methods: Survey to establish numbers of APs in acute NHS hospital Trusts in England (2007). In-depth case studies of three acute Trusts (13 wards) (April 2007-December 2008) to establish the impact of ward-based AP roles at varying stages of implementation. Mixed quantitative and qualitative methods have been used for case studies (documentary analysis, questionnaires, focus groups, interviews, observation of activities and quality of care delivery).

Results: This paper explores and describes the extent of AP role development in acute hospitals in the UK and the impact of the role on the existing workforce, service delivery and patient care. It highlights relationships between formal policy expectations of the role, expectations of colleagues in practice and factors that act as facilitators or barriers to development, implementation and integration of the AP role.

Discussion and Conclusions: These findings will help policy makers, organisations and practitioners understand factors that enable and or inhibit the integration of 'new' assistant roles within existing occupational structures to develop and innovate service delivery and enhance patient care. The findings provide evidence of the wider impacts of introducing new roles on occupational structures, workload and practices and their potential impact on patient care. These factors are important when considering how care will be delivered to maximise the skills of the entire nursing workforce.

Funding source:

UK – Health Service (National)

100,001 – 500,000

3.6　　Fatigue

3.6.1

'It's an inside experience': An interpretive study of fatigue in patients with heart failure

Jacqueline Jones, Associate Professor, College of Nursing, University of Colorado Denver, United States

Co-authors: C Horton; C Nowels; D Bekelman

Abstract:

Background: Heart failure (HF) is a leading cause of death and suffering across the globe. Contemporary management of HF relies on patient self-care and yet the voice of people living with heart failure is, as yet, infrequently heard and poorly understood.

Aim: To explore the embodied and existential meaning of fatigue for patients in the context of heart failure.

Methods: The study is part of a parent study: 'Development of a palliative care intervention for people with chronic heart failure'. Fatigue was described as 'most difficult' or most distressing' (n=16, 13 patients and three caregivers) or as a symptom of HF (n=8, six patients and two caregivers). We ask, what is it like to experience fatigue as the most distressing symptom for patients with heart failure? 10 dyads and a total of 24 participants are included in this in-depth interpretive analysis.

Results: Analysis of living with fatigue produced three core themes of symptom experience, contextual meaning and existential meaning. As one participant described 'it's like having a time bomb in your chest'. Themes related to what the person 'can not do anymore', how they 'don't look the same' and how they 'just don't want to deal with them' illustrate their changed reality.

Discussion: The experience of fatigue brings a person's bodily existence into focus; how their body 'feels' and how much energy they have is on their mind from the moment they wake up. The dis-ease of facing their own mortality presents challenges for daily activity, their relationships with others around them and how they communicate with health professionals.

Conclusion: Health professionals need to consider patients' experience of fatigue as an individual yet all encompassing way of existing in order to bridge professional discourses of disease management with the distress of 'mortality dis-ease' fatigue brings.

Funding source:

50,001 – 100,000

3.6.2

An ethnoscience approach to develop a cross-cultural understanding of fatigue

Marilyn Kirshbaum, Reader, School of Human and Health Sciences, University of Huddersfield, UK

Co-authors: Kärin Olson; Guendalina Graffigna; Kanaungnit Pongthavornkamol

Abstract:

Fatigue attributable to the disease process and treatment is a common cause of distress in individuals who have advanced cancer. The conceptualisation of fatigue presented in the Fatigue Adaptation Model (Olson 2007) and the Edmonton Fatigue Framework (Olson et al. 2008) centres upon fatigue as a behavioural marker for the inability to adapt to stressors. The core attributes of fatigue include declines in ability to concentrate, stamina, sleep quality, social interactions and control over body processes and an increase in anxiety. Depression is viewed as a consequence and as an important

contributor to exhaustion, a related but distinctly different state.

From a global perspective, it is interesting to note that most research on fatigue has been conducted in one culture only i.e. North America. According to ethnoscience, people 'make sense' to their world, using behavioural patterns that are consistent and shared through language (Evanesko and Kay, 1975). Since language is the primary symbol system used to convey cultural meaning, our study of the variation in language used to describe fatigue across cultures will help us understand if the nature and meaning of fatigue varies across cultures. Understanding these differences, if they exist, is important since they have implications for the cross – cultural translation of interventions.

If nature and meaning of fatigue varies across cultures, approaches to the management of fatigue developed in one culture may not be effective in other cultures. This presentation will describe how a cross-cultural, multinational research team representing Canada, Thailand, Italy and England, have developed strategies utilising ethnoscience methods to advance understanding of cancer-related fatigue and thereby contribute to the development of a globally relevant conceptual framework addressing fatigue. It is envisioned that the study will stimulate discussion surrounding the ways culture shapes the meaning of illness and therefore influence directions toward culturally sensitive nursing interventions.

Recommended reading:

Olson, K. (2007): A new way of thinking about fatigue: A reconceptualization: Oncology Nursing Forum, vol 34, no 1, pp 93-99.

Olson, K., Turner, A.R., Courneya, K.S., Field, C., Man, G., Cree, M. & Hanson, J. (2008): Possible links between behavioural and physiological indices of tiredness, fatigue and exhaustion in advanced cancer: Supportive Cancer Care, vol 16, no 7, pp 2

Evaneshko, V. and Kay, M.A. (1982): The Ethnoscience Research Technique: Western Journal of Nursing Research, vol 4, no 1, pp 49-64.

Funding source:

UK – Research Charity/Foundation

1,000 – 10,000

3.6.3

The experience of fatigue in people with inflammatory bowel disease: An exploratory study

Wladyslawa Czuber-Dochan, Lecturer, Florence Nightingale School of Nursing and Midwifery, Kings College London, UK

Co-authors: L Dibley; C Norton

Abstract:

Background: Inflammatory Bowel Disease (IBD) affects 3.6 million people across Europe and the United States. More than 40% of people with IBD

report fatigue to be the most troubling symptom when the disease is in remission.

Aims: To explore the nature of fatigue and its impact on daily life of people with IBD.

Methods and Participants: An exploratory qualitative study into people's experience and perceptions of living with IBD-related fatigue. Fifty participants were recruited from the National Association for Colitis and Crohn's Disease (UK) member database. Illness duration varied from recently diagnosed, to over 50 years. Focus group interviews were conducted in five separate United Kingdom locations between November 2008 and January 2009. Interviews lasted between 90 and 120 minutes, were digitally recorded and transcribed verbatim. The data were read several times and analysed thematically.

Results and **Discussion:** Five main themes were identified: the experience of fatigue, causes of fatigue, managing fatigue, consequences of fatigue and seeking help and support. Participants stressed the at times totally overwhelming nature of their IBD, contrasting the difference between normal 'end of the day' tiredness and a constant state of exhaustion that disrupts functioning. Fatigue is often all-encompassing, and has a major debilitating effect on the physical, social, emotional and financial wellbeing of people with IBD. They also express the need for the problem to be recognised by healthcare professionals.

Conclusion: Issues relating to IBD fatigue are not well understood and often not addressed in clinical consultations. Further research is needed to understand the impact of fatigue and to develop assessment intervention and support strategies for people with IBD.

Recommended reading:

Minderhoud IM et al (2003) High prevalence of fatigue in quiescent inflammatory bowel disease is not related to adrenocortical insufficiency. The American Journal of Gastroenterology. 98(5); 1088-93

Dudley-Brown S (2002) Prevention of psychological distress in persons with inflammatory bowel disease. Issues in Mental Health Nursing. 23; 403-22

Bernard HR (2000) Social research methods qualitative and quantitative approaches. Sage Publ Ltd: London

Funding source:

No Funding

3.6.4

Emerging nursing-led research into chronic fatigue syndrome/myalgic encephalomyelitis (ViPER)

Amanda McGough, Infection and Travel Medicine, South Tees Hospitals NHS Trust, UK

Co-authors: *Colette Bennett; Kirstie Haywood; Dianne Burns*

Abstract:

The aim of this ViPER session, workshop or concurrent session is to raise nurses' understanding and stimulate active discussion into emerging research in this area of long-term illness and disability.

Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or encephalopathy) (CFS/ME) is a relatively common long-term illness and is estimated to affect at least 0.2-0.4 of the population with around 250,000 sufferers in the UK. It can cause profound, prolonged illness and disability, which has a substantial impact on people with CFS/ME and their carers (NICE, 2007).

The focus of the session will be on two key research initiatives in which nurses play a key role as researchers and clinicians. The FINE trial is a randomised controlled trial of nurse-led patient self help intervention, which has been funded by the Medical Research Council (MRC). This is one of the first key trials into effectiveness of interventions in CFS/ME, which has been regarded as a neglected area in research as recognised by the Department of Health and the MRC.

The second initiative is to develop patient-reported outcome measure for CFS/ME patients. A recent systematic review highlighted the inadequacy of assessment reflecting the patient perspective and this research initiative has been developed to address this gap. These findings have been supported by the NICE guidance for the diagnosis and management of CFS/ME (2007). A patient reported outcome measure is needed both for assessment of outcome both in routine clinical practice and in research for CFS/ME patients.

This session will stimulate lively discussion about the active part nurses can play in generating research ideas from clinical practice, their involvement in the research process and transfer of new knowledge back into the clinical environment with improved patient-reported outcome measures to advance the assessment of health care delivery and outcome for CFS/ME patients.

Recommended reading:

Wearden AJ et al (2006) Fatigue Intervention by Nurses Evaluation – the FINE trial. A randomised controlled trial of nurse led self-help treatment for patients in primary care with chronic fatigue syndrome: study protocol. Biomed Central Medicine; 4:9, doi 10.1186/1741-7015-4-9

Haywood K et al (2009) Health status and quality of life in people with ME/CFS: a structured review of patient-reported outcome measures. Qual Life Res (under review) www.prime-cfs.org.uk/

NICE (2007) Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children. Guideline 53. London. NICE. http://www.nice.org.uk/nicemedia/pdf/CG53NICEGuideline.pdf for executive summary

Funding source:

UK – Research Council

100,001 – 500,000

3.7   Education

3.7.1

Student nurses' perceptions of dealing with complex situations: A qualitative study

Barry Hurst, Health, Liverpool John Moores University, UK

Co-authors: *M Browne; J-A Hayes*

Abstract:

Background: The concept "Complex Care" is used widely in health care literature, however its meaning can be ambiguous. Nevertheless, from the literature, complex care can be seen to include: Care across a range of settings; Co-morbidity; Uncertainty. This paper reports the first results of a longitudinal study that aims to explore how students' perceptions of complex care and their ability to cope with complexity develop over a 3 year undergraduate nursing programme.

Aims:

• To explore students nurses' perceptions of the meaning of complex care and factors which give rise to complexity.

• To explore students nurses' perceptions of their ability to contribute to the care of clients in complex situation and the knowledge and skills required to provide effective care.

Methods: 35 first year students on a pre-registration graduate nursing programme were invited to submit an account of a critical incident involving complex care. 16 students responded and qualitative analysis of their accounts identified a number of themes. A focus group of six students was then formed to explore the identified themes in greater depth.

Results: Analysis produced two major themes: creating complexity and managing complexity. Issues around communication and multi-agency / team working emerged as important categories within both these themes. Students saw their role evolving as they developed the skills needed to deal with these situations.

Discussion: It appears that even in their first year students reported that with increasing experience and increasing confidence they were becoming more able to contribute to complex situations rather than being passive observers

Conclusions: This study demonstrates students were able to recognise and reflect upon the com-

plexity of situations and the skills required. This is considered a skill more usually recognised in specialist practitioners and highlights the benefits of a more advancing approach to nursing curriculum.

3.7.2

What do they do? Student study behaviour

Paul C Snelling, Senior Lecturer, School of Health and Social Care, University of the West of England, UK

Co-author: Martin Lipscomb

Abstract:

Enhancing the student experience is seen as crucial in reducing attrition (Department of Health, 2006) and improving attainment in nurse education and, in order to improve provision, a greater understanding of how students actually go about their studies is required.

We here present the findings of an exploratory study that prospectively investigated the number of hours diploma level students spent in activities connected with a single third year module in a pre-registration nursing programme.

Two important themes emerged from the data. First, the overwhelming majority of study group students spent less time in activities related to the module than module design assumes. On average, students studied for approximately two thirds of stipulated hours and, for the study group, required programme hours are not being met. This finding supports those reported elsewhere (e.g. Sastry and Bekhradnia, 2007). Interestingly, study group students had better attendance records and achieved better pass rates than non-study group students. Although our data do not permit extrapolation, it is possible that the non-study group spent even less time in activities related to the module. Second, more than half of students in the study group undertook paid work. Indeed, some students spent more time in paid work than they did on academic work. No substantive reduction in grade attainment was found in the paid working group as opposed to the non-working group. However, for some, paid work was at a level associated with reduced academic performance by, for example, Salamonson and Andrew (2005).

The study raises interesting and important questions about course design and the student experience. In particular, the findings point towards practical and logical difficulties in meeting regulatory requirements within a framework of a three year, 4600 hour programme. We suggest these 'difficulties' are likely to become more overt as English nursing becomes 'degree only'.

Recommended reading:

Department of Health (2006) Managing Attrition Rates for student nurses and midwives: A guide to good practice for strategic health authorities and Higher Education Institutions. London: Department of Health.

Salamonson, Y. and Andrew, S. (2006) Academic performance in nursing students: influence of part time employment, age and ethnicity. Journal of Advanced Nursing 55(3) 342-351

Sastry, T. and Bekhradnia, B. (2007) The Academic Experience of Students in English Universities (2007 report). Higher Education Policy Institute, London [on line] http://www.hepi.ac.uk/466-1309/The-Academic-Experience-of-Students-in-English-Universities

3.7.3

Understanding the nurse practice environment and how to change it

Paul Slater, School of Nursing, University of Ulster, UK

Co-author: B McCormack

Abstract:

Background: Nursing faces a shortage in staff over the next decade (Slater and McCormack 2009). The nursing practice environment plays a vital role in the recruitment and retention of staff (Slater et al 2009). To date there is limited knowledge of a working model describing the nurse practice environment, a model that is supported with statistical evidence.

Aim: The aim of the study is to develop and empirically test a model that describes a nurse practice environment and to measure the strength of the relationships between variables.

Methodology: A repeated measures time series panel design was used to survey a purposive sample of nurses (n=124). A psychometrically tested instrument, the Nursing Context Index (Slater et al 2009), was administered at four time points over a 24-month period. The instrument measured 19 areas of job stress, satisfaction, organisational characteristics and intention to leave. Structural equational modelling techniques were used to develop and test a model of the nurse practice environment.

Results: A model of the practice environment derived from the data was tested for stability at each of the four time points. The model provides details of a complex relationship between factors with direct and indirect statistically significant relationships between factors. The strength of the relationships were fluid and changeable.

Discussion: The measurement of the factors relevant to the nurse practice environment and the subsequent development and testing of the model

to describe the practice environment help provide a clearer understanding of the practice environment.

Conclusion: A clearer understanding of the practice environment will allow us greater control over it and assist its manipulation fro the better of staff. This will provide a valuable tool in addressing the nursing shortage facing nursing.

Recommended reading:

Slater, P & McCormack B. (2009). Happy in their Work. Nursing Standard. vol 24 no 7 p80.

Slater, P; McCormack B, Bunting B (2009). The development and pilot testing of and instrument to measure nurses work environment: The Nursing Context Index: Worldview of Evidence based Nursing Vol 6, ino 3 p 173 – 182

Slater, P & McCormack B. Ohalloran, P. and Connolly, D. (2009). Testing the factor structure of the Nursing Work IndexRevised. Worldsview of Evidence based Nursing DOI 10.1111/j.1741-6787.2009.00158.x

3.7.4

'Being valued': A phenomenological study of the empowerment of nursing students in clinical practice

Caroline Bradbury-Jones, School of Nursing and Midwifery, University of Dundee, UK

Co-authors: F Irvine; S Sambrook

Abstract:

Background and Aim: This presentation reports on a longitudinal study conducted in the UK that explored the empowerment of nursing students in clinical practice. Specifically, its aim is to focus on the importance of being valued as a nursing student. Although there is a great deal of research regarding empowerment in nursing, most focuses on the empowerment of patients and registered nurses. There is a paucity of research regarding the empowerment of nursing students.

Methods: This longitudinal study was underpinned by van Manen's (1997) hermeneutic phenomenology. Thirteen first-year nursing students were recruited in 2007 using purposive sampling. Annual, semi-structured interviews were conducted with them on their trajectory from first-third year of the under-graduate programme. Data analysis was inspired by Moustakas (1994) and each year of the study culminated with the formulation of a composite textural /structural description of the empowerment of nursing students in clinical practice.

Results: Throughout their programme, knowledge and confidence were the essential, core structures of nursing students' empowerment. However, a significant determinant on gaining knowledge and confidence was the extent to which students were valued. 'Being valued' takes three forms: being

valued as a person; a team member; and a learner. Registered nurses (mentors) play an essential role in fostering this sense of value. However, the study revealed that students are not powerless; they go to great lengths to promote their own sense of value, and thus their own empowerment.

Conclusions: This presentation provides new insight into the means by which nursing students can be empowered; specifically, in terms of enhancing their feelings of value. Because exposure to clinical placements is a global requirement for nursing students, this presentation has international relevance. It will appeal to conference delegates interested in learning how nursing students can be empowered, rather than disempowered in clinical practice.

Recommended reading:

Moustakas C. (1994) Phenomenological Research Methods. Thousand Oaks: Sage Publications.

Van Manen M. (1997) Researching Lived Experience. University of Western Ontario: The Althouse Press.

Funding source:

No Funding

3.8   Methods

3.8.1

Methodological pearls and pitfalls: Using realistic evaluation to evaluate the impact of end-of-life care education on practice in care homes in the UK

Moira Attree, Senior Lecturer, School of Nursing, Midwifery and Social Work, University of Manchester, UK

Co-authors: I Jones; M Johnson

Abstract:

Introduction: This paper will present a critical analysis of the methodological pearls and pitfalls involved in using Realistic Evaluation (Pawson & Tilley 1997) to evaluate the impact of end-of-life care education on practice in care homes in the UK. Realistic Evaluation offers an alternative to quasi-experimental designs and aims to produce an in-depth analysis of how programmes work in context, dissemination and implementation of findings are seen as primary objectives; however, empirical evidence of the efficacy of the evaluation design is lacking. Realistic Evaluation is increasingly adopted in nursing and healthcare education; recent examples include an evaluation of Pre-registration Fitness for Practice Curricula (Lauder et al 2008). The paper aims to promote scholarly debate of the methodological issues involved in using Realistic Evaluation in education.

Methods: Realistic Evaluation was used to evaluate the impact of introducing The Gold Standards Framework in Care Homes (GSFCH) programme in two case study care homes in the North-West of England. Mixed methods of data collection were used: quantitative measures included a pre and post-training staff attitude scale, confidence log and an after-death analysis. Qualitative data was collected by interviews with 2 Care Home managers, 24 staff, 6 residents, 12 relatives, fieldwork observation and documentary analysis. The methods and data collection tools will be critically evaluated.

Discussion: The methodological issues and efficacy of Realistic Evaluation will be critically debated and evaluated in relation to the rhetoric and reality of claims made about the design and its ability to address the study aims. Scholarly debate of the methodological issues and future challenges involved in evaluating the impact of education on practice will be facilitated.

Recommended reading:

The Gold Standards Framework in care homes: www.goldstandardsframework.nhs.uk last accessed 14/10/2008.

Lauder W, Holland K, Johnson M, Roxburgh M, Topping K, Watson R, Porter M, Behr A (2008) Measuring competence, self reported competence and self-efficacy in nursing students. Nursing Standard. 22, 20, 35-44.

Pawson R & Tilley N (1997) Realistic Evaluation. London: Sage

Funding source:

UK – Research Charity/Foundation

10,001 – 50,000

3.8.2

'Getting going' with action research

Christine Boomer, Research Fellow, School of Nursing /Institute of Nursing Research, University of Ulster, UK

Abstract:

This presentation will share a journey of 'getting going' with an action research study as a part time PhD student.

I am a part time PhD student undertaking an action research study and the 'getting going' experience has been a challenging journey for me. Action research asks the researcher to travel a complex and challenging journey of learning, understanding, knowing and being. Utilising a critical creativity framework (McCormack & Titchen 2006) to enable critical reflection has enabled me to gain understanding of my experiences and the key issues (as I see them) in undertaking an action research study.

Key issues in getting going with action research:

• Preparation

• Philosophical stance

• Researcher/facilitator role

• Desire, motivation and belief

• Space

• Relative stability of culture and context • Challenge and support network

• Work on self

In presenting this personal journey I will highlight the theory and knowledge that has enabled me to understand the experiences more fully and ultimately to keep going. My current philosophical work is enabling me to gain clarity of intent and I now have a strong ontological framework enabling me to be authentic in the research.

By presenting a critically reflective journey this paper will add to the knowledge regarding the use of critical and creative processes in research and provide practical knowledge on the issues involved in undertaking an action research study as a PhD student within the ever-changing healthcare context.

Recommended reading:

Carr W, Kemmis S (1986) Becoming Critical Education, Knowledge and Action Research. Deakin University Press, Abingdon

McCormack B, Titchen A (2006) Critical creativity: melding, exploding, blending. Educational Action Research, Vol 14, No 2, PP 239-266

Funding source:

No Funding

3.8.3

Achieving participation in action Research: Sharing the lessons

Julie Gregory, Pain Management, Bolton Hospitals NHS Trust, UK

Abstract:

Action research was the methodology used to study and change the assessment and management of pain on a medical unit in a District General Hospital. Parkin (2009) describes action research as a core strategy for implementing change in healthcare. It is grounded in the belief that research should be participative and democratic (Ladkin 2004). The extent of participation and active involvement can vary from awareness of a project to full partnership and collaboration with the researcher (Kelly and Simpson 2001).

This research project moved along the typography over time as described by Hart and Bond (1995). Initially the approach used was experimental or technical collaborative, the researcher was the expert from outside the medical unit and participation was minimal and the relationship between the researcher and participants remained formal.

Over time the project has moved towards an empowerment approach as a relationship has been established and developed between the researcher and practitioners. The researcher raises awareness to enable the participants to identify the problem and question their underlying assumptions and values (Holloway and Wheeler 2002) to assist them to change their practice. As a result of group learning, facilitation and active involvement by

the researcher practitioners themselves have critically reflected and discussed aspects of practice generally and in particularly pain assessment and initiating change themselves. The success of a group to identify a problem, proposed alternative solutions, to implement, act and evaluate changes depends on the personality of the researcher (Meyer 1993, Waterman et al 2001).

The difficulties of gaining participation and involvement have not always been reported in the literature. The intention of this paper is to describe the phases that occurred in this research study to achieve participation and share with delegates the lesson learned along the way.

Recommended reading:

Kelly D and Simpson S (2001) action research in action: reflections on a project introducing clinical practice facilitators to an acute hospital setting. Journal of Advanced Nursing 35 (5) 652-659

Parkin P (2009) Managing Change in Healthcare Using Action Research. London. Sage

Waterman H Tillen D Dickson R de Koning K (2001) Action **Research:** a systematic review and guidance for assessment. Health Technologies Assess; 5 (23)

Funding source:

UK – Professional Association

1,000 – 10,000

3.9.1

A theory of community-based Taiwanese elder care

Hsiao-Yu Chen, Nursing, National Taichung Nursing College, Taiwan

Co-author: Shiou-Huang Yeh

Abstract:

The elderly population has increased dramatically in the 21st century, especially in Taiwan. It is important to provide holistic care for the elderly. However, very limited research exists regarding integrated community-based Taiwanese elder care. The aims of this study were to develop a theory of community-based Taiwanese elder care. Grounded theory was used in exploring the process of community-based Taiwanese elder care. Data were collected through interviews, participant observations and documentary resources; analysis was an interrelated process. A multi-step synthesis of data analysis was used. Theoretical sampling was used throughout all areas of the study. The total of 35 interviews involved 30 individuals (22 elderly and five of their family, three health-related professionals); participant observations were carried out and relevant documents scrutinised. Methods of constant comparison, asking questions, keeping memoranda, diagramming records and reading literature were interwoven with each other from the beginning of data collection until theoretical saturation was achieved. The core category 'continuing living and integrating process' explained the

complex structure of interactions observed during the investigation and indicated the importance of developing a theory entitled the 'Living Exchange and Integration Theory'. This theory includes the following six needs of elder: security, achievement, valuable, expectancy, warm feeling and solicitude. The positive consequence is achieved life integration, and the negative consequence is waiting for death. The results of this study improve quality of life for the elderly and their family. Moreover, an integrated community-based Taiwanese elder care was established.

Recommended reading:

Nolan, M. Brown, J. Davies, S. Nolan, J. Keady, J. (2006) The senses framework: Improving care for older people through a relationship-centred approach. UK: The University of Sheffield.

Chen, H.Y. & Boore, J.R.P. (2009) Using a synthesises technique for grounded theory in nursing research. Journal of Clinical Nursing 18 (16), 2251-2260.

Charmaz, K. (2006) Constructing grounded theory: a practical guide through qualitative analysis. London: SAGE Publications Ltd.

Funding source:

10,001 – 50,000

3.9.2

The socio-cultural context of nutritional care in care homes: Insights for nursing

Susan Philpin, School of Health Science, Swansea University, UK

Co-authors: J Merrell; J Warring; V Gregory; D Hobby

Abstract:

Background: Malnutrition, is common, especially among older people living in care homes and may lead to physical weakness and poor health, (BAPEN, 2007). In the UK the need to detect, prevent and treat malnutrition in older people is recognized (BAPEN, 2007) and incorporated into national guidelines (NICE, 2006) for nutritional support in adults. However, there is little research into the extent to which care home staff are able to implement such guidelines.

Aims: To investigate factors which influence nutritional care provided to residents in two different types of residential care settings.

Methods: We sought to explore perspectives and experiences of residents, carers and social care practitioners, thus a qualitative approach was deemed appropriate. This included focus group interviews with relevant staff members, individual interviews with managers and residents of the care homes and their carers, observation of food preparation and meal times throughout the day and analysis of appropriate documents. Service users and carers were included in the steering group in order to ensure their perspectives informed

the research process. Data were analysed using thematic analysis.

Findings: Two broad, essentially social, interacting themes concerning addressing residents' nutritional needs emerged. First, the influence of various environmental factors, such as the home's geographical location, physical lay-out and ambience; health and safety constraints; staffing levels and skills and the nature and quality of the food. Second, the ways in which residents' experiences were mediated through the myriad socio-cultural meanings attached to eating and drinking by residents, staff and carers. In both care homes 'family-style' mealtimes were encouraged with an emphasis on enjoying social interaction as well as eating and drinking.

Conclusion: Greater understanding of the socio-cultural context of eating and drinking in residential care settings may be used to inform nursing practice in relation to meeting older people's nutritional needs in other settings.

Recommended reading:

British Association of Enteral and Parenteral Nutrition (2007) Nutrition Screening Survey in the UK in 2007 British Association of Enteral and Parenteral Nutrition: Redditch

National Institute for Health and Clinical Excellence (2006) Nutrition support in adults: Oral nutrition support, enteral tube feeding and parenteral nutrition Clinical Guideline 32 National Institute for Health and Clinical Excellence: London

Funding source:

10,001 – 50,000

3.9.3

The making of place: The meaning of home for older people

Jean Davison, Research Methods, Teesside University, UK

Abstract:

People in all parts of the world, and particularly in industrialised nations, are living longer than ever before (Butler 1997). Neo-liberal governments since the 1980s in the United Kingdom have changed the policy with regard to supporting older people from residential care to encouraging people to remain in their own homes (National Consultative Ethics Committee for Health and Life Sciences 1998). Inevitably such policy changes have led to an increased likelihood of health and social care interventions occurring in the home (Martin et al 2005). Professional authority and medicalisation of the home space could create a dichotomy between private and public worlds that could negate any positive feelings an older person has for their home. This research aimed to explore the psychological, social and cultural aspects of the home in the context of ageing. Narrative accounts, which allow older people to express themselves through story-telling, were collected from a sample of 12

41

older people on two separate occasions on a one-to-one basis in 2008/09. The data was transcribed verbatim and a narrative analysis was conducted in order to appreciate the personal stories of the older people. A number of themes highlighted crucial factors for maintaining life style choices for these participants including embodiment, independence, autonomy and psychological attachment to the home and possessions. However older people are not a homogenous group and some participants found the home to be a restrictive and isolated place. The findings demonstrate the unique appreciation each individual had for their home and the creative strategies that older people devised to either attain or maintain life style choices. Professionals who work with older people in their own homes would be advised to consider the impact of their presence on the meanings and practices of the home for older people as they age.

Recommended reading:

Butler RN (1997) Population aging and health. BMJ Vol 315, No. 7115: 1082-1084

Martin GP, Nancarrow SA, Parker H, Phelps K & Regen EL (2005) Place, policy and practitioners: on rehabilitation, independence and the therapeutic landscape in the changing geography of care provision to older people in the UK. Social Science & Medicine,

National Consultative Ethics Committee for Health and Life Sciences (1998) Report on Ageing, No.59. [online]: http://www.ccne-ethique.fr/english/avis/a_059.htm Accessed 28.3.07

Funding source:

UK – Higher Education Institution

€ 1,000

4.1.1

A self-efficacy oriented educational program may lower the cesarean section rate

Wan-Yim Ip, The Nethersole School of Nursing, Faculty of Medicine, The Chinese University of Hong Kong, Hong Kong

Abstract:

Background: The cesarean section rate in Hong Kong as reported by the latest Hong Kong College of Obstetricians & Gynecologists was about 22.5%-27.6%. This high incidence rate is well above the 15% limit recommended by the WHO. The Bandura's self-efficacy theory is found to be effective in guiding the development of health promoting activities for various behavioral changes. However, there is limited application of this theory to childbirth care.

Aims: To test the effectiveness of a self-efficacy oriented educational programe (SEOEP) to promote women's self-efficacy for childbirth and coping ability during labour. The effect on labour outcomes in terms of mode of delivery and selected labour outcomes was also investigated..

Methods: The design of the study was a single-blinded, two group randomized controlled trial. The eligible Chinese first-time pregnant women were randomly assigned to experimental (n= 96) or control (n=96) group. The experimental group received two 90-minute sessions of an educational program, based on Bandura's self-efficacy theory (SEOEP) offered at 33-35 weeks of pregnancy. Follow-up assessments were made within 48 hours after delivery. The outcome measures included self-efficacy for childbirth, performance of coping behavior during labour and selected labour outcomes including mode of delivery.

Results: The experimental group demonstrated significantly higher levels of self-efficacy for childbirth and coping behaviour during labour than the control group (P<0.05). The odds of cesarean section of the control group are almost 2.5 times higher than that of the experimental group.No other group differences were observed in the selected outcome measures.

Conclusion: The short term theory based educational intervention demonstrated significant impact on women's belief of their self ability to cope with childbirth and thus their coping behaviour. The clinical significance of lowering the cesarean section rate should be interpreted with cautions in view of the limitations of the study.

4.1.2

Does it matter? Progress of labour after loop excision of the transformation zone

Val Colgan, PhD Student/Specialist Midwife/ Community Midwife, School of Health, Community and Education Studies, Northumbria University, UK

Abstract:

Background: This presentation argues that progress of labour after excision of abnormal cells of the cervix is altered and that it does matter. Previous research was inconclusive. More women will be affected according to National Statistics(Patnick 2007; ONS 2007).

Aim: To determine if Loop Excision of the Transformation Zone (LETZ), affected the pattern and progress of women in labour.

Methods: A retrospective case control study of 57 Para 0 and 37 Para1 subject women giving birth in 2004/2005 in one hospital were identified. Notes and databases yielded LETZ and delivery information, collected in 2005/2006. Control women were randomly selected after matching parity, year of birth and delivery. Sample calculations gave 80% power to detect Relative Risk (RR) of 1.3 with Î± − value of 5% for dichotomous variables.

Results: For Para 0 and Para 1 subject women RR=2.33 for Premature Birth.

For Para 0 subject women RR=1.8 for admitted 4cm or more dilated, an important emergent issue.

For Para 1 subject women RR=1.417 for less time to reach full dilatation, clinically important but not statistically significant.

Discussion: The study had sufficient power to confirm statistical significance for Premature Birth indicated previously (Kyrgiou, Koliopoulos et al., 2006).

Later admission of Para 0 subject women may be misdiagnosis of established labour.

The relation between time to reach full dilatation in Para 1 subject women and Cervical Intraepithelial Neoplasia grade 3, could reflect total area of tissue excised, a speculation also formulated by Kyrgiou, Koliopoulos et al. (2006).

Conclusions: The study reveals for the first time important differences in pattern and progress of labour and adds to our knowledge of Premature Birth after LETZ. This needs to be incorporated into pre-LETZ and pre-birth counselling of women.

Width of excised tissue needs to be available in future for further research to be meaningful.

Recommended reading:

Kyrgiou, M., G. Koliopoulos, et al. (2006). â œObstetric outcomes after conservative treatment for intraepithelial or early invasive cervical lesions: systematic review and meta-analysis: The Lancet Vol. 367, Iss 9509, pp 489-498.

ONS (2007a). Birth Statistics. O. o. N. Statistics, HMSO: 108.

Patnick, J. (2007). Annual Review 2006: NHS Cervical Screening Programme. N. C. S. Programme. Sheffield, Trimedia Communications UK Ltd: 24.

4.1.3

The bottom line: A measure of labour progress?

Ashley Shepherd, Nursing and Midwifery, University of Stirling, UK

Co-authors: H Cheyne; S Kennedy; Colette McIntosh; Maggie Styles; Catherine Niven

Abstract:

Background: The progress of labour is measured in a number of ways including cervical dilatation and decent of the fetal head. The presence of a purple line seen to extend along the gluteal cleft as labour progresses has been described (Bryne and Edmonds 1990).

Aim: To assess in what percentage of women in labour the line was present and also to determine if any relationship existed between length of the line and labour progress.

Methods: Women were invited to participate when they were admitted to hospital in either spontaneous labour or for induction of labour. Immediately before routine admission observations and subsequent vaginal examinations, the presence or absence of a purple line was noted and, if present, its length was recorded.

Results: Data was recorded throughout labour for 144 women. The line was present in 109 women (76%) and there was a medium positive correlation between length of the line and cervical dilatation r=+0.36, n=66, P=0.0001 and also length of the line and station of the fetal head r=+0.42, n=56, P<0.0001 (Bland and Altman 1994). The purple line was also more significantly likely to be present in women in spontaneous labour when compared with those women admitted for induction of labour X_2 (df=1, n=144) = 4.9, p=0.03, phi=-0.20). No significant association between parity and presence of line was found X_2 (df=1, n=144) = 0.43, p=0.51, phi =-0.07).

Discussion: This study confirms that the purple line is present in the majority of women in active labour and its length correlates with labour progress. Our data suggests that the line begins to appear at between 3-4cm dilatation.

Conclusions: What needs to be considered now is whether the line is clinically useful in the management of labour and whether the assessment and measurement of the line is acceptable to both women and midwives.

Recommended reading:

Bryne DL and Edmonds DK (1990) Clinical method for evaluating progress in first stage of labour. The Lancet 335 (8681) pp122

Bland JM and Altman DG (1994) Correlation, regression and repeated data. British Medical Journal 308 (6933) 896

4.2 Knowledge transfer

4.2.1

Developing research and knowledge translation capacity in nursing through the NIHR Collaborations for Leadership in Applied Health Research and Care

Kate Gerrish, Professor of Nursing, Centre for Health and Social Research, Sheffield Hallam University & Sheffield Teaching Hospitals NHS Trust, UK

Abstract:

Nine Collaborations for Leadership in Applied Health Research and Care (CLAHRC) were established in 2008 by the National Institute in Health Research with the remit to undertake high quality applied health research and facilitate the translation of research findings into practice within the National Health Service in England. The CLAHRCs represent a collaborative partnership between one or more universities and their neighbouring NHS organisations. Each CLAHRC will receive up to £10 million in core funding over a five year period from the NIHR and an equivalent amount in matched funding from partner organisations. This significant financial investment in research infrastructure presents a range of opportunities for nursing to exploit. Each CLAHRC is taking forward a research agenda relevant to the health needs of local populations, focused on long-term conditions and public health. CLAHRCs are also testing and evaluating initiatives to encourage implementation of research findings in practice, thereby increasing capacity for research and knowledge translation.

CLAHRCs have three key interlinked functions:

- Conducting high quality applied health research;

- Implementing the findings from research in clinical practice;

- Increasing the capacity of NHS organisations to engage with and apply health research.

The opportunities for nursing arising from each of these functions will be examined and illustrated by drawing upon the experience of the first 18 months of the NIHR CLAHRC for South Yorkshire. CLAHRCs present a unique opportunity for supporting the development of clinical academic careers in nursing and developing the capacity and capability of nurses to undertake knowledge translation. By engaging commissioners, managers and front-line nurses in research and implementation activities, CLAHRCs provide a means of embedding research within organisational structures and process. The paper will conclude with recommendations for how nursing might best maximise the potential of CLAHRCs.

Recommended reading:

Mawson S, Scholefield H (2009) The National Institute for Health **Research:** Collaboration for Leadership in Applied Health Research and Care for South Yorkshire. Journal of Research in Nursing 14:2 169-174

NIHR (2007) Collaborations for Leadership in Applied Health Research and Care: call for proposals to establish pilots. http://www.nihr.ac.uk/files/pdfs/CLAHRC%20-%20Call%20for%20 Proposals%20for%20Pilots.pdf

UKCRC Subcommittee for Nurses in Clinical Research (Workforce) (2007) Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. London, UKCRC

4.2.2

Developing, exploring and refining a modified whole systems based model of evidence-informed nursing

Robert McSherry, School of Health and Social Care, Teesside University, UK

Abstract:

In spite of a plethora of evidence-based nursing literature and numbers of models/frameworks designed to facilitate it's cause, registered nurses continue to struggle to use evidence to support their practice.

Aim: The research aimed to develop a new and alternative Evidence-Informed Nursing (EIN) model designed to facilitate evidence into practice.

Design: A Modified Whole Systems Theory (MWST) design using Soft System Methodology (SSM) combining quantitative and qualitative methods was the framework of choice for this research study.

Population, Sample: A probability sampling technique was used for the qualitative aspect of the study where all 239 registered nurses had an equal chance of participation by completing and returned the Research Awareness Questionnaire (RAQ) n = 149 (62%). A purposive sample of n=31 (30%) of all grades of nursing staff participated in the six qualitative Focus Group Interviews (FGI).

Methods: Data from the RAQ was entered into a Statistical Package for Social Science (SPSS) database where both descriptive and inferential statistics were used for data analysis. A thematic analysis was undertaken of the FGI transcripts. Ethical approval was granted to undertake the study.

Findings: The re-presented EIN model unlike the original theoretical EIN model clarified that evidence-based nursing is undoubtedly a complex system comprising of several important attributes contained within six elements. These are: professional accountability, informed decision-making, research awareness, application of knowledge, evaluation and conditions affecting research utilisation. The results confirmed that the EIN model is systems based by possessing a clearly defined input; to encourage nurses to use evidence in practice, throughput; facilitation about the processes associated with the six elements and an output; improved standards of professional practice.

Conclusions: The EIN model offers a new and alternative framework for nursing colleagues to use and apply when faced with a real problem of getting evidence into practice.

Recommended reading:

Checkland, P, B (1981) Systems Thinking Systems Practice. John Wiley: Chichester.

McSherry, R, Simmions, M, Abbott, P (2001) (eds) Evidence-Informed Nursing A Guide for Clinical Nurses, Routledge: London.

Pratt, J, Gordon, P, Plamping, D (1999) Working Whole Systems: Putting theory into practice in organisations. Kingsfund: London.

4.2.3

Research plus: Using knowledge transfer to create new knowledge and improve outcomes for stakeholders

Christina Lyons, School of Nursing and Caring Sciences, University of Central Lancashire, UK
Co-authors: K Whittaker; A Brotherton

Abstract:

Within academic circles in the UK knowledge transfer (KT) is viewed largely as a by-product of research. KT funding has an ambiguous position in the assessment of research quality regardless of what research outputs are realised. Paradoxically, the results of the last UK 2008 research assessment exercise highlighted a paucity of KT within the nursing unit of assessment, raising this as an issue of concern (McKenna 2008). This paper challenges the prevailing view in the UK, and elsewhere, that KT is not research. It is contended that KT is 'Research Plus'. With reference to 3 case studies the presentation will illustrate not only how new knowledge can be generated but how KT projects can directly contribute to improved outcomes for stakeholders.

Case study 1: Development of a practical framework to improve communication between service users,

third sector providers and commissioners in the design and planning of community based mental health services.

New knowledge: ethnographic insights into health service bureaucracy and institutional inertia that resist change.

Improved stakeholder outcomes: Overcoming bureaucratic barriers to link service user defined recovery outcome measures to performance monitoring of contracts.

Case Study 2: Evaluation and development of new interventions within an integrated community weight management pathway.

New knowledge: Use of realistic evaluation as a framework to examine the rationale for the success of innovative interventions.

Improved stakeholder outcomes: An effective service that focuses on understanding what works for individuals.

Case study 3: Evaluation of a home based children's accident prevention service in order to develop a model of accident prevention for older people.

New Knowledge: 'Road testing' of realistic evaluation methodology, developing new research skills and refining the team's conceptual model.

Improved stakeholder outcomes: Key elements, such as relationships between stakeholders that make the service effective, have been identified and helped secure continued funding.

Recommended reading:

McKenna H (2008) Subject overview report from RAE 2008 Main Panel C and sub-panel C11. Available: http://www.rcn.org.uk/development/researchanddevelopment/rs/rae2008 [Accessed 02/11/09].

Funding source:

50,001 – 100,000

4.3 Medication management

4.3.1

Development of an algorithm for moderate intensity exercise in Type 1 diabetes

Lynn Kilbride, School of Nursing and Midwifery, Edinburgh Napier University, UK

Co-authors: J Charlton; R Davison; G Aitken; G Hill; J McKnight

Abstract:

Background: Many people with Type 1 diabetes wish to take part in sport or exercise. However strategies to manage dysglycaemia during and after exercise present a significant challenge to them and to health care professionals (Gallen 2004, Perry & Gallen 2009).

Aims: To investigate the effect and reproducibility of the glucose response to an algorithm for carbohydrate and insulin adjustment during and after

exercise in people with Type 1 diabetes compared to their self management strategies.

Methods: Over a period of 14 days, 14 participants (well controlled Type 1diabetes, habitual exercisers, and experienced users of basal bolus regimen) undertook four exercise sessions; two sessions in week 1 and two in week 2. Each exercise session consisted of a 40 minute walk on a treadmill to elicit 50%VO2max. In week 1 participants self managed their diabetes. In week 2 participants managed their diabetes in accordance with an algorithm for carbohydrate (CHO) and insulin adjustment.

Results: The mean reduction of blood glucose levels detected during exercise of was 3.1±2.03mmol/l. Time spent within the range of 4-9 mmol/l., during exercise was not significantly different between the self managed and the algorithm weeks (-3 to 22.4 min). The mean reduction of blood glucose for each individual over all four exercise sessions ranged between 0.8 and 5.95 mmol/l. The TE (technical error) between days one and two was 2.4 mmol/l (CV= 33.2%), and between days 3 and 4 the TE was 2.7 mmol/l (CV= 33.7%).

Conclusion: The results of this study provide valuable data about the reproducibility of the blood glucose response to moderate intensity exercise The Despite the reproducibility of individual responses being variable 40 mins of moderate intensity excercise decreases CGMS glucose by 3mmols. Health care professionals may use this information to advise patients who wish to exercise. The findings will also be used to underpin future studies.

Recommended reading:

Gallen I (2004) Helping the athlete with type 1 diabetes. The British Journal of Diabetes and Vascular Disease 4: 87-92

Perry E and Gallen I (2009) Guidelines on the current best practice for the management of type 1 diabetes sport and exercise. Practical Diabetes International 26: 116-123

Funding source:

UK – Industry

10,001 – 50,000

4.3.2

Type 1 diabetes and adolescence: An exploration of lived experiences

Joy Spencer, Faculty of Health and Social Care, University of Chester, UK

Co-authors: H Cooper; B Milton

Abstract:

Background/Aims: A systematic review of qualitative studies of Type 1 diabetes (T1D) in adolescence defined the need for rigorous qualitative research exploring the lived experiences of adolescents with T1D and their parents in the UK. Complexity science provided a theoretical starting point but merited empirical validation. The study had two
Aims: (i) To qualitatively explore the lived experi-

ences of adolescents with T1D and their parents; (ii) To determine the applicability of complexity science as a framework for T1D management in adolescence.

Methods: Data collection took place in 2007. A maximum variation sample of adolescents with T1D (age 13-16) and their parents/guardians was recruited from a North-West clinic. Lived experiences were explored through a hermeneutic, multi-method approach to data collection and analysis, encompassing clinical data, an original computerised self-management diary tool, interviews and focus groups with adolescents and parents.

Results: 20 families participated (48 interviews). Self-management of T1D in adolescence was underpinned by the normalisation of T1D within surrounding environments, the physical embodiment of T1D, relationships with significant others and experiential learning.

Discussion: Living with T1D in adolescence is an emergent and adaptive process underpinned by many interacting psychosocial factors, supporting previous evidence of varied psychosocial determinants of blood glucose control. Exploration of the lived experience themes in relation to the principles of complexity science validated this approach as a theoretical framework for understanding T1D management in adolescence.

Conclusion: The findings encourage a shift from the biomedical focus on blood glucose control, to one of balancing T1D with 'meaningful' aspects of adolescent life. Findings are being used to develop a computer-based diabetes learning needs assessment tool for young people. This will enable an approach to diabetes care which adolescents and their families can translate into 'real life', and has the potential to improve blood glucose control through meaningful education and learning.

Funding source:

UK – Higher Education Institution

10,001 – 50,000

4.3.3

Development of an adolescent diabetes needs assessment tool (ADNAT Study)

Helen Cooper, Community and Child Health, University of Chester, UK

Co-authors: J Spencer; S Edwards; G Lancaster; M Johnson; R Lwin; M Didi

Abstract:

Background: Four out of five young people with diabetes in the UK have inadequate blood glucose control and research continues to describe poor long-term clinical and psychological prognosis. To improve outcomes, evidence points to the need for educational and psychological support based on clearly identified needs. This study builds upon existing work including a qualitative study

exploring the impact of diabetes on adolescents and their carers, and two systematic reviews.

Aims: To develop an age and diabetes-specific needs assessment tool to guide the organisation/delivery of care to address individual needs; to assess how ADNAT can be used effectively in clinical practice.

Methods: Methodology includes five stages: identification of a pool of potential items from the previous studies; systematic reduction, pretesting, and cross validation of the items; transfer to IT format; and development of dissemination strategies through focus groups with users and practitioners. Three of the five stages have been completed, user involvement has been key to all.

Results: Content validity, established through user, carer and expert review, produced five self-assessed domains: eating, physical activity, monitoring blood glucose, medication taking, and living with diabetes. Mental health and independence including social skills underpin all five domains. The process of completion, a learning activity in its own right, produces five different outcomes including a unique three-dimensional 'diabetes fitness landscape', mapped using traffic light labelling to highlight problem areas. This allows the adolescent to see how his/her domains and their blood glucose inter-relate and impact on their personal diabetes fitness. In this way, ADNAT acts as a communication aid and an on-going record of learning needs and how they are being met.

Conclusions: This study potentially has extensive health care application, including adaptation/validation for other age groups, and data to guide educational resource development including training programmes for health professionals, parents, and school teachers.

Recommended reading:

Bryden KS, Dunger DB, Mayou RA. et al. (2003) Poor prognosis of young adults with type 1 diabetes. A longitudinal study. Diabetes Care, 26, pp1052-1057.

Swift PGF. (2007) ISPAD clinical practice consensus guidelines 2006-2007: diabetes education. Pediatric Diabetes, 8, pp 103-109.

Funding source:

4.4 Children

4.4.1

The attitudes of neonatal nurses towards extremely preterm infants

Katie Gallagher, Tutor, Department of Midwifery and Child Health, Kings College London, UK
Co-authors: *D Porock; A Edgley; N Marlow*

Abstract:

Background: As more infants receive intensive care at extremely preterm gestations, the attitudes neonatal nurses hold towards these infants will potentially have a significant impact upon the nursing care they provide to infants and families.

Aim: The aim of this investigation was to explore the attitudes of neonatal nurses towards extremely preterm infants.

Methods: Q methodology explored the attitudes of 36 neonatal nurses across six neonatal units in 2008. Nurses sorted 53 statements representing the debates surrounding extremely preterm infants from 'agree to 'disagree'. Nurses then participated in a post Q sort interview to explore their statement placement rationale. Factor analysis and card content analysis analysed the data.

Results: A shared set of attitudes ('consensus') amongst all neonatal nurses highlighted their non-judgemental perceptions towards nursing. Three separate sets of attitudes ('distinguishing') highlighted the differences between them, centred on the involvement of parents in end of life decision making. Some nurses reported their belief in accounting for parental choice in decision making. Others discussed their beliefs that the health care professional should undertake decisions. The remaining nurses believed in technology over decision making, suggesting technology would advance and allow more preterm infants to survive.

Discussion: Neonatal nurses shared concerns regarding extremely preterm infants, yet held differing attitudes towards resolving the 'situation'. These attitudes culminated in a difference of opinion towards decision making, reflecting the dilemmas nurses routinely found themselves in when working with extremely preterm infants. The attitudes highlighted the complexity of the neonatal environment where core 'learnt' nursing values were difficult to implement.

Conclusion: Neonatal nurses shared concerns regarding extremely preterm infants which resulted in different attitudes towards end of life decision making. This led to the recommendation of the creation and implementation of a palliative care protocol to improve the experiences of nurses, parents and infants.

Funding source:

4.4.2

Differences between fathers' and mothers' views of their contributions to management of childhood long term conditions: A qualitative study

Veronica Swallow, School of Nursing, Midwifery and Social Work, University of Manchester, UK
Co-authors: *A Macfadyen; S Santacroce; H Lambert; R Olley*

Abstract:

Background: The importance of parents' contributions to chronic disease management is well documented but until recently research tended to focus on mothers' as the main respondents, meaning fathers' views are under-represented.

Aim: To explore and compare mothers' and fathers' individual and joint accounts of their contributions to their child's care.

Methods: A qualitative design was used. Parents were selected from one UK children's kidney unit using a purposive sampling approach based on their child's age, gender and level of clinical intervention needed. The resulting sample involved 14 couples (parents of 15 children with a long-term condition) who represented a range of educational backgrounds and occupations. Data were obtained through 28 individual and 14 joint, semi-structured interviews that were conducted in parents' homes or workplaces. Interviews were digitally recorded and transcribed verbatim before being analysed using Framework Analysis.

Results: Analysis revealed five themes:

• Developing skills

• Impact of the condition on daily life

• Mutual support

• Coping

• Things that help

Emotional and physiological effects were reported by some when managing clinical care at home. Fathers sometimes coped by 'disengaging' from the situation, they needed to understand the 'bigger picture', what might happen in the future and be reassured that professionals 'know what they are doing'. Mothers' coping was facilitated by remaining close to the situation. They were more likely to consider the impact on family life and how to adapt to it.

Discussion: Although fathers' and mothers' health-care roles are similar, they may deal differently with the consequences, and their emotional/practical support needs may need to be addressed differently.

Conclusion: The information obtained during can be used by practitioners to inform their communications and teaching interventions with fathers as well as mothers. This paper will discuss the main differences between mothers' and fathers' accounts within the five themes that emerged.

Recommended reading:

Knafl K, Zoeller L. Childhood chronic illness: a comparison of mothers' and fathers' experiences. Journal of Family Nursing. 2000; 6: 287-302.

Gavin L, Wysocki T. Associations of paternal involvement in disease management with maternal and family outcomes in families with children with chronic illnesses. J Pediatr Psychol. 2006; 31: 481-89.

Swallow V. An exploration of mothers' and fathers' views of their identities in chronic-kidney-disease management: parents as students? J Clin Nurs. 2008; 17: 3177-86.

4.4.3

A concept analysis of online breastfeeding support

Maria Herron, Health and Life Sciences, University of Ulster, UK

Co-authors: Marlene Sinclair; George Kernohan; Janine Stockdale

Abstract:

Background: Breastfeeding is a natural behaviour, but is also a learned skill that can be challenging to master. Despite international promotion of the associated health benefits to both mother and baby, evidence demonstrates that women often find it difficult to access appropriate and timely support with breastfeeding (Gill et al, 2007). Women are increasingly using the Internet to seek health related information and there is evidence of a high level of online searching for 'breastfeeding support'. Emerging technology may be able to offer effective online support to breastfeeding women (Stockdale et al, 2007). However, we need a clear definition of the concept in order to identify, develop and measure 'online breastfeeding support'.

Aim: To develop a tentative definition of the concept of 'online breastfeeding support'.

Methods: A concept analysis of 'online breastfeeding support' has been undertaken using the eight phases of concept analysis advocated by Walker and Avant (2005). Key attributes, antecedents and consequences have been identified through this iterative process which included a structured literature review. Selected papers were synthesised and themes confirmed using an expert reference group.

Results: A tentative definition of 'online breastfeeding support' has emerged from this process. A model case depicting successful online breastfeeding support has been designed in addition to borderline, related and contrary cases.

Discussion: The next stage of this work will be to empirically validate the identified attributes of 'online breastfeeding support' through concept testing.

Conclusion: This paper provides the audience with a step by step guide to the processes involved in concept analysis.

Recommended reading:

Gill, S.L., Reifsnider, E., Lucke, J.F., (2007): Effects of Support on the Initiation and Duration of Breastfeeding. Western Journal of Nursing Research. Vol 29, No 6, pp 708-729.

Stockdale J., Sinclair M., Kernohan W.G., Keller J.M., (2007): Exploring the power of the Internet to motivate breastfeeding. Evidence Based Midwifery. Vol 5, No 1, pp 10-15

Walker, L.O., & Avant, K.C., (2005). Strategies for theory construction in nursing (4th edition). Upper Saddle River, NJ: Pearson Prentice Hall.

4.5	Gynaecology

4.5.1

Laparoscopic surgery for endometrial cancer: A phenomenological study of patient experience

Cathy Hughes, National Reporting and Learning Service, National Patient Safety Agency, UK

Co-authors: H Allan; W Knibb

Abstract:

Aim: This study aimed to develop an understanding of laparoscopic surgery for endometrial cancer from the patient perspective.

Background: Cancer of the uterus is the seventh most common cancer in women. It is more common in Western industrialised nations (Parkin et al., 2005). The current recommended treatment for most women with endometrial cancer is hysterectomy (Benedet et al., 2000). Laparoscopic surgery is increasingly used to treat early endometrial cancer where there are surgeons trained in the procedure. It is associated with low levels of morbidity and considered safe for cancer surgery but research is limited on quality of life and patient experience (Walker et al. 2006).

Method: Heideggerian hermeneutic phenomenological methodology was used to explore the experiences of 14 women who had undergone the procedure in two South of England cancer centres. Unstructured taped interviews were transcribed and analysed using Colaizzi's framework.

Findings: A phenomenological description emerged from the five identified themes; having cancer, information and support, independence, normality and transfer of responsibility to the surgeon. The experience of laparoscopic surgery is overshadowed by the presence of endometrial cancer. Fear of cancer and lack of knowledge play a significant role in the decision to entrust the surgeon with the responsibility for decision making. Information is obtained from healthcare professionals. Information needs are individual but focus on what will be done, what to expect and the practicalities of being in an unfamiliar situation and environment. Loss of control, vulnerability and dependence are associated with illness and surgery but postoperative mobility and minimal pain facilitate a rapid return to independence and normality which enhances wellbeing.

Conclusion: Healthcare professionals should deliver care in early endometrial cancer that recognises the significance of the cancer diagnosis, the role of the surgeon, the need for practical information and the use of treatments that reduce dependence.

Recommended reading:

Benedet J.L, Bender H., Jones H. 3rd, Ngan H.Y., Pecorelli S., 2000. FIGO staging classifications and clinical practice guidelines in the management of gynecologic cancers. FIGO Committee on Gynecologic Oncology. Int. J. Gynaecol. Obstet. 70 (2), 209-262.

Parkin D.M., Bray F., Ferlay J., Pisani P., 2005. Global Cancer Statistics 2002. CA Cancer J. Clin. 55 (2), pp. 74-108.

Walker J.L., Piedmonte M., Spiritos N., Eisenkop S., Schlaerth J., Mannel R.S., Spiegel G., 2006. Surgical staging of uterine cancer: randomized phase III trial of laparoscopy vs laparotomy â " a Gynecologic Oncology Group (GOG) study: preliminary results

4.5.2

Exploring the needs and expectations of women presenting for hysterosalpingogram examination following a period of sub fertility: A qualitative study

Maggie Williams, Gateshead Health NHS Foundation Trust. Co authors: L Green, K Roberts

Abstract:

This qualitative study uses grounded theory methodology to explore women's experience of healthcare following referral for hysterosalpingography (HSG) after a period of sub fertility. An HSG is an invasive procedure involving the administration of intrauterine contrast via a catheter inserted transvaginally. The demonstration of this contrast within and spilling out of the fallopian tubes determines patency.

These otherwise healthy women enter the healthcare system failing to become pregnant. They find themselves trying to negotiate a system designed for sick people.

Interviews with women were undertaken just prior to their HSG examination (n=10). Discussions centred around their expectations of the

HSG examination, the importance of HSG and what methods were available to them to reduce any anxiety they may be experiencing. A literature review demonstrated an absence of nursing research in this field and medical research mainly looked at the procedure itself rather than the wider needs of the women involved.

HSG is seen by healthcare providers as a routine out patient examination at the start of sub fertility investigations. In contrast to this, interview data highlighted that HSG was seen by the women as a very important examination and a defining test that would signpost their future treatment options to become pregnant.

The results showed that there was little psychological support from health care providers and that the written information given did not fulfil all of their needs. Women described written information often raised additional questions that remained unanswered. The literature review noted that anxiety can lead to mental health issues but that properly focused and timely information can reduce anxiety. The implications of the findings are that if anxiety relating to treatment at this early stage can be managed effectively it could minimise the possible physical and emotional trauma to the woman as her sub fertility journey continues.

Funding source:

UK – Health Service (Local)

10,001 – 50,000

4.5.3

An exploration of the influences on women making decisions about treatment for menstrual problems

Pat Bramble, School of Health and Social care, Teesside University, UK

Abstract:

Background: Studies suggest five percent of women, annually, consider their menstrual bleeding to be abnormal, accounting for between 12 and 15 percent of hospital referrals in the UK, (Bonnar & Sheppard, 1997) and significant costs to the NHS. Literature latterly centers on the effectiveness and efficiency of management designed to treat the symptoms which rely greatly on the subjective presentation of women's experiences.

Aim: This study explores the influences on women of childbearing age to sacrifice their fertility in order to regain control over their bodies.

Design: Grounded theory

Setting: A Northeast of England NHS Trust Hospital

Method: Twenty-five participants, all pre menopausal and diagnosed with a menstrual problem of no known pathology were included in the study and data gathered before and after their hospital consultation, complemented by non-participant observation of their interaction with their Consultant. Constant Comparative methodology was adopted to analyse data, (Glaser and Strauss, 1967) guided

by open axial and selective coding procedures, (Strauss and Corbin, 1990).

Results: Emerging themes reflected women's embodied experiences and without exception highlighted an equal impact on their physiology and psychology associated with shame, embarrassment and a general silencing of the topic.

Conclusion: Interim findings suggest women's inability to express their emotional responses to their menstrual bleeding during medical consultations as a result of shame and embarrassment of a socially constructed taboo topic.

Recommended reading:

Bonnar J, Sheppard BL. (1997) Treatment of menorrhagia during menstruation: randomised controlled trial of ethamsylate, mefanamic acid, and tranexamic acid. BMJ; 313:579Â82.

Glaser, BG. & Strauss, AL. (1967). The Discovery of Grounded Theory: Strategies for Qualitative Research. New York, NY: Aldine

Strauss, A. & Corbin, J. (1990). Basics of Qualitative **Research:** Grounded Theory Procedures and Techniques. Newbury Park, CA: Sage Publications.

Funding source:

UK – Higher Education Institution

10,001 – 50,000

| 4.6 | Older people |

4.6.1

Complexity and frailty in old age: The same or different? And, does it matter?

Sarah McGeorge, Nurse Consultant, Mental Health Services for Older People, Tees, Esk and Wear Valleys NHS Foundation Trust, UK

Abstract:

Background and Aims: National and local policy in the UK tends to confuse 'complexity' with 'frailty' and use the two terms synonymously. Whilst there has been much research into frailty, little attention has been directed at describing complexity in the context of old age and mental health. This paper explores findings from a constructivist grounded theory study that aimed to explain registered nurses' construction and experiences of 'age related complexity' and identify implications for practice.

Methods: A constructivist grounded theory approach with 'loosely guided' interviews was used. A set of pre-interview prompts was developed following the first phase of interviews. The sample comprised 17 registered nurses working with older people in mental health services. Theoretical sampling was used. Interviews took place in 2009. Data were analysed using the constant comparative method involving line by line, focused and theoretical coding.

Results: Nurses are clear that complexity and frailty are not the same, nor are they mutually dependent. Frailty is described principally in relation to older people's physical state, whereas complexity is a consequence of the interaction of needs across a number of areas. Frailty is linear and unidirectional but complexity is a dynamic state from which there can be recovery. Complexity often demands intense nursing intervention with older people, their families and other professionals but this is not always recognised by people outside the immediate clinical team.

Conclusions: While policy confuses complexity and frailty, nurses are clear that there are important differences. The findings from this study suggest that complexity and frailty should be recognised as distinct concepts and states requiring different nursing approaches. Furthermore, it highlights the need for clarification and debate around the concepts in order to meet the needs of older people more effectively.

Recommended reading:

Bergman, H., Ferrucci, L., Guralnik J., Hogan, D.B., Hummel, S., Karunananthan, S. and Wolfson, C. (2007) Unconventional views of frailty. Special article. Frailty: an emerging research and clinical paradigm issues and controversies. Journal of Geront

Department of Health (2007) Mental health: new ways of working for everyone. Developing and sustaining a capable and flexible workforce. Progress report. Department of Health pp46-51

Levers, M.-J., Estabrooks, C.A. & Ross Kerr, J.C. (2006) Factors contributing to frailty: literature review. Journal of Advanced Nursing Vol 56, No 3, pp282-291

Funding source:

No Funding

4.6.2

Dementia and risk: Contested territories of everyday life

Charlotte Clarke, Community, Health & Education Studies Research Centre, Northumbria University, UK

Co-author: J Keady

Abstract:

Background: The everyday life of people with dementia has had little focus in research. This presentation explores how constructions of risk are embedded within everyday events and social contexts, and communicates such constructions through the voices of people with dementia, carers and practitioners.

Aims and Method: The project aimed to understand the construction of risk in dementia care from the perspective of the person with dementia, family carers and practitioners with the intention of developing negotiated partnerships in risk management. One aspect of the project involved data collection

from 55 people with dementia, and their nominated carer and practitioner.

Results: Five 'contested territories' of everyday living with dementia are presented: friendships, smoking, going out, domestic arrangements, and occupation and activity.

Discussion: These contested territories are purposeful and allow for sense making, maintenance of self, claiming and relinquishing decision making, and creating purpose(lessness) in people's lives.

Conclusion: Assessing and managing risk in a way that respects the dynamics and purposes of contested territories will support care that is person centred, and moreover respectful of the relationships that contribute to maintaining the individual's sense of self and purpose.

4.7. Mental health

4.7.1

Rural illicit drug use: Themes from an international review of the research literature

Trudi Petersen, PhD student, HESAS (Health, Sport and Science), University of Glamorgan, UK

Abstract:

Substance use is a cross cutting issue that has numerous potential implications for a range of health professionals and partner organisations. It is an issue of contemporary concern for all nurses. The assumption that substance use is solely an urban issue has been challenged (Schifano 2008). Research on rural illicit drug use has been identified as an underrepresented area (Robertson et al 1997, Payne 2007).

This presentation describes the findings from an international review of the literature on rural drug use conducted as part of a PhD on rural illicit drug use in Wales. The review identifies six broad themes. The first theme relates to the types of drugs commonly identified as being 'rural' or which feature most significantly in the rural literature. The second theme relates to the level and nature of rurality, the third theme examines the protective nature of the rural environment, the fourth theme explores risk, the fifth examines rural residence as a barrier to change behaviours and help seeking and the sixth relates to methodological and professional imbalances in the published research. Much of the research on rural drug use emanates from the United States. Relatively little work has been done in the UK. Out of 191 abstracts reviewed for the initial literature review, where rural drug misuse was the focus, only 22 were British. 14 of these were 10 years old or older, making the contemporary culturally relevant UK evidence base minimal.

The presentation will outline the search strategy; briefly examine differences in the international literature and the challenges in comparing these to the UK before going on to identify themes. The potential implications of these themes for researchers and practitioners working with drug users in rural settings in Britain will be explored.

Recommended reading:

Payne, J., (2007) Women drug users in North Cumbria: what influences initiation into heroin in this non urban setting. Sociology of Health and Illness 29(5) pp633-655

Robertson, E, Sloboda Z, Boyd G and Kozel N (Eds) (1997) rural substance abuse: state of knowledge and issues. NIDA research monograph 168. Rockville M.D. National Institute on Drug Abuse

Schifano, F (2008) Current Opinion in Psychiatry, 21(4): pp 391-397

4.7.2

Behavioural activation for depression delivered by mental health nurses. A systematic review of the evidence and controlled clinical trial

David Ekers, Nurse Consultant Primary Care Mental Health/Honorary Clinical Lecturer, Tees Esk & Wear Valleys NHS Trust/Centre for Mental Health Research, Durham university, UK

Abstract:

Introduction: Depression affects 5-10% of the population, is set to become the second largest cause of disease burden by 2020 and is the third most common reason for primary care consultation. Cognitive Behavioural Therapy (CBT) is the gold standard treatment consisting of both behavioural and cognitive interventions; lack of clarity exists regarding the optimum mix of these. Behavioural activation (BA) alone has been seen to be as effective as full CBT and may offer increased access if suitable for delivery by a wide range of mental health staff.

Method: We conducted a meta analysis of trials of behavioural treatments of depression to ascertain clinical efficacy of such approaches & develop a pragmatic RCT.

Results: Twenty trials were identified. BA is effective compared to controls (SMD – 0.70, 95% CI – 1.0~-0.39) and as effective as CBT (SMD 0.08 95% CI – 0.14 to 0.30). All trials used experienced psychotherapists hence parsimony has not yet been demonstrated.

RCT: Based upon review results we delivered a controlled clinical trial to test the feasibility of BA delivered by junior mental health nurses. Nurses

had no previous formal therapy qualifications, attended a five day training and received fortnightly supervision. 47 participants were randomly allocated to 12 sessions behavioural activation or usual care via GP or primary care mental health workers. Participants had a primary diagnosis of depression/mixed anxiety and depression. Depression symptom level and functioning was assessed monthly throughout the trial and satisfaction at the end point. Service use was measured by questionnaire for the six months prior to entry to the trial and for the duration.

In this presentation we will outline the method and results from our systematic review and RCT. This is the first controlled clinical trial testing the parsimony of behavioural activation and implications for mental health nurses will be considered.

Recommended reading:

Ekers, D, Richards, D and Gilbody S. (2008). A Meta Analysis of Randomised Trials of Behavioural Treatment of Depression. Psychological Medicine. 38(5) 611-623.

4.7.3

An evaluation fo the effect of a peer-led mutual support group for family caregivers of Chinese schizophrenia sufferers

Wai-Tong Chien, Associate Professor, The School of Nursing, The Hong Kong Polytechnic University, Hong Kong

Abstract:

Background: Studies of common approaches of family interventions for people with schizophrenia have consistently shown improvements in patients' medication and treatment compliance and their relapse rates. However, their effects on family health-related outcomes have been neither carefully examined nor consistently demonstrated.

Aims: This research to evaluate the effects of a mutual support group for a sample of family caregivers of Chinese people with schizophrenia in Hong Kong on multiple psychosocial health outcomes of both family caregivers and patients and to identify the therapeutic factors influencing the success of the program.

Methods: This was an evaluation research on a mutual support group program, using both a randomized controlled and a qualitative exploratory design. The 12-session support group for a randomized sample of 38 families was conducted over six months and their psychosocial outcomes were compared with another 38 families who received routine psychiatric care only, at recruitment and one week and 12 months after intervention. All group sessions and 30 interviews of the support group participants were audio-taped and content analyzed.

Results: Results of repeated-measures MANOVA test showed that the mutual support group experienced significantly greater improvements in family functioning and patients' relapse rate than the standard care group at two post-tests. The process data supported these statistical findings that the participants with regular attendance to the support group also reported more positive changes in caregiving attitudes and skills and family functioning and perceived social support and other benefits for group participation.

Conclusion: The study provided evidences that mutual support group is an effective intervention to improve the psychosocial burden and functioning of families of schizophrenia sufferers in a Chinese population. The findings also added knowledge to therapeutic components of a family-led mutual support group.

Recommended reading:

Chien WT., Norman I, Thompson DR (2004) A randomized controlled trial of a mutual support group for family caregivers of patients with schizophrenia. International Journal of Nursing Studies, 41, pp. 637-649.

Chien WT, Norman I, Thompson DR (2006) Perceived benefits and difficulties experienced in a mutual support group for family carers of people with schizophrenia. Qualitative Health Research,16, pp. 962-81.

Funding source:

No Funding

4.8   Public and patient involvement

4.8.1

The impact of patient and public involvement (PPI) on NHS healthcare services: A systematic review

Carole Mockford, School of Health and Social Studies, University of Warwick, UK

Co-authors: S Staniszewska; F Griffiths; S Herron-Marx

Abstract:

Background: There has been little research conducted on evaluating the impact of PPI on healthcare services (e.g. Crawford et al, 2002) and the concept of 'impact' as it relates to involvement is unclear (e.g. Daykin et al, 2007). It is a critical time to consolidate our understanding of PPI, identify key challenges and make recommendations to enable the area to move forward in developing a coherent evidence base.

Aims: To review the literature on the impact PPI has had on healthcare services. We also examined how PPI is being defined, conceptualised and theorised, how 'impact' has been captured or measured, and the level on which the changes were taking place. We also examined the economic cost of PPI.

Methods: A systematic review was conducted for the period 1997-2009. 17 databases and websites were searched e.g. Medline and the King's Fund. Following data extraction, a qualitative synthesis was performed from which key themes were identified.

Results: The search retrieved 28 studies which satisfied the inclusion criteria.

A common understanding of PPI appears to exist but conceptual and theoretical underpinnings of the review studies were scarce. The way the impact of PPI is being captured or measured is largely descriptive e.g. the provision of additional services and the re-organisation of existing ones. There were some indications of the cost involved but no economic analyses.

Discussion and Conclusion: The use of clear definitions is not common and findings are not placed on a comprehensible theoretical basis. Despite claims of the impact PPI is having, and costing, there is a weak evidence base to support these. PPI is an area where authors need to include more supporting evidence of the impact they claim PPI makes, and there is a need for clearer reporting, the key to developing a stronger evidence base for the future.

Recommended reading:

Crawford MJ, Rutter D, Manley C, Weaver T, Bhui K, Fulop N and Tyrer P (2002) Systematic review of involving patients in the planning and development of health care. British Medical Journal 325: 1263-1267

Daykin N, Evans D, Petsoulas C and Sayers A (2007) Evaluating the impact of patient and public involvement initiatives on UK health services: a systematic review. Evidence and Policy 3(1): 47-65

Funding source:

No Funding

4.8.2

Involving the public in Research: Reflecting on the collaborative process from both a researcher and service user perspective

Liz Crathern, School of Healthcare, University of Leeds, UK

Co-author: B Jacobs

e.crathern@leeds.ac.uk

Abstract:

I am particularly interested in consumers of health care having a voice, and contributing actively to healthcare research. The desire to collaborate with the public on both design and management of the research project was not only driven by my personal beliefs, it was also congruent with contemporary views on users and carers within the NHS (DOH 1999; DOH 2003) and met with research and development guidance strategy for public involvement (INVOLVE 2004). This paper will discuss how I involved the father of a preterm

infant in the design and execution of a research project. He will share his experiences as a member of the research advisory panel and together we will present the strengths and challenges of keeping that collaboration active and meaningful. I will also reflect on how I could improve on that process with future research. The research aimed to explore the experiences of first time fathers who had a preterm infant admitted to NIC and had three broad objectives: to explore the transition to first time fatherhood within NIC; to explore individual fathers' experiences over time and to extend the existing knowledge base for neonatal care. Eight first time fathers were interviewed in NIC who had a preterm infant, no less than 48 hours old and no more than 10 days old. The second interview was before discharge. The three research themes are:

1. The uninvited self: pregnancy narrative; early neonatal period; on the edge of fatherhood

2. The vulnerable self: fears about death; emotional fragility; knowing versus not knowing

3. The mobilising self: reshaping anticipatory parenting; juggling paid work with parenting; hovering on the edge of fatherhood

All three themes were inextricably lined to biographical disruption and Heidegger's notion of time, space and historicity. The father will reflect on the resonance of those themes with his own experiences.

Recommended reading:

DOH. (1999) Making a difference: Strengthening Nursing, Midwifery and Health Visiting contributions to health and health care. Department of health London

DOH. (2003) Getting the right start: NSF for children: Emerging findings. Department of Health April 2003 HMSO

Steel R (2004) 2nd ed Involving the public in NHS, public health and social care research. Briefing notes for researchers INVOLVE Hampshire

Funding source:

UK – Higher Education Institution

1,000 – 10,000

4.8.3

Facilitating nursing research in mental health and learning disability clinical settings

Saeideh Saeidi, Yorkshire Centre for Eating Disorders, Leeds Partnerships NHS Foundation Trust, UK

Co-author: N Needham

Abstract:

Nurses are in the position to influence patient care and service outcomes significantly. The clinical nurse plays a central role in nursing research, audit and evaluation by identifying the constraints contributing to the research-practice gap. There is an extensive research literature which shows that

for a variety of reasons, nurses do not routinely use research in their practice. There are organisational, political, environmental and attitudinal barriers that can prevent nurses getting involved in research.

The aims of the session are to present findings from two workshops that focused on mental health nurses' views of research priorities for the nursing profession, what would encourage nurses to participate in research and what their line managers can do to support them to undertake research. Thirty clinical nurses at different grades including support workers, staff nurses, lead nurses and also clinical team managers, service managers and directors participated in the workshops. Each workshop lasted for an hour and it consisted of a 20 minutes presentation, 20 minutes group work and 20 minutes discussion.

The findings showed that nurses identified cultural issues as the main barrier for undertaking research. The participants ascertain that positive attitude, leadership and direction from their managers as well as protected time and support could facilitate nursing research in clinical settings and help them to be motivated and encourage participation in research. The absence of these factors would lead the nurses to feel discouraged in being involved within research. Creating an environment that supports clinicians as they question practice and allows innovation and creativity can facilitate involvement in research. Embedding research based practice improves significantly when nursing staff are involved with the research from start.

The main themes for research priorities were identifying the value of nursing and how nurses can be more effective in delivering clinical care.

Funding source:

No Funding

5.1.1

Failing to care: Representations of perinatal loss in medical textbooks

Joan Cameron, School of Nursing and Midwifery, University of Dundee, UK

Co-authors: J Taylor; A Greene

Abstract:

Background: High risk pregnancy and childbirth present considerable challenges for the maternity services and are associated with increased rates of stillbirth and neonatal death. Medical textbooks can provide rich detail of how perinatal loss is represented within the professional fields of obstetrics and neonatology.

Method: Neonatal and obstetric textbooks from the UK and North America from 2000 to 2008 were identified systematically and reviewed to assess how perinatal loss was presented and understood. Using the process developed by Sandelowski (2000), qualititative content analysis was undertaken and themes identified from the literature.

Results: Two themes emerged from the examination of the textbooks: perinatal loss as failure and perinatal loss as the business of other health professionals and voluntary groups. Obstetric and neonatal textbooks provided detailed information about rates of perinatal loss associated with specific pathological conditions. Few textbooks discussed the impact of perinatal loss on parents. When this was presented, it was discussed in relation to the roles that health professionals such as nurses and midwives and voluntary groups can play in supporting parents. Reasons for the non involvement of the medical profession in perinatal loss included pressure of work, the availability and accessibility of nurses and midwives and the assumption that voluntary groups have a better understanding of bereaved parents' needs. The evidence base for the care of bereaved parents was not presented in the textbooks.

Conclusion: Despite the increased incidence of stillbirth and neonatal death associated with high risk birth, medical textbooks do not address the personal aspects of perinatal loss. The reasons for these omissions and the potential implications for midwifery and nursing practice will be discussed.

Recommended reading:

Sandelowski, M. (2000) Whatever Happened to Qualitative Description? Research in Nursing and Health, 23, 3pp 334 – 340.

5.1.2

An examination of breastfeeding support for mothers in the community in Ireland

Patricia Leahy-Warren, Senior Lecturer, School of Nursing and Midwifery, University College Cork, Ireland. Co autthors: H Mulcahy; A Phelan

Abstract:

Background: Breastfeeding is a complex phenomena and the duration of breastfeeding is influenced by many variables. Breastfeeding support services in Ireland include statutory and non statutory resources and informal sources However, there is a paucity of research examining new mothers perspectives of these breastfeeding supports using a national cohort.

Aim: To examine breastfeeding supports for new mothers in the community in Ireland.

Methods: A quantitative, cross sectional study using a large random national sample of mothers with children under three years of age (n=1854). Self report questionnaires were completed and returned either by mail or online.

Analysis and Results: Descriptive and inferential statistics were used to analyse the data. Mothers were relatively evenly distributed among the four HSE regions; were over 35 years, married and had third level education. Results found that mothers had a preference for one-one support and support groups. In relation to Public Health Nurse (PHN) services such as home visits, telephone contact and well baby clinics, mothers reported high levels of satisfaction with them, but expressed a desire for greater availability and accessibility. Non statutory services were positively appraised.

Conclusions: Mothers' favoured one-to-one support; 24 hour help lines, access to peer counsellors and internet technology that supports breastfeeding. Specifically in relation to PHNs, mothers indicated that breastfeeding support groups in their area, phone numbers of PHNs, especially with same day response, seven day week PHN service, more home visits, and scheduled phone calls would have been considered beneficial. Mothers are provided with statutory supports which they endorse favourably, however these may not always be responsive and timely enough for their individual needs. Therefore mothers seek and use other non-statutory breastfeeding support and as a result create a model of support using statutory and non-statutory that is timely and responsive to their individual needs.

Recommended reading:

Dennis, C. L. (2006). Identifying predictors of breastfeeding self-efficacy in the immediate postpartum period. Research in Nursing and Health, 29(4), 256-268.

De la Mora, A., Russell, D. (1999). The Iowa Infant feeding attitude scale: Analysis of Reliability and Validity. Journal of Applied Social Psychology, 29(11), 2362-2380

Di Napoli, A., Di Lallo, D., Fortes, C., Franceschelli, C., Armeni, E., & Uuasticchi, U. (2004). Home breastfeeding support by health professionals: findings of a randomized controlled trial in a population of Italian women. Acta Paediatrica, 93(8), 1108-

5.1.3

Diversity, identity and pregnancy loss: Implications for policy and practice

Joan Cameron, School of Nursing and Midwifery, University of Dundee, UK

Co-authors: J Taylor; A Greene

Abstract:

Birth and death are significant events in most societies. Birth is associated with new life which normally leads to the incorporation of an individual into a community. Death is associated with the loss of someone who has been part of a community. Pregnancy loss, however, is neither of these. How individuals and communities deal with pregnancy loss may depend on the way in which the loss is represented.

Midwives, doctors and nurses in the UK base their practice in relation to pregnancy loss on guidelines (Schott et al, 2008). These guidelines encourage the pregnancy loss to be seen as the loss of a baby, irrespective of the gestational age at which the loss occurred. Such policies may suggest a number of ritualistic activities to reinforce the parental caring role, including naming and holding the dead baby.

However, some cultures attribute human status only to babies which show signs of life at birth (Cecil, 1996). Within these cultures pregnancy loss may be ignored or even feared. The physical remains of pregnancy loss may be regarded as polluting or evil. This aspect is missing from UK policy and practice literature relating to pregnancy loss. There is also evidence that parents who do not conform to the expected norms promoted by guidelines are marginalised within the maternity services (McHaffie, 2001).

Equality and diversity are emphasised as being at the heart of health services policy. Current policies relating to pregnancy loss fail to acknowledge the diversity of views that may exist within the UK. Some service users may receive care that conflicts with their personal beliefs. Evidence from different cultures will be used to demonstrate how policies may be developed to meet the diverse needs of maternity service users experiencing pregnancy loss.

Recommended reading:

Schott, J., Henley, A., Kohner, N. (2008) Pregnancy loss and the death of a baby: guidelines for health professionals 3E. London, SANDS.

Cecil, R. (ed) (1996) The anthropology of pregnancy loss. Oxford, Berg.

McHaffie, H. (2001) Crucial decisions at the beginning of life. Oxford, Radcliffe Publishing.

5.1.4

Caring dads: An evaluation

Toity Deave, Centre for Child & Adolescent Health, Health & Social Care, University of the West of England, UK

Co-authors: K McCracken; H Fergusson

Abstract:

Background: Caring Dads is a group-based programme (Garfield, 2006) and originates from Canada (Scott & Crooks, 2004). It is for fathers at risk of abusing, or who have abused, their children. The dominant approach by service providers has been to exclude abusive and neglectful fathers from contact with their children. Abusive fathers excluded from one family often have contact with children in a new family (Holt et al, 2008). The programme is being piloted in three areas of Wales, delivered by the NSPCC.

Aim: To evaluate the process and outcome of the Caring Dads pilot programme in Wales.

Methods: In each of the three pilot areas, the research team undertook the following:

- Semi-structured interviews with programme facilitators (N=9)
- Structured interviews with Caring Dads participants pre-, mid – and post-intervention (N=11)
- Participants completed three standardised measures pre – and post – intervention: (Parenting Stress Index short version, Abidin, 1995), the Paulhus Deception Scale (Paulhus, 1999), Treatment Motivation Questionnaire (McMurran et al., 2006))(N=6)
- Semi-structured interviews with professionals involved in the lives of the Caring Dads participants (N=5)
- Semi-structured, post-intervention, interviews with partners of the Caring Dads participants (N=5)
- Content analysis of the interview data and descriptive statistics for the standardised measures are being undertaken.
- Ethical approval was gained from the NSPCC research ethics committee.

Results: The data are currently being analysed. We aim to identify mechanisms of intervention successes, barriers, facilitators and changes in participants' attitudes and/or behaviours towards their children and families. These data will be presented.

Discussion: The findings of the study will be discussed in relation to any changes in the fathers' attitudes, beliefs and reported behaviours, their understanding of the impact of their behaviour on partners and children and their interaction with their partners and child(ren). The implications for health care professionals will also be discussed.

Recommended reading:

Scott, K. and Crooks, C. (2004), Effecting change in maltreating fathers: critical principles for intervention planning. Clinical Psychology: Science and Practice, 11: 95-111.

Holt S., Buckley H. & Whelan S. (2008) The impact of exposure to domestic violence on children and young people: a review of the literature. Child Abuse & Neglect, 32: 797-810.

Minding the Gap: The therapeutic alliance in domestic abuse intervention groups: Unpublished PhD, University College London.

5.2 Methods/Nursing roles/nursing practice

5.2.1

The experience of conducting interviews and observation in one setting in India: A step in the concept analysis of the cultural responsiveness of defined aims and definitions of rehabilitation

Sally Davis, Programme Lead, School of Health and Social Care, Oxford Brookes University, UK

Abstract:

This presentation focuses on interview and focus group data collected in Manipal, India as a stage in the concept analysis of rehabilitation as part of a PhD study exploring whether rehabilitation as defined in the literature is culturally responsive.

The presenter leads an MSc programme in Physical Rehabilitation and became aware due to international students accessing the programme that the definitions and aims of rehabilitation as discussed in the literature are not transferable across cultural norms. A concept analysis approach is the main methodology for the study guided by Morse's priniciples of concept analysis (Morse et al 1996.1, Morse et al 1996.2, Penrod and Hupcey 2005).

The data collected in Manipal is part of the body of evidence explored which includes the literature. Data was collected in India over a three week period. This involved:

- interviews with 13 patients and 2 carers, 6 focus group
- interviews with physiotherapy, occupational therapy and
- nursing students and 2 focus groups with lecturers
- observation on the neurological ward, the outpatient

- orthopaedic department and in the community
- attendance at a nursing conference on action research and a
- graduation event and a visit to an Aruyveda hospita
- search of Indian data bases and books
- use of a reflective field journal.

Initial findings would suggest that rehabilitation is a feature in Manipal hospital in India and the themes beginning to come through the interviews are rehabilitation as a process, motivation, 'making it meaningful' and health education. This presentation will discuss the experience of collecting data in this setting in India and will discuss the data comparing it with the findings so far from the literature. The presenter would like to thank the Nightingale Foundation who through a Travel Scholarship made the trip to India possible.

Recommended reading:

Morse JM, Hupcy JE, Mitcham C (1996). Concept analysis in nursing **Research:** a critical appraisal. Scholarly Inquiry for Nursing Practice: An International Journal, vol.10, no3, 253-277

Morse JM, Mitcham C, Hupcey JE, Cerdas Tason M (1996) Criteria for concept evaluation. Journal of Advanced Nursing, vol 24, 385-390.

Penrod J, Hupcey JR (2005) Enhancing methodological clarity: a priniciple-based concept analysis. Journal of Advanced Nursing, vol 50, no 4, 403-409.

5.2.2

Using focus group research to inform the development of effective information strategies for critical care discharge: A discussion of its relative merits and challenges

Suzanne Bench, Florence Nightingale School of Nursing and Midwifery, King's College, London, UK

Abstract:

Background: Healthcare interventions must meet the needs of service users. Current methods of information delivery used for critical care patients upon discharge to the ward have not proven to be effective in reducing transfer anxiety, improving perceptions of ward care or reducing length of hospital stay (NICE, 2007). This justifies the reinvestigation of information strategies with an aim to develop future models, which 'recognise the role of participants in the process of securing appropriate, effective, safe and responsive healthcare' (Coulter and Ellis: page 7).

Focus group research data has the potential to ensure that user views are incorporated in the design of effective interventions, thus addressing the recommendations for best practice for user

involvement in designing and managing healthcare research (INVOLVE, 2004).

Aim: The aim of this paper is to discuss the methodological and practical challenges, which need to be considered during focus group research, in order to produce valid user informed data for future development of effective healthcare interventions.

Discussion: A study, conducted by the author in 2009, will be used as a basis for scrutinising the potential merits and limitations of using focus group research to develop a new information strategy for the support of adult critical care patients and their families at the point of discharge to the general ward. Critical analysis of each part of the process of conducting the focus group research will be presented in order to determine the potential value of, and challenges associated with, the use of such a strategy.

Conclusion: Focus group findings from this study will inform the development of a new information strategy. If development of such a complex intervention is to be successful, it is vital that attention is paid to factors, which could affect outcomes throughout the whole process of development.

Recommended reading:

Coulter A, Ellis J (2006) Patient focused interventions; a review of the evidence. London, The Health Foundation.

INVOLVE (2004) Involving the public in NHS, public health and social care research; briefing notes for researchers. Available online at: www.invo.org.uk/keypublications.asp Accessed 21/09/2009

NICE (2007) Acutely ill patients in hospital; recognition and response to acute illness in adults in hospital. National Institute for Health and Clinical Excellence. Available online at: www.nice.org.uk. Accessed 21/09/2009

Funding source:

No Funding

5.2.3

Scoping the role of the breast care nurse (BCN): A national survey

Fiona Irvine, Health and Applied Social Science, Liverpool John Moores University, UK
Co-authors: J Brizell; Jan Hopkins

Abstract:

Background: BCNs were introduced to the UK in the 1980's in response to the need for support and information for women with breast cancer. Previous evaluations of the BCN role have highlighted significant benefits for patients, (Raja-Jones, 2002). However, few studies have adequately defined the BCN role and critically examined the activities undertaken, (Moons et al, 2006).

Aims: The study aimed to identify the main roles undertaken by BCNs and the associated costs and benefits.

Methods: A 31-item questionnaire which explored the scope of the BCN role was mailed to all BCNs (N=572) in England in June 2009.

Results: We will discuss the main findings of the study thus: 178 (31%) questionnaires were returned. BCNs are involved in all phases of the patient journey including diagnosis (97.2%), treatment (94%), reconstruction (91%) and recurrence (93.2%). Fewer are involved in screening (58.2%) and end of life care (32.8%). Whilst some of the activities that BCNs undertake are also performed by consultants, many provide interventions which they believe are not routinely offered by consultants; such as coping with diagnosis, lymphoedema and body image. Although some BCNs (15%) are required to undertake administrative duties unrelated to patient care, none are obliged to undertake other non specialist roles such as helping out on wards.

Discussion: BCNs contribute to various aspects of practice which are also undertaken by consultants. However, BCNs also provide a range of interventions that are not offered by other professional groups and it is here that they believe they have the greatest impact on patients' lives. Unlike other specialist nurses, BCNs' specialist work is rarely being unnecessarily diluted by undertaking peripheral duties.

Conclusion: The research sheds new light on the complexity of the BCN role in the UK and offers evidence that BCNs provide an invaluable service for people with breast cancer.

Recommended reading:

Moons P, Scholte op Reimer W, De Geest S, Fridlund B, Heikkila J, Jaarsma T, Martensson J, Smith K, Stewart S, Stromberg A and Thompson DR (2006) Nurse specialist in adult congenital heart disease: the current status in Europe, European Journal of Cardiov

Raja-Jones H (2002) Role boundaries: Research nurse or clinical nurse specialist? A literature review, Journal of Clinical Nursing, 11, 415-420

Funding source:

UK – Research Charity/Foundation

10,001 – 50,000

5.2.4

Addressing dignity issues in diverse care settings in the UK: A qualitative case study evaluation

Lesley Baillie, Reader in Healthcare, Research and Education, University of Bedfordshire
Co-author: A Gallagher

Abstract:

Background: Preserving patients' dignity is a universal professional expectation of nurses (International Council for Nurses 2006). In the UK dignity has become a key priority in healthcare but reports of indignity in care continue (Healthcare Commis-

sion 2007). Research studies of dignity have mainly focused on specific patient groups, for example older people and palliative care. In 2008, the Royal College of Nursing (RCN) initiated a campaign (Dignity at the Heart of Everything We Do) aimed at the UK nursing workforce. In 2009, using a qualitative multi-case study design with embedded units of analysis (Yin 2003), the campaign was evaluated. Seven UK healthcare providers participated including acute hospitals, care homes and community care.

Aims: The study aimed to explore: dignity developments prior to the campaign, factors affecting the campaign' s progress and the campaign's impact on practice.

Methods: At each organisation, using purposive sampling, researchers conducted semi-structured interviews with nurses (total n=51), direct observation of the care environment and documentary analysis. Data were analysed using thematic analysis.

Results: This paper will present findings relating to dignity issues in diverse care settings, which included acute adult hospital wards, intensive care, neonatal and maternity units, children's wards, care homes, community and mental health care, and outpatient units. The nurses had identified and were addressing dignity issues arising from patients' vulnerability due to their age, health condition and treatment, and the care environment. Nurses were also addressing communication, and privacy issues, applied to their specific practice areas.

Discussion: Nurses are well-placed to identify and address locally the dignity issues which relate to patients in their specific care settings.

Conclusions: This study gives insights into patient dignity in diverse care settings and the importance of nurses identifying and addressing dignity issues in their own practice areas.

Recommended reading:

Healthcare Commission (2007) Caring for Dignity: A National Report on Dignity in Care for Older People While in Hospital Commission for Healthcare Audit and Inspection, London.

International Council for Nurses, (2006) Code of Ethics for Nurses. ICN, Geneva.

Yin, R.K. (2003) Case study **Research:** Design and Methods, 3rd edn. Thousand Oaks: Sage Publications

Funding source:

10,001 – 50,000

5.3 End of life

5.3.1

Thinking about death and what it means: Conversations with people with intellectual disabilities

Sue Read, Reader in Learning Disability Nursing, School of Nursing and Midwifery, Keele University, UK

Abstract:

Introduction: People with an intellectual disability will come to a dying phase of their lives, yet professionals may be uncertain about how to talk (and support) the person at such sensitive times. This paper will introduce a collaborative, funded research study in the UK. The aim of this study was to explore and critically examine the understandings and experiences that adults with intellectual disabilities have about loss, death and dying. This paper will introduce the aims, objectives and rationale for the research undertaken; describe methodological approaches used; and present the findings.

Methods: Previous research has identified that adults with an intellectual disability are eager to talk about sensitive topics such as death and dying when given the opportunity to do so in a supportive, comfortable and engaging environment. Focus groups provided an ideal method to explore the perceptions of death and dying among this population. Two groups of adults with intellectual disabilities (n=-6; n=10) in both North Staffordshire and South East Wales (n=5; n=6) attended a series of three progressive focus groups in each geographical area. The focus groups had identified primary foci, and were audio-taped, transcribed and analysed using grounded theory.

Results: This study used traditional research approaches with a sensitive population to facilitate conversations around death and dying. Adults with an intellectual disability displayed no awkwardness when talking about loss, death and dying. The researchers were struck by the number of losses experienced; the roles of spirituality in helping individuals accommodate their loss; and the significance of pet loss.

Discussion: The tangible outcome of this work was the professional production of a DVD of the loss experiences of those who participated in the research. The results will contribute to the growing body of knowledge around death, dying and bereavement from a unique perspective: namely people with intellectual disabilities.

Recommended reading:

Blackman, N. (2004). Loss and learning disability. London: Worth Publishing.

Read, S. (2008). Loss, bereavement, counselling and support: An intellectual disability perspective. Grief Matters, 11(2), pp54-59.

Todd, S. (2004). Death counts: The challenge of death and dying in learning disability services. Learning disability practice, 7(10), 12-15.

5.3.2

'Me, I feel proud in my uniform': The impact of being a palliative care community volunteer in Uganda

Barbara Jack, Professor, Head of Research and Scholarship, Director EPRC, Faculty of Health, Edgehill University, UK

Co-author: A Merriman

Abstract:

Background: Approx 27,000 new cases of cancer are reported in Uganda in each year affecting 1.5% of the population (Makokha 2006). A shortage of Doctors, wide geographical distribution, and poor transport systems lead to many patients experiencing severe uncontrolled symptoms. Hospice Africa Uganda developed a community volunteer worker programme where local villagers are trained to identify patients with palliative care needs. The volunteers refer patients to the hospice and provide basic care and support for patients and families. A training course with ongoing support has resulted in 85 volunteers practicing out of the hospice in Kampala (40) and Hoima (45).The volunteers receive no payment, except for a bicycle enabling them to reach remote areas. This study evaluated the community volunteer worker scheme, and this paper focuses upon the impact of the role on the volunteers.

Methods: A qualitative methodology using semi structured individual and group tape recorded interviews was adopted for the study. Data was collected from the volunteers based in two sites (Hoima and Kampala). A purposive sample of 32 volunteers participated in the study. Data was analysed for emerging themes using thematic analysis.

Results and Discussion: The volunteers all reported how they found the role to be of great value to themselves, including having an increased knowledge and satisfaction at helping the dying in their villages. Interestingly they all commented on the pride of being a volunteer and how they felt when they put on their uniform and the resulting respect their received. This paper will discuss these findings as well as the challenges that the volunteers are finding regarding language barriers and old bicycles.

Recommended reading:

Makokha T (2006) Africa no longer willing to suffer in silence. Cancer World Dec – Jan Special Issue 42-45

5.3.3

The impact of education on the practice of end-of-life care planning and delivery in care homes

Martin Johnson, Professor in Nursing, Nursing and Midwifery, University of Salford, UK

Co-authors: M Attree; I Jones

Abstract:

Introduction: This paper will present a critical synthesis of end-of-life care education literature, summary of study methods, selected findings and discuss implications from research that evaluated the impact of The Gold Standards Framework in Care Homes programme on end-of-life care for care home residents.

End-of-life care is increasing delivered in care homes by staff who lack specialist palliative care preparation. The Gold Standards Framework in Care Homes (GSFCH) provides care pathways and tools to plan and deliver end-of – life care and staff training. Evidence exists that links advanced care planning with improved outcomes: increased care quality; reduced crisis hospital admissions and increased achievement of preferred place of care (Hockley 2006; Badger et al 2007; Clifford et al 2007).

Methods: Realistic Evaluation was used to evaluate the impact of introducing the GSF in CH programme in two case study care homes in the North-West of England. Mixed data collection methods were used: quantitative measures included a pre and post training staff attitude scale, confidence log and an after-death analysis. Qualitative data were collected by interviews with two care home managers, 24 staff, six residents, nine relatives and fieldwork observation.

Results: Care home staff had experience in providing end-of-life care; however many felt under-prepared and lacked confidence in their ability to discuss and plan resident's end-of-life care. Post-training staff reported increased knowledge, skills and confidence, and valued the structure, tools and training the GSF program provided. Support was needed for implementation.

Discussion: End-of-life care quality in care homes can be improved through staff training and practice development. However, time is a scarce resource required to assimilate knowledge and skills, and implement change in practice. Current curricula need revision to provide the advanced level communication and practice skills required to provide high quality end-of-life care in care homes and other non-specialist care locations.

Recommended reading:

Badger F, Thomas K & Clifford C (2007) Raising standards for elderly people dying in care homes. European Journal of Palliative Care, 14(6): 238-241

Dickinson GE, Clark D, Sque M (2008) Palliative care and end of life issues in UK pre-registration, undergraduate nursing programmes. Nurse Education Today 28, 163-170.

Hockley J (2006) Developing high quality end of life care in nursing homes: an action research study. Department of Nursing, Ph.D Edinburgh University, Edinburgh

5.3.4

Nursing and medical professionals' perceptions of the palliative care needs of people with Parkinson's Disease

George Kernohan, Professor of Nursing Research, Institute of Nursing Research, University of Ulster, UK

Co-authors: M Waldron; F Hasson; B Cochrane; H Chambers; Sue Foster

Abstract:

Background: The appropriateness of a palliative care approach for people with Parkinson's disease (PD) has been highlighted (Chen et al, 2008). However patients with PD rarely benefit from hospice care (Kristjanson et al, 2005). There are also unmet palliative care needs such as lack of information, ad-hoc delivery of services and a lack of preparation for the advanced symptoms of PD (Giles & Miyasaki 2009).

Aim: To explore the palliative care needs of people with PD from the perspective of a range of nursing and medical professionals.

Methods: Exploratory qualitative design using the following Individual semi structured interviews: PD Nurse Specialists (5), district nurses (5), general practitioners (3), geriatricians (3), neurologists (3), who all had experience of Parkinson's disease. Data were subjected to thematic content analysis.

Results: Although there were many references to palliative care being synonymous with end of life care, respondents agreed that ideally, palliative care is a holistic approach to the care of people with life-limiting conditions. People with PD require regular assessment and multidisciplinary care as their condition progresses and their needs change.

Lack of resources and time, under-staffed services, budgetary constraints, a lack of patient referral to palliative care services and negative attitudes towards palliative care from both patients and their carers were identified as barriers to the delivery of palliative care to people with PD. Differing views were also expressed on when and how palliative care could be introduced to the patient's care pathway.

Discussion: Facilitation of palliative care is needed to achieve optimum quality-of-life for people with PD. This requires appropriate resources, communication and organisation to address the barriers to good quality care.

Conclusion: This qualitative exploratory investigation, supports the development of a more proactive, integrative palliative care approach to address the needs of people with PD. Questions remain about when and how best to initiate palliative care.

Recommended reading:

Chen, JJ, Trombetta DP and Fernandez HH (2008) Palliative Management of Parkinson Disease: Focus on Non Motor, Distressing Symptoms. Journal of Pharmacy Practice 21(4), 262-272.

Giles, S. & Miyasaki, J. (2009) Palliative Stage Parkinson's Disease: Patient and Family Experiences of Health Care Services. Palliative Medicine 23 (2), 120-125.

Kristjanson, LJ., Anoun, SM. & Oldham, L. (2005). Palliative Care and Support for People with Neuro-degenerative Conditions and their Carers. International Journal of Palliative Nursing 12, 368-377.

5.4 Older people

5.4.1

DORIS – Database of research in stroke

Alex Pollock, Stroke Programme, Nursing Midwifery and Allied Health Professions (NMAHP) Research Unit, UK

Co-authors: M Brady; L Firkins; F Graham; M Halliday; P Langhorne; C Ritchie; P Sandercock; B Thomas

Abstract:

Background: DORIS's goal is to facilitate access to stroke rehabilitation research evidence, research uncertainties, research gaps and research priorities, and promote collaborative and effective research planning, research activity and translation of research into practice.

DORIS has 3 years funding (April 2009 – March 2012).

Aims: DORIS aims to facilitate the establishment, specific to stroke rehabilitation, of:

Easy access to completed and ongoing research evidence, keeping clinicians, researchers and funders up-to-date with current best evidence and research activity.

Treatment uncertainties, evidence gaps and priorities for future research, promoting funding applications which matter to patients and clinicians.

A collaborative and inclusive approach to research planning and activity, facilitating effective partnerships between researchers, clinicians and the public.

Methods/Progress (Oct '09):

Agreed collaboration with the Cochrane Stroke Group (CSG) to enable access to Cochrane reviews, protocols and the CSG trials register (the most comprehensive register of stroke trials, continually updated, in the world).

Agreed collaboration with the James Lind Alliance to identify treatment uncertainties and prioritise future research questions.

Agreed collaboration with stroke Managed Clinical Networks (MCNs), charities, patient groups and user-involvement organisations to develop a unique on-line database of lay members, clinicians and researchers prepared to collaborate on / contribute to future research.

DORIS will provide a freely-available sustainable web-database.

Conclusions: DORIS will uniquely and effectively address all key aspects of the process of evidence-based stroke rehabilitation â " from clear identification of where there is established evidence, to the identification of future research priorities and the facilitation of collaborative and effective stroke rehabilitation research activity.

This presentation will:

• Demonstrate planned DORIS website resource

• Describe consultations with patients / public, held during collaborative World Stroke Day workshops (Oct 29th 2009)

• Detail proposed methods for identifying research priorities

• Discuss the planned collaborative approach to research planning and activity.

5.4.2

What care regulators perceive having a choice means for people living in care homes

Katie Tucker, Methods Directorate, Care Quality Commission, UK

katie.tucker@cqc.org.uk

Abstract:

Background: The Health and Social Care Act, 2008 requires the care sector to deliver services, which are safe, good quality and enable people to make choices. The Care Quality Commission (CQC) is the regulatory body who ensures care services are compliant. CQC inspectors' perception of whether a breach of regulation has occurred is a fundamental to any prosecution but unlike other regulations those on choice are extremely subjective.

Aims: To explore CQC staff perceptions of what having choices means for people living in residential care homes.

Research Design: Initially an audit was conducted to establish inspectors' prosecutory and reporting practice for regulations related to choices. The findings prompted questions around the conception of choice, therefore within a phenomenologi-

cal approach four interviews and five focus groups explored any differences in perceptions.

Results: The audit found 4.89% of care home prosecutions related failure to enable people to make choices, whereas 75% of the respective inspection reports stated residents were not offered even the most basic of choices. Early findings from the subsequent research show CQC staff are immersed in different cultural values so have different interpretations of what choice means. Thus, when applying regulations staff make different judgments about what constitutes a breach.

Discussion: A critique of existing literature reveals choice is a complex and amorphous concept, which cuts across philosophy; sociology; psychology; social policy as well as legal, health and social care practice. CQC employs staff from a wide variety of care backgrounds therefore it is not surprising their perceptions of what are acceptable, as choices for people using care homes are inconsistent.

Conclusion: Hegelian's theory of knowledge supports the researcher's findings that each individual will hold slightly different and wholly personal perceptions around matters located in the private inner world of the mind such as choice.

Recommended reading:

Pinkyard, T. (1994) Hegel's Phenomenology: The Sociality of Reason. Cambridge University Press.

Seedhouse. D. (2005) Values-based decision-making for the caring professions. Wiley: Chichester.

CSCI (2006) Real Voices, Real Choices. DH

Funding source:

No Funding

5.4.3

The exploration of perceived health, life quality and coping strategies of the community-living elderly with cardiovascular diseases

Shu-Fen Su, Assistant Professor in Nursing, School of Nursing, Hung-Kuang University, Taiwan
Co-authors: P E Liu; Y W Lin; X Y Su

Abstract:

It is a global phenomenon that world population is aging due to the longevity of people increases worldwide. Several studies indicated that the elderly have a high risk in cardiovascular diseases, resulting in approximately 50% of all deaths. In Taiwan, the aging population rate is nearly 11%, and 41% of the elderly have cardiovascular diseases. However, very few studies have been conducted to investigate the health status and quality of life among the elderly with cardiovascular diseases.

This study was aimed to explore the perceived health status, quality of life and coping strategies among the cardiovascular diseases oldies. A total of 26 elderly individuals from 6 communities participated in the semi-structured in-depth interviews. Data were analyzed by using the methodology of

grounded theory. Asking questions, reviewing references, constant comparison, and theoretical sampling were utilised throughout the data collection process for achieving theoretical saturation and maintaining research integrity.

Findings in this study demonstrated that cardiovascular diseases are often found in the Taiwanese oldies, resulting in physical, psychological, social, and economic problems. Hypertension, diabetes mellitus, hyperlipidemia, or impaired physical functions usually accompany cardiovascular diseases in the aging population. The health issues caused by cardiovascular diseases and aging influence the quality of life, and induce physical function impairment and psychological distress to the oldies. Problem-focused coping strategies, such as getting family support, meeting friends, taking exercises, using relaxation, and watching TV, were reported by the elderly to be very helpful. Sufficient coping resources and strategies are necessary for them in dealing with their health problems and life issues. The better the body function and coping strategies, the happier the community elderly. However, for ones without enough social supports or resources, they lived unhappily and poorly. Therefore, we suggest that adequate resources and early prevention for the elderly with cardiovascular diseases are necessary.

Recommended reading:

Hong, G.Z., Wang, N.Y., Diao, W.S. & Fei, S. (2005) â œA comprehensive evaluation on stroke prelevence among elderly in urban and rural areas of Beijingâ . Chung-Hua Liu Hsing Ping Hsueh Chinese Journal of Epidemiology, vol26, no10, pp767-71.

Niemine et al. (2006): EuroHeart Failure Survey II (EHFS II): a survey on hospitalized acute heart failure patients: description of population: European Heart Journal, vol 27, pp 2725-2736.

Tenconi, M.T.& Gruppo di, L.S.(2008): New indications for the prevention of cardiovascular diseases: Annali di Igiene, vol 20, pp53-57.

Funding source:

10,001 – 50,000

5.4.4

Developing practice guidelines for bereavement care for older people

Audrey Stephen, Faculty of Health and Social Care, Robert Gordon University, UK

Abstract:

Title: Developing practice guidelines for bereavement care for older people

Background Older people are likely to be bereaved, and many also have to cope with failing physical and mental health, economic and social difficulties. However, it is unclear what is done for bereaved older people in generic healthcare services and what enhancements are possible.

Aims:

- Explore service provision for bereaved older people;

- Develop a guideline for practice.

Methods: Qualitative research was used to explore healthcare staffs' experiences of caring for bereaved older people, and older people's experiences of bereavement and receiving bereavement support. Purposive recruitment and interviewing took place during 2008-09. Staff participants were in general practice, hospital wards and care homes in North East Scotland. Bereaved older people were recruited via participating centres. Data analysis led to development of a guideline for practice that was validated through focus group discussions.

Results: There is a distinct timeline for bereavement care provision by healthcare staff. Bereaved older people, however, experience complex responses to loss that are non linear and are reflected in the Dual Process Model (Stroebe and Schut 1999). Bereavement follow up by healthcare staff is inconsistent and often depends on having had a relationship with a family before the death. In addition, communication between sectors about bereaved older people is lacking. The guideline reflects findings and provides recommendations to enhance pre-bereavement preparation; bereavement care at the time of the death; follow up; and signposting.

Discussion: Healthcare staff recognise that bereavement impacts on the wellbeing of older people. In response they strive to provide appropriate support. The guideline was developed to enhance their ability to take a consistent approach that responds to people's needs and supports coping.

Conclusion: Use of the guideline could help staff to respond flexibly to the bereaved, and support older people to be independent.

Recommended reading:

Stroebe, M. and Schut, H., 1999. The dual process model of coping with bereavement: rationale and description. Death Studies, 23, pp. 197-224

Funding source:

UK – Research Council

50,001 – 100,000

5.5 Drug and alcohol related issues

5.5.1

Privileging client experience within methadone maintenance treatment (MMT) in British Columbia, Canada: Lessons for heath care system change and research practice

Tessa Parkes, Senior Lecturer, Department of Nursing and Midwifery, University of Stirling, UK

Co-author: Bill Nelles

Abstract:

Despite a 50 year involvement with MMT, the province of British Columbia (BC), Canada commissioned its first MMT systems review in 2008. This presentation describes the strengths and weaknesses of the BC Methadone Program according to people using services, presenting their specific recommendations for change.

The study aimed to examine BC's MMT systems and identify factors related to treatment access, retention, quality, effectiveness and equity, with implications for policy, practice and system change.

A multi-phase, multi-method, qualitative design was used to collect data over 14 months between February 2008-March 2009. 309 people from 36 stakeholder groups participated: 30% were MMT clients. Data were transcribed and thematically coded using Atlas.ti.

MMT clients commonly experience severe, concurrent physical, psychological and social problems, and can therefore become particularly marginalised within healthcare services/addictions treatment, as well as within society more generally. While MMT can save and turn lives around, many factors negatively impact healthcare experiences, posing barriers to access and undermining client confidence in the treatment system. Client concerns include: MMT as a 'full time job'; punitive, shame-based and controlling practices; low expectations of clients; poor pain management; lack of psycho-social supports; negative physical effects of methadone; user fees; lack of information about, and alternatives to, methadone; and significant stigma and discrimination associated with MMT.

Privileging MMT client concerns identifies multiple opportunities for system improvement, including: client involvement in MMT services and policy; relational models of care, treatment and support; peer led models of outreach/networking/mentoring; better quality information for clients, families and supporters; and robust systems of accountability and regulation to protect clients and ensure quality. The challenges of translating client views into policy, practice and systems change are significant. The presentation concludes by emphasising the importance of involving people with experience of problem substance use treatment in health care policy-making, practice and research.

5.5.2

Efficacy of brief interventions delivered by nurses for dependent drinkers: A prospective cohort study

Kathryn Rosemary Cobain, Research and Devlopment/Primary Care, Liverpool Primary Care Trust, UK

Co-authors: L Owens; R Fitzgerald; I T Gilmore; M Pirmohamed

Abstract:

Objective: To establish if BI's delivered to alcohol-dependent patients in an acute hospital setting are effective in reducing alcohol consumption and dependence.

Design: A prospective cohort control study.

Setting: Two acute NHS hospital trusts in the North West of England UK; one provided BI (university teaching hospital-test site) and the another which did not (district general hospital-control site).

Participants: Alcohol dependent patients aged ≥18 years were recruited; 100 from each site between March and September 2007.

Interventions: In the test site BI's were delivered at the time of initial assessment, with follow-up interventions at intervals of between one and four weeks, to a maximum of six interventions; all delivered by an Alcohol Specialist Nurse (ASN). The control site patients were given only a six-month follow-up appointment.

Main outcome measures: The primary outcome measures were alcohol consumption, Alcohol Use Disorders Identification Test (AUDIT), and severity of alcohol-dependence as measured by Severity of Alcohol Dependence Questionnaire (SADQ). Secondary outcome measures were length of stay in hospital and Emergency Department (ED) attendance.

Results: 100 patients were recruited at each of the test and control sites. There were no significant differences at baseline between groups for age, sex, alcohol consumption, severity of dependence or medical co-morbidity. At six months patients at the test site showed significantly improved primary outcome measures; a) alcohol consumption ($p=0.0001$), b) AUDIT score ($p=0.0001$) and c) SADQ score ($p=0.0001$). They also had significantly shorter length of stays ($p=0.0001$) and fewer ED visits ($p=0.023$). Outcomes were found to be independent of both baseline level of dependence and medical co-morbidity.

Conclusions: BI delivered by a dedicated ASN for non-treatment seeking alcohol dependent individuals are effective. Furthermore, the ED is an ideal setting for identification of, and implementation of treatment for alcohol-dependent patients, who although having significant medical co-morbidity responded well.

Recommended reading:

Department of Health, Safe Sensible Social, The next steps in the national Alcohol Strategy, Department of Health, Editor. 2007.

Drummond, C., Oyefeso, A., Phillips, T., Cheeta, S., Deluca, P., Winfield, H., Jenner, J., Cobain, K., Galea, S., et al, Alcohol Needs Assessment Research Project. Department of Health, 2005.

Raistrick, D., Heather, N., Godfrey, C., Review of the effectiveness of treatment for alcohol problems. National Treatment Agency for Substance Misuse, 2006.

5.5.3

Can partnership working be seamless? An example of a nursing and voluntary agency partnership model for community alcohol services

Sarit Carlebach, Centre for Health and Social Evaluation (CHASE), Teesside University, UK

Co-authors: D Wake; S Hamilton

Abstract:

Background: Partnership models across agencies and disciplines can be used to develop innovative health and social care services in the community. This evaluation explored a partnership between the public and voluntary sector which provides home alcohol detoxification delivered by NHS employed nursing staff alongside the provision of acupuncture, psychosocial support and counselling delivered by the voluntary agency. This service offers an alternative to inpatient alcohol detoxification.

Aim: To identify the experiences and perceptions of service users, their families and service providers involved with a community detoxification service.

Methods: Semi structured interviews were conducted with staff (n=7), steering group members (n=3), staff from referring agencies (n=1), service users (n=18) and their families (n=6). Thematic analysis was used to analyse the data.

Results: Overall, users and families were very positive about the treatment they had received. They particularly valued the therapeutic relationship with nursing staff. Comments that the nurses were like 'family' were common. Members of the service steering group felt that the partnership between the voluntary and statutory agencies was seamless and worked well. However, this contrasted with the views of service users who perceived there to be two very separate and distinct services with little or no communication between them.

Discussion: The service model was based on one of partnership working between statutory and voluntary agencies. However, further work needs to be done by the steering group to achieve this aim. Examples include improving service users' transition from one part of the service to the other. Furthermore simple things like introducing users to staff members across the services may go a long way to improving perceptions of a single service.

Nevertheless this is a major public health issue in which community based nurses are making a real difference.

5.5.4

Do psychosocial treatments decrease alcohol consumption for patients with alcohol dependence? A systematic review

Kathryn Rosemary Cobain, Research and Devlopment/Primary Care, Liverpool Primary Care Trust, UK

Co-authors: L Owens; R Dickson; M Pirmohamed

Abstract:

Background: The prevalence of alcohol dependence varies across the world. Several studies have demonstrated a strong relationship between the estimated per adult total consumption within a country and the estimated rate of alcohol dependence. A recent study in England estimated the prevalence to be 3.6% of the total adult population (16-64). This is comparable with the reported figure of between 4-6% in the United States of America. Available psychosocial treatments range from the very brief to those increasing in duration and intensity: Although conceptual frameworks for treatments are well described, the methods for delivery are less robust. It is therefore difficult for the clinician to know what works best in what setting, and therefore who is best placed to deliver the treatment.

Aim: To determine differences in effectiveness of psychosocial treatment on drinking behaviour in alcohol dependent individuals.

Methods: Systematic Review, explicit Inclusion and exclusion criteria were applied only studies that utilised a control arm were included. Bibliographic searches were completed using; Medline, Embase, PsychInfo, Cochrane library, Cinahl. Reference lists and hand searching of recent issues of substance misuse/healthcare journals were also conducted. All papers were assessed for quality using the York tool.

Results: 241 initial studies were identified, of those eleven studies met inclusion criteria. Methodological quality was variable; descriptors for psychosocial interventions were conflicting and assessment of alcohol consumption was variable. All studies reported reduction in alcohol consumption, however only three found statistical significance between groups

Conclusion: There is insufficient evidence to support any one psychosocial intervention being more effective than any other. Neither duration of intervention nor intensity affected intervention outcome.

Recommended reading:

Drummond, C., Oyefeso, A., Phillips, T., Cheeta, S., Deluca, P., Winfield, H., Jenner, J., Cobain, K., Galea, S., et al, Alcohol Needs Assessment Research Project. Department of Health, 2005.

Raistrick, D., Heather, N., Godfrey, C., Review of the effectiveness of treatment for alcohol problems. National Treatment Agency for Substance Misuse, 2006.

Department of Health, Safe Sensible Social, The next steps in the national Alcohol Strategy, Department of Health, Editor. 2007.

5.6 Pain

5.6.1

An ethnographic study of parental involvement in neonatal pain management

Caryl Skene, Neonatal Nurse Consultant, Neonatal Unit, Sheffield Teaching Hospitals NHS Foundation Trust, UK

Co-authors: Penny Curtis; Kate Gerrish

Abstract:

Background: Guidelines for neonatal pain management recommend that parents are given information and encouraged to participate in the assessment and management of their baby's pain. They do not however, explain how this might be achieved or what effect such a change in practice might have. This study aimed to address this gap in the literature by exploring the following question:

'How do parents interact with babies and nurses around the provision of comfort care in a NICU where specific information and training in comfort care has been provided?'

Methods: An ethnographic methodology utilised observation and interview methods to collect data in a large neonatal unit. Parents were given specific information around comfort care and staff received training in pain management and the facilitation of parental involvement. Eleven families contributed to the study which involved 25 periods of observations and 24 interviews between January and November 2008. Constant comparative analysis and ongoing reflection on the findings took place throughout the study.

Results: This study offers a different picture of the parental experience to that presented in previous research. Findings suggest that providing appropriate information and support can facilitate increased parent-infant interaction and the development of the parental role. Involvement in comfort however requires the parent to spend time at the cot side and a number of barriers to cot side access were apparent. Findings also highlighted the key role played by the nurse in supporting parents in the

neonatal unit, despite a lack of time and in some cases, appropriate training.

Conclusion: This study identifies benefits of parental involvement in neonatal comfort care and describes the role of the nurses in providing support. It concludes by highlighting a number of recommendations for practice, education, management and future research.

5.6.2

Experiences of surgical patients: A second look at pain

Sheila Rodgers, University of Edinburgh, UK

Co-authors: J Tocher; M Coulter; D Watt; L Dickson; M McCreaddie

Abstract:

Background: A series of surveys were carried out in one Health Board over the last 10 years to elicit service user views of patient care provision. Five questions in the survey relate directly to pain and its management. Descriptive results from the studies have been widely disseminated amongst the service providers. Pain was identified by staff as an area where there were a small but significant number of patients for whom serve and enduring pain was a problem.

Aim: To identify and characterize surgical patients reporting severe and enduring pain and to identify demographic variables associated with sever and enduring pain (SEP).

Method: The survey data were examined for surgical patients who had SEP. These patients were characterized and compared to other surgical patients without SEP. A total of 2,251 patients from the most recent survey were included in the analysis with up to a total of 7,266 included in analysis across different time periods.

Results: 12% (278) of all surgical patients had SEP. Surgical patients with SEP were more likely to be female than male, to be emergency admissions, and were on average younger than those without SEP. Rates of SEP remained fairly constant over the 8 years of the study. Overall, patients with SEP viewed their experiences of care as significantly poorer than others. A range of other more detailed findings will be presented.

Discussion and Conclusion: Several methodological issues were identified in analyzing a secondary data source. These somewhat limited the extent of analysis that could be performed.

Although there have been many service initiatives to improve pain management of in-patients such as the development of Acute Pain Teams and Specialist nurses, little change in the proportion of patients reporting severe and enduring pain over an 8 year period was found in this study.

5.6.3

The socialisation of registered nurses responses to post operative pain: a descriptive qualitative study

Carolyn Mackintosh,, Nursing, University of Bradford,

Abstract:

Background: Pain is an important part of the post operative experience. Intensive efforts to improve the management of post operative pain in the UK have been ongoing since the 1990 report by the Royal College of Surgeons and College of Anaesthetists highlighted the urgency of the issue. Results from efforts to improve pain management practices have been contradictory, and in some instances only limited improvements have been achieved.

Aims: This study seeks to explore why success in improving this area of practice has been elusive. It focuses on the previously unconsidered issue of socialisation of the registered nurses who work in this area.

Method: The study has a descriptive, qualitative design that involves using semi-structured interviews, incorporating the use of critical incidents, to explore a convenience sample of 16 registered nurses ideas and feelings about working with patients experiencing post operative pain. Ethics committee approval was obtained, and full confidentiality was assured to all participants.

All interviews were tape recorded and transcribed verbatim; analysis was carried out using the 4 stages identified by Morse and Field (1996) for qualitative data analysis.

Results/Discussion: Findings identified 5 key themes: the normality of pain, practical management, pathological indicators, the effectiveness of management and personal experience. Each of these themes will be explored in more depth in the discussion of this paper.

Conclusion: Findings suggest that registered nurses responses to post operative pain are a socialised response, and that this has many negative consequences for practice. Where nurses were able to recognise the limitations of their responses they are equally circumscribed by the socialised responses of their colleagues. Implications for practice are serious as unless underlying socialised practices are challenged, new initiatives can only have limited effectiveness.

Recommended reading:

Morse, J.M. and Field, P.A. (1996) Nursing **Research:** the application of qualitative approaches. Chapman Hall: London.

Funding source:

5.6.4

Emergency department pain management: An Australian audit

Margaret Fry, Associate Professor of Nursing, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney, Australia

Abstract:

Timely assessment, monitoring and pain management interventions need to be consistent to ensure pain reduction. The audit aimed to explore i) emergency department pain management practices, ii) the type and timeliness of pain management interventions, and iii) nursing aspects of assessment, documentation and interventions used for the relief of pain.

Methods: A 12 month (June 2005 – June 2006) retrospective descriptive cohort audit was undertaken. The sample population consisted of those patients with a discharge diagnosis of migraine, abdominal pain and fractured neck or femur.

Data for each patient was extracted and included age, gender, time of arrival to the ED, triage code, seniority of treating doctor, diagnosis and disposition from the ED.

Results: Thirty-six (48%) hospitals provided data. The total number of patient notes reviewed was 2066. Pain scales (23/29;79.3%) were commonly used to assess pain. Patients with a documented pain score (56.4%; 547) arrived in severe pain. There was a statistical difference (x2=5.07; p=0.0243) for patients receiving analgesia if pain scores were documented compared to those without. From time of ED arrival, the median time for analgesic administration was 1hour 10 minutes (IQR 58minutes to 132minutes).

Non-adjusted Cox Regression Analysis factors associated with receiving timely analgesia included: nurse initiated medications (HR 1.17; p<---0.011), age (child) (HR 0.62;p<---0.001), analgesia taken prior to ED arrival (HR 1.24; p=0.001), documentation of a pain score (HR 1.45; p<---0.001), severe pain (HR1.35;p<---0.001), hospital admission (HR 1.45; p<---0.001), and regular staff feedback and formal quality improvement structures (0.85;p=0.031).

Sixty-seven percent of EDs (24/36) had specific policies or guidelines related to the management of painful conditions.

Conclusion: All EDs need to ensure adequate policies are in place to enable nurses to deliver timely analgesia. Further research is needed to be undertaken into the association between triage pain scores, documentation and ED pain management practices.

Funding source:

5.7	Workforce

5.7.1

Understanding advanced nursing practice: Perspectives from Jordan

Zainab Zahran, School of Nursing and Midwifery, University of Sheffield, UK

Abstract:

Aims and Objectives: The aim of the study was to examine the extent to which advanced nursing practice was evident in Jordan, with a particular focus on the contribution of Master's level nurses.

Background: In Jordan, nurse education evolved over a relatively short period of time. Jordanian nurses are becoming increasingly aware of the expanding role of nurses in developed countries (Al-Ma' aitah & Momani 1999). This awareness was reflected in the new Master's programmes that were opened which intended to prepare nurses to practise at an advanced level as potential clinical nurse specialists (Shuriquie et al. 2007).

Design and Methods: The study used an ethnographic design using qualitative and quantitative methods. The study comprised two stages. The first stage involved interviewing key stakeholders and surveying M-level nurses. Stage two involved interviewing and observing M-level nurses working in clinical practice in five Jordanian hospitals and interviewing the main stakeholders with whom those nurses had contact.

Results: The findings of this study illustrate participants' understandings of ANP. They described advanced nursing practice in terms of its generic features and core competencies. The themes which emerged from the data were: core competencies, generic and specific understandings, beneficiaries of advanced nursing practice, and drivers for educational change.

Discussion and Conclusion: The study concludes that there is no clear notion of advanced nursing practice in Jordan, although participants do describe a number of different elements of advanced practice. The lack of clarity about advanced nursing practice is not peculiar to Jordan but is also seen internationally (Duffield et al. 2009). Taking this into consideration, nurse educationalists, professional bodies and employers need to collaborate to identify a framework for advanced nursing practice in Jordan. Nurse managers need to work in collaboration with physicians, nurses, and other healthcare professionals to provide a supportive environment for M-level nurses.

Recommended reading:

Al-Ma'aitah, R., & Momani, M. (1999). Assessment of nurses' continuing education needs in Jordan. Journal of Continuing Education in Nursing, 30(4), 176-181.

Duffield, C., Gardner, G., Chang, A. M., & Catling-Paull, C. (2009). Advanced nursing practice: A global perspective. Collegian: Journal of the Royal College of Nursing, Australia, 16(2), 55-62.

Shuriquie, M., While, A., & Fitzpatrick, J. (2007). The development of role adequacy for

5.7.2

Exploring nurse leadership in research development in clinical practice: An action research study

Loretta Bellman, University College London Hospitals NHS Foundation Trust, UK
Co-authors: Amy Cole; Theresa Wiseman

Abstract:

One of the major challenges in healthcare in the 21st century is for all healthcare practitioners to feel that they can say with confidence that they do use research in their practice (Clifford and Clark 2004). There is both global and national recognition of the challenges ahead for providing support for research and development opportunities in NHS Trusts for nurses and midwives. This includes a growing literature regarding the drivers and barriers to getting research into practice. Making change actually happen takes leadership (Maben & Griffiths 2008). A key leadership component of advanced practice is facilitation of research in practice. Nurses working at an advanced level of practice, such as Consultant Nurses, are required to implement research findings into practice, and also to undertake research in practice. A methodology which enables a systematic exploration of individual and collaborative engagement to bring about clinical change is action research (Bellman 2003). This presentation will provide an overview of the first phase of a Burdett Trust funded project (2008-2009). Methods included: focus groups; semi-structured interviews; audio-taped meetings, and co-researchers' reflective journals. A three stage thematic data analysis has enabled the explication of key themes regarding:

How clinical and education stakeholders perceive nurse leadership in research & development in clinical practice

The ways in which Consultant Nurses have started to explore their research & development role in their field of practice.

It is anticipated that an overview of the process and outcomes from this phase of the project will a) contribute to the knowledge base of colleagues who are striving to implement practice-based research b) highlight the need for an integrated strategic and operational NHS Trust & university policy to enhance this leadership role.

Recommended reading:

Bellman, L. (2003) Nurse-Led Change & Development in Clinical Practice. Nursing Research series. WileyBlackwell

Clifford, C., Clarke, J. (2004) Getting Research Into Practice. Edinburgh: Churchill Livingstone

Maben, J., Griffiths, P. (2008) Nurses in society: starting the debate. National Nursing Research Unit, London: King's College

5.7.3

Succession planning of the education workforce: Commonalities, differences and challenges facing midwifery and diagnostic radiography

Elizabeth Anne Rosser, Associate Dean (Nursing), School of Health and Social Care, Bournemouth University, UK
Co-author: J W Albarran

Abstract:

Background: Education's role in developing the workforce within a modernised United Kingdom National Health Service is highly prised. Having a skilled and inventive education workforce is therefore paramount. However, recruiting healthcare practitioners into higher education to maintain the life-blood of this workforce is challenging as increasingly clinical staff are being enticed by different career opportunities.

Aims: To report on commonalities and contrasting views of midwifery and diagnostic radiography academics in recruiting clinicians into higher education and retaining staff.

Methods: A mixed methods approach to data collection was used. Between August/September 2008, we recruited a purposive sample of departmental heads and lecturing staff from midwifery and diagnostic radiography in three institutions. We conducted a series of individual and focus group interviews. Quantitative data were analysed using descriptive statistics and thematic analysis was applied to qualitative data.

Findings: The study illustrates a difference in age profile across the studied professions. The absence of a clear education pathway and career trajectory, hindered staff recruitment with remaining in clinical practice or moving to industry being attractive better paid alternatives. There were other similarities and differences across these professions in respect of personal drivers, strategies and challenges to actively recruit practitioners to pursue such a career. In spite of the apparent stability in the current education workforce within the two professions, there exist similar tensions which pose a threat to retaining staff in the future.

Conclusion: The changing expectations of universities in pursuit of academic and research excellence pose a serious challenge to recruiting suitable individuals into an education career. Both professions need to consider targeting recruits very early in their development and providing a realistic and well structured probationary period to encourage transparency and permit them to progress along a satisfying career. Resources and a facilitative

management style would significantly aid their retention.

Recommended reading:

Council of Deans and Heads of UK Faculties of Nursing and Health (2006) Academic Staff Survey 2005. London, Council of Deans.

Department of Health (2008) National Health Service, Workforce Review Team, workforce summary – Diagnostic Radiographers. Version 2. July – England only. Accessed from: http://www.wrt.nhs.uk/index.php/component.docman.doc_view/7-diagnostic-radiographe

Department of Health (2008) High Quality Care for All. NHS Next Stage Review Final Report [Lord Darzi]. June, London, Deparament of Health

5.8	Education

5.8.1

Applying Gadamer's philosophical hermeneutics to interpret the mentor experience of failing pre-registration nursing students in their final placement

Sharon Black, Faculty of Health and Social Sciences, University of Bedfordshire, UK

Abstract:

A qualitative study underpinned by philosophical hermeneutics (Gadamer, 2004), was carried out to explore, interpret and develop a shared understanding of mentors' experiences of failing pre-registration nursing students in their final placement. As Gadamer (2004) does not provide a method for carrying out research, the five step method provided by Fleming et al. (2003) was adapted to suit the purposes of this study.

Ethical approval was obtained and in 2008-2009 nineteen mentors from seven different organisations were interviewed, and guided through a process of structured reflection on their experience (Johns, 2004). Transcripts of these conversations with the mentors were analysed using a process of textual interpretation that is synonymous with Gadamerian principles.

Whilst there has been extensive debate in recent years about fitness for practice at the point of registration, and UK mentors failing to fail student nurses, the results from this study show further complexities in relation to these phenomena. Considerable attention should be paid to the issue of failing to challenge students earlier in their course, and there should be more collaboration between the mentor and university in determining fitness for practice. The whole philosophy of mentorship needs to evolve if we are to truly make a difference in improving fitness for practice at the point of registration. These mentors were, despite the difficulties and emotional investment, willing to fail

students at this final stage in order to protect the standards of the nursing profession.

The purpose of this presentation is to share the method used to collect reflections on this experience, and to present the stages of analysis developed to interpret the interview texts. It is hoped that this will provide researchers with another method of interpreting experience, and reassure them that using Gadamer's (2004) philosophy to underpin their research could open up new perspectives and possibilities.

Recommended reading:

Fleming, V., Gaidys, U. & Robb, Y. (2003) "Hermeneutic research in nursing: developing a Gadamerian-based research method" Nursing Inquiry, vol 10, no.2, pp. 113-120

Gadamer, H.G. (2004) Truth and Method (2nd revised edition, translation revised by Joel Weinsheimer & Donald G. Marshall) London, New York: Continuum Publishing Group

Johns, C. (2004) Becoming a reflective practitioner (2nd edn.) Oxford: Blackwell Publishing

5.8.2

Using phenomenography to understand pre-registration nurse lecturers perception of the observed structured clinical examination (OSCE)

Laura Taylor, Faculty of Health, Edge Hill University, UK

Abstract:

Background: The OSCE is a widespread mode of assessment that presents transparent verification of clinical competence (Alinier 2003). Given the importance and attention placed on verifying clinical competence, this promises to be a safe and ideal option to test clinical competency. However, despite the promises to date there is little evidence that the OSCE can better prepare students for their practice role.

Aim: The aim of the enquiry is to capture the OSCE process through the eyes of examiners to bring depth and understanding to the complex issues taking place during the OSCE.

Methods: The study reports a phenomenography study and data derived from a focus group interview and twelve semi-structured face to face interviews utilising purposive sampling. Standard phenomenographic analysis, defines the categories of description (Matron and Booth 1997) to reveal the critical variation and differences in ways the participants' perceive the OSCE.

Results: Four distinct categories which describe all possible ways of experiencing the OSCE emerge

from the data establishing the 'outcome space' (Marton and Booth 1997, p125). Revealing that the OSCE is perceived as being a highly valued active teaching and learning opportunity to test clinical competence. However, data reveals that the OSCE is not viewed to be sufficient to ensure adequate performance in everyday practice.

Discussion: The OSCE is an opportunity to formally objectively test ability to perform clinical skills. This demonstrates that the student has learned to do something well. This must not be underestimated as it offers students the opportunity to test their clinical skills in conditions that mimic the real world to provide demonstrable and measurable evidence of clinical competence. Although this is no guarantee of adequate performance in everyday practice, the OSCE must be considered as a credible alternative to work base assessment to prepare students for their practice role.

Recommended reading:

Alinier, G. (2003) Nursing Students' and Lecturers' perspectives of objective structured clinical examination incorporating simulation. Nurse Education Today. 23, p419-426.

Matron, F. Booth, S. (1997) Learning and Awareness, Lawrence Erlbaum Associates, Pub

Nursing and Midwifery Council (2007) Simulation and Practice learning Project: Outcome of a pilot study to the test principles for auditing simulated practice learning environments in the pre-registration nursing programme. Final Report. NMC: London

5.8.3

An investigation of race and the mentor-student relationship in nursing: The limitations of holistic approaches in tackling racism

Janet Scammell, School of Health and Social Care, Bournemouth University, UK

Abstract:

This paper describes an investigation of Internationally Recruited Nurse mentor and White student encounters in one nurse education department in England. The research aim was to analyse mentorship relationships, focusing on examples of interaction in which perceptions of racialised difference are in play. Whilst there is an increasing body of evidence that racism occurs (Alexander, 1999; Allan & Larsen, 2003), less is known about how it gets constructed and reconstructed on a daily basis.

The research approach draws upon the principles of qualitative ethnography. Data were collected through focus groups, semi-structured interviews, participant observation and documentary analysis. Using purposive sampling, 10 internationally recruited nurses, 25 nursing students, two univer-

sity lecturers and five placement-based staff development nurses participated. Through the analysis of discourses at work, the findings indicated that difference was perceived as a 'problem', leading to the reinforcement of boundaries that differentiate 'them' from 'us'. The reality of racism (that is to say attributions of behaviour to racial difference) was ignored or denied.

This paper will explore an important implication of the findings, namely a reliance on holism to prepare nursing students for anti-discriminatory practice. The study illustrated that despite exposure to curricula based on holistic principles, students seemed poorly prepared to deal with discrimination faced by colleagues or clients. Cultural competence within a framework of holistic care has dominated nurse education for decades, but this strategy leaves race unnamed and largely ignored. The study of racism seemed subsumed under the topic of cultural diversity and it was assumed that by learning about individualised, holistic care, equality would result. There was an inadequate depth of critical analysis of the structural factors that produce such inequalities. Together with the failure to make visible the effects of Whiteness, it is argued that holistic approaches are insufficient to prepare students to tackle racism.

Recommended reading:

Allan, H. & Larsen, J. (2003). 'We Need Respect': Experiences of Internationally Recruited Nurses in the UK. London: RCN.

Alexander, A. (1999). Study of Black, Asian and Ethnic Minority Issues. London: Department of Health.

6.1 Research methods

6.1.1

Issues impacting on the perception and practice of advocacy by clinical research nurses

Polly Tarrant, Lead Research Nurse, Addenbrookes Clinical Research Centre, Cambridge University Hospitals NHS Foundation Trust, UK

Abstract:

The RCN Research Society has, in conjunction with leading nurse researchers throughout the UK, drawn up a Research Competency Framework (2008)within which advocating for participants is an underpinning principle. However, it appears that this principle is not always easy to apply in practice, especially when it results in conflict with research investigators. Anecdotal evidence highlights a need to explore the experience of research nurses in advocating for participants under their care, and their perceptions and understanding of this aspect of their role. While both advocacy in nursing and the role of the research nurse are subjects of a number of articles and studies, a review of the literature reveals that there is no real research examining the two together.

Within research, the conflict between acting in a participants best interests and protecting their wishes is less pronounced than in 'mainstream' healthcare, particularly in the case of healthy volunteers. However, it can be argued that any research volunteer is vulnerable (Leavitt, 2006) and as such is in need of advocacy.

As a profession, and regardless of the individual gender of practitioners, nursing is historically perceived as female, and this is reflected by its standing in the traditional health care hierarchy. Adopting a critical theory approach to consider factors impacting on this aspect of nursing practice from the perspective of practitioners experience is, therefore, entirely appropriate.

Many further education institutes are currently setting up Masters courses in Clinical Research, so the importance of education in advocacy as part of ethics should be established. Furthermore, if research nurses are to provide an effective service for research participants, they need to recognise how they perceive their role, how they are able to act, and how they can work together as a group to empower themselves and their client group.

Recommended reading:

RCN Research Society (2008) Competency framework for Clinical Research Nurses V1 http://www.rcn.org.uk/development/researchanddevelopment/rs/publications_and_position_ statements/competencies accessed 24th June 2009

Leavitt, Frank J (2006) 'Is any Medical Research Population Not Vulnerable' Cambridge Quarterly of Healthcare Ethics, New York, Winter 2006, Vol 15 Iss 1 pp 81-89

UK Clinical Research Collaboration. (2006) Developing the Best Research Professionals. Report of the UKCRC Subcommittee for Nurses in Clinical Research (Workforce) Chair Janet Finch. UKCRC: London.

6.1.2

Multiple perspectives and Methods: Helping to understand the factors influencing QOL

Wendy Moyle, Griffith Institute of Health and Medical Research, RCCCPI, Griffith University, Australia

Abstract:

Background: Although quality of life (QOL) is acknowledged as being pertinent to individuals with a diagnosis of dementia, this concept has been neglected for the most part in this population, and in particular in people living with dementia (PWD) in long-term care (LTC). Personal evaluations are often overlooked in favour of observation and proxy measures because of the challenges of measurement in this population. The presenter will demonstrate that by including multiple perspectives such as the primacy of the views of the person with PWD, family and staff, as well as multiple data collection methods, a more expansive understanding of QOL is offered that adds to synergistic and complementary understanding of QOL and moral value in people with dementia.

Method: This research aimed to provide an understanding of the QOL and perception of moral worth of people with dementia living in LTC. Multiple data collection methods (surveys, interviews, observations, documentation analysis) and multiple perspectives were attained from PWD (n=61), family (n=58) and staff (n=49) in four long-term care sites.

Results: Findings indicate a possible gap in the translation of values such as person-centred care into practice. Interviews and observations support views that staff are task orientated. Staff surveys and interviews suggest a strong focus on valuing the person, yet PWD and family interviews and observations, reveal care that is more tailored to the needs of the organization than individual. Documentation analysis also revealed a strong emphasis on the value of individuals but resident interviews reveal a sense of being undervalued.

Discussion/Conclusions: Multiple methods and perspectives help overcome the limitations of single research methods and the influence of social desirability bias and offer opportunities to get behind the rhetoric of QOL and standardised care practices.

6.1.3

Colleague supervision of in-house masters' level dissertations

Annette Jinks, EPRC, Faculty of Health, Edge Hill University, UK

Co-authors: J Kirton; K Straker; J Brown; B Jack

Abstract:

Introduction: This study explored the issues and challenges facing supervisors required to act as a supervisor to their fellow educators' research dissertations. This situation often stems from the need to enhance the research profile of Faculty staff. For example, the studies of Porter and Mansour (2003) and Ried and Fuller (2005) identify the need to enhance research outputs of nurse educators. However, where there is no critical mass of experienced researchers as is the case in many Nursing Faculties nationally and internationally it becomes a difficult issue to provide the research support needed.

Methods: In-depth interviews were undertaken with students (n=7) and their supervisors (n=5) in order to explore the experiences of Faculty staff that have successfully completed an in-house masters' level dissertation when being supervised by a fellow member of staff.

Results: A wealth of qualitative data was obtained which was subject to a thematic analysis. Findings revealed that the majority of student and supervisors had a positive supervisory experience. However, many student respondents said they felt uncomfortable with the assessment aspect where they felt they were under 'public' scrutiny in Faculty meetings. Conversely the supervisors felt that on occasions students did not take the established norms of any supervisory relationship seriously enough causing tensions in the relationship.

Discussion: Generally the literature gives numerous accounts of what constitutes good supervisory practice but less about what the actual experiences of students and research supervisors are. However, Denicolo (2004) relates that colleague supervision is special on a number of counts. For example, colleague supervision gives the potential for further role conflicts that both parties have to contend with. This study gives indications of how Faculty policies and practice may be developed so as to enhance student and supervisor experiences of MSc dissertation supervision.

Recommended reading:

Denicolo P (2004) Doctoral supervision of colleagues; Peeling off the veneer of satisfaction and competence Studies in Higher Education, 29, (6), 693 – 707

Porter EJ & Mansour TB (2003) Teaching nursing research to undergraduates: a text analysis of instructors' intentions Research in Nursing & Health 26 (2) 128-42

Ried K Fuller J (2005) Building a culture of research dissemination in primary health care: the South Australian experience of supporting the novice researcher Australian Health Review February 29 (1) 6-11

6.1.4

The impact of masters degree education in nursing: A case study within an inner city acute NHS trust

Ruth Harris, Reader, Faculty of Health and Social Care Sciences, Kingston University and St. George's, University of London, UK

Co-authors: A McEwen; E Vangeli

Abstract:

"Nursing should become a research-based profession" (Briggs, 1972). Since then there has been considerable effort to increase the capacity of nurses to undertake research and apply research findings in practice. The recent UK Clinical Research Collaboration (UKCRC) report on the nursing research workforce recommends that a structured, funded career pathway for nurse researchers offers the best opportunity to build research capacity in nursing (UKCRC, 2007). Education at Masters level forms an integral part of this research development strategy. Furthermore, with the development of advanced clinical roles for nurses there has been a proliferation in the availability of Masters courses in nursing. However, little is known about the impact these postgraduate degrees have had on the careers and performance of nurses who have undertaken them (Ashworth et al 2001).

This paper presents findings from a study undertaken within one inner city acute NHS teaching trust. Data were collected using biographical semi-structured interviews with nurses (n=5) who had completed or were undergoing Masters degrees. The findings of these interviews were used to construct a survey instrument, which was administered to all eligible nurses within the trust.

The study found considerable variation in the support that nurses received from the trust. This presentation will discuss how managers decide how much support to provide and other important findings, for example, the reasons nurses embarked on their studies, their experience of masters education, factors influencing successful completion, the perceived outcomes from course completion and impact the degree has had on the nurses' clinical practice and subsequent career.

The findings have implications for maximising the benefits of masters education for nurses and for NHS organisations and will contribute the development of clinical academic pathways for nurses, midwives and health visitors.

Recommended reading:

UK Clinical Research Collaboration (2007) Developing the best research professionals. Qualified graduate nurses: recommendations for preparing and supporting clinical academic nurses of the future. Report of the UKCRC Subcommittee for Nurses in Clinical R

Ashworth, PD, Gerrish K, McManus M (2001) Whither nursing? Discourses underlying the attribution of master's level performance in nursing. Journal of Advanced Nursing 34 (5), 621-628

Briggs A (1972) Report of the Committee on Nursing CMND 5115 London, HMSO

6.2　　Chronic disease

6.2.1

The nursing contribution to chronic disease management (CDM): A case of public perception?

Patricia Wilson, Centre for Research in Primary and Community Care, University of Hertfordshire, UK

Co-authors: S Kendall; S Procter; F Brooks

Abstract:

Background: Nurses are seen as central in shaping patient experience and this remit is expanding most rapidly within CDM. Nurses are at the CDM frontline, however there has been little research evaluating their CDM contribution. This paper reports a national evaluation, focusing on results illustrating the service user perception of nurses' roles within CDM.

Aims: To explore, identify and characterise the origins, processes and outcomes of effective CDM models and the nursing contributions to such models using a whole system approach.

Methods: Seven case study sites were selected to ensure a range of CDM models. Methods included semi-structured interviews with over one hundred patients and family members, fifty health professionals and focus groups with adolescents and children.

Results: The results suggested that service users had a persisting belief in the secondary care monopoly of expertise. Equally, patients were more satisfied if they saw the nurse as diagnostician, prescriber and medical manager of the condition. Although offset by accessibility and approachability, patients were less satisfied when the nurse was perceived as physicians' assistant or had transferred from an established doctor-led to nurse-led service.

Discussion: While all nurses within the study were highly skilled and competent, patient perception was guided by the familiar rather than most appropriate service delivery. Most patients saw CDM as a medicalised approach and the nursing contribution was most valued when emulating it.

Conclusions: The expanding roles and CDM expertise of nurses should be more visible and the perception of expertise being solely located in secondary care must be challenged if there is to be a successful shift of CDM to primary care.

Recommended reading:

Department of Health (2008) High Quality Care for All. Stationery Office London.

Health Technology Assessment Programme (2004) Extending the nursing role. Health Technology Assessment Programme, Southampton, pp. 1-4.

6.2.2

Living with severe chronic obstructive pulmonary disease (COPD): The male carer's story

Terry Robinson, Respiratory Nursing, Harrogate and District NHS Foundation Trust, UK

Co-author: G Fitch

Abstract:

Background: COPD is a leading cause of morbidity and mortality, resulting in a significant burden on healthcare systems worldwide (Roca et al. 2008). Several studies have looked at the impact severe COPD has on the patient (Elkington et al. 2005 & Robinson, 2005) but little is known about the role of the carer, and to date published research focuses mainly on female carers.

Aims: The aim of this qualitative study was to gain a better knowledge and understanding of the male caring role in COPD, and to explore the ways in which individual carers live with COPD patients, drawing upon their experiences and views of living with this chronic disease.

Methods: A prospective unstructured audiotaped interview using a phenomenological approach was used to collect data from ten men (mean age 70.1 years) living with wives or partners who had severe COPD.

Results: Recurrent themes emerged from the data analysed:

• Needs of carers

• Burden of caring

• Male carer role.

The themes and subordinate themes demonstrate how caring in this disease area affected men physically, psychologically and socially.

Discussion: Participants reported lack of support and social isolation. Previously enjoyed activities were no longer possible, leading to increased stress and resentment. The majority described hospitalisations negatively, as it led to increased work load for them and even less time for themselves. Eight described how the future filled them with fear, especially if their own or their partners health deteriorated further Surprisingly six men did not perceive themselves as carers, thereby not asking for or thinking they were entitled to from agencies such as social services.

Conclusion: Severe COPD impacts on all aspects of male carers' lives. The specific needs of male carers should be considered when designing and delivering services to this patient group.

Recommended reading:

Elkington, H., White, P., Addington-Hall, J., Higgs, R. & Edmonds, P. (2005) 'The healthcare needs of chronic obstructive pulmonary disease patients in the last year of life' Palliative Medicine. 19 (6) pp.485-491.

Robinson, T. (2005) 'Living with severe, hypoxic COPD: the patient's experience' Nursing Times. 101 (7) pp. 38-42.

Roca, J., Alonso, A. and Hernandez, C. (2008) 'Integrated care for COPD patients: time for extensive deployment' Breathe. 5 (1) pp. 27-35

Funding source:

No Funding

6.2.3

Evaluating the nursing contribution to chronic disease management (CDM): A comparison of four models

Sue Procter, Centre for Research in Primary & Community Care, University of Hertfordshire, UK
Co-authors: S Kendall; S Procter; P Wilson; F Brooks, P Wilson

Abstract:

Background: Nursing has been recognised as central in helping people to manage chronic disease and recently has been at the forefront of CDM, However, the transfer of nurse-led models developed in different contexts, particularly the US, into the UK has not replicated the patient outcomes demonstrated in the US. This paper reports a national evaluation, comparing the nursing contribution within four CDM models.

Aims: To explore, identify and characterise the origins, processes and outcomes of effective CDM models and the nursing contributions to such models using a whole system approach.

Methods: Seven case studies were selected to ensure a range of CDM models; public health, primary care, nurse specialist, community matron. Semi-structured interviews were conducted with over one hundred patients and carers, fifty health professionals and focus groups with younger people. A survey and self-report audits formed the basis of an economic evaluation.

Results: The nurses' role within the public health model was most effective in enabling a seamless service but was the most invisible to service users. Contradictory policies generated blocks to the provision of patient-centred care by nurses, for example disease centric approaches such as the Quality Outcomes Framework (QOF). Large, hospital-based teams of nurse specialists had lowest costs per patient, whereas community matrons with complex caseloads had highest costs, reflecting expected service delivery.

Discussion: A number of conditions need to be met in each model if nursing is to make an effective contribution. These include achieving a level of clinical expertise necessary to earn clinical autonomy through peer review, and the ability to work across at least one other sector of provision to meet broader CDM needs.

Conclusions: Nurses are spearheading approaches envisaged by current CDM models. However, there are a number of policy contradictions that hamper the contribution of nurses to many CDM models.

Recommended reading:

Department of Health (2004) Distillation of Chronic Disease Management programmes in the UK. Matrix research & consultancy/Modernisation Agency, London.

Department of Health (2008) High Quality Care for All. Stationery Office London.

Funding source:

UK – Health Service (National)

100,001 – 500,000

6.2.4

Online forums as a tool for research in children's cancer care (ViPER)

Stephanie Kumpunen, Department of Childrens Nursing, London South Bank University, UK
Co-authors: S Aldiss; L Forbat; N Goulden; G MacIntyre; N Ranasinghe; F Gibson

Abstract:

Background: Parents of children diagnosed with Acute Lymphoblastic Leukaemia (ALL) can be hard-to-reach populations, particularly fathers; likewise, health professionals juggle busy work schedules inhibiting participation in research. Online methods of research like synchronised focus groups and bulletin boards are increasingly being used over face-to-face alternatives because they are convenient and inexpensive. Online chat rooms have similar benefits, but are criticised for producing superficial data (Gaiser, 1997).

Aims: To explain how we created an online chat room into a hybrid space for asynchronised discussion and real-time chat in order to increase participants' flexibility and comfort in responding to researcher's questions.

Methods: A web-based discussion tool, Campfire, was adapted from its original corporate chat room use to invite 50 research participants (25 parents [split into two or more groups], 25 health professionals [split into two or more groups]) who were identified through theoretical sampling methods (Corbin & Strauss, 2008) to anonymously answer researcher-posed questions on their opinions of information exchange and communication between professionals, parents and children about ALL during treatment.

Results: The tool satisfied many desired characteristics of online research, such as participant anonymity, control, flexibility, security and opportunity to experiment in the space prior to use to increase comfort (Tates et al., 2009). It additionally provided real-time chat and transcripts of chat to increase participant familiarity with the group.

Discussion: Through our post-discussion evaluation survey we found that presenting online chat spaces as forums to participants increased flexibility of not only when to participate, but also how. This likely resulted in an increased quality of data; however, we have no control for comparison. Evaluations will take place in the future.

Conclusions: Online chat spaces can provide safe and flexible environments for research participants sharing sensitive information.

Recommended reading:

Corbin, J. & Strauss, A. (2008)

Gaiser, T.J. (1997)

Tates, K., Zwaanswijk, M., Otten, R., van Dulmen, S., Hoogerbrugge, P.M., Kamps, W.A., & Bensing, J.M. (2009)

Funding source:

UK – Research Charity/Foundation

50,001 – 100,000

6.3 Older people

6.3.1

We're just not getting it right; How should we provide care to the older person with multimorbid chronic conditions?

Marina Lupari, Head of Nursing – Research &DEvelopment/PhD student, Trust Headquarters, Northern Health & Social Care Trust, UK
Co-authors: Vivien Coates; Gary Adamson

Abstract:

Background: Enhanced nursing roles developed in response to demands for increased efficiency in healthcare provision especially in chronic disease management. It is apparent that evidence to support the combination of nurses providing a case management (CM) approach for patients with multimorbid chronic conditions is ambiguous. There is a need to examine the evidence if the health service is to adopt this as a widespread model.

Aim/Objectives: The aim was to review research and service evaluation evidence on nurse-led CM services targeting older people with multimorbid chronic conditions within their own homes in order to highlight important issues for health policy, nursing practice, healthcare provision and health service research. The outcome measures incorporated effectiveness metrics including hospital resources used, effects on the client, and effects on the caregiver with cost-effectiveness metrics.

Methods: Systematic review was carried out across multiple sources including search and alert engines, electronic databases, relevant journal websites and grey literature. Inclusion criteria applied; original article; English language; published between 1985-April 2009, CM intervention involving nurses providing care in the patients' own home and older people (aged over 65 years) with multiple chronic illness. Of a total of 568 papers identified, eight were of relevance and included in the review.

Results: The qualitative data derived from this systematic review suggests that access to CM services had a positive impact on the patient, the carer and the healthcare staff particularly the GP. In contrast the robust quantitative data does not demonstrate a significant impact on emergency admissions, bed days, nor costs.

Conclusions: Further research is needed to understand how CM can most effectively improve the cost/ effectiveness of care for patients and their carers with multiple chronic diseases. A new emphasis is required which has the potential to reshape the whole system of healthcare provision for complex patients.

Recommended reading:

Russell, M., Roe, B., Beech, R. & Russell, W. (2009) Service developments for managing people with long-term conditions using case management approaches, an example from the UK. International Journal of Integrated Care, 9: 1-10.

Hutt, R., Rosen, R. & Mc Cauley, J. (2004) Case-managing long term

Gravelle H, Dusheiko M, Sheaff R et al (2007) Impact of case management

Funding source:

UK – Health Service (National)

50,001 – 100,000

6.3.2

Nurse case management in England: A study of different models of for community dwelling older people with long term conditions

Vari Drennan, Professor of Health Policy and Service Delivery, Faculty of Health & Social Care Sciences, Kingston University and St. George's, University of London, UK
Co-author: C Goodman
v.drennan@sgul.kingston.ac.uk

Abstract:

Aim: This paper presents findings from a National Institute of Health Research funded project evaluating the contribution of different types of nurse case management in support of community dwelling older people with long term conditions (LTC). Current Department of Health (England) policy advocates primary care nurses as integral to the provision of health services for people with long term conditions; in particular through case management roles.

Methods: The study had two phases: 1) an England and Wales wide survey of Local Primary Care organisations, building on an integrative review and 2) an in depth comparative case study prospectively over nine months of the patient experience (n=60) and nursing contribution (n=12) within four different models of nurse case management that are provided in three different areas of England.

Results: This paper will present findings from both phases but focus on the case study phase. The case studies demonstrated how the different models of nurse case management influence patient care, access to services and outcomes.

Conclusion: Discussion and conclusions will focus on the extent to which the range of possible approaches to nursing involvement in case management acts as a compensation for the shortcomings of primary care or as an innovation that represents new approach to chronic disease management.

Recommended reading:

Goodman C, Drennan V, Davies S, Massey H, Gage H, Scott C, Manthorpe J, Brearley S and Iliffe S. 2009. The nursing contribution to chronic disease management: nurse case managers in primary care settings. Report for the NCCNHS Service Delivery and Orga

DH (2005) Supporting People wiht Long Term conditoons: An NHS and Social Care Model to Support People with Long Term Conditions. London: The Department of Health

Funding source:

UK – Health Service (National)

50,001 – 100,000

6.3.3

In the shadow of ageing: The experiences of older women living with a long-term condition

Dianne Roy, Senior Lecturer, Department of Nursing, Unitec, New Zealand
Co-author: L S Giddings

Abstract:

Background: Ageing shapes and is shaped by women's experience of living with a long-term condition (Giddings et al., 2007).

Aim: This study explored the experiences of women aged 65 to 74 years as they grow older while living with a long-term condition (LTC). The phenomenon of focus was 'ageing with a long-term condition', not on the experience of developing a LTC after reaching older adulthood (⋯>60 years).

Methods: Nine women were recruited using purposive and snowball sampling strategies. Data from a series of focus groups (x3), held between June 2007 and April 2008, were analysed thematically using interpretive description processes (Thorne, 2008, Thorne et al., 1997). The study was approved by our institutions' research ethics committees.

Results and Discussion: For the women in this study, their LTC was a constant referent point for organising and interpreting their world. In contrast, health professionals and others in the community were found to focus on their age and the effects of the ageing process. When their LTC was at risk of becoming invisible by being 'in the shadow of ageing' the women used 'strategies already-to-hand' to deal with it; it became 'just another barrier' for them to navigate. For them 'ageing was matter-of-fact'. Rather than birthdays being a negative milestone to be dealt with, they were experienced as a celebration; for the women it was a 'privilege to grow older'. These themes will be explored in this presentation.

Conclusions: If health professionals focus on older women clients' age and its concomitant effects rather than the centrality of the LTC in their life, they are at risk of delivering inappropriate care. Health professionals need to be prepared to advocate for the special needs of older women who live with a LTC, but remain cognisant of their resourcefulness and expertise developed over time.

Recommended reading:

Giddings, L. S., Roy, D. E. and Predeger, E. (2007) Women's experience of ageing with a chronic condition. Journal of Advanced Nursing, 58, 557-565.

Thorne, S. (2008) Interpretive description, Walnut Creek, CA, Left Coast Press.

Thorne, S., Reimer-Kirkham, S. and MacDonald-Emes, J. (1997) Interpretive description: A non-categorical qualitative alternative for developing nursing knowledge. Research in Nursing and Health, 20, 169-177.

Funding source:

1,000 – 10,000

6.3.4

Findings from a qualitative study of older people's experiences of changed medication appearance

Tracey Williamson, Research Fellow, University of Salford, UK
Co-authors: M Howarth; L Greene; A Prashar

Abstract:

Background: This presentation will illuminate findings from a qualitative study of older adults concerning their experiences of changed tablet/ capsule medication appearance due to 'generic prescribing' and 'parallel import' practices and their impact on their medication taking practices

These common pharmacy practices mean that the same tablet medication can be issued to older people in different colours, sizes and shapes to their previous prescriptions.

Aim: To elicit older people's experiences of medication that changed appearance

Sample: Older adults aged 50 years and over and who were prescribed three or more tablet/capsule medications were eligible to take part. With the help of GPs from across Greater Manchester eligible participants were sent invites to request further information to which 130 potential participants responded. From these 32 participants went on to be interviewed.

Method: A semi-structured interview guide was informed by input from six older people as study advisors, the literature and findings from a short postal survey focusing on the same topic. Several participants consented to interviews being video-recorded with the full knowledge that they would not be anonymous. Individual interviews were held in participant's homes.

Findings: Findings indicate that several participants have experienced impact on their ability to manage medicines safely due to the number and nature of changes they have experienced amongst their prescribed medications. Key themes include importance of routine; confidence – in medicines and practitioners; views about 'getting older' and retaining control. Use of video clips of real participants makes the presentation of these findings compelling.

Discussion/Conclusions: Financial gain from supplying the least costly version of a medicine is at the cost of various medicines management consequences and occasional health risks for older people. The impact of appearance changes is significant and has practice implications for primary health care teams. Findings add to the existing weak knowledge/evidence base.

Recommended reading:

Teeling, M and Feely, J (2005) Adverse drug reactions: reducing the risk in older people. Prescriber, 16, 12-19

Overgaard, ABA; Møller-Sonnergaard, J; Christrup, LL; Højsted, J; and Hansen, R (2001) Patients' evaluation of shape, size and colour of solid dosage forms. Pharmacy World and Science, 23, 185-188.

Kippen, S (2005) As time goes by: Issues for older people with their medication use. Australasian Journal on Ageing, 24, 103-107.

Funding source:

UK – Health Service (Local)

10,001 – 50,000

6.4	Cancer

6.4.1

Developing a community based cancer survivorship coaching programme: Using mixed methodology to inform the development of a complex intervention

Karen Roberts, Queen Elizabeth Hospital NHS Trust, UK

Co-authors: S Rao; C Clarke; S Rushbrooke

Abstract:

There is currently much work looking at the needs of people who are living with and beyond cancer treatment. This paper will describe a project taking place in the north-east of England, funded as part of the National Cancer Survivorship Initiative and NHS Improvements.

There is an evidence base that describes the psychological consequences of physical illness (Sumalla et al 2009) and the researchers' hypothesis is that psychological problems in the longer term can be prevented if people can access their strengths and build the resilience necessary to re-frame their lives following cancer treatment using a mindfullness based cognitive therapy approach. The programme focuses on 'wellness' not 'illness or symptoms' which is novel in cancer services.

The aim is to test if a cognitive behavioural therapy approach to survivorship care, based upon current evidence in other areas, can be applied to this patient group and reduce distress, anxiety and depression in the longer term. More importantly, teach people the life skills to be resilient in facing the uncertainty and distress about a future that comes with a cancer diagnosis (Padesky, 2007).

This pilot project included two cohorts (n=14) who attended for two hours skills training weekly for eight weeks. Focus groups were carried out before the programme commenced and after completion of the programme. Individual semi-structured interviews were carried out with each participant during the course of the programme. The programme was developed and facilitated by a Nurse Consultant and Liaison Psychiatrist working with the researchers in an iterative and dynamic way brining together the project evaluation team, the participants, and the clinicians as one learning community.

This paper will describe the theoretical development of the intervention, the underpinning philosophy of this approach to survivorship care, and results from the implementation of the health and lifestyle coaching programme.

Recommended reading:

Sumalla,E.C. Ochoa,C. and Blanco,I. (2009) Post-traumatic growth in cancer: Reality or illusion? Clinical Psychology Review 29, p.24-33.

Padesky,C. (2007) Uncover strengths and build resilience with CBT: A 4-step model. A two day

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workshop. Institute of Education, London. May 14-15.

6.4.2

Living beyond treatment for colorectal cancer

Susan Goodlad, Senior Lecturer, Faculty of Health and Applied Social Sciences, Liverpool John Moores University, UK

Co-authors: Fiona Irvine; Christine Wall; Helen Poole; Lynda Appleton

Abstract:

Background: Colorectal cancer is the third most common cancer in the UK (Cancer Research UK 2004).The experience for patients can be extremely distressing as the individual copes with the effects of the disease and its treatments. People are living longer and yet relatively little is known about the long term impact of cancer on daily life,(NICE 2004).

Aim: To explore the experience of living beyond colorectal cancer.

Method: A purposive sampling strategy was used and 14 people who had completed a course of treatment within the past 6months to 5years and met pre defined eligibility criteria were recruited to the study. Face to face semi – structured interviews were used to gather data in the summer of 2009. Interpretative phenomenological analysis was undertaken (Smith J 2004).

Results: In this paper we will discuss some of the key themes that emerged from the data and particularly focus on the themes of 'dealing with cancer treatment' and 'reverting to normal living'. We will explore some of the categories that characterize these themes including support from the multidisciplinary team, family and friends, getting stuck and moving forward; and social integration.

Discussion: The knowledge, support and information provided throughout the pathway of care from key members of the multidisciplinary team, together with underpinning support from family and friends emerged as central elements in surviving colorectal cancer. These elements are fundamental to moving people from a place where they perceive themselves to be cancer victims to a point where they can embrace the future.

Conclusion: The study has made a contribution to understanding how people live beyond colorectal cancer. We acknowledge that this small qualitative study from which generalisations cannot be made. However, we intend to give sufficient descriptive detail to enable the audience to judge the trustworthiness of the findings.

Recommended reading:

Cancer Research UK (2004) Cancer Stats: Survival, England and Wales, 2004

NICE(2004)Improving Supportive and Palliative Care for Adults with Cancer. London. National Institute of Clinical Excellence

Smith J. (2004) Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology, Qualitative Research in Psychology, 1: 39-45.

Funding source:

6.4.3

Introducing volunteers into chemotherapy day units: A mixed method evaluation

Theresa Wiseman, Senior lecturer/nursing research fellow, Specialist care, Florence NIghtingale School of Nursing and Midwifery, Kings College London, UK

Co-authors: D DeBerker; C Miller; M Griffin; A Richardson

Abstract:

Within many USA Cancer Centres, the presence of volunteers is an important factor for improving patient experience. The purpose of this study was to evaluate a pilot project of introducing a volunteer role to support cancer patients using two Chemotherapy Day Units.

The study sought to answer the following questions:

• Did the volunteer training programme meet the needs of the volunteers and prepare them for their role?

• How did the volunteer programme impact on patients' experiences and satisfaction with care?

• What benefits were realised and challenges encountered from the perspective of stakeholders involved?

• What structures and processes are necessary to ensure the volunteer programme maximises its effect on future patient care?

This mixed methods evaluation was exploratory and spanned one year. Data collection included:

• A prospective audit of patients' experiences and satisfaction with care undertaken at baseline and end of the pilot project.

• Questionnaires and interviews with volunteers at the end of the project.

• Interviews with staff and stakeholders at the end of the project.

Findings: The evaluation revealed the introduction of volunteers in cancer services was successful. The training programme met the volunteers' needs, prepared them for their role. It also fostered feelings of being supported and part of a team. The patient survey and staff interviews revealed volunteers enhanced patients' experience and satisfaction with care. The evaluation has shown how a 'neutral' person can have a positive impact on patient care. Much of the volunteers' time was spent talking to patients and providing companionship which was appreciated by patients and carers. Staff and stakeholder interviews revealed benefits in terms of 'bridging the gap' between the healthcare team and the patient and family. The results have provoked discussion about how best to sustain this initiative and incorporate others areas of care delivery.

Recommended reading:

Creswell J. & Plano Clark V. (2006) Designing and conducting mixed methods research Thousand Oaks CA Sage Publications

Sadler C. & Marty F. (1998) Socialization of hospice volunteers: members of the family Hospital Journal 13 (3) 49-68

Wilson D. Justice C. Thomas R. Sheps S. Macadam M. & Brown M. (2005) End of life care volunteers: a systematic review of the literature. Health Services Management Research 18 (4) 244-57

Funding source:

6.4.4

Thirty-day mortality in critical care outreach patients with cancer: An investigative study of predictive factors related to outreach referral episodes

Natalie Pattison, Clinical Nursing Research Fellow, Nursing, Royal Marsden NHS Foundation Trust, UK
Co-authors: S Ashley; L Roskelly; G O'Gara
natalie.pattison@rmh.nhs.uk

Abstract:

Background: Prevention of admission to critical care is an important area of practice, given high mortality figures for cancer patients admitted to CCU (Taccone et al 2009).

Objectives: To establish whether there are any factors that predict outcome in critically ill, deteriorating cancer patients through critical care outreach (CCO) referral episodes, characteristics and care reviews.

Method: A population-based prospective/retrospective investigative study exploring factors regarding critically ill cancer patients referred to the CCO team and their subsequent outcome. Prospective and retrospective analysis of activity and referral patterns around outreach episodes was undertaken.

Results: 407 episodes of care were reviewed. Referrers were categorised as doctors (n=92, 29%), nurses (n=195, 61%) or other (n=5, 2%). The category of referrer did not influence 30-day mortality (p=0.4 Fishers Exact). Patients seen by outreach and admitted to critical care requiring level 2/3 care accounted for 26% (n=83) of referrals. Of those, 42% (n=35) died. For level 2/3 care admissions, the mean length of stay was 151.19 hours (95% CI 114.8-187.57).

Outreach have initiated 'aversion' (limitation of treatment and initiation of do not attempt resuscitation orders) to critical care with multi-disciplinary teams in 32.2% (n=103/318) of all patients. There was a low incidence inappropriate referrals (8%) overall; inappropriate referrals had a marginally higher 30-day mortality and nearly reached significance (p=0.07 Fishers Exact).

The final logistic regression model, which will be presented, correctly predicts the 30 day outcome of 71% of the patients, demonstrating a relatively high predictability in this patient population. The odds of mortality increase with a higher potassium, heart rate and as the oxygen saturation at deterioration worsen.

Conclusion: This study reinforced the argument that MEWS alone are insufficient to predict outcome, but have clinical value in alerting staff. Critical care outreach initiated discussions for decisions for limit treatment which had an effect on mortality.

Recommended reading:

Taccone FS, Artigas AA, Sprung CL, Moreno R, Sakr Y, Vincent J-L (2009) Characteristics and outcomes of cancer patients in European ICUs. Critical Care. 13 ppR15 (accessed online at http://ccforum.com/content/13/1/R15 on August 8th 2009)

Funding source:

6.5	Learning disability

6.5.1

Developing a validated measure of peace of mind: A case study of carers of people with learning disabilities living in a residential facility

Marie Gressmann, School of Health and Social Care, Teesside University, UK

Abstract:

Background: The concept of satisfaction has traditionally been used as a key criterion of quality (Felce et al 1999). Yet there is evidence in studies focusing on family carers of people with learning disabilities living in residential facilities that the concept of 'peace of mind' might be equally as important (McConkey et al 2004). However a literature search found no validate instrument to measure this. This study addressed this gap and reports the development of a 'peace of mind' measure for this carer group.

Aims:

• To explore determinants of 'peace of mind' for family carers

• To develop a measure of 'peace of mind' and test validity and reliability

Method: Three focus groups were used to collect data from 13 family carers of people with learning disabilities living in a residential facility. Data were analysed using thematic analysis and categorised into themes which were used to develop the Peace of Mind questionnaire; validity and reliability tests were then conducted.

Results: Peace of mind was important to most relatives and was reflected in 16 categories which fitted into five broad domains: staff attitudes, communication, training/ recruitment and safety. Consequently, a 16 item 'peace of mind' measure was constructed. Preliminary validity tests (face/ content) and a pilot test on 15 family carers reported its acceptability; good reliability was also found (Cronbach's alpha.99).

Discussion and Conclusion: The results highlight the importance of family carer's peace of mind when evaluating service quality; the study also has significance for the way service staff perceives and treats family carers of people in residential services. The measure has potential be used in other services (e.g. elderly), although further testing/retesting is needed.

Recommended reading:

McConkey, R., Truesdale, M., & Conliffe, C. (2004). The features of short-break residential services valued by families who have multiple disabilities. Journal of Social Work, 4(1), 61-75.

Felce, D., Lowe, K., Perry, J., Jones, E., Baxer, H., & Bowley, C. (1999). The quality of residential and day services for adults with intellectual disabilities in eight local authorities in England: Objective data gained in support of a social services inspectorate inspection.

Funding source:

No Funding

6.5.2

A mixed methods research study of the impact and outcomes of four learning disability liaison nursing services across South East Scotland

Michael Brown, Nursing, Midwifery & Social Care, Napier University, UK

Abstract:

Background: There has been a significant focus on the care experienced by people with learning disabilities in general hospitals and government policy is explicitly directed at addressing institutional discrimination and poor clinical practice. As a consequence Learning Disability Liaison Nursing Services have been established across the UK to ensure there are access to additional support in general hospitals.

Aims: The aims of the study is to identify the impact and outcomes of four Learning Disability Liaison Nursing (LDLN) services across South East Scotland on the healthcare experiences of people with learning disabilities attending for general hospital care.

Methods: A mixed methods design was employed using both quantitative and qualitative methodologies to identify the demographic profile of (i) the use of general hospital services by people with learning disabilities & utilisation of the LDLN service (ii) focus groups and individual interviews involving key stakeholders drawn from adults with learning disabilities, carers, general hospital professionals and liaison nurses.

Results: The LDLN services impacts on outcomes in three domains: clinical outcomes, education and practice development and strategic service developments. The elements of the LDLN service that effect change in care are supporting adherence to capacity legislation, enabling adjustments to the care environment, coordinating healthcare, enhancing patient compliance, promoting patient choice and experience, preventing poor outcomes, enabling communication and 'taking the pressure off'.

Discussion: This is the first research study to be undertaken to identify the impact and outcomes of LDLN models. The LDLN service improves the health outcomes of this group when attending general hospitals and enables equal access to healthcare while reducing poor outcomes.

Conclusion: Establishing LDLN services in general hospitals impacts on the outcomes for people with learning disabilities and contributes to ensuring their care needs are effectively met.

Recommended reading:

Brown M. & MacArthur J. (2006) A New Research Agenda: Improving Healthcare in General Hospitals. Journal of Clinical Nursing, vol 13, (4), 224-231.

Department of Health (2008) Healthcare for All? The report of the independent inquiry into access to healthcare for people with learning disabilities. London: HMSO

Backer C., Chapman M. & Mitchell D. (2009) Access to secondary healthcare for people with intellectual disabilities: A review of the literature. Journal of Applied Research in Intellectual Disabilities, vol 22, pp 514:525.

Funding source:

UK – Health Service (Local)

10,001 – 50,000

6.5.3

'You get people muddling along... often doing the wrong thing': The role of the learning disability liaison nurse in supporting implementation of the adults with Incapacity Act (Scotland) 2000

Juliet MacArthur, CPPD Department, NHS Lothian, UK

Co-author: M Brown

Abstract:

The attitudes and behaviour of healthcare professionals are decisive in securing informed consent for people with a learning disability (Goldsmith, Skirton and Webber 2008). The Adults with Incapacity (AWI) Act (Scotland) 2001 created a legislative framework that includes a general authority to treat provided that a certificate of incapacity has been completed. There has been a dearth of research examining the implementation of the Act since early evaluations which highlighted variable understanding amongst health practitioners and confusion over the role of the adult's next-of-kin in consenting to treatment (Davidson et al 2004, Ramsay 2005).

In the course of a mixed methods study examining the impact of Learning Disability Liaison Nursing (LDLN) Services across four Scottish Health Boards adherence to the requirements of the AWI Act was repeatedly raised as an area of concern. The study involved analysis of 323 referrals during an 18 month period. AWI issues were present in 41% of referrals and were raised by a quarter of the 85 individuals (liaison nurses, primary and secondary healthcare professionals, carers and patients) who took part in semi-structured interviews or focus groups. The findings demonstrated that, in the main, secondary healthcare professionals still require support, advice and in some cases direct intervention by the Liaison Nurses to ensure that patient's rights are protected and that staff operate within the legal framework.

This paper examines the range of concerns and issues including inappropriate carer involvement, lack of certification (in some cases leading to failure to treat) and acquiesce being interpreted as consent. It will put forward the perspectives of healthcare professionals include uncertainty about how to present information and assess understanding. Recommendations will be made regarding measures to support implementation including examples of positive practice that highlight the expert role of the LDLN that enhances patient's rights and promote their safety.

Recommended reading:

Goldsmith L., Skirton H. & Webb C. (2008) Informed consent to healthcare interventions in people with learning disabilities – an integrative review. Journal of Advanced Nursing 64(6), pp.549-563

Davidson, S., Wilkinson, H., Urquhart, G., Wasoff, F.& Mason, A. (2004) Review of the implementation of Part 5 of the Adults With Incapacity (Scotland)

Act 2000: a qualitative study of implementation and early operation. Scottish Executive.

Ramsay, S (2005) The Adults with Incapacity (Scotland) Act--Who knows? Who cares?. Scottish Medical Journal. 50(1) pp.20-2.

6.5.4

Factors influencing the experiences of family carers who have a relative with a learning disability living in a residential facility

Marie Gressmann, School of Health and Social Care, Teesside University, UK

Abstract:

Background: The situation of family carers of those with learning disability has been a major focus of research with most studies focusing on challenges when a family member lives at home. However it is recognised that family carers have equal concerns when their relative moves to a residential facility (Seltzer, Krauss, Hong, & Orsmond, 2001) and their experiences and appraisal of the situation might differ according to type of facility such as private or NHS care environments.

Aim: To explore factors that affect carer outcomes such as satisfaction, health and service engagement.

Methods: A purposive sample of 86 family carers of people with learning disability, living in 5 different care environments, comprising 23 residential homes were selected from regional service providers. Data were collected via a range of validated questionnaires including Family Measures (FM) (McCubbin and Comeau 1987); Revised Residential Services Settings Questionnaire; Service Satisfaction scale, General Health Questionnaire and Outcome Measure. Data were analysed using standard statistical tests.

Results: Differences in carer experiences between care environments were identified. For example private hospitals and NHS environments were perceived to be less homelike than residential facilities (z = 6.176, p ⟵ 0.001) and residential services had better support for activity than NHS (z = 3.079, p = 0.002). Furthermore, there were significant correlations between family stressors and appraisal (p ⟵ 0.01); support for activity and appraisal (p ⟵ 0.05); appraisal and outcome (p ⟵ 0.01). Multivariate analysis (Stepwise) highlighted that stressors, support for activity and appraisal were predictors of outcome.

Discussion / Conclusion: The results confirm family stressors are connected to service characteristics and appraisal; this has a significant effect on whether outcomes for family carers are positive or negative.

Recommended reading:

McCubbin, H. I., & Comeau, J. K. (1987). FIRM Family Inventory of Resources for Management. In H. McCubbin & A. I. Thompson (Eds.), Family assessment inventories for research and practice (pp. 143-160). Madison: The University of Wisconsin-Madison

Seltzer, M. M., Krauss, M. W., Hong, J., & Orsmond, G. L. (2001). Continuity or discontinuity of family involvement following residential transitions of adults who have mental retardation. Mental Retardation, 39(3), 181-194.

6.6 Clinical practice

6.6.1

Randomised controlled trials with complex interventions: Design issues

Vivien Coates, Professor Nursing Research, University of Ulster, UK

Co-author: D Chaney

Abstract:

Background: The randomised controlled trial (RCT) is regarded as 'the gold standard' for providing evidence to underpin health care policy and practice. However, this standard can easily be compromised if the design of the experiment does not allow for issues that can cause bias or compromise the external validity of the study.

The Study: A multi centre RCT to investigate a complex behavioural intervention entitled: 'Diabetes education for adolescents' is currently being conducted. 132 adolescents have been recruited from five hospitals, with a total recruitment of 192 required. Those recruited were randomised to either the experimental or control groups and for those in the former group educational programmes, comprising a session a week for four weeks, have been completed. A total of 10 diabetes education programmes (the intervention) have been completed across the five hospital sites. Data is gathered by means of a structured questionnaire and from clinical records. This data has been gathered for baseline and at three monthly intervals post intervention for one year post intervention.

The Issues: Using the above study as an example the following five issues will be explored:

• The influence of the context in which the research is conducted

• The need for clarity of definition of the intervention and outcome variables

• Recruiting a representative sample

• Randomisation versus patient preference trials

• The control group.

In recognition of problems encountered when designing RCTs for complex interventions the

UK Medical Research Council (2000) produced a framework to help guide design and evaluation of such trials. In the light of experienced gained through conducting RCTs strengths and weaknesses of the MRC Framework will be analysed.

Finally the consequences of a tightly controlled experiment in terms of the implications of reduced external validity will be discussed.

Recommended reading:

Medical Research Council. A framework for development and evaluation of RCTs for complex interventions to improve health. Discussioin coument April 200. www.mrc.ac.uk/Utilities/Documentrecord/index.htm?d=MRC003372

6.6.2

Randomised control trial feasibility study on the use of medical grade honey to reduce the incidence of wound infection

Val Robson, CNS Leg Ulcer Care, Ward 2, Aintree University Hospitals NHS Foundation Trust, UK

Co-authors: Simon Rogers; Derek Lowe; Rachel Sen; Stephen Barrow

Abstract:

Background: Over five year period there were 10109 admissions to regional Maxillofacial ward.

115 episodes with MRSA (1.1%) occurring in 97 patients. In half the cases the wound was the primary site of infection. The biggest risk factor for MRSA infection was oncology patients particularly those with advanced stage disease who had free flap reconstructions.

George & Cutting (2007) found that the growth of S. Aureus and MRSA was inhibited by 4% honey.

Aim: To assess the feasibility of using Leptospermum honey at reducing the incidence of wound infection following microvascular free tissue reconstruction for head and neck cancer.

Method: Of the 70 patients having free tissue reconstruction 56 (80%) consented to be randomised and 49 (70%) were actually randomised. 25 were received honey and 24 received conventional treatment. Six were missed at consent stage, eight refused to consent and seven with consent were missed at the randomisation stage in theatre. Data were collected between February 2008 and March 2009

Results: Positive wound swab results were found for 36% of the honey group, 38% non-honey group and 43% external control group. MRSA wound swabs were found for 28%, 25% and 33% respectively. Honey dressings were acceptable to both patients and nurses.

Discussion: The collection of data and the sites swabbed at seven days and 10 days post op and

repeated at discharge proved appropriate in capturing data on wound infection.

The study has given a baseline for the incidence of wound infection in this group of patients.

The study has shown statistical significance in the honey group having a reduced length of stay, (p = 0.047).

Conclusion: This study has shown that a RCT is feasible. It would require a substantial number of patients to prove a statistical benefit for honey in the reduction of infection rates.

Recommended reading:

Rogers S.N, Proczek K, Sen R.A, Hughes J, Banks P, Lowe D. (2008) Which patients are most at risk of methicillin resistant Staphylococcus aureus: a review of admissions to a regional maxillofacial ward between 2001 and 2005. Br. J. of Oral and Maxill

George N.M & Cutting K.F (2007) Antibacterial Honey (Medihoney): in-vitro Activity Against Clinical Isolates of MRSA, VRE and Other Multiresistant Gram-negative Organisms Including Pseudomonas aeruginosa.Wounds 19:9;231-236

Funding source:

No Funding

6.6.3

Preoperative fasting for adults to prevent perioperative complications: An updated Cochrane review

Valerie Ness, School of Health, Glasgow Caledonian University, UK

Co-authors: M Brady; S Kinn; P Stuart

Abstract:

Aim: This Cochrane Review update aimed to include new evidence. It systematically assessed the effects of different fasting regimes' impact on perioperative complications and patient well being in different adult populations.

Background: There are many fasting guidelines for adult patients undergoing elective surgery (ASA 1999; RCN 2005). In practice however, the fasting period has been found to be in excess of these guidelines (Crenshaw 2008).

Method: This was an update of a Cochrane systematic review of randomised controlled trials which compared the effect on perioperative complications of different preoperative fasting regimes (duration, volume and type of fluid). Primary outcome measures (rate of adverse events, gastric volume and/or pH) and secondary measures of well-being (thirst, hunger, pain, nausea, vomiting and anxiety) were evaluated.

Results: 70 randomised controlled comparisons were included (including 42 new comparisons). Those given a drink of water preoperatively were found to have a lower volume of gastric contents

than the groups that followed a standard fast. There was no indication that the volume of fluid given had any effect. Where differences occurred in relation to secondary outcomes, fasted adults rated thirst and hunger as worse than those who were given fluids. Few trials investigated 'at-risk' patient populations.

Conclusions: There was no evidence to suggest that a shortened fluid fast results in an increased risk of aspiration, regurgitation or related morbidity compared to the standard â œnil by mouthâ policy in non-at-risk adults.

Implications for practice: This update further supports the conclusion that patients who are not at risk of anaesthetic complications should be allowed to drink up to two hours prior to surgery. Local guidelines should include this evidence and be visible to all staff.

Discovering why patients fast for prolonged periods of time may be useful in making recommendations to improve the implementation of these guidelines.

Recommended reading:

American Society of Anesthesiologist Task Force on Preoperative Fasting (ASA) (1999)

Royal College of Nursing (RCN) (2005)

Crenshaw, J. T., Winslow, E.H. (2008)

Funding source:

No Funding

6.6.4

Mining digital stories to illuminate patient safety concerns: Being unsafe in safe places (ViPER)

Annie Topping, Director – CHSCR, University of Huddersfield, UK

Co-authors: P Hardy; C Haigh

Abstract:

Introduction: Over the last decade there has been an increasing recognition by patients that healthcare organisations and health professionals can be dangerous. Numerous studies have highlighted the alarming incidence of errors, omissions and adverse events across health care settings worldwide (Walshe & Broaden 2005). Failings in care regularly appear in the media; many of the concerns raised relate to inadequacies in medicines management and omissions in fundamental aspects of care (Patients Association 2009).

Methods: Digital storytelling is a powerful approach for gathering personal accounts. The Patient Voices Programme aims to capture the normally unwritten and often unspoken stories of people who use, and work, in health and social care settings. Since the programme commenced in 2003 over 300 stories have been created through a workshop-based process that offers storytellers the chance to transform ideas into short multimedia digitalised accounts. Subject to consent, the digital stories are made freely available via the web.

This rich resource was mined to identify recurring themes concerning patient safety threaded through the accounts. All the stories were categorised in terms of the key message contained in the account and those identified as illustrating patient safety accounts were subjected to content analysis to reveal the common features (Spiers 2004).

Findings: The act or adverse event was recognised as context – as well as content – contingent. The perceived absence of caring, subsequent impact on loss of trust in health care providers, and overall feelings of safety, were evident across accounts.

Discussion: The recent attention given to patient safety has highlighted the importance of robust processes and procedures to reduce error. This paper will focus on the less tangible contextual concerns evident in the accounts that illuminate feelings of being unsafe in safe places and the implications for practice.

Recommended reading:

Walshe K & Broaden P (2005) Patient Safety: Research into Practice Maidenhead. Open University Press.

Patients Association (2009) Patients...not numbers, People not Statistics Harrow Patients Association Retrieved [28.08.09] from http://www.patients-association.org.uk/DBIMGS/file/Patients%20not%20numbers,%20people%20not%20statistics.pdf

Spiers, J. A. (2004). Tech tips: Using video management/ analysis technology in qualitative research. International Journal of Qualitative Methods, 3(1). Article 5. Retrieved [28.08.09] from http://www.ualberta.ca/~iiqm/backissues/3_1/pdf/spiers-video.pdf

Funding source:

No Funding

6.7	Research methods

6.7.1

The synthesis of qualitative and quantitative Research: Its role in producing an evidence base for practice

Kate Flemming, Health Sciences, University of York, UK

Abstract:

Evidence-based nursing (EBN), although not without its critics, has become an integral part of nursing practice. EBN requires nurses to use research evidence to inform their clinical decision making, not in isolation, but in combination with their clinical experience, the resources available to finance care, and the preferences of patients and carers. The complexity of health-care delivery ensures that decision making is not straightforward. Nurses can face a multitude of decision challenges within a single consultation (Thompson et al 2004) and need an evidence-base which supports

this. There is a growing appreciation that healthcare needs to be evaluated and informed through a variety of research methods and that it is clinical uncertainty or policy requirements that need to drive evaluation, rather than an allegiance to a particular research methodology.

This paper will explore how the synthesis of qualitative and quantitative research can contribute to developing the evidence-base available to inform decisions for nursing and wider aspects of healthcare. It will begin by examining the epistemological, methodological and practical feasibility of combining primary research, in particular the use of qualitative research within and alongside randomised controlled trials. This theoretical justification will be built upon and a synthesis of qualitative and quantitative research will be presented. In the synthesis, effectiveness research in the form of a systematic review and guideline is synthesised with qualitative research examining the use of morphine to treat cancer-related pain. Adaptations to a method of synthesis called Critical Interpretive Synthesis (Dixon Woods et al 2006) facilitate this. The work provides an exemplar of methodological innovation which adds to the existing typology of approaches to synthesising qualitative and quantitative research. The findings also hold clinical credibility and identify a number of key social, contextual and physical factors associated with the use of morphine to treat cancer-related pain.

Recommended reading:

Thompson C, Cullum N, McCaughan D. et al (2004) Nurses, information use, and clinical decision making – the real world potential for evidence based decisions in nursing. Evidence Based Nursing 7, 3, pp 68-72

Dixon-Woods M, Cavers D, Agarwal S. et al. (2006) Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. BMC Medical Research Methodology 6, 35

Funding source:

UK – Health Service (National)

50,001 – 100,000

6.7.2

A picture speaks a thousand words

Victoria Ridgway, Pre Registration Nursing, University of Chester, UK

Abstract:

Visual methodology has been widely used in art and design and psychoanalysis, however in health care research the application of this research method is sparse and marginalized. This paper proposes that the use of the visual has a place in social science research. This method encompasses a board range of tools, which include videos, photographs, drawings, cartoons and many more.

Methodological approaches to the visual will be critically discussed; these include visual elicitation and visual ethnography. Key themes noted in the lit-

erature, Pink (2007) and Emmison and Smith (2007) will be drawn upon. The paper will emphasise that the use of images for illustrative purposes rather than to analyse a particular problem negates the true application of the method and proposes that the image should not be seen as a record but rather "what the eye can see" which supports an observational approach to data collection.

The methodological approach has itself has been discussed within peer review journals and books with each expert proposing differing approaches. For the novice researcher in this field this clouds the opportunity to use a method which allows the contextual meaning of the image to be established. Therefore this paper draws upon the current thinking (Pink 2007, Gray and Malins 2004) and argues that the use of several complementary methods will yield a significant data set therefore producing triangulation and re-contextualisation of the data. It will discuss how drawings and pictures represent a forum for expression that words can not generate and how these can be used to measure meaning of a subject/dilemma. Further, possible analyses of the data will be discussed. Finally benefits and limitations of the method will be drawn upon.

Recommended reading:

Emmison,M.Smith,P. (2007). Researching the Visual. Sage Publications:London.

Gray,C. Malins,J,.(2004). Visualizing **Research:** a guide to the research process in art and design. Ashgate Publishing:Aldershot

Pink,S. (2007), Doing Visual Ethnography.2nd Ed.Sage Publications:London

Funding source:

No Funding

6.7.3

The value of case study design for nursing research

Louise Shorney, Professional Development and Allied Health Care, University of Chester, UK
l.shorney@chester.ac.uk

Abstract:

Case study methodology has historically been embedded in social sciences research, but is increasingly being selected for nursing research. Case study is an empirical enquiry that analyses a contemporary phenomenon in a real life situation, particularly when the boundaries between the phenomenon and the real life situation are not apparent (Rosenburg and Yates 2007; Yin 2009). This approach is cognisant with the qualitative paradigm as it seeks to understand through the 'how' or 'why' method of questioning rather than directly predicting an outcome.

Rosenburg and Yates (2007) suggest that case study research is pragmatically rather than paradigmatically driven and should be conceptualised as an approach rather than a method. Therefore,

designing a case study piece of research requires a logical approach through clarification of the study questions, propositions and boundaries.

Case study methodology allows the researcher the opportunity to critically examine the meta-paradigm of health care (person, environment & health) through analysis and interpretation of multi-data sources (Gangeness and Yurkovich 2006). This can be though a descriptive, exploratory or an explanatory approach (Yin 2009).

This paper will argue that the dynamic working environment of healthcare, where conflicting domains and variables impact upon the quality of service provided is a ripe context for using this method. It gives the nurse researcher strong analytic purchase on nursing in the real life situation. The argument will be illuminated through reference to a current study of Exploration of how 2 primary care trusts within NHS North West interpreted and implemented the Department of Health Community Matron policy – England.

Recommended reading:

Gangeness, J and Yurkovich, E. (2006). Revisiting care study as a nursing research design. Nurse Researcher. Vol. 13, No. 4, pp. 7 – 18.

Rosenburg, JP and Yates, PM (2007). Schematic representation of case study research design. Journal of Advanced Nursing. vol. 60, no 4, pp. 447 – 452

Yin, RK. (2009). Case Study **Research:** Design and Methods. London, Sage. 4th Edition

Funding source:

UK – Higher Education Institution

10,001 – 50,000

6.7.4

Applying mixed methods in a single concurrent instrumental case study design (ViPER)

Lauretta Luck, School of Nursing and Midwifery, University of Western Sydney, Australia
Co-author: D Jackson
Lauretta.Luck@uws.edu.au

Abstract:

Case study is used in a number of ways in many disciplines (Stake, 2005; Yin, 2003). This presentation will argue the coherence of using mixed methods within a single, concurrent instrumental case study design (Luck, Jackson, & Usher, 2006). We assert this research approach or framework is relevant for practice based disciplines where theoretical abstractions and empirical understandings are compatibly applied in the real world. We will briefly define case study and explore the distinctiveness of the instrumental case study design. In doing so, we will substantiate the simultaneous development of the 'case of' as both a theoretical construct and an empirical unit. The links between accepting the phenomena of interest as theoretical constructs and empirical units, the position of pragmatism

and the compatibility of choosing mixed methods to collect data will be explicated. Finally, we will illustrate how a single concurrent mixed methods instrumental case study design was implemented in a study of the problem of violence towards emergency department (ED) nurses.

Recommended reading:

Luck, L., Jackson, D., & Usher, K. (2006). Case study: a bridge across the paradigms [corrected] [published erratum appears in NURS INQUIRY 2006 Sep;13(3):239. Nursing Inquiry, 13(2), 103-109.

Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), Handbook of qualitative research (2nd ed., pp. 443-466). Thousand Oaks, California: Sage Publications Inc.

Yin, R. K. (2003). Case study research; Designs and method (3rd ed.). California: Sage Publications, Inc.

Funding source:

No Funding

6.8   Cardiac

6.8.1

Patients' and partners' beliefs about treatment benefits and risks, before and four months after coronary artery bypass grafting surgery

Patricia Thomson, Lecturer, Nursing and Midwifery, University of Stirling, UK
Co-authors: C A Niven; D Peck

Abstract:

Background: Patients' beliefs about treatment may be a salient influence on health behaviours and emotions and the outcome of treatment (Hiram and Newman 2005). Patients often over-estimate the benefits of revascularisation, compared to lifestyle and medical treatment (Kee et al 1997). Partners' views about lifestyle and medication may negatively influence patient adherence to treatment (Harmer et al 2004).

Aim: To identify changes in patients' and partners' perceptions of treatment benefits and risks before and four months after CABG; to explore whether patients and partners pre-operative treatment beliefs are associated with their quality of life four months after surgery.

Methods: Data were collected from 80 cohabitating patients and partners aged 40-80 years (2003-2004). Participants were interviewed separately, when the patient went on the waiting list for elective CABG, and four months after surgery. The research nurse administered a pre-validated questionnaire in interviews lasting 20-25 minutes.

Results: Patients and partners had similar beliefs about CABG, lifestyle change and medication that did not change significantly post-operatively. Patients estimated greater mortality benefit from CABG (mean gain of 12.21 years (SD 5.85) than from lifestyle change or medication, and far in excess of the survival gain actually obtained in randomised trials (mean 8.8 months in high risk patients); and their partners a mean gain of 10.50 years (SD 4.07). They both downplayed the risks associated with CABG, and were most unsure about the benefits of increasing physical activity. Unrealistic expectations about CABG were associated with the patients' poorer post-operative mental health (p= 0.029) and partners' poorer post-operatve mental health (p = 0.041) and emotional and functional dimension (p = 0.016).

Conclusion: This study uniquely identified the participants' unrealistic expectations about treatment. Nurses need to address patients' and partners' beliefs about CABG to help counter unrealistic expectations about surgery, to improve outcomes and encourage lifestyle change.

Recommended reading:

Hirani SP, Newman SP (2005) Patients' beliefs about their cardiovascular disease. Heart 9, pp 1235-1239.

Karner A, Dahlgren MA, Bergdahi B (2004) Coronary heart disease: causes and drug treatment: spouses' conceptions. Journal of Clinical Nursing 13, pp 167-176.

Kee F, McDonald P, Gaffney B (1997) Risks and benefits of coronary angioplasty: the patient's perspective: a preliminary study. Quality in Health Care 6, pp 131-139.

Funding source:

No funding

6.8.2

Communication of individual cardiovascular risk: A practice nurse perspective

Sue Boase, Research Associate, General Practice and Primary Care Research Unit, University of Cambridge, UK
Co-author: S Sutton

Abstract:

Background: With the current shift towards prevention and health promotion in primary care (DOH 1999) practice nurses are becoming increasingly involved in discussing cardiovascular risk with patients (DOH 2002) although little is known about how this is approached.

Aim: To explore the attitudes and perspectives of primary care nurses towards communicating cardiovascular risk to patients

Methods: Two focus groups (2005) and 16 semi-structured interviews (2008) were conducted with nurses working in GP practices. Qualitative analysis was undertaken using the 'framework approach' (Ritchie and Spencer 1994) and NVIVO 8 software.

Results: Four themes were identified: the need to communicate, uncertainty, time and use of cardiovascular risk assessment tools. Opportunistic discussion of a patient's cardiovascular risk appeared common, although limited by time constraints caused by workload. There appeared to be an uncertainty and selectivity in the process. This was influenced by a judgement of the balance between seizing the opportunity when it arose against the need to know the patient beforehand. There was an awareness that there was little training on how to approach cardiovascular risk with patients. There was variation in the use of cardiovascular risk assessment tools, with a perceived advantage in being able to demonstrate change in risk level visually.

Discussion: The sense that communicating cardiovascular risk was an important part of the practice nurses' role was tempered by an uncertainty of the best way to approach this in practice. This suggests there is a need for further debate and consideration within this area of primary health care.

Conclusion: This study raises 2 important questions:

- Should cardiovascular risk be addressed opportunistically outside the context of the patient's expectations and consent to discuss?

- Should more consideration and focus be given to relevant training to support health professionals who discuss cardiovascular risk with patients in the clinical setting?

Recommended reading:

Department of Health (1999) Saving Lives – our Healthier Nation London: The Stationery Office

Department of Health (2002) Liberating the Talents – helping Primary Care Trusts and nurses deliver the NHS Plan London: Department of Health

Ritchie J, Spencer L (1994) Qualitative data analysis for applied policy research In: Bryman A and Burgess R (Eds.) Analysing Qualitative Data London: Routledge

Funding source:

1,000 – 10,000

6.9   Tools development

6.9.1

Using card sort methodology in the development of a mobile phone based intervention to assess and alleviate symptoms in children receiving palliative care

R Taylor, Department of Childrens Nursing, London South Bank University, UK
Co-authors: Susie Aldiss; M Comac; L Forbat; N Rowa-Dewar; D Murphy; F Gibson

Abstract:

Approximately 25-30% of children diagnosed with cancer require palliative care. While there are limited reports on the physical and psychological symptoms children experience during this period, the symptom burden for children dying from cancer

is recognised as being high (Theunissen et al., 2007). ASyMS©-YG is an advanced symptom management system for young people using mobile phone technology. The system was developed in consultation with young people and health professionals (Gibson et al., 2009) and involves young people recording and sending symptom reports to the hospital and receiving tailored self care advice. The integration of such technology into palliative care may provide another level of support, reduce child and parent anxiety and increase knowledge about symptoms.

The first step in this feasibility study was to identify relevant symptoms to include on the ASyMS©-Ch (child) system questionnaire and develop self-care advice. The card sort methodology (Coad & Lewis, 2004) was used with children receiving palliative care aged 8 to 16 years to determine the most common and burdensome symptoms. This method required children to select cards depicting symptoms, or words of symptoms that they had experienced the most and sort them into a pyramid with the most burdensome symptoms at the top. The cards were used to explore what the child does to try and relieve symptoms: what they find helpful and what does not work. This visual technique was a useful tool to help to engage the children in the interviews and talk with them about sensitive information.

The aim of this methods paper is to focus exclusively on the use of adapted card sort methodology as a participatory method to involve children in the development of ASyMS©-Ch.

Recommended reading:

Coad, J. & Lewis, A. (2004) "Engaging children and young people in research". Literature review for The National Evaluation of the Children's Fund, Birmingham.

Gibson, F., Aldiss, S., Taylor, R., Maguire, R. & Kearney, N. (2009) "Involving health professionals in the development of an advanced symptom management system for young people: The ASyMS©-YG Study. European Journal of Oncology Nursing". 13, 3, pp 187-1

Theunissen, J., Hoogerbrugge, P., van Achterberg, T., Prins, J., Vernooij-Dassen, M. & van den Ende, C. (2007) "Symptoms in the palliative phase of children with cancer". Pediatric Blood and Cancer, 49, 2, pp 160-165.

Funding source:

6.9.2

Renal treatment education: A patient needs assessment study

Kate McCarthy, Health Sciences Research Institute, University of Warwick, UK

Abstract:

Background: Renal guidelines recommend pre-dialysis patient education, twelve months prior to treatment commencement but do not identify the specific educational components for delivery (NICE 2008, NSF 2004).

Aims: To assess patient pre-dialysis educational needs, detecting gaps in the education currently delivered and identify potentially useful components.

Methods: Qualitative semi-structured interviews; sequential sampling of 29 respondents in 2007/8: 19 male, 10 female; aged 25 – 83 years (median 65 years); 21 haemodialysis, 8 peritoneal dialysis. Interviews transcribed verbatim. Thematic analysis using grounded theory.

Findings: Nephrology consultants and Clinical Nurse Specialists were cited as positive and beneficial education sources, in conjunction with written materials, for both educative and reference purposes. Group education sessions and expert patient contact was reported positively and peer support in groups identified. However, for some participants consultation and information giving were preferred on a one-to-one basis, due to the perception of a highly individualised disease state. Planned vicarious experience resulted in positive impacts. However, several unplanned vicarious experience resulted in negative impacts. Varied participant learning styles, were reflected in their reports of mastery. Potential educational components; expert patient contact, DVD, relaxation CD, support group, internet programmes.

Discussion: Patients' illness journey and educational need are varied. Findings suggest a single educational intervention would fail to provide the wealth, variety and individual levels of education desired. Self-efficacy theory offers a theoretical perspective on understanding patients' educational needs. Participants identified decision making and treatment choice as highly individual, influenced by medical staff and objective written information.

Conclusion: A multi-component, pre-dialysis educational intervention would provide patient education that is individualised, disease stage appropriate, enabling informed treatment decision making. Recommendation: Research to identify, trial and evaluate the educational components effective in renal treatment education, should utilise the MRC Complex Intervention Framework (MRC 2000).

Recommended reading:

Campbell, N., Murray, E., Darbyshire, J., Emery, J., Farmer, A., Griffiths, F., Guthrie, B., Lester, H., Wilson, P. & Kinmonth, L. 2007. Designing and evaluating complex interventions to improve health. British Medical Journal, 334, 455-459.

Mason, J., Khunti, K., Stone, M., Farooqi, A. & Carr, S. 2008. Educational interventions in kidney disease care: A systematic review of randomised trials. American Journal of Kidney Disease, 51, 933-953.

National Institute for Clinical Excellence. 2008. Chronic Kidney Disease Guidelines [Online]. London: NICE. Available: http://www.nice.org. uk/nicemedia/pdf/CG073NICEGuidelines.pdf [Accessed 01.10.08 2008].

Funding source:

6.9.3

Q methodology & interview analysis: An innovative approach

Katie Gallagher, Tutor, Department of Midwifery and Child Health, Kings College London, UK
Co-authors: D Porock; A Edgley; N Marlow

Abstract:

Background: Q methodology is an increasingly popular method of nursing research where investigators wish to explore the subjective account of a phenomenon. Whilst literature exists surrounding how to conduct a Q methodological study, little has been documented exploring the purpose and analysis of interviews in Q methodology.

Aim: This paper will discuss the aim and subsequent analysis of interviews undertaken as part of a Q methodological study.

Discussion: Developed in the 1930's by Psychologist William Stephenson, Q methodology was invented to provide a means in which the subjectivity involved in any situation could be revealed (Cross 2005). Q methodology involves participants rank ordering a set of statements ('Q sorting') about a phenomenon under a condition of instruction. By-person factor analysis then reveals groups of attitudes which are shared ('consensus') and which are 'distinguishing' between participants. The aim of the addition of a post Q sort interview is to determine the rationale behind individual participant's statement placement. This enhances the results as it ensures that interpretation is based upon participant's self identified influences. Interview analysis is undertaken once factor analysis is complete. Participant's transcripts are placed into their respective 'factor', and for each statement within that factor which appears as 'distinguishing' or 'consensus' respectively, individual transcripts are searched to find instances of where participants discussed their placement of this statement ('Card Content Analysis'). These instances are used in addition to the factor analysis results to interpret the emerging factors and explore participants' attitudes towards the phenomenon in question.

Conclusion: The aim of the post Q sort interview is to determine the rationale behind individual participant's statement placement. Card Content Analysis provides a framework to facilitate interview analysis by extracting this rationale from the transcripts on each respective factor to further enhance the understanding of factor interpretation.

Recommended reading:

Cross, R.M. (2005) Exploring attitudes: the case for Q methodology. Health Education Research, 20(2): 206-213

Funding source:

UK – Research Council

10,001 – 50,000

S1

Patient involvement in patient safety

Dorothy McCaughan, Research Fellow, Department of Health Sciences, University of York, UK
dmm5@york.ac.uk

Abstract:

The proposed symposium will present results from a major national project which aimed to investigate how patients (and their family members and other representatives) might appropriately be involved in their health care to effectively promote their own safety. Study data were collected between 2006-2008.

The study objectives were achieved in three main phases, each of which built on previous work. The first phase comprised a focused set of literature reviews, summarising current knowledge on patient roles, interventions and the potential for patients to contribute to reporting systems. The second phase involved primary research to generate new knowledge about patients' views on, their experiences of, and contributions to, safety in health care settings. The third phase involved developing and piloting a potential patient involvement strategy.

Findings from each of these inter-linked phases will be presented in the symposium through a series of 4 presentations:

Paper 1 will present results from 2 focussed literature reviews: a scoping review which identified how patients might be involved in promoting their own safety; and a systematic review of the effectiveness of such interventions.

Paper 2 will present findings from primary research designed to explore patientsâ ™ views and experiences of involvement in promoting, protecting and enhancing their own safety.

Paper 3 will describe a pilot approach to enhancing safety which involved individual patients feeding back their particular experiences while using NHS services to relevant clinical governance groups.

Paper 4 will describe an overview of the various types of safety incident reporting systems that have been developed in Europe and elsewhere, and the extent to which patients have been involved in the development, use and evaluation of such systems.

Individual papers would be presented by research team members. The symposium would be chaired by the study Principal Investigator, Professor Ian Watt, University of York.

Paper 1:

A focused set of literature reviews summarising current knowledge on patient safety roles and interventions

Jill Hall; Maggie Peat; Ian Watt, University of York, UK: Vikki Entwistle, University of Dundee, UK; on behalf of the PIPS Group

Background: There is growing international interest in involving patients in interventions to promote and secure their own safety.

Aims: This paper aims to report results from:

- A scoping review identifying how patients might be involved in promoting their own safety.

- A systematic review of the effectiveness of such interventions.

Methods: We searched Cochrane Database of Systematic Reviews, Database of Abstracts of Reviews of Effects, CENTRAL, CINAHL, EMBASE, HMIC, MEDLINE, MEDLINE in-process, PsycINFO and ASSIA. We also searched databases of reports, conference proceedings, grey literature, ongoing research, relevant patient safety organisations and hand searched two journals.

Main Results: 745 reports were included in the scoping review (437 descriptions of interventions, 299 comments or opinion pieces, with 42 describing patients' willingness and ability to adopt safety promoting behaviours). Three broad routes by which patients' actions might contribute to their safety were identified.

The systematic review identified 14 individual experimental and quasi-experimental studies plus one systematic review.

Discussion: We outline an approach for appraising safety interventions involving: identification of the routes by patients might contribute to their safety; identification of the necessary conditions, and support, for patients to engage in safety promoting behaviour; and consideration of the potential negative effects of interventions.

Conclusions: There appeared to be potential for patients to use their 'expert' knowledge to ensure that health professionals have appropriate information to make treatment decisions. Monitoring and delivering their own care safely also seems to be achievable by most patients, while some patients seem able to contribute to making healthcare systems safer. Importantly, facilitation of patient action by healthcare professionals or systems appears essential.

There is limited evidence for the effectiveness of interventions designed to promote patient involvement in patient safety incidents. Existing evidence is confined to the promotion of safe self-management of medication, most notably oral anticoagulants.

Paper 2:

Patients' views and experiences of patient involvement in patient safety

Dorothy McCaughan, Jill Hall, Maggie Peat, Yvonne Birks, Ian Watt, University of York, UK; Vikki Entwistle, Brian Williams, University of Dundee, UK on behalf of the PIPS Group

Background: Although many organisations offer advice to encourage patients to adopt safety promoting behaviours (Weingart et al 2009), little is known about patients' views of their potential contributions, or the acceptability of such interventions from the patients' perspective (Davis et al 2007).

Aims:

- To present study findings relating to:

- Patients' awareness of and concerns about health care safety.

- A range of situations in which patients (or their representatives) acted (or considered acting) to help secure their own safety.

- Patients' views about various specific safety roles.

Methods: In-depth interviews (N=71) and focus groups (N=12; 68 participants) were used to explore patients' views and experiences of safety in relation to using health care services. Study participants were strategically sampled from six different clinical groups. Data were collected during 2007-2008. Transcripts were analysed using 'Framework' approach (Ritchie & Lewis 2003) and role theory used to interpret findings.

Results: Study participants expressed a desire to be involved in promoting and enhancing their own safety, but indicated that their willingness and ability to adopt patient safety roles would be affected by a range of factors relating to themselves as individuals; their relationship with health care professionals; contextual factors; and features of the wider health care system.

Conclusions: It would appear that recommendations for consistent or blanket adoption of patient safety roles may not be appropriate, and that patients can not, and should not be expected to, routinely adopt safety roles as a means of acting as a safety check in their own care.

Discussion: Health care professionals may potentially enhance patient engagement in safety through the provision of a broadly supportive environment. To be able to offer patients the time and attention that might facilitate their involvement, health care professionals need to be supported within the wider health care system.

References:

Davis, R., Jacklin, R., Sevdalis, N. and Vincent, C. (2007) Patient involvement in patient safety: what factors influence patient participation and engagement? Health Expectations 10, 259-267.

Ritchie, J. and Lewis, J. (2003) Qualitative Research Practice. London: Sage

Weingart, S., Morway, L., Brouillard, D. et al (2009) Rating Recommendations for Consumers about Patient Safety: Sense, Common Sense or Nonsense? The Joint Commission Journal on Quality and Patient Safety 35, 4, 206-215.

Paper 3:

Using patient stories to enhance safety in healthcare: An exploratory study

Maggie Peat, Jill Hall, Ian Watt, University of York, UK; John Wright, Bradford Teaching Hospitals NHS Foundation Trust, UK; on behalf of the PIPS Group

Background: Many patients are reluctant to adopt safety promoting behaviours because they perceive that the current culture within healthcare is not receptive to patient reports of safety threats and because they fear adverse consequences for their treatment (Entwistle 2005; Wachter 2004).

Aims:

• To present findings from a pilot intervention that used patient 'stories' (experiences) to facilitate interaction between patients and healthcare professionals and to challenge professional norms about patient experience and involvement.

• To describe the evaluation of this approach in terms of feasibility, acceptability and perceived usefulness.

Methods: We designed and modified an exploratory approach that involved five patients feeding back their safety experiences while using NHS services to five clinical groups, either in person and/ or using a DVD. This small scale pilot study took place in 2008. We evaluated the approach through patient and clinical group feedback via post-intervention discussion, questionnaires, and a researcher diary.

Main Results: The intervention was largely evaluated by staff as feasible, acceptable and useful. While staff had initial concerns about the appropriateness of the clinical governance group meeting as a forum for patient stories and about patients feeling intimidated by the setting, these concerns were not realised in practice and the stories stimulated discussion, reflection and pledges for action.

Conclusion: Patient stories are a feasible and potentially effective method of enhancing patient safety and clinical governance groups would seem to provide an appropriate forum for patients and clinical teams to discuss and learn from stories based on safety experiences.

Discussion: Results from this small scale pilot study must be interpreted with caution. Limitations of the intervention included time and resource constraints in preparation of both patients and clinical groups. Nonetheless, this approach shows promise for helping ensure that quality and safety improvement through clinical governance is truly patient centred.

References:

Entwistle, V.A., Mello, M.M. and Brennan T.A. (2005) Advising Patients about Patient Safety: Current Initiatives Risk Shifting Responsibility. Joint Commission Journal on Quality and Patient Safety 31, 9, 483-494.

Wachter R.M. and Shojania K.G. (2004) The faces of errors: a case-based approach to educating providers, policy makers and the public about patient safety. Joint Commission Journal on Quality and Safety 30 (12), 665-670.

Paper 4:

The patient contribution to adverse event reporting systems

Yvonne Birks, University of York, UK, on behalf of the PIPS Group

Background: A number of countries now have reporting systems either for medical error/harm or for adverse events or both, some of which accept reports from patients. The development and implementation of such systems has been designated a major national priority in the UK (DoH 2000) and elsewhere (Kohn 2000).

Aims: This study aimed to:

• Investigate how the various types of safety incident reporting systems have been developed and how they have solicited, received and used reports from patients and their representatives.

• Ascertain the extent to which patients have been involved in the system's development and evaluation.

Methods: A list of reporting systems which accept reports from patients and the public was developed from a variety of sources, including: examination of several overviews and reports of reporting systems; individual papers which describe or evaluate reporting systems; internet searches for reporting systems. An identified contact was sent a copy of a short questionnaire which requested details of how or if patient involvement influenced the design and evaluation of the system as well as information about the number and proportion of patients' reports received.

Results: Thirteen systems in a variety of countries were identified and their individual characteristics noted and reported. The majority of reporting systems identified demonstrated little real engagement/involvement with or by patients. Exceptional systems were identified, however, where patient reports had been successfully captured and used in reporting and learning.

Conclusions: Potential strategies to increase patient engagement with reporting include: designing systems in consultation with patients; ensuring systems are appropriately publicised; and providing evidence that patient reports are used to support learning by professionals and systems.

Discussion: If the way in which reporting systems treat patients' reports is clear and patients perceive their reports as useful and treated seriously, they may be more likely to provide reports.

References:

Department of Health (2000) Department of Health Expert Group on Learning from Adverse Events in the NHS. An Organisation with a Memory. London: Department of Health

Kohn, L., Corrigan, J. and Donaldson, M. (eds) (2000) Committee on Quality of Healthcare in Amercia To Err is Human: Building a Safer Healthcare System. Washington: National Academy Press.

S2

Strategic development of nursing and midwifery R&D: A regional approach

Tanya McCance, Mona Grey Professor for Nursing R&D, Belfast Health and Social Care Trust, Central Nursing & Midwifery Group/Institute of Nursing, UK

Abstract:

This symposium will present a portfolio of work that is being progressed within Northern Ireland, which focuses on the strategic development of nursing and midwifery R&D. The work is being co-ordinated by the R&D Subgroup of the Central Nursing Advisory Committee (CNAC), a statutory committee that is constituted with the purpose of advising the Chief Nursing Officer on a range of nursing and midwifery issues. The remit of the R&D Subgroup of CNAC (CNAC R&D) reflects this advisory function, with the emphasis on influencing the strategic direction of nursing & midwifery R&D in Northern Ireland.

The papers included in this symposium will present workstreams that are aimed at supporting and enhancing nursing and midwifery R&D in line with the national agenda.

Paper 1 will provide the strategic context within Northern Ireland that has supported the development of nursing & midwifery R&D.

Paper 2 will describe a project aimed at articulating what is understood by 'development' in the context of R&D, emphasising the importance of recognising the spectrum of activity that can contribute to innovation and knowledge generation.

Paper 3 will describe scoping activity that provides essential insights into building capacity and developing an infrastructure that supports nursing & midwifery R&D.

Paper 4 presents models of mentorship drawn from the literature and from discussions with recognised research leaders.

The final paper, paper 5, will draw together the key issues addressed in papers 1 to 4, by reflecting on the quality of nursing and midwifery R&D nationally and internationally, highlighting issues for the future development.

Paper 1:

Providing the strategic context

Tanya McCance, University of Ulster /Belfast Health and Social Care Trust, UK

The R&D landscape in nursing and midwifery has undergone significant developments in the last decade. The culture of evidence based practice highlighted by clinical governance and service improvements through the modernisation agenda, places a responsibility on all professionals to ensure that their practice is grounded in sound evidence. In Northern Ireland, priorities for R&D within Health and Personal Social Services (HPSS) have been guided by the Research & Development Office (established in April 1998), through the R&D strategy 'Research for Health and Well-being' (R&D Office 1999). It is recognised that nursing and midwifery R&D has progressed within Northern Ireland, since the establishment of the R&D Office, and particularly since the work undertaken by McKenna & Mason (1998) and more recently by McCance & Fitzsimons (2005). Furthermore, this progress has been influenced and shaped by developments at national level, and indeed the radical review of health and social care structures within Northern Ireland. The DHSSPS, through the Chief Nursing Officer, continues however to recognise the need to evaluate developments in nursing and midwifery R&D and the importance of progressing this agenda in a planned, cohesive and systematic manner. This paper will present the strategic context within which the work of CNAC R&D currently sits.

References:

McCance T.V. & Fitzsimons D. (2005) Using and Doing Research: Guiding the Future. Northern Ireland Practice and Education Council for Nursing and Midwifery, Belfast.

McKenna H.P. & Mason C. (1998) Nursing and the wider R&D agenda: Influence and contribution. NT Research 3(2), 108-115.

Research and Development Office. (1999) Research for Health and Well-being. R&D Office, Northern Ireland.

Paper 2:

A creative concept analysis of "Development" in the context of R&D

Liz Henderson, Northern Ireland Cancer Network, UK

Through discussion and debate within CNAC R&D and from the findings presented by McCance & Fitzsimons (2005), it became apparent that although the phrase "Research and Development" is frequently used, the term "development" means different things to different people. It was agreed that a definition of "development" in the context of research, would be a worthwhile activity, as clarity of meaning may help to garner support for future nursing R&D.

A workshop session was subsequently held to clarify the meaning of "development". Colleagues with an interest in and experience of developing practice work, as well as those with organizational responsibility for leading it, were invited to attend. Using an inductive approach, a creative concept analysis was undertaken, drawing on participants' experience, knowledge and understanding of development activity. The outcome of the workshop was an agreed list of pre-requisites, attributes and consequences of "development" in the context of R&D.

From the attributes, a draft definition of the concept "development", in the context of R&D, was crafted, shared, critiqued and refined. It is postulated that "D" in the context of R&D is the implementation of evidence that is applied systematically to innovate or improve practice, requires evaluation in order to demonstrate clear outcomes, and has the potential to generate new knowledge. A mapping template was created and the definition subsequently tested against a number of case studies, including: a practice development project, a regional audit and a service improvement project. The definition is also being tested against the concept of "knowledge transfer".

This session will outline the processes used, expose the suggested definition for further debate, and report on the testing of the definition against case studies.

References:

McCance T.V. & Fitzsimons D. (2005) Using and Doing Research: Guiding the Future. Northern Ireland Practice and Education Council for Nursing and Midwifery, Belfast.

Paper 3:

Scoping organisational infrastructure and capacity

Carolyn Mason, RCN, UK; Gillian McCorkell, Western Health & Social Care Trust, UK

This workstream aims to assess the organisational infrastructure to support R&D in nursing and midwifery, and the current clinical research capacity and capability of the workforce across the five health and social care Trusts in Northern Ireland.

A benchmarking tool is being used to assess the extent to which HSC Trusts can demonstrate: strategic developments for nursing and midwifery R&D; and the extent to which they can demonstrate an infrastructure that supports nursing and midwifery R&D activity. Nursing and midwifery R&D capacity in the HSC Trusts will also be assessed. This will focus on the number of nurses and midwives with completed PhDs and Masters degrees, and the number of nurses and midwives who are currently undertaking these degrees. Scoping activity will also be undertaken to establish the number of nurses and midwives working in clinical trials across the Trusts in Northern Ireland. Initial work will involve the use of focus groups with key stakeholders, defined as those who have a vested interest in the role of the clinical research nurse. This initial work will provide insight into the variety of roles undertaken by Clinical Research Nurses (CRNs) within a Northern Ireland context and the different working models currently in existence.

This is the first time that such baseline information has been sought in Northern Ireland, in a way that brings together the recommendations of the Finch Report and those of the Northern Ireland Using and Doing Research report. As such, it will provide an important starting point from which to identify

gaps and build an action plan for harnessing and building capacity and capability for the future. Furthermore, gaining an understanding of research activity at local level can help inform the development of clinical academic careers in Northern Ireland.

Paper 4:

Models of mentorship in nursing R&D

Donna Fitzsimons, University of Ulster / Belfast Health & Social Care Trust, UK

Background: Mentorship is an important mechanism for developing new talent in any discipline. A review of the literature found few examples of successful models of mentorship for nursing research and development internationally. The aim of this work stream was to develop a model of mentorship for nursing research in Northern Ireland that was based on best practice.

Approach: In order to develop an evidence based programme of mentorship for nurse researchers semi-structured interviews with (n= 5?) identified experts were conducted and transcribed prior to qualitative analysis.

Findings: It was evident from the data that most of these experts in R&D had a wide variety of career histories and that they attributed their success to many different issues. Most described the personal difficulties and challenges they had encountered in their career and outlined a number of different strategies by which they had negotiated these. The Clinical Academic Careers Framework was highlighted as one potential mechanism for developing improved mentorship but all participants stressed that this should not be the only initiative we rely on as a profession. There was recognition that health care trusts and professional organisations must see a tangible benefit in employing nurses with advanced R&D skills if they are going to invest in their development. This will require more integration of HPSS priorities into nursing R&D programmes. Individual nurses need to spot opportunities, develop stronger networking ability, and creatively source funding opportunities in order to develop a career in nursing R&D.

Conclusions: This paper draws on best evidence in the literature and the experience and views of recognized experts to develop salient features on which a mentorship model for nurse researchers can be built.

Funding source:

No Funding

Paper 5:

Looking to the future

Hugh McKenna, Dean of the Faculty of Life and Health Sciences, University of Ulster

Internationally, nursing research has come a long way in a relatively short period of time. However, we still have a substantial distance to travel. The profession should be pervaded by a culture of research where knowledge generation, testing and application for improved care are the norm. To establish such a research culture requires at least three major essentials:

- A commitment to become known as a scholarly discipline.
- Qualified leaders to guide the planning and development of such an undertaking.
- Financial and other resources to support the endeavor.

Clinical Academic Career pathways are an important aspect of this culture. They provide invaluable avenues for nurses to project a career trajectory and pursue clinical and research careers that heretofore were not available. This opens up opportunities for nurses to engage in exciting careers that link research, teaching, and practice in the clinical setting. Across the world, academic staff need to pay closer attention to this linkage for they will be the main mentors for this cadre of clinical academic nurses. It will be argued that, properly resourced, such career paths will make an impact on scholarship and clinical leadership far beyond expectation. People in need of health care in the UK and around the globe deserve these highly qualified nurses who can provide the best possible evidence-based care at the bedside and in the community, and generate new knowledge that will augment their practice and that of others. This paper will present the national and international context within which capacity building has to be established and thrive.

Funding source:

No Funding

Going to the PROM? Are patient reported outcome measures (PROMs) a useful tool to measure the impact of nursing interventions?

Simon Palfreyman, Research Nurse, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Vascular Institute, UK

Abstract:

PROMs are short, self-completed questionnaires, which measure the patient's health related quality of life (HRQoL) at a single point in time. Information from the patient provides a means for collecting information on the clinical quality of care. Measuring these health benefits to patients allows clinical interventions to be evaluated and their cost effectiveness to be determined.

The symposium will consider ways of evaluating outcomes of nursing interventions. It will outline the development and application of PROMs (Patient Reported Outcome Measures) and their potential for use within economic evaluations of nursing interventions. Details of how PROMs are developed will be discussed and the presenters will share their experience of constructing both generic and a disease-specific PROMs for their PhDs. The session will be Chaired by Professor John Brazier, Director of Health Economics, ScHARR, Sheffield. He has published widely on the measurement and valuation of health for economic evaluation. The session will also explore the key challenges of measuring outcomes in nursing and the pros and cons of using PROMs within assessments of nursing care. The challenges of developing PROMs for different groups will be discussed through different papers presenting the experiences of those who are either currently undertaking or have recently completed their PhDs.

Paper 1:

An introduction to health economics, health related quality of life and PROMs

John Brazier, University of Sheffield, UK

This paper will provide the context to the symposium by describing the link between economic evaluation, health related quality of life (HRQoL) and PROMs. It will provide an outline of the history and use of PROMs within healthcare, and identify how PROMs are used to measure the outcome of clinical interventions.

A large number of PROM questionnaires are in existence, most of which define health status in terms of various dimensions, e.g. mobility, pain, mental health, etc., with each dimension having a number of levels indicating different degrees of severity. These can be grouped into those which define health in general terms, generic questionnaires, and those which focus on the attributes
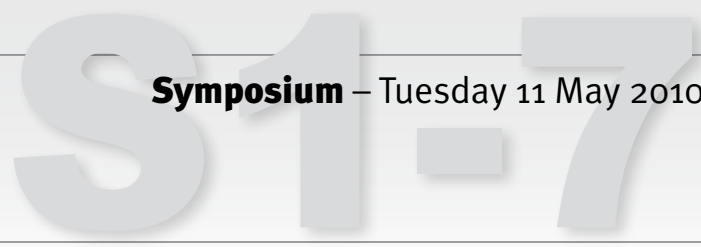
of health associated with a particular condition: disease-specific questionnaires. The aim will be to provide an overview to the subject area and emphasise the importance of being able to measure patient outcomes in order to decide on the allocation and funding of healthcare interventions. It will describe the origins of PROMs and the use of HRQoL as an outcome measure. The potential importance of the report published in the UK by Lord Darzi, 'High Quality Care for All' (Darzi 2008) will be discussed. This report advocated that care should be based on: 'what we can actually measure'. It proposed that this could be achieved through the routine collection of PROMs data. Finally, the symposium will detail how QALYs (Quality Adjusted Life Years), which are used by bodies such as NICE to decide on which treatments to fund, can be calculated from PROMs. It will explain how QALYs bring together information on length of life (mortality) and quality of life into a single measure. It will also highlight the benefits and problems of using QALYs as a measure of effectiveness.

References:

Darzi, A. (2008) High Quality Care for All, HMSO, London.

Drummond, M. F., Sculpher, M. J., Torrance, G. W., O'Brien, B. J., & Stoddart, G. L. (2005) Methods for the Economic Evaluation of Health Care Programmes, 3rd edn, Oxford University Press, Oxford.

Testa, M. A. & Simonson, D. C. (1996) "Current concepts: assessment of Quality of life outcomes", New England Journal of Medicine, vol. 334, no. 13, pp. 835-840.

Paper 2:

Why nurses need to understand about measuring outcomes, PROMs and economic evaluations

Simon Palfreyman, Sheffield Teaching Hospitals NHS Foundation Trust, UK

This paper will focus on the importance of nurses being able to describe the impact of their interventions on patient outcomes and advocate that PROMs should form a component of the evaluation of nursing interventions.

The nursing profession's response to the Darzi report, was to commission a review of the current state of nursing outcome by the National Nursing Research Unit (NNRU) to try and establish the link between nursing practice and patient outcomes (Griffiths 2008). The review identified 21 potential indicators from a total of a 123 different sources, and recommended, with reservations, three areas that may be of use: safety, effectiveness and compassion. These indicators will be discussed and the potential advantages and disadvantages highlighted. A critical examination will be presented of

the reliance on auditing the presence or absence of these metrics as a basis for establishing whether nursing interventions are effective. It will be advocated that a better measure of effectiveness would be to use the criteria currently employed by UK Government agencies such as NICE. The basis for their decisions is an assessment of the impact of a treatment on the patient's quality of life using PROMs.

Finally, the conversion of PROMs into preference-based forms so that they can be used to calculate QALYs and so used in economic evaluations will be described. Emphasis will be placed on the need for the different dimensions (aspects) of health contained in PROMs to be combined in such a way as to provide an overall indicator of health (Brazier et al. 2007) and that it should take account of the relative importance of the different dimensions (Neumann et al. 2000).

References:

Brazier, J., Ratcliffe, J., Tsuchya, A., & Salmon, J. (2007) Measuring and valuing health benefits for economic evaluation. Oxford University Press, Oxford.

Griffiths, P. (2008) "Metrics for nursing", Nursing Management – UK, vol. 15, no. 8, pp. 10-12.

Neumann PJ, Goldie SJ, Weinstein MC. (2000) Preference-based measures in economic evaluation in health care. Annual Review of Public Health 2000; vol. 21, pp 587-611.

Paper 3:

Challenges encountered in developing PROMS: The experience so far in the creation of a PROM for amblyopia in the paediatric population

Jill Carlton, University of Sheffield, UK

This paper will describe the progress in developing a PROM as part of a PhD. It will highlight the practical and methodological hurdles related to the development of PROMs and also the researcher's challenges in conducting the project.

The key stages involved in developing PROMs are consideration of the patient group (i.e. target condition, how the illness impacts on their quality of life, and what items to include in the questionnaire). The subjective nature of quality of life means that the clinician and patient perspective are likely to be different. It could therefore be argued that the best people to ask when developing PROMs are the patients. Historically the development of PROMs has relied upon "experts", usually medical staff, or has incorporated items identified from previous questionnaires. One limitation of this approach is that clinicians tend to either overestimate or underestimate the impact of a condition on quality of life.

The study described in this paper will use a bottom-up approach to identify items related to the impact of amblyopia on children. Amblyopia is defined as defective visual acuity in one or both eyes and is treated in childhood, by occlusion therapy (wearing an eye-patch). Although literature exists investigating the impact of occlusion therapy upon family life few studies have addressed the effect of occlusion therapy upon HRQoL from the child's perspective.

The paper will describe the process by which the need to develop a PROM to measure the impact of the treatments for amblyopia and the researcher's efforts to secure funding to develop such a measure. It will outline the problems encountered in defining, gaining access to and interviewing this group of patients. It will pay particular attention to detailing the research governance and methodological hurdles encountered.

References:

Woodruff G, Hiscox F, Thompson JR. (1994) Factors affecting the outcome of children treated for amblyopia. Eye; 8: 627-631

Theunissen NCM, Vogels GC, Koopman HM, Verrips GHW, Zwinderman KAH, Verloove-Vanhorick SP, Wit JM. (1998) The proxy problem: child report versus parent report in health-related quality of life research. Quality of Life Research; 7: 387-397

Shotton K, Powell C, Voros G. (2005) Interventions for refractive amblyopia (protocol). In: The Cochrane Library. Chichester, UK: John Wiley & Sons, Ltd.

Paper 4:

Development of a preference-based PROM for use in a paediatric population

Katherine Stevens, University of Sheffield, UK

This paper provides an example of the development of a generic PROM designed for use in children; the Child Health Utility (CHU9D) to illustrate the advantages and disadvantages of using these measures.

Background: There are currently around 30 different generic paediatric PROM measures. None have been explicitly developed for use in economic evaluation or used a bottom-up approach using children to determine their content.

Methods: Items for inclusion and wording for the item levels were identified through a series of interviews with children aged 7-11 years. All interviews were recorded, transcribed and thematic content analysis tused to identify dimensions of health related quality of life. Levels for each of the dimensions were developed using data from the interviews and further ranking work with children to determine the ordinality. The PROM was tested on both a general and clinical paediatric population and refined as necessary. Finally, preference

weights were obtained from a sample of the UK general population which give a utility (preference) value to each health state defined by the descriptive system, allowing the calculation of quality adjusted life years (QALYs) for use in paediatric health care resource allocation decisions.

Results: A total of 74 interviews were undertaken with children with a wide range of acute and chronic conditions, Eleven dimensions of HRQoL were identified including physical, emotional and social aspects. These 11 dimensions were developed into a descriptive system which demonstrated good practicality and validity amongst the general and clinical paediatric populations. Further refinement led to the elimination of two dimensions to give a nine dimensional measure. Preference weights were successfully developed for each health state defined by the PROM classification system, allowing the calculation of quality adjusted life years (QALYs).

Conclusion: The study resulted in a valid measure that can be used to determine the outcome of interventions within the paediatric population.

References:

Petrou S. (2003) Methodological issues raised by preference-based approaches to measuring the health status of children. Health Economics. 12: 697-702.

Riley AW. (2004). Evidence that school-age children can self-report on their health. Ambulatory Pediatrics; 4(4):371-376.

Stevens, K. J. (2008) Working with children to develop dimensions for a preference based generic paediatric health related quality of life measure. Health Economics and Decision Science Discussion Paper 08/04. Available from http://www.shef.ac.uk/scharr/sections/heds/discussion.html

Funding source:

UK – Research Council

50,001 – 100,000

Paper 5:

The development of a preference-based, condition specific PROM for use with patients who have venous leg ulcer

Simon Palfreyman, Sheffield Teaching Hospitals NHS Foundation Trust, UK

The final paper reports the development of a disease-specific PROM developed for use with patients having venous ulcers: The Sheffield Preference-based Venous Ulcer questionnaire (SPVU-5D).

Methods: Qualitative methods including semi-structured interviews and focus groups were used to identify items for inclusion in the new instrument. Levels for the items were allocated and a draft questionnaire developed. Item reduction was undertaken using data from a postal survey of 262

patients and based on item performance, factor and Rasch analysis. A time trade-off (TTO) valuation by 160 members of the general public of 25 selected health states was used to estimate preference weights for all of the health states described by the instrument.

Results: A total of 16 potential items were identified from interviews with 19 patients and 12 clinicians. Items were discarded based on poor completion rates, evidence of floor ceiling effects, poor fit to the Rasch model and disordered levels. The final instrument consisted of five items which had between three and five levels. The TTO data was used to estimate regression models to derive level coefficients for the items in the instruments. The predictive performance of the models was compared to the actual values from the TTO valuation. The model predicted 25 out of the 26 health states to within 0.1 and 24 within 0.05.

Conclusion/ Discussion: None of the current condition-specific PROM instruments have preference weights for the health states they describe and so can not be used to derive Quality Adjusted Life Years (QALYs). This means that they are limited in their use within economic analyses. This study used a bottom-up approach to develop an instrument specifically for use within cost-effectiveness and cost-utility economic analyses. The SPVU-5D is currently the only instrument of its type for use with venous leg ulcer patients.

References:

Palfreyman SJ, Michaels JA, Brazier JE (2007). Development of a tool to examine the effect of venous ulcers on patients' quality of life. Nursing Standard 21 (45), 57-69

Palfreyman, S. (2008) Assessing the impact of venous ulceration on quality of life. Nursing Times; 104: 41, 34-37.

Streiner, D.L. & Norman, G.R. (1995) Health Measurement Scales. A Practical Guide to their development and use. 2nd ed. Oxford University Press. Oxford.

Funding source:

UK – Research Charity/Foundation

50,001 – 100,000

Developing and evaluating complex healthcare interventions: Where to start?

Susan Kerr, Reader, Glasgow Caledonian University, School of Health, UK

Symposium statement:

The symposium will focus on three programmes of research currently being undertaken in the School of Health, Glasgow Caledonian University. These programmes have taken a staged approach to the development and testing of lifestyle interventions designed to improve health. The MRC Framework for the development and evaluation of complex healthcare interventions guides this staged approach [1].

Interventions which aim to encourage and support lifestyle change are often 'complex', as they comprise several interacting components, have a range of possible outcomes and may target a heterogeneous population. A key consideration in the development and evaluation of complex interventions relates to practical effectiveness i.e. whether the intervention is likely to work in everyday practice. Another feature for consideration is determining which components of the intervention are effective in a particular context and with a particular population. It is only by addressing these questions that researchers/practitioners can develop an understanding of causal mechanisms, design more effective interventions and apply them appropriately across populations and settings [1].

Before undertaking a full-scale evaluation of the cost-effectiveness of an intervention, the intervention should be developed to a point where it can reasonably be expected to achieve its intended outcomes. Guided by the MRC framework, the development process involves identifying current evidence (systematic review/s), developing the evidence base (primary research and evidence synthesis activities), identifying/developing appropriate theory, and modelling or testing the intervention and outcomes [1].

The symposium will open with a discussion of the merits of using the MRC's iterative framework to guide the development of programmes of health promotion/lifestyle research. This will be followed by three papers, which exemplify the importance of conducting evidence-building and other developmental work prior to undertaking definitive trials of complex healthcare interventions.

References:

(1) MRC (2008) Developing and evaluating complex interventions: new guidance www.mrc.ac.uk/interventionsguidance

Paper 1:

Developing and evaluating complex interventions: The new MRC guidance

Susan Kerr, Glasgow Caledonian University, UK

This introductory paper will set the scene by discussing the new MRC framework [1] for developing and evaluating complex interventions. Guided by the content of the framework, areas discussed will include:

• What makes an intervention complex?

• The development-evaluation-implementation process

• Assessing feasibility and piloting methods

• Evaluating a complex intervention

• Implementation

Three papers will follow that discuss the utility of the Framework in the development and conduct of programmatic research:

Paper 1 – Developing and testing smoking cessation support for people with severe and enduring mental health problems

Paper 2 – Developing complex family-centred interventions to prevent stroke re-occurrence

Paper 3 – Addressing the tobacco and alcohol-related health promotion needs of people with learning disabilities

References:

(1) MRC (2008) Developing and evaluating complex interventions: new guidance www.mrc.ac.uk/interventionsguidance

Funding source:

No Funding

Paper 2:

Developing and testing smoking cessation support for people with severe and enduring mental health problems

Susan Kerr, Glasgow Caledonian University, UK; Charlotte Woods, Glasgow Caledonian University, UK; Robert Hunter, University of Glasgow, UK; Christina Knussen, Glasgow Caledonian University, UK; Hazel Watson, Glasgow Caledonian University, UK; Robin McCreadie, NHS Dumfries & Galloway, UK; Murray Lough, NHS Education for Scotland, UK; Barry Gibson-Smith, NHS Greater Glasgow & Clyde, UK

Background: National surveys have demonstrated that smoking is 2-3 times more common in people with mental health problems than in the general population [1]. UK public health policy highlights the need to develop tailored smoking cessation services for this client group, as there is strong evidence that simply applying/intensifying interventions known to reduce smoking in the general population is unlikely to be effective [2]. While the need to develop and test tailored services has been recognised, there is a dearth of evidence to inform the development and delivery of appropriate services [3].

Aim: We aim to develop and test an intensive smoking cessation intervention for people with severe and enduring mental health problems. This paper will discuss the developmental phase of the programme of research.

Method: Undertaken in 2007/08, the study adopted a qualitative approach, underpinned by social cognitive theory. Participants were recruited purposively from three Scottish NHS Boards and included 37 service users and 60 professionals working in community-based mental health teams. Data were collected using semi-structured interviews. When analysing the data an ethnographic content analysis approach was used to facilitate understanding and to explore conceptual links.

Findings: The presentation will highlight the complex interplay of factors that influence the use of tobacco in people with mental health problems, including cessation attempts. Issues such as emotional coping, observational learning, identity, outcome expectancies, motivation, self-efficacy and the role of health and social care professionals will be discussed.

Discussion/Conclusion: The findings from this developmental study, and other relevant research-based evidence, have been used to design an exploratory trial that will assess the feasibility of a behavioural intervention based on the principles of cognitive behavioural therapy. The intervention will include the use of nicotine replacement therapy. On completion of the exploratory trial our next step will be to undertake the definitive trial.

References:

(1) Coulthard M, Farrell M, Singleton N & Meltzer H. Tobacco, alcohol and drug use and mental health. London, Stationery Office, 2002.

(2) Naidoo B, Warm D, Quigley R, Taylor L. Smoking and public health: a review of reviews of interventions to increase smoking cessation, reduce smoking initiation and prevent further uptake of smoking. London, Health Development Agency, 2004

(3) Kerr S, Watson, H, Hunter R, McCreadie R, Lough M, Gibson-Smith B, Knussen C, Woods C Reducing the prevalence of smoking in people with mental health problems: a Phase 0/1 trial. Final Report to the MRC/NPRI, 2008.

Funding source:

UK – Research Council

10,001 – 50,000

Paper 3:

A family-centred approach to the management of lifestyle risk factors for recurrent stroke

Maggie Lawrence, Glasgow Caledonian University, UK; Susan Kerr, Glasgow Caledonian University, UK; Caroline McVey, Lisbeth Hockey Research Fellow/Public Health Nurse, UK; Dorothy Ferguson, Glasgow Caledonian University, UK

Background: Stroke is a common long-term condition which recurs in 20-25% of patients within five years. It is the most common cause of adult disability in the UK. Modifiable risk factors for recurrent stroke include lifestyle behaviours that are influenced by family life i.e. tobacco use, alcohol consumption, poor diet and physical inactivity, yet stroke patients/families have reported receiving little or no secondary prevention (SP) information. A systematic review [1] highlighted the limited nature of the current evidence base. Four interventions were identified; none adopted a family-centred approach and only one described a theoretical underpinning. The interventions reported little/no significant effect on lifestyle behaviours.

Aim: We aim to develop a family-centred behavioural intervention, which will address lifestyle risk factors for recurrent stroke. This paper reports the evidence gathering/synthesis element of this programmatic research.

Methods: In 2007, a postal survey of the members of the Scottish Stroke Nurse Forum, ascertained stroke nurse practice in relation to SP interventions. In 2008, focus groups enabled an understanding of the experiences of people who have had a stroke (PwS)/family members (FMs) regarding SP interventions.

Theory: As family systems nursing and behaviour change are complex issues, we selected the Calgary Family Assessment/Intervention Model [2] and the Theory of Planned Behaviour [3] as the theoretical underpinning for our work.

Results: The survey response rate was 54.8% (n=97). The results demonstrated that whilst stroke nurses reported engaging in SP activities, they did not demonstrate knowledge of evidence-based guidelines. Using purposive sampling, twenty-seven PwS and twenty-two FMs participated in focus groups. They reported receiving little/no SP information, they had difficulty accessing support services and found health promotion messages contradictory and confusing.

Discussion/Conclusions: The evidence gathered and synthesised here will inform the next stage of our research, in which a family-centred behavioural intervention will be developed and evaluated.

References:

(1) Lawrence M, Kerr S, Watson H, Jackson J, Brownlee M. A survey of stroke nurses' knowledge and practice regarding four secondary prevention lifestyle issues: tobacco use, alcohol consumption, diet and physical activity. British Journal of Neuroscience Nursing 2009; 5(11):

(2) Wright, L.M., Leahey, M. Nurses and families. 4th ed. Philadelphia: F.A. Davis Company, 2005

(3) Ajzen I. The theory of planned behaviour. Organizational behaviour and human decision processes 1991; 50:179-211.

Paper 4:

Addressing the alcohol and tobacco-related health promotion needs of people with learning disabilities

Alan Middleton, Glasgow Caledonian University, UK; Chris Darbyshire, Glasgow Caledonian University, UK; Lorna Fitzsimmons, Glasgow Caledonian University, UK; Maggie Lawrence, Glasgow Caledonian University, UK; Susan Kerr, Glasgow Caledonian University, UK

Background: In recent years there has been increasing concern regarding the mortality, morbidity and behavioural determinants of health in people with learning disabilities (PwLD) [1]. The need for tailored health promotion interventions has been recognised [2]; however, while there is some evidence of activity linked to diet, physical activity and sexual health, there has been a limited focus, to date, on smoking and alcohol consumption [3].

While the prevalence of smoking and excessive alcohol consumption in PwLD is lower than in the general population [3], levels do present a cause for concern, and the prevalence is rising, linked to the increase in independent living [3]. While the need for tailored services has been identified [2]; there is a dearth of evidence to inform the development/delivery of appropriate interventions.

Aim: We aim to develop and test tobacco and alcohol-related health promotion interventions for PwLD. This paper reports the evidence gathering/synthesis element of this programme of research.

Methods: In 2009, following a systematic review of the literature (SR), purposive sampling methods were used to recruit 16 PwLD, 15 health/social care professionals and two family carers from two Scottish NHS Boards. Underpinned by social cognitive theory, qualitative data were gathered during focus groups and telephone interviews.

Findings: The SR highlighted only five studies that have assessed the effectiveness of smoking/alcohol-related interventions for PwLD. All have major methodological limitations; however, some important issues regarding the feasibility and appropriateness of interventions were identified

The qualitative findings demonstrate the personal and environmental factors that influence the use of tobacco and alcohol in people with PwLD, including attempts to stop smoking or reduce alcohol consumption.

Discussion/Conclusions: Synthesis of the evidence-gathering elements of this study has established a robust evidence-base upon which to found the development of person-centred tobacco and alcohol-related interventions for PwLD.

References:

(1) Emerson, E, Turnbull, L. Self-reported smoking and alcohol use amongst adolescents with intellectual disabilities. Journal of Intellectual Disabilities 2005; Vol. 9(1): 58-69

(2) NHS Health Scotland. Health Needs Assessment Report. People with Learning Disabilities in Scotland. Glasgow: NHS Scotland, 2004

(3) Lawrence M, Kerr S, Darbyshire C, Middleton A, Fitzsimmons L. Tobacco and alcohol use in people with learning disabilities: giving voice to their health promotion needs. Final Report to the Queen's Nursing Institute. Glasgow: Glasgow Caledonian University, 2009

S5

Consenting children for clinical research: The realities and the potential

Margaret Fletcher, Reader in Children's Nursing, University of the West of England, School of Health and Social Care, UK

Abstract:

This symposium explores the complex, disputed and difficult area of consenting children to take part in clinical research studies.

Differences exist between respected experienced researchers, relating to everything from the notion of assent vs. consent through to the age at which a child's assent or consent should be formerly sought. These personal differences impact significantly upon approaches to involving children both within and between research teams.

The four papers are:

1. The pressures felt by the nurse gaining consent (Margaret Fletcher), explores the issues which concern the research nurse when communicating information and gaining consent from parents and children within clinical studies.

2. Patient information for children – leading to fully informed consent? (Margaret Harper), examines that much loved and much hated device, the patient information sheet (PIS) and its near relatives. The issues explored include content, presentation and requirements for approval – of all stakeholders. Appropriate, well designed and presented information is a powerful tool in the bid to inform. Complex, poorly designed and presented information helps no-one, least of all the patient.

3. Children's consent and paediatric research; is it appropriate for healthy children to be the decision-maker in clinical research? (Tessa John), describes a study of 6 to 8 year old children's understanding of their participation in a vaccine trial. Vaccine trials are complex, tightly regulated and closely monitored. Parental views are commonly more extreme than for other studies. Within this, the researcher must try to ensure that a child understands the context and demands of the study.

4. Strategies to ensure children's consent is informed (Faith Gibson), builds on this by exploring a range of methods and tools which have been used to obtain informed consent in clinical studies. These include approaches which allow the child's understanding to be tested during the very process of developing that understanding.

Paper 1:

The pressures felt by the nurse gaining consent

Margaret Fletcher, University of the West of England, UK; Pete Bailie VOX Coaching, UK; Kate Byers, VOX Coaching, UK

When gaining informed consent from parents and children for a child to participate in a clinical research study, attention is directed, appropriately, almost exclusively at the parents and the child. Whilst this is appropriate, it negates the very real stresses individuals responsible for gaining consent may be experiencing.

This paper presents the difficulties and concerns voiced by participants (47 over two specialist communication workshops) in a structured exercise involving one-to-one dialogue (speed dating format)

All but one member of the workshops had experience of gaining informed consent for clinical research, or would imminently be required to do so, and all but one was an experienced nurse, doctor or AHP.

From the very structured exercise:

Reported difficulties already experienced could be categorised as relating primarily to imparting information and ensuring it had been understood; having an insecure personal knowledge base; managing parental anxiety or conflict or practical aspects such as space, signatures etc.

Predictably, when asked to name concerns, these follow a similar pattern but in addition interpersonal relationships between all involved featured much more strongly.

Whilst the researcher obtaining consent is expected to and (should be) supported in gaining a sound understanding of the study and the rationale and science behind, the additional factors are easily missed, especially when working in relative isolation.

When consenting parents and children to participate in studies, the researcher may not be as competent or confident as appearances suggest (the professional persona mask). By airing and addressing the issues raised here, and sharing experience and strategies in managing the consenting process competently, researchers can better be equipped to ensure that consent is informed, voluntary and freely given. As importantly, years of experience are not required before having strategies to manage the myriad of scenarios encountered within any study when dealing with children and their families.

References:

RCN Research Society Competency Framework For Clinical Research Nurses

RCN 2008 http://www.rcn.org.uk/__data/assets/pdf_file/0019/201466/Competency_Framework_v1_dec08.pdf Accessed 02/11/2009

Fallowfield, L, et al (2002) Efficacy of a Cancer Research UK communication skills training model for oncologists: a randomised controlled trial. Lancet 359:650-656

Rascoa, D.W. et al (2009). The Impact of Consenter Characteristics and Experience on Patient Interest in Clinical Research. Oncologist 14 (5): 468-475.

Wade, J. et al (2009) It's not just what you say, it's also how you say it: opening the 'black box' of informed consent appointments in randomised controlled trials. Soc Sci Med. 68(11):2018-28

Paper 2:

Patient information for children – Leading to fully informed consent?

Margaret Harper, London South Bank University, UK

This paper explores the notion of information giving in relation to gaining informed consent in clinical studies involving children.

Patient information sheets have come to be seen as both the mainstay and 'flack jacket' of informed consent: consent itself having been described by Lord Donaldson (1) as the "legal 'flak jacket'" which protects the doctor from claims by the litigious. Evidence from studies with adults shows that the ability of a written document to convey the protocol and clinical implications of a study clearly and precisely to a lay person remains suboptimal in many cases (2). This may be particularly so when commercial studies depend on a form of English more familiar in legal circles than with the general public, to ensure that they are operating within statutory requirements. Often, more than one national legislative structure is encompassed within a single information sheet. While this mode of expression may satisfy one set of standards it may alienate and confuse potential participants, compromising the quality of the informed consent it aims to achieve. These issues are compounded when the patient is a child and it is only in very recent years that a child-appropriate version of patient information has been required in research involving children under 16 years of age.

This presentation will explore the state of current understanding of the value, nature and use of information sheets and other media in promoting informed assent and consent in research with children and young people. Aspects of studies that may alienate or interest children in participating in research will be highlighted, along with strategies to enhance engagement with written materials. The needs and understanding of children and young people, the expectations of the ethics committee (3) and the role of the information sheet in the wider consent process will be addressed.

References:

(1) Re W. (A Minor) (Medical Treatment: Court's Jurisdiction) [1992] 3 W.L.R. 758

(2) Stead,M., et al (2005) "Hello, hello – it's English I speak!": a qualitative exploration of patients' understanding of the science of clinical trials. Journal of Medical Ethics, 31: 664-669.

(3) NRES guidance on information sheets and consent forms v3.5 May 09 http://www.nres.npsa.nhs.uk/applications/guidance/#PIS Accessed 2.11.2009

Paper 3:

Children's consent and paediatric research: Is it appropriate for healthy children to be the decision-maker in clinical research?

Tessa John, University of Oxford, UK; Tony Hope, University of Oxford, UK; Julian Savulescu, University of Oxford, UK; Alan Stein, University of Oxford, UK; Andrew J Pollard, University of Oxford, UK

This paper will discuss the child's role in decision making with respect to participation in clinical trials based on the findings of the study described below, which specifically addressed this issue within the context of an ongoing trial.

Aim: To determine the appropriateness of asking healthy children to make a decision regarding participation in a research study.

Methods: Participants constituted a group of children taking part in a follow-up to a vaccine study which involved a blood test to look at the persistence of antibodies. Information about the study was given to each child and following venepuncture an oral questionnaire was completed to establish understanding of the vaccine study. Parental views concerning their child's ability to make a decision regarding research participation were also sought.

Results: 73 children participated overall. Following venepuncture 59% (n=43) had grasped some aspect of the reasoning behind venepuncture with 33% (n=24) unclear. The majority of parents (n=55) and a substantial number of children (n=28) believed that the parent should make the decision about study participation, though it is clear that a significant minority of parents thought it is right to involve the child in that process.

Conclusion: New guidance about the requirements for informed consent involving children in research is needed, that can respect the autonomy of the child and the role of the parent, whilst recognising the limited capacity of some children to understand age-appropriate information.

References:

Royal College of Paediatrics and Child Health: Ethics Advisory Committee. Guidelines for the ethical conduct of medical research involving children Arch. Dis. Child 82, 177-182 (2000)

John, T. et al, (2007) Children's consent and paediatric research: is it appropriate for healthy children to be the decision-makers in clinical research? Arch Dis Child 93(5):379-83.

Directive 2001/20/EC of the European Parliament and of the Council of 4th April 2001 on the approximation of the laws, regulations and administrative provisions of the Member States relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use Official J. Eur.Comm. L 121/34-121/44 (2001)

Paper 4:

Strategies to ensure children's consent is informed

Faith Gibson, Great Ormond Street Hospital and London South Bank University, UK

This paper highlights some of the processes used to actively engage with children in the consenting process. Informed consent, in the context of child health, is described as a combination of informed parental permission and (when appropriate) the assent of the child. Parents have an important role to play, not merely in giving parental permission, but showing how capable their child is, and guiding them through this encounter (1). Our role is to support parents in this role and also assist the child in making an informed decision. This process begins with the development and sharing of age appropriate patient information. Making this an active rather than a passive process is important, as are using the right language supported with pictures relevant to the research study if appropriate. Ensuring the child has many opportunities to ask questions, looking for cues that the child has either disengaged or looks confused are all strategies of true engagement. Despite these strategies, it might still be difficult to be confident that a child has really understood what is involved. A question remains about the best way to assess a child's understanding of the research project and the consequent willingness to participate. This presentation will describe a range of strategies from our research and that of others, where participatory tools have been used to increase a child's engagement in the process. Bray's (2007) (2), activity board uses text and pictures to stimulate research related discussion between the child and researcher. Word searches, a story board and more recently a familiar toy used by children for many years, a 'cootie catcher' will all be discussed. The inclusion of serious fun (3), makes the most of the time with the child and exploits the benefits of strategies familiar to children of different ages.

References:

(1) Kodish, E. (2003) Informed consent for pediatric research: is it really possible? Journal of Pediatrics 142: 89-90.

(2) Bray, L. (2007) Developing an activity to aid informed assent when interviewing children and young people. Journal of Research in Nursing. 12 (5): 447 – 457

(3) Twycross A, Gibson F and Coad J (2008) Guidance on seeking agreement to participate in research from young children. Paediatric Nursing 20(6) 14-18.

Domestic abuse and its impact on health: The use of different methodologies to explore a complex phenomenon

Caroline Bradbury-Jones, University of Dundee, School of Nursing & Midwifery, UK; Caroline Bradbury-Jones; Julie Taylor, Research Dean, School of Nursing & Midwifery, University of Dundee, UK

Abstract:

The aim of this symposium is to show how different methodologies can be used to explore one phenomenon. To facilitate this we draw on our collective experiences of undertaking research in the area of domestic abuse. Domestic abuse is a global issue that accounts for significant detrimental health outcomes for women. Such is the extent of the problem that it has been declared a major public health concern (World Health Organization 2009).

Our five presentations move through a continuum of exploration from the experiences of women and children experiencing domestic abuse, through to perspectives of healthcare professionals. This begins with a presentation regarding the experience of women and children living with domestic abuse, through the use of in-depth interviews. Next, we present a literature review that focuses on domestic abuse among women with disabilities. The focus then shifts to a health professional perspective. Here we discuss focus groups and concept mapping as a way of understanding nurses' and midwives' experiences of supporting women living with domestic abuse. The penultimate presentation refocuses on children and reports on a study that examined the response of health visitors to children with domestic abuse experiences. We bring the symposium to a close by showing how action research was used to investigate the integration of domestic abuse training into interprofessional education in healthcare. A consistent theme in our presentations is the challenges of undertaking research in this area of healthcare and the measures we have taken to overcome them.

Our symposium should be of interest to healthcare researchers seeking a critical perspective on the use of different methodologies. It will be relevant to delegates undertaking research with vulnerable populations who seek to overcome some of the challenges. Finally, because domestic abuse transcends national boundaries, the symposium should appeal to the international conference audience.

Paper 1:

Accessing health services for women and children living with domestic abuse: A qualitative study

Caroline Bradbury-Jones, Univeristy of Dundee, UK; Fiona Duncan; Julie Taylor; Thilo Kroll; Maxine Moy

Background: Poor health outcomes for women and their children living with domestic abuse render their needs for health services to be of critical importance. However, the nature of their use of such services is not well understood.

Aim: The aim was to explore the healthcare experiences of women and their children living with domestic abuse. Specifically, the intention was to identify the facilitators and barriers in relation to their access to services.

Methods: Semi-structured interviews were conducted with women (n=17) who had experienced domestic abuse. Data were analysed using a thematic framework.

Results: Women reported a high degree of poor health among themselves and their children. Yet paradoxically, their expectation of healthcare services was low and similarly their uptake of such services was poor.

Discussion: The study provided new insight into the experiences of women and their children who are experiencing domestic abuse my proposing a cycle of barriers and facilitators of access to healthcare services. Analysis revealed three themes relating to such barriers and facilitators: systems-based; interpersonal; and psychological. A significant finding was the psychological inhibitor to accessing services, particularly perceptions of failure and low self-esteem. Women's sense of failure can be ameliorated through supportive action of healthcare professionals. Moreover, access to much-needed health services can be improved by breaking a negative cycle of barriers to services and creating a positive cycle of facilitation.

Conclusions: A range of systems-based; interpersonal; and psychological factors influence access to healthcare among women and children experiencing domestic abuse. The presentation highlights issues of rigour particularly regarding the power relationships between researcher and participant. I discuss the strategies we employed in order to address these issues. The presentation should be of interest to delegates seeking ways of augmenting rigour in studies that draw participants from vulnerable populations, such as women experiencing domestic abuse.

References:

World Health Organization (2009) Violence Against Women. World Health Organization: Geneva.

Funding source:

Paper 2:

Domestic abuse directed against women with disabilities: A review of the literature

Thilo Kroll, University of Dundee, UK

Background: Domestic abuse statistics so far fail to account for how many women with disabilities experience domestic abuse. However, anecdotal evidence suggests that health and well-being consequences may be further compounded in this segment of the population.

Aim: The aim of this literature review was to determine the nature of domestic abuse directed at women with disabilities and its consequences for their health, well-being and social participation.

Methods: A structured literature review was conducted of multiple electronic databases (PubMed, Medline, Cochrane, CINAHL, PsycINFO), limited to: English language literatures; scientific journals; years 1999-2009.

Results: The review highlighted a paucity of literature that focuses on the immediate health and participation consequences of domestic abuse on women with disabilities. Abuse patterns are somewhat linked to the nature of disability, i.e. denial of assistance for women with mobility impairments, physical violence towards women with intellectual disabilities and emotional abuse of women with psychiatric disabilities.

Discussion: Abusive behaviour encompasses physical, emotional and social elements and in many cases a combination of these. The consequences are both direct in terms of aggravations of health issues through physical and emotional abuse and indirect, in terms of delays in access to needed health services.

Conclusions: Women with disabilities who are exposed to domestic abuse continue to be an under-researched group and evidence is scarce on how they can be best reached and supported by the health and social care services. At present, research in this area is fragmentary and scattered across a range of research disciplines. Like most research on domestic abuse it is 'emotion-centric' and lacks focus on wider health consequences. Greater multidisciplinarity is needed to overcome 'silo thinking'. This presentation will provide the audience with an overview of the state of research into the complexities arising at the intersection of disability, domestic abuse and health.

Funding source:

Paper 3:

Using focus groups and concept mapping to explore community nurses' and midwives' experiences of supporting abused women

Fiona Duncan, NHS Fife, UK; Julie Taylor; Thilo Kroll; Maxine Moy

Background: Community nurses and midwives are uniquely placed to provide care, support and information to families living with domestic abuse. The additional impact of homelessness can make access to healthcare services for these families problematic (Barron 2005) and nurses and midwives have an important role in minimising that impact.

Aim: The aim was to explore nurses' and midwives' experiences of supporting homeless women and children living with domestic abuse.

Methods: Nurses, health visitors and midwives participated in focus group interviews as part of a larger study into women's experiences of accessing healthcare for their children. Community nurses (n=10) participated in a series of concept mapping meetings (Kane & Trochim 2007), an innovative approach which maximises the direct involvement of participants in identifying problems and formulating solutions.

Results: Analysis of the data suggests three key areas reported by practitioners that significantly affect access to health care services: psycho-social; health system-related and geographical factors.

Discussion: Nurses and midwives in the study identified a number of creative solutions employed to circumvent these barriers. The extent to which the experience of living with domestic abuse can impair a woman's ability to negotiate healthcare for herself and her children was found to be significant.

Conclusions: Health systems which rely on permanency of residence, GP registration and high levels of patient compliance fail to adequately meet the needs of this population. In this presentation I hope to illustrate the benefits of engaging participants in an interactive process which promotes the sharing of experiences and a collaborative approach to overcoming problems or barriers.

References:

Barron, J. (2005) Multiple challenges in services for women experiencing domestic violence. Housing, Care and Support, 8(1), 11-15.

Kane, M. & Trochim, W.M.K. (2007) Concept Mapping for Planning and Evaluation. Thousand Oaks, CA: Sage

Funding source:

Paper 4:

The response of health visitors to children with domestic abuse experience

Julie Taylor, University of Dundee, UK; Sandra Rodwell

Background: Domestic abuse is now understood internationally as a serious public health concern (WHO, 2009). It is also recognised that children living with domestic abuse experiences are at risk of harm and should be considered as children 'in need'. Nurses, midwives and health visitors play a crucial role in prevention, protection and the provision of services to women and children living with domestic abuse experience (Keeling, 2004).

Aim: There is a large body of literature which has explored the factors which influence the response of health care workers to women and children as a family unit. However, few studies focus on the factors which impact on their response to children living with domestic abuse, as children 'in need'. This study aimed to explore the views and experiences of nurses and midwives working in a community setting in response to children living with domestic abuse.

Methods: A sequential mixed method study design, influenced by the policy Delphi technique, was undertaken. This comprised individual face-to-face interviews and two rounds of self completion questionnaires.

Findings: Through the collective responses of participants a role for nurses and midwives working in a community setting was identified. This comprised four key elements: advocating for children; identification; assessment of need; and acting as a referral agent to support services and child protection. The interaction between multiple factors at each of the levels of analysis was identified as having the potential to influence their response. Findings suggest that current response may be inadequate.

Conclusion: The needs of children living with domestic abuse experiences are still often treated as secondary to those of adults. The responses of practitioners working in a community setting have the potential to address a current gap in practice.

References:

Keeling, J. (2004) A community-based approach to domestic violence

Nursing Times, 100(11): 28

WHO 2009 Multi-country study on women's health and domestic violence against women. Available: http://www.who.int/gender/violence/who_multicountry_study/summary_report/en/index.html Accessed: 31/10/2009

Funding source:

Paper 5:

Evaluation of an inter-professional education initiative on domestic abuse: An action research approach

Catherine Burton, University of Dundee, UK

Background: The integration of multi-agency, domestic abuse training into mainstream undergraduate programmes has been recognised as being important (Scottish Executive 2004). Baird et al. (2005) highlight the opportunities for inter-professional education as domestic abuse requires a multi-agency response.

Aim: This presentation reports on an action research approach that investigated how domestic abuse training could be integrated within nursing, medical and social work curricula.

Methods: Adult learning theory influenced the design of an inter-professional education workshop where ten students (four nursing, four social work; two medical) explored perceptions and attitudes to domestic abuse and working together to support victims of abuse. Data on knowledge and attitudes were collected pre – and post – workshop and subjected to a paired samples t-test. Students completed an evaluation which explored their understanding of the role of other professional groups.

Results: Findings showed that students' perceived and actual knowledge of domestic abuse and their confidence in recognising the signs and symptoms of domestic abuse, had improved. Their perceptions and attitudes to domestic abuse had a positive directional change, which was significant in relation to three attitudinal statements.

Discussion: All professional groups demonstrated an increased awareness of each others' roles and how this could benefit outcomes for patients and service users. Students proposed that domestic abuse and child protection should be compulsory elements within their programmes and inter-professional education should be incorporated into the curricula from the outset.

Conclusions: These findings suggest that the combination of inter-professional collaborative learning with domestic abuse content results in desirable learning outcomes. In this presentation I will share our experience of the ethical challenges associated with researching domestic abuse and the strategies we employed to address these. The presentation will also explore why action research is valuable in researching one's own practice and in making research more available and relevant to practitioners.

References:

Baird, K, Salmon, D. & Price, S. (2005) Learning from the Bristol Pregnancy and Domestic Violence Programme. British Journal of Midwifery, 13 (11) 692-696

Scottish Executive (2004) Domestic Abuse – A national training strategy. Edinburgh, Scotland.

Funding source:

S7

Methodological, theoretical and practical challenges to improving patient safety research, policy and practice

Moira Attree, Senior Lecturer, School of Nursing, Midwifery & Social Work, University of Manchester, UK

Abstract:

This symposium, comprises of three papers on patient safety and reliability in healthcare aand aims to contribute to the development of knowledge, policy and practice in health and healthcare by:

- Critically analysing the relevance of theories of risk and safety to nursing and healthcare research, policy and practice.
- Critically exploring the cultural similarities and differences between safety and high reliability in health care.
- Critically analysing current literature and research on patient safety in healthcare settings.
- Identifying and critically evaluating the methodological challenges in designing credible and robust research for these two areas.
- Exploring current challenges in health care service quality (safety, solvency, sustainability and solidarity).
- Critically evaluating different models/ service cultures by how they address the challenges to service quality.

Paper 1 will critically analyse the relevance of theories of risk and safety to nursing and healthcare research, policy and practice and explore the cultural similarities and differences between safety and high reliability in health care.

Paper 2 critically analyses the methodological and pragmatic challenges involved in researching patient safety culture.

Paper 3 explores and debates whether safe and reliable, solvent and sustainable health care culture is possible.

The symposium will conclude by drawing together issues, implications and recommendations for safe and reliable healthcare research, policy and practice; time will be allowed for scholarly debate of the issues raised in the 3 papers.

Paper 1:

Theories of risk and safety: A critical analysis of their relevance to nursing and healthcare research, policy and practice

Hannah Cooke, University of Manchester, UK

This paper will set the scene for the symposium by critically appraising the use of reliability theory in health care, comparing Perrow's (1984) original concept of normal accident theory, high reliability theory as currently adapted to health care, and an anthropological approach known as grid-group cultural theory (Douglas 1992). The concept of patient safety has only recently risen to prominence as an organising principle in healthcare.

This paper considers the wider social context in which contemporary concepts of risk and safety have developed. In particular it looks at sociological debates about the rise of risk culture and the risk society and their influence on the patient safety movement.

The paper discusses three bodies of theory which have attempted to explain the management of risk and safety in organisations: normal accident theory, high reliability theory, and grid-group cultural theory. It examines debates between these theories and their implications for healthcare. It discusses reasons for the dominance of high reliability theory in healthcare and its strengths and limitations.

The paper suggests that high reliability theory has particular difficulties in explaining some aspects of organisational culture. It also suggests that the implementation of high reliability theory in healthcare has involved over reliance on numerical indicators.

The paper concludes by suggesting that patient safety could be improved by openness to a wider range of theoretical perspectives. For example grid-group theory (Douglas 1992) is offered as a more bottom-up perspective approach to service culture, where 'grid' (relating to the rules and hierarchy) interacts with 'group' (the degree of social cohesion) to produce four stable cultural subsets. These form a useful framework to consider the meaning of risk within an organisation, which in turn permits managers to select appropriate management strategies.

References:

Douglas M. (1992) Risk and Blame: Essays in Cultural Theory. Routledge, London.

Perrow C. (1984) Normal Accidents: Living with High Risk Technologies. Basic Books, New York.

Reason J (1997) Managing the Risks of Organisational Accidents. Ashgate, Aldershot.

Funding source:

No Funding

Paper 2:

Methodological and pragmatic challenges involved in researching patient safety culture

Moira Attree, University of Manchester, UK

Cultural measurement is relatively new in healthcare; this paper will critically analyse and evaluate the methodological challenges involved in measuring patient safety culture.

Safety culture refers to a commitment to safety that pervades the entire organisation, from frontline staff to executive management. Currently healthcare systems are focusing explicitly on developing a culture of patient safety. The impact of these efforts is difficult to assess as safety culture is a complex construct to measure empirically; standardised, valid and reliable measurement tools are not yet established. Health care organisations have adapted safety culture surveys from other high reliability organisations to benchmark their own safety culture. Research into patient safety culture is challenging as culture is a complex, abstract construct that cannot be measured directly and must be inferred from behaviours. Cultural analysis relies on self-report data from surveys; standard research approaches are mostly quantitative, e.g. epidemiological studies and surveys. Current healthcare safety culture research is limited by the use of single research methods, small size and scope, and methodological flaws, including non-standardised data collection tools and limited analysis strategies. Tools for quantifying patient safety culture in healthcare organisations will be critically analysed.

Research challenges include the development of a model of safety culture that permits measurement of several interconnected concepts at the individual and organisational level: including individuals' perceptions and attitudes about safety and observable safety behaviours, and an organisation's safety management system, evidenced by its management policies and processes. Healthcare safety and reliability research requires different theoretical, methodological approaches and also different evidence benchmarks from those traditionally used in medicine. Non-traditional approaches, e.g. qualitative research, case studies and mixed methods research are required to achieve comprehensive cultural assessment. These approaches may constitute a paradigm shift in healthcare research, as well as in management, policy and practice.

References:

Colla, J B, Bracken, A C, Kinney, L M and Weeks, W B (2005). Measuring patient safety climate: a review of surveys. Quality & Safety in Health Care, 14 (5): 364-366

Kirk, S, Marshall, M, Claridge, T, Esmail, A & Parker, D (2006) Evaluating safety culture. IN. R Boaden (eds.) Patient safety research into practice. Maidenhead: Open University Press.

Sorenson, J N (2002) Safety culture: a survey of the state-of-the-art. Reliability Engineering and System Safety, 76 189-204

Funding source:

No Funding

Paper 3:

Safe and reliable, solvent and sustainable: Can a health care culture do all this?

David Newbold, University of East London, UK

All health systems face future difficulty with four factors: safety, reliability, sustainability, and solvency. Safety is vital in high-risk industries like health care. Yet, service quality varies and this may compromise safety. The complex, interacting reasons for this include: rapid technological change in health care, economics and finance, and the skills and morale of the workforce. Similarly, health care reliability also varies, characterized by high error rates and low productivity. According to Kenagy et al (1999): "If banks, airlines, maintenance companies……treated their customers to the levels of waiting, unanswered questions, inconvenience and obscure instruction that are the norm in health care, they would be unable to survive". More recently, Sutker et al (2008) suggest health care reliability is still poor by that comparison.

A new healthcare delivery culture is needed, which can adequately marshal these diverse goals. "Safety Culture", based on Crew Resource Management techniques used in aviation (Dunn et al 2007), is one possibility. Others include "Lean Manufacturing" (Bush 2007), which aggressively targets waste, and the so-called "4-E's" model (Pronovost 2008), seemingly a hybrid of these two, underpinned by the EPOC evidence base.

Efficient evaluation of these cultures may be difficult. Single research programmes although progressive, may live in parallel worlds: e.g. workforce, safety research, service quality, finance and reimbursement. However, new service models may have measurable costs and consequences beyond the remit of a single programme. Substantial scholarly effort may identify all trade-offs and interactions and reconcile diverse findings. Alternatively, a 'supradisciplinary' research culture can fully capture the impact of alternative service cultures on safety and reliability.

References:

Dunn EJ et al (2007) Medical Team Training: Applying Crew Resource Management in the Veterans Health Administration The Joint Commission Journal on Quality and Patient Safety 33: 317-325.

Bush RW (2007) Reducing waste in US health care systems. Journal of the American Medical Association. 297: 871-874.

Pronovost P, Berenholtz S, Needham D (2008) Translating evidence into practice: a model for large scale knowledge translation. British Medical Journal 337: 963-965.

Funding source:

No Funding

S 8

Implementing evidence into practice using different approaches: Methodological and practical strengths and challenges

Jo Rycroft-Malone, Professor of Health Services & Implementation Research, Bangor University, School of Healthcare Sciences, UK

j.rycroft-malone@bangor.ac.uk

Abstract:

Seers (2007) asks 'How do we show what we do in clinical practice works'?. Given often quoted figures suggesting that 35-45% of patients are not receiving care according to research evidence, and 20-25% of care provided is not needed or could cause harm, it is an appropriate question to ask – but a difficult one to answer. Despite considerable investment in the generation of research, for the most part, it is not used routinely in practice or policy. Traditionally the translation of research into practice was seen as a linear and technical process at the level of the individual describing changes in clinicians' behaviour in line with guidelines. Recently there has been an increasing recognition, emanating from a growing international multi-disciplinary evidence base that knowledge use is complex, mediated by multiple factors. This complexity raises particular challenges for both implementers and evaluators.

The overall aim of this symposium is to unpack some of the strengths and challenges of different approaches to implementing and evaluating evidence implementation and use by drawing on past and current projects.

We will be taking a pluralistic view by focussing the presentations around three main approaches:

- Pragmatic and randomised trials that aim to test the effectiveness of implementation strategies.
- An organisational approach to implementation through the activity of one of the UKâ™s Collaborations for Health and Leadership in Applied Research and Care (CLAHRCs).
- Participatory approaches such as action research and practice development.

The final presentation will draw together the key issues, which present a challenge to the robust implementation and evaluation of complex interventions.

We will provide a critical analysis of different approaches to implementation through varied methodological and theoretical lenses, as well as practical information about ways forward in future research. The symposium will be chaired by Professor Kate Gerrish.

Paper 1:

Evaluating the effectiveness of implementation strategies using randomised controlled trials

Kate Seers, University of Warwick, UK

Evidence of effectiveness is often only considered robust when based on data from randomised controlled trials (RCTs). However, implementing evidence into practice is complex and involves many factors. If an RCT is the gold standard when assessing evidence of effectiveness, does the gold still glitter when derived from evaluations of complex interventions, or is it somewhat tarnished? This session will present case studies from three implementation studies based on randomised controlled trial designs. All three studies examine the process of implementing different evidence based guideline recommendations into practice in the areas of pain management, peri-operative fasting and continence management and care.

The presentation will address the theoretical and methodological challenges posed by using an RCT to assess the effects of complex interventions, and the tensions and benefits of combining an RCT with other approaches. It will examine some very practical challenges when different approaches are used within one study. The lessons learnt from the three case studies and the implications for future research designs will be highlighted.

Paper 2:

TRiPLaB (Translating Research into Practice in Leeds and Bradford)

Carl Thompson; Andria Hanbury; Kate Farley; Paul Wilson; Duncan Chambers; Erica Warren; John Bibby

Background: TRiPLaB is an implementation programme within the UK's NIHR CLAHRC for Leeds, York and Bradford. TRiPLaB is a multi-method (time series analysis, multilevel modelling, conjoint preference modelling, qualitative exploration, quasi experimental testing) longitudinal case study of implementation projects. TRiPLaB relies on enacting theories of organisational and individual behaviour change through "developing, implementing and evaluating" ideas and knowledge. This presentation will provide an account of the theoretical and methodological challenges faced, the team's strategy for addressing these challenges, and progress thus far.

Project Example(s): As an exemplar of the techniques, challenges, responses and progress we will focus on TRiPLaB's role in developing the city of Bradford's maternal and child health innovative strategies, and maternal mental health in particular.

Implementation & Evaluation Strengths:

- Explicit use of theories of individual and organisation behaviour change.
- The role of "culture" as a variable in knowledge transfer and improving performance.
- The role of description and prediction of innovation uptake in a complex health system.
- Combining mixed methods of research in a theoretical framework.

Implementation & Evaluation challenges:

- The politics of a large, sensitive and 'new' partnership between the NHS and academia.
- Ethics and governance in a complex programme of work with an emerging and uncertain plan of action.
- Uniting scientific quality and rigour with NHS timeframes for action.
- Making the academic and sometimes complex findings of research accessible to non scholars.
- Matching academic ambitions for innovative application of methods with the reality of sensitive NHS data and nervous clinician gatekeepers.

Conclusion: Translating research into practice is no small undertaking if it is to be controlled and sustainable. Whilst the scale of the TRiPLaB implementation programme may be bigger than most, the lessons learned will apply to many tasked with translating knowledge into high quality clinical practice.

Paper 3:

An action research approach to evidence implementation and evaluation

Brendan McCormack, University of Ulster, UK

Action research (AR) as a methodology has aspired to transgress the methodological silos that sometimes hinder advancements in evidence implementation and evaluation and this is being increasingly recognised in the field of evidence implementation (see for example, Leykum et al 2009). AR has much to offer evidence implementation, particularly with regards to understanding the complexity of context – an increasingly recognised factor in the success of implementation projects.

In this presentation I will draw upon the findings from three AR projects that have a specific focus on the development of practice in services for older people (Brown & McCormack, in press; McCormack et al 2009; Parlour, in progress). Through the analysis of the findings, I aim to elucidate the contributions of AR to evidence implementation and evaluation. Together these projects provide a rich source of evidence about the challenges and

successes of an AR approach. Four 'balances' that need to be considered will be presented:

1. Balancing the aspirations of AR with the reality of practice.

contexts: issues of ownership of evidence, co-construction of knowledge, and dealing with competing realities will be addressed.

2. Balancing and prioritising different forms of evidence: whilst all the studies had the intention of implementing empirical evidence, in all three, local information and audit findings were given greater priority by research participants.

3. Balancing micro, meso and macro context issues: The degree of attention paid to these contexts played a significant role in how success was judged by different stakeholders.

4. Balancing competing conceptions of success: In these projects, increased uptake of evidence was not a primary outcome, but evidence of a changing practice context that was more receptive to evidence was a key focus/outcome.

Taking these 'balances' into account, key considerations for the design of future evidence implementation and evaluation programmes will be outlined.

References:

Leykum LK, Pugh JA, Lanham HF, Harmon J and McDaniel RR (2009) Implementation research design: integrating participatory action research into randomized controlled trials. Implementation Science, 4

http://www.implementationscience.com/content/4/1/69

McCormack B, Dewing J, Breslin L, Coyne-Nevin A, Kennedy K, Manning M, Peelo-Kilroe L and Tobin C (2009) Practice Development: Realising active learning for sustainable change, Contemporary Nurse, 32(1-2): 92-104

Brown D, McCormack B and McGarvey H (2005) Factors influencing the control of post-operative pain in older people, Reviews in Clinical Gerontology, 15: 149-156

Parlour R (in progress) An emancipatory practice development study implementing continence guidelines in community hospitals in the Republic of Ireland, Unpublished Doctoral Thesis, University of Ulster.

Funding source:

Paper 4:

Implementation evaluation and research: Summarising challenges and finding solutions

Jo Rycroft-Malone, Bangor University, UK

By drawing on practical and real examples, a number of issues and challenges have been highlighted within the previous presentations that relate to the different approaches to implementation evaluation, research and development. Broadly these can be themed as:

Theoretical – how one applies theory within different methodological frameworks, and how does that influence data collection and interpretation, including the appropriate application of theoretical and conceptual frameworks.

Practical – there is still much to learn about what works, with whom and how – therefore how do we design robust studies that are more likely to increase the likelihood of successful evidence use.

Methodological – how do we best deal with the complexities of implementation from a methodological point of view whilst ensuring a robust approach and credible outcomes and impact.

Contextual – how do we best incorporate context, including culture, as a variable within implementation efforts and as a possible implementation outcome.

Relational – how does the development of relationships and collaborations both strengthen but potentially compromise particular evaluation approaches, and how does one manage competing priorities and agendas.

The final presentation in this symposium will unpack these issues, and consider the practical implications they present for future evaluation and research that is concerned with the implementation of evidence into practice.

Funding source:

S 9

Realising the ambition of best research for best health: Opportunities and challenges for clinical research nurses

Caroline Gunnell, West Essex Primary Care Trust, UK

Abstract:

The publication of Best Research for Best Health in 2006 and subsequent implementation of a raft of new systems, structures and process designed to support the development of a research active NHS, has created a new climate of opportunity for clinical research nurses. This symposium will take a critical look at how clinical research nurses are responding to these opportunities and taking a leading role in the unprecedented expansion in people focused health and social care in the NHS. The symposium will include five papers that address key policy and practice issues and include time for debate and questions. The contributors to this symposium are all nearly all members of the NIHR Clinical Research Network Senior Nurses Forum, apart from a contributor presenting the picture in Scotland. This symposium will showcase innovation and development and also provide a critical edge about the need for more strategic support for research nurses from within and outside the nurisng profession and highlight the importance of influence and the political dimension. The symposium will cover both policy issues and include some evidence of best practices and barriers. The session will end with an overview of opportunities available and the importance of having a voice and influence for the national picture.

Paper 1:

An update of the NIHR networks and offer example of innovation and best practice in an English NIHR CLRN with regards to the latest developments in clinical research workforce

Caroline Gunnell, NHS West Essex, UK

Following the Best Research for Best Health Strategy (2006) there has been a need for all NIHR networks to expand their workforce of clinical research nurses to an extent and at a speed that has had little preparation. This presentation will deliver an update on where nursing fits in the new and expanding clinical research environment, highlighting an example of best practice within an English NIHR CLRN to develop a flexible clinical research workforce resource with a sustainable career pathway. The presenter will outline some of the challenges that the primary care clinical research environment has produced and examples of how these have been overcome.

Funding source:

Paper 2:

Optimal management arrangements for clinical research nurses across north east England

Debbie Carrick-Sen, Newcastle Hospitals NHS Foundation Trust, UK

There is a national objective to develop an appropriately trained and managed clinical research workforce [1].

During 2009, a regional review of non medical clinical research support staff (NMCRSS) across 13 NHS organisations was undertaken. Organisations included one tertiary, six secondary, five primary care and an ambulance NHS Trust. During the review a minimum data set was collated on all identified NMCRSS, identified nurses and midwives were invited to complete a self completion questionnaire and 51 semi structured interviews were undertaken with key national, regional and local stakeholders.

Most organisations had difficulty identifying NMCRSS, 248 were identified including 205 clinical

research nurses (CRNs), 8 AHPs, 10 clinical trials officers (CTOs) and 25 research administration staff.

Level of research activity within each organisation varied, with 80% research activity taking place in one organisation. There was a low response (21%) rate from questionnaires.

Results indicated that most CRNs had attended good clinical practice training in research, but few had attended research consent training. Low research activity organisations were associated with low support and increased role isolation. There was wide variation in role titles and agenda for change banding. Majority of CRNs reported incorrectly having professional accountability to the principle investigator (PI) usually a medical doctor.

Findings from the interviews confirmed a lack of understanding regarding a) the CRN and the nurse researcher and b) existing and potential NMCRSS roles. There were major concerns regarding CRN capacity, recruitment and retention, role isolation, short term contracts and suboptimal management and support arrangements. Interviewees reported a need to a) ensure continual frequent contact between CRN and PI, b) increase interaction/ working with clinical staff and c) develop a national coordinated framework. This review highlights ongoing major concerns regarding suboptimal understanding and management arrangements for CRNs.

References:

(1) UKCRC Subcommittee for Nurses in Clinical Research (2007) Developing the best research professionals, UKCRC.

Funding source:

No Funding

Paper 3:

Putting clinical research nurses on the map: Policy and practice perspectives on Best Research for Best Health

Fiona o'Neill, Workforce Development Lead NIHR CRN, UK

This paper will set the context and focus on how the strategy for NHS Research and Development outlined in Best Research for Best Health and subsequent policy has created a climate of opportunity for clinical research nurses.

A brief look at key policy developments will be followed by an overview of how clinical research nurses are contributing to increases in high quality clinical research activity in the NHS.

Against this background of opportunity and expansion there are also challenges and uncertainties. The paper will illustrate the essentially contested and insecure nature of the clinical research nurse role. This will include consideration of theoretical perspectives on the professional

politics of nursing and the impact of professionalising strategies that have focused on the development of 'nurse researchers' as opposed to 'research nurses'.

The paper will also examine workforce development issues, including skill mix and the emergence of new roles, such as Clinical Trials Officers, able to undertake duties previously the more exclusive domain of nurses and other clinically qualified health professionals.

The paper will conclude by examining the cultural changes involved in creating a research intensive NHS where research is integrated as a 'front-line' service, where all those involved in supporting, and not only leading, research are valued and supported. Clinical research nurses have a critical role to play in ensuring that the opportunity to make significant and lasting changes that benefit patients, science and the national economy is not lost. Leadership, evidence led and collaborative approaches that align policy and practice developments within the nursing profession to the vision and ambition of Best Research for Best Health are required. The paper will close with an overview of current initiatives that may support this strategic approach.

Funding source:

No Funding

Paper 4:

The Scottish Research Nurse and Co-ordinators Network: Raising the national profile of clinical research nurses and supporting career development

Gordon Hill, Edinburgh Napier University, UK

This paper will focus on the development of the Scottish Research Nurse and Co-ordinators Network, how it can support this group and help to raise the profile of clinical research nurses nationally.

The Scottish Research Nurse and Coordinator's Network was established in 2005 to provide a resource for clinical research nurses, trial co-ordinators, data managers and others working in the field of clinical research. To date, the network has in excess of 200 members and organised three highly successful national conferences. We communicate regularly with the members of the network informing them of legislative changes, pertinent educational resources and career development opportunities.

The network supports nurses in their current role and also encourages them to consider utilising their skills and expertise to become researchers in their own right. To assist with this we have recently been awarded £30,000 by the Scottish Academic Health Sciences Collaboration to help to build the research capacity and capability of the group.

The profile of the group has also led to invitations to contribute to Scottish Government scoping report on Nursing and Midwifery Research (Tierney 2007) and the RCN Scotland Policy position paper on the nursing contribution to health and social care research. It has also facilitated a collective response to UKCRC workforce consultation documents.

It is vitally important that this group of nurses contribute to the future of research within nursing and the formation of the SRNCN has provided a strong focus for this to be taken forward in Scotland.

References:

Tierney A. (2007) Capacity and capability for nursing & midwifery research in Scotland: Report of a scoping exercise conducted towards the end of 2006. Scottish Executive/NHS Education for Scotland. Edinburgh

UKCRC Subcommittee for Nurses in Clinical Research (2007) Developing the best research professionals, UKCRC.

Funding source:

UK – Higher Education Funding Council

10,001 – 50,000

Paper 5:

The United Kingdom Clinical Research Facilities Network: Developing and sharing best practice

Jennifer Allison, Wellcome Trust Clinical Research Facility, UK; Caroline Saunders, Wellcome Trust Clinical Research Facility, UK; Helen Pidd, Wellcome Trust Clinical Research Facility, UK

This paper discusses the creation of the United Kingdom Clinical Research Facility Network. In December 2007 the Nurse/Clinical Managers of the five Millennial Wellcome Trust Clinical Research Facilities (WTCRFs) sought competitive funding for a UKCRF Network. The UK Government awarded £316,000 over two years. Supporting a portfolio of activities, the Network embraces all components (44 in total) of the UK infrastructure for experimental medicine including Clinical Research Facilities, Experimental Cancer Medicine Centres and NIHR Biomedical Research Centres and Units.

A Strategic Planning Team (SPT) was established to steer Network activity and comprised the five original WTCRF Managers and a Network Director. The funding supported sessions of the SPT members, an Operations Manager and Administrator. Membership grew to include representatives from new CRFs and the NIHR.

The initial focus of the SPT was to develop a bespoke information platform hosted on the NIHR sharepoint/portal website. The SPT created and populated subsections including: document repositories, discussion boards, links to research facilities and units, meeting notes, general information, news and events. Documents (SOPs, job

descriptions, management structures) were made available with the opportunity to upload modified and new versions, keeping information current, comprehensive and include developments from across the UK. Workstreams identified by the UK Nurse Managers' Association have been adopted by the Network and facilitated by the website (Study Intensity Tool, Quality Assurance, Education and a Paediatric Forum).

Other SPT work includes: organisation of nationwide CRF Public Open Days, coordinated engagement with national and international professional groups, oversight and support of the multi-professional/agency annual UKCRF Conference, a forum for sharing innovation and best practice.

The UKCRF Network has become a recognised and invaluable focal point for the collaborative growth and sharing of translational clinical research expertise. Further funding has been awarded to continue to build on initial success and develop new initiatives.

References:

Wellcome Trust Clinical Research Facilities Review Stage 1. Wellcome Trust. (2004)

UKCRC Subcommittee for Nurses in Clinical Research. Developing the best research professionals, UKCRC.(2007)

Best Research for Best Health: Implementation Plan 5.5. NIHR Office for Clinical Research Infrastructure (NOCRI). Department of Health. (September 2009)

S 10

Implementing nurse prescribing: The views and experiences of stakeholders

Molly Courtenay, Health and Social Care, University of Surrey, UK

Abstract:

Developing and enhancing the roles of healthcare professionals is key to modernising the National Health Service (Department of Health (DoH) 1999, DoH 2000). Prescribing by non medical healthcare professionals is key to this modernisation. Since the introduction of independent and supplementary prescribing training seven years ago, over 17,000 nurses now have virtually the same prescribing rights as doctors. These nurses work in a variety of areas (including primary care, hospital trusts and mental health) and care for patients with a broad range of conditions encompassing those requiring one-off treatments and long-term care.

Given the cost (in terms of both the personal and organizational commitment) in order to implement the prescribing role, and the need to develop and improve efficiency and deliver services in a more patient centred way, it is important to consider the

views and experience of non-medical prescribing from a range of stakeholders.

This symposium, Chaired by Nicola Carey comprises of 4 papers i.e.:

• An exploration of the practices of nurse prescribers who care for people with diabetes: A case study (Professor Molly Courtenay)

• How patients with diabetes view nurse prescribing in primary care (Karen Stenner)

• An exploration of the views of the NMP lead with regards to their role in supporting prescribing (Nicola Carey)

• Developing competence in mental health nurse prescribing (Austyn Snowden)

Papers explore the practices of nurse prescribers, patient's views on these practices, the support required by nurses adopting the prescribing role and how nurses develop their prescribing competencies. Findings are presented from both primary and secondary care, adult nursing (including the therapeutic areas of diabetes), and mental health.

References:

DoH (1999). Making a Difference. Strengthening the Nursing, Midwifery and Health Visiting Contribution to Healthcare. London: DoH.

DoH (2000). The NHS Plan. A Plan for Investment. A Plan for Reform. London: DoH.

Paper 1:

How patients with diabetes view nurse prescribing in primary care

Karen Stenner, University of Surrey, UK

Background: A UK survey found that 30% of nurses prescribe for patients with diabetes (Courtenay and Carey 2008). Nurses are considered adept at providing advice and building therapeutic relationships (Avery et al. 2004). The communication skills of nurses prescribing for patients with diabetes were highly rated by patients and observed to be consistent in practice (Courtenay et al. 2009). There is little evidence exploring the patients' perspective on nurse prescribing.

Aim: To explore the views patients with diabetes have on their relationship with their nurse prescriber.

Method: Qualitative study involving semi-structured interviews with 41 people with diabetes. Participants were randomly selected patients of seven nurse prescribers from primary care sites across England. Data was collected in 2009 and was subject to thematic analysis.

Results: Patients were happy to be prescribed medicine by an appropriately trained nurse and this was believed to improve service efficiency. Various aspects of the nurse consultation style were said to enhance patients' understanding of their condition and ability to follow treatment plans. These included nurses' knowledge about diabetes, unhurried consultation, caring approach, ability to communicate, and tendency to invite participation.

As a result, patients felt able to discuss problems and gain treatment suited to their needs. Consulting with the same nurse over time enhanced the personal care received and improved the consistency of advice. Patients stressed the importance of up-to-date training on developments in the treatment of diabetes.

Discussion and Conclusion: Patients' views about the benefits of nurse prescribing concur with those of health professionals. A holistic style of consultation was preferred by patients and reported as beneficial. Continuity and flexibility over appointment times appeared to enhance communication and shared decision-making. Promotion of the positive aspects of consultation described by patients may help to improve concordance.

References:

Avery, A., Savelyich, B. & Wright, L. (2004) Doctors' views on supervising nurse prescribers. Prescriber, 5, 56-61.

Courtenay, M. & Carey, N. (2008) The Prescribing Practices of nurse independent prescribers caring for patients with diabetes: findings from a national questionnaire survey. Practical Diabetes International, 25(3), 1-5.

Courtenay, M., Stenner, K. & Carey, N. (2009) Nurse prescribing in diabetes: implications for practice. In National Prescribing Centre (NPC) 5th Non-medical prescribing conference London.

Paper 2:

An exploration of the practices of nurse prescribers who care for people with diabetes: A case study

Molly Courtenay, University of Surrey, UK

Background: The use of medicines is an important component of the care of patients with diabetes. However, education and support is equally important to the successful management of this group (DoH 2007). These are areas of care in which nurses have traditionally been involved (Carey & Courtenay 2007). Evidence suggests that combining nursing skills with prescribing may result in shared decision-making and increased medicines concordance (Stenner and Courtenay 2008).

Aim: To explore the practices of nurse prescribers who care for people with diabetes.

Design and Methods: A collective case study of nine practice settings across England in which nurses prescribed medicines for people with diabetes. Data comprised of semi structured interviews (n=31), patient questionnaires (n=131) and video-taped observations of nurse consultations (n=35). Data analysis included thematic analysis and descriptive statistics. Data were collected between October 2007 and September 2008.

Results: Nurses demonstrated good communication skills, which they integrated with the ability to prescribe. Questionnaire and video data confirmed an exchange of information between nurse and patient about aspects of self-care and medicines management. Additional benefits included improved efficiency, supported by patient satisfaction with access and waiting times. Nurses were inconsistent in explaining the risks and benefits of treatments and side-effects and exploring the use of non-prescribed herbal or over-the-counter medicine.

Discussion and Conclusion: The care nurses are able to provide to people with diabetes is enhanced through prescribing. Prescribing is a valuable development through which nurses are able to encourage self-care and work towards shared-decision making with patients in a way that supports national guidance on the care of people with diabetes. Further evidence is required evaluating nurse prescribing from the patient's perspective. Our findings will be of interest to those keen to develop the prescribing role for nurses involved in diabetes service delivery.

References:

DoH (2007). Working together for better diabetes care. London: DoH

Carey, N & Courtenay, N (2007). A review of the activity and effects of nurse-led care in diabetes. Journal of Clinical Nursing, 16, 294-304

Stenner, K. and Courtenay, M (2008). The benefits of nurse prescribing according to nurses prescribing for patients in pain. Journal of Advanced Nursing, 63 (1), 27-35

Funding source:

Paper 3:

An exploration of the views of the NMP lead with regards to their role in supporting prescribing

Nicola Carey, University of Surrey , UK

Background: There is growing evidence that non-medical prescribing (NMP) enables healthcare professionals to contribute to improved services in a number of ways including greater choice and access for patients, better use of time and skills within the healthcare team and improved patient care (Bradley & Nolan 2007). Effective implementation of the NMP role can be influenced by a number of factors including individual and organizational expectations, lack of clinical skills, access to support and inadequate workforce planning and preparations (Carey et al. 2009). The views of the NMP lead with regards to their role in supporting prescribing have yet to be explored.

Aim: To explore the views of the NMP lead with regards to their role in supporting prescribing.

Methods: Structured interviews with a purposive sample (n=25) of prescribing leads across the EoE were conducted between September 2009 and October 2009.

Findings: There was general agreement that the role substantially involved effective communication and dissemination of information, and ensuring clinical governance procedures were in place and up-to-date. However, systems for monitoring prescribing, including access to prescribing data, and clinical audit were weak. The extent of involvement and level of support varied widely. There was extensive variation in terms of the number and types of prescribers, and geographical areas that each lead covered. Leads who were more actively involved in the selection process of students, and discussed and addressed potential problems at an early stage reported that this reduced the number of barriers and problems encountered.

Conclusion: Trusts need to ensure that NMPs have access to their own prescribing data. The extent to which leads are involved in the selection process appears to be pivotal to preventing problems later on. More guidance needs to be provided to ensure consistency across trusts on what the NMP lead role entails.

References:

Bradley, E. & Nolan, P. (2007) Impact of nurse prescribing: a qualitative study. Journal of Advanced Nursing, 59, 2, 120-128.

Carey, N., Stenner, K. & Courtenay, M. (2009) Views on implementing nurse prescribing in a specialist children's hospital. Nurse Prescribing, 7, 5, 205-210.

Funding source:

Paper 4:

Developing competence in mental health nurse prescribing

Austyn Snowden, University of West of Scotland, UK

Background: The Medicines and Human Use (Prescribing) (Miscellaneous Amendments) Order of May 2006 effectively means that in UK non-medical prescribers can prescribe virtually any drug for any condition, given they are trained appropriately and feel competent enough to do so (Department of Health, 2006). Competence is therefore a fundamental issue for individual prescribers.

Aims: This paper develops an interpretation of the impact of mental health nurse prescribing in the UK.

Method: A constructivist grounded theory methodology was applied to 13 semi structured interviews with mental health clinicians and service users. The literature was concurrently analysed where the focus was on prescribing in action. Thirty-two practicing UK mental health nurse prescribers

gave structured feedback on the coherence of the emergent theory in November 2008.

Results: The theory illustrates the process of owning and demonstrating competence in mental health nurse prescribing. All prescribers go through this process in order to integrate prescribing into their practice. The process is a composite of four themes: 'managing ambiguity', 'concording in action', 'understanding v UNDERSTANDING' and 'delivering better medicines management'. This presentation will illuminate these themes from the primary data.

Discussion: This process describes high level medicine management in mental health nursing. By contrast it also highlights deficits in non prescribing mental health nurses which would otherwise not have come to light. This is the most significant finding and this paper's major contribution to practice within mental health nursing.

Conclusions: It is recommended that structured education in medicines management be introduced into pre and post registration mental health nursing in UK. The findings of this research offer a framework. That is, the categories emerging within this research translate easily into learning outcomes which can underpin delivery of a consistent medicine management strategy across all levels of nurse education. Examples will be given.

References:

DoH (2006). Improving patients' access to medicines: A guide to implementing nurse and pharmacist independent prescribing within the NHS in England. London: DoH

Funding source:

S 11

User-Centred Healthcare Design: A new model of Engagement

Daniel Wolstenholme, Professional Services, Sheffield Teaching Hospitals NHS Foundation Trust, UK

Symposium statement:

The National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care, South Yorkshire (CLAHRC SY) is one of nine CLAHRCs across England which commenced in October 2008 with funding for five years.

The CLAHRCs were introduced in response to recognised gaps in the translation of health research into new products and treatment approaches, and in the implementation of new approaches to clinical practice (Cooksey Report 2006). They are designed to develop mutually beneficial partnerships between higher education institutions and NHS organisations to improve patient outcomes through applied health research and local implementation of the results. The three primary functions of the CLAHRCs are:

- The conduct of high quality applied health research.
- Implementing findings from research in clinical practice.
- Increasing the capacity of NHS organisations to engage with and apply research, including continuing professional development for professionals and managers.

The mission is to undertake, over the next five years, high quality, strategic, applied research and related education in order to enable a 'step change' in the way research is delivered and services are designed in South Yorkshire; and to foster knowledge transfer that will improve the quality and effectiveness of health care delivery across South Yorkshire.

One of the themes within the SY CLAHRC is User-Centred Healthcare Design, the presentations which make up the symposium will provide background to UCHD as a new model of engagement for all stakeholders within healthcare, and describe the first two case studies this innovative, multi disciplinary team, are undertaking.

References:

Cooksey, D. 2006 A review of UK health research funding. HMSO, London

Paper 1:

User centred healthcare design

S Bowen, Sheffield Hallam University, UK; M Cobb, Sheffield Teaching Hospital NHS Foundation Trust, UK; A Dearden, Sheffield Hallam University, UK; D Wolstenholme, Sheffield Teaching Hospital NHS Foundation Trust, UK; P Wright, Sheffield Hallam University, UK

This presentation will provide the background and philosophy of User Centred Health Care Design. The classical model of NHS healthcare involves the delivery of specific interventions to combat a patient's illness. For the increasing numbers of people with long term conditions, delivery of acute care is only a one (possibly small) part of their health care. Day-to-day care and management of people's health is increasingly about self-care and self-management. People are surrounded by a diverse ecology of products, services, information and other resources that they draw upon to care for their health. User-centred healthcare implies new ways of structuring and providing services that people can interact with to jointly realise their own healthcare.

User-Centred Design: User-centre Design emphasises users' perspectives and users' lived experience. User-centred design engages the people who use, and the people who are affected by, products, services and systems at every stage of development. User-centred design combines the specialist skills of trained designers with the specialist knowledge of people about their own lives, their own capabilities, their challenges, their experience

and their desires. User-centred design recognises users and other stakeholders as co-designers.

User Centred Healthcare Design: UCHD within the CLAHRC is a research project to develop, trial, evaluate and promote user-centred methods for designing user-centred healthcare (Bate and Robert 2007). We are investigating methods where people can participate as co-designers of the systems (social, technological, institutional) that they use to promote their health and wellbeing.

We work in collaboration with health researchers, healthcare providers and healthcare users to investigate the impact of user-centred methods in healthcare design, and the issues and challenges faced in adopting such methods. The authors believe that through UCHD we are offering an innovative way to truly engage patients, public and staff in their health care and health care systems.

References:

Bate, P. and Robert, G. (2007) Bringing user experience to healthcare improvement: the concepts, methods and practices of experience-based design. Radcliffe Publishing, Abingdon, UK.

Funding source:

UK – Health Service (National)

⤑1,000,000

Paper 2:

Better outpatients services for older people

S Bowen, Sheffield Hallam University, UK; M Cobb, Sheffield Teaching Hospital NHS Foundation Trust, UK; A Dearden, Sheffield Hallam University. UK; D Wolstenholme, Sheffield Teaching Hospital NHS Foundation Trust, UK; P Wright, Sheffield Hallam University, UK

Everyday over one thousand older people attend an outpatient clinic at the local hospital. Some come for a diagnosis, others for treatment, but all will have to navigate and use outpatient areas, facilities and services. Many older people have complex needs that require additional support such as a mobility problem or a cognitive or sensory impairment. When the service fails to meet the particular needs of individual users, their independence, dignity and confidence may be compromised or undermined. Consequently older people regard an outpatient visit with apprehension or simply impossible and this may prevent them from receiving the treatment and support they require resulting in a deterioration in their health, wellbeing and independence. This also has a very real impact on service provision in these financially challenged times with the cost of Do Not Attends.

The UCHD team used the framework described in the Experience Based Design toolkit produced by The NHS NHS Institute for Innovation and Improvement (2008) which was used to guide the process, and the UCHD team used their own experience of the project to reflect on the usefulness of the toolkit.

The project looked to improve outpatients services using a collaborative process of understanding and improving the outpatients service based on patient's and staff' experience.

This presentation will outline the creative and facilitated engagement of service users with service providers to develop mutual understanding and to identify process and service improvements. How this led into prioritising specific aspects of the outpatient process, which were developed by smaller co-design groups of patients and staff. We will offer examples of the solutions that were co-designed alongside the process of engaging a diverse group in a complex NHS context.

References:

The ebd approach guide and tools 2008, NHS Institute for innovation and improvement, http://www.institute.nhs.uk/ accessed 02 Nov 2009, 22:00

Funding source:

UK – Health Service (National)

⤑1,000,000

Paper 3:

Diabetes case study

S Bowen, Sheffield Hallam University, UK; M Cobb, Sheffield Teaching Hospital NHS Foundation Trust, UK; A Dearden, Sheffield Hallam University, UK; D Wolstenholme, Sheffield Teaching Hospital NHS Foundation Trust, UK; P Wright, Sheffield Hallam University, UK

Recent experience-based co-design projects undertaken by the NHS Institute in collaboration with the Design Council have shown the potential value of a co-design approach to services in the area of chronic illness (The Design Council 2006). This case study will be a close collaboration with the CLAHRC-SY Diabetes theme, who are undertaking both qulaitative and quantitative approaches to looking at the adolescents with diabetes in South Yorkshire.

The aim of this project is to design innovative new tools to support teenagers' self management of their diabetes. This group has been identified as experiencing particular problems in relation to sustained self management of their illness and the project will look at solutions that are personalised to the obstacles experienced by teenagers and to their lifestyles.

The project plan is to identify young people with Type 1 diabetes who are interested in working with the UCHD team to understand adolescents' experiences of living with diabetes. To work with these young people to co-design tools (websites, applications, devices etc.) to support their self-management and improve their quality of life.

Participating young people would also become 'co-researchers' and work with other young people with diabetes, their families and carers, to develop a broader understanding of their experiences, with training and support from the UCHD team.

As possible ideas/ themes develop, appropriate 'expert friends' would be brought in to support the co-designers

This presentation will describe the process and progress of this project and the challenges inherent in working towards a new model of health, where the service provision and therefore the research is centred on and co-designed by users.

References:

RED REPORT 01: Open Health, 2006, The Design Council. http://www.designcouncil.info/mt/RED/health/REDREPORT01OpenHealth.pdf accessed 02 Nov 2009 22:00

S 12

Managing multiple information sources within the development of a complex intervention for incontinence after stroke

Beverley French, Reader, University of Central Lancashire, UK

Abstract:

The Medical Research Council (MRC) guidelines for the evaluation of complex interventions in healthcare includes a development phase, requiring a comprehensive review of existing research, consideration of theory in intervention and implementation design, evaluation of feasibility in practice, with evidence of service user involvement throughout this process. This symposium will consider the tasks involved in developing and implementing a complex intervention, with particular attention to how the different sources of information from research, practice evaluation, theory and service user involvement can be managed and integrated.

The symposium will be based on an ongoing National Institute for Health Research (NIHR) funded programme to develop and evaluate an intervention for urinary incontinence after stroke. After a short introduction to the MRC guidelines for developing a complex intervention by the symposium leader, the first three presentations will illustrate how different sources of information can be used.

1) Practical requirements of intervention development for a pilot cluster randomised controlled trial.

2) Reviewing evidence of effectiveness, feasibility, acceptability and moderators of outcome.

3) Service user involvement in the design of a complex trial, and how their contribution can be managed.

The final presentation will discuss how these different strands can be drawn together in the management of information flows for a complex trial.

Paper 1:

Practical requirements of intervention development for a pilot cluster randomised controlled trial

Lois Thomas, University of Central Lancashire, UK

ICONS is a collaboration between Lancashire NHS Foundation Trust, University of Central Lancashire, Wirral University NHS Foundation Trust and six other Universities. It has been successful in obtaining a prestigious NIHR Programme Grant (£1.2 million). The programme is based on the MRC framework for the evaluation of complex interventions. It aims to develop, implement and explore the potential effectiveness and cost-effectiveness of a systematic voiding programme, with or without supported implementation, for the management of urinary incontinence after stroke in secondary care.

Methods: Phase I: MRC Development phase

• Evidence synthesis of combined approaches to managing urinary incontinence post-stroke.

• Development of the systematic voiding intervention and an associated protocol for its implementation.

• Case study of the introduction of the systematic voiding programme algorithm in one stroke service.

Phase II: Exploratory trial (MRC Feasibility and piloting phase)

Phase II aims to test to test the interventions for preliminary evidence of effect and feasibility. The trial will use cluster randomisation at the level of the stroke service and involve stroke services randomised to receive:

• Systematic voiding programme (n=4);

• Systematic voiding programme plus supported implementation (n=4);

• Usual care (n=4).

This presentation will explore the practical issues encountered in implementing the intervention in one stroke service and how these have influenced the design of the Phase II trial. Issues discussed will include:

• Adapting behavioural interventions to take account of the impact of stroke.

• Barriers and facilitators to staff taking part in pre-intervention training (face-to-face and electronic) and delivering the interventions as per protocol.

• Barriers and facilitators to patients adhering to behavioural interventions.

• Ways of ensuring quality and good practice are maintained in the management of multiple sources and types of information.

• Implications of points 1 to 4 for the Phase II trial.

Paper 2:

Reviewing evidence of effectiveness, feasibility, acceptability and moderators of outcome

Beverley French, University of Central Lancashire, UK

NICE guidelines suggest that behavioural interventions should be the first line of therapy for urinary incontinence, with recent research suggesting that using more than one behavioural intervention can be more effective than single interventions. While Cochrane reviews of single behavioural interventions are available for pelvic floor muscle training, bladder training and prompted voiding, there is no systematic review of combined behavioural interventions. There is also insufficient evidence for this evidence to be applied to incontinence after stroke.

To underpin the design of an intervention for urinary incontinence after stroke, we have completed a systematic review and meta-analysis of existing trials of combined behavioural interventions to determine the likely effect size of the intervention, and to construct a clear specification of the content of the behavioural intervention. In addition to this conventional review of evidence for effectiveness, we have also reviewed evidence for feasibility of implementation by extracting data from 12 studies on rates of uptake, treatment adherence or withdrawal/drop-out from behavioural intervention programmes; undertaken a narrative review of 11 studies of client or staff experience with behavioural interventions to determine the acceptability of the intervention and barriers and enablers to implementation; and synthesised the evidence from nine multivariate analyses of predictors of treatment adherence or outcome.

Extracting and synthesising evidence on feasibility, acceptability, and moderators of involvement and outcome aims to maximise the potential for success of the intervention in stroke, but methods for synthesising types of evidence other than effectiveness are less well developed, and there is little guidance on how the products of a synthesis should subsequently be used to influence intervention development. This presentation will conclude with considerations for presenting the results of complex evidence syntheses to management, steering and service user groups and how they can use the information to improve intervention design.

Paper 3:

Service user involvement in the design of a complex trial, and how their contribution can be managed

David Britt, Representative of the Patient and Public Involvement Groups, ICONS Project, United States

From an early stage, the intention has been to involve service users, carers and the public as comprehensively as possible in this study with the aim of developing a model of best practice for active public participation in healthcare research. Good evidence of the value of such involvement remains sparse so an evaluation of the impact made by the ICONS Patient, Public and Carer Involvement (PPCI) Groups is ongoing and will, we hope, result in a publication to encourage similar arrangements.

As an input to this presentation we, as service users, will describe how the groups have been set up, how they are managed and what they do. Our major focus in the project is on how we can contribute most meaningfully to developing and evaluating a new clinical intervention to benefit future ranks of stroke patients. An associated theme is helping to ensure that the research process itself is optimised to ask the right questions and elicit the necessary data for careful analysis in framing the outcome and is conducted in a manner that will encourage patient and NHS staff enrolment.

We will reflect in the presentation on common problems of managing groups of individuals with long-term health conditions and how specific needs such as communication difficulties, can be and are being accommodated. How can service users be adequately prepared and supported to be most effective? And, how can we maintain interest and involvement throughout the life of a long project? Just as the professional members of the research team bring a wide variety of skills, knowledge and experience to the project, so too our PPI Groups are far from homogenous. Collectively, we believe we can make an important difference – but we must not anticipate the evaluation.

Funding source:

UK – Health Service (National)

⸽1,000,000

Paper 4:

Bringing it all together: Information flows within the design and evaluation of a complex intervention

Christopher Burton, Bangor University, UK

Within a programme of inter-related research activities, we are challenged to effectively manage the different sources of information and knowledge that are generated. This includes the timeliness of information production where interim products inform subsequent phases of the research programme.

However, in this applied research programme, other information sources (trial management committees, service user engagement, feedback from the development of research tools and activities, and study quality assurance / process review) will influence the design and conduct of the research programme. An overarching strategy integrating individual research components within a research programme is required (Hakim 1987)

The focus of our research is the clinical and cost effectiveness of an evidence-based algorithm for post-stroke urinary incontinence. Its implementation will be influenced by a wide range of practitioner and organisational factors. As such, the whole organisation or system needs to be considered. Recent research and theoretical frameworks also provide compelling evidence for the critical role of organizational, leadership, and system supports for changes to services such as the implementation of practice guidance (Iles & Sutherland 2001).

Within ICONS, we are addressing these issues through the development of an overarching framework which synthesises aspects of whole system thinking, organisational development and implementation theory. This framework is impacting on our work in a number of ways, including:

• Informing the structure of the research programme.

• Shaping the design and content of study interventions and implementation strategies.

• Providing a framework for managing and integrating research information across different aspects of the research programme.

A number of challenges have been faced in the development of the framework, including the lack of empirical evidence within some aspects of the framework. These challenges will be discussed within the context of our ongoing work, as will progress with the development of strategies to refine and evaluate the framework.

References:

Hakim C. (1987) Research Design. Strategies and Choices in the Design of Social Research. Routledge, London.

Iles, V. & Sutherland, K. (2001). Organisational Change: A Review for Health Care Managers, Professionals and Researchers . London, England: National Co-ordinating Centre for NHS Service Delivery and Organisation for NHS Service Delivery and Organisation R & D (NCCSDO).

Funding source:

UK – Health Service (National)

⸽1,000,000

Shifting the balance of care: Implications for community nursing practice

Claire Roxburgh, Lecturer in Nursing, Nursing and Midwifery, University of Stirling, UK; Professor Roger Watson, University of Sheffield, UK

Abstract:

The direction of travel for health care provision in Scotland is now firmly targeted towards shifting the balance of care where care in increasingly delivered in patients homes or as close to home as possible. This approach to care will extend the current provision of community based health care and consequently provides increased scope for developing innovative approaches to nursing practice. This symposia will reflect on some of the key elements that have been identified to maximise nurses contributions in community settings (Scottish Executive 2006).

The symposia will provide primary data and methodological insights into the outcomes of three inter-related research projects – Case Management in Community Nursing; Skill Transfer to support Shifting the Balance of Care and Community Practitioners with Special Interest on behalf of NHS Highland, informing models of nursing in remote and rural communities and the role of Extended Community Care Teams (ECCT). Importantly, outcomes will contribute to wider debates and opportunities around 'shifting the balance of care' ,and the practice, education and training priorities set out in Delivering care, Enabling Health (Scottish Executive 2006) by supporting sustainable role development within community care.

Paper 1:

Case management in community nursing

Annetta Smith, University of Stirling, UK; Willam Lauder, University of Stirling, UK; Kathleen McCulloch, University of Stirling, UK; Seonaid Mackay, NHS Western Isles, UK

Scotland has an increasing ageing population with a corresponding rise in the health and social care needs of a significant proportion of that section of the population. A growing number of people will develop long term conditions and some of these will develop complex health needs that require to be supported by health and social care agencies. Interventions by these agencies requires a co-ordinated way that will support self management approaches, contribute to improved health outcomes for people with complex health needs and reduce episodes of unscheduled care. Scottish health care policy promotes case management as one solution to address the challenges (SEHD 2005,SEHD 2007).

Case management is an intervention that involves assessment, service planning, service co-ordina-

tion, monitoring and re-assessment of high-risk individuals to provide the best care while containing costs (Hyduk 2002: 19). The overall purpose is to facilitate the client to remain independent and improve his or her quality of life. Community nurses play a pivotal role as case managers for people with long term conditions with the emphasis of providing proactive, integrated care within the community.

This study reports on the development of a case management approach within community nursing in areas of the Highlands of Scotland. Based on action research principles the research was conducted in four notionally discrete but interconnecting phases. These phases promoted a reflective and iterative process that a) encouraged community nurses to review and analyse their practice and b) evaluated approaches to case management and identified strategies for implementation in practice.

Findings demonstrate nurses have a clear understanding of the principles underpinning case management; however there are challenges with implementation. Challenges include organisational barriers, inconsistencies with aspects of referral and patient assessment systems, attitudes both of patients and carers, and health and social care professionals.

References:

Hyduk C (2002) Community-Based Long-Term Care Case Management Models for Older Adults Journal of Gerontological Social Work Volume 37, Issue 1 pages 19 – 47

Scottish Executive Health Department (2007) Better Health, Better Care. SEHD

Scottish Executive Health Department (2005) Delivering for Health. SEHD

Funding source:

Paper 2:

Skills Transfer to Support Shifting the Balance of Care

Claire Michelle Roxburgh, University of Stirling, UK

The concept of transfer, much overlooked in nursing and midwifery, has a fundamental role when considering the extent to which performance in one skill or skills developed in one setting transfer to another skill or another setting. Lave (1988) has articulated a widely held view that there is overwhelming evidence that transfer frequently does not occur. The distinction between low road and high road transfer may illuminate this issue. Skills within skills clusters that are sufficiently similar to allow low road transfer in which skill transfer of relatively well-practiced skills takes place in what is an almost automatic fashion (Schunk 2004). High road transfer is required for transfer between

different skills clusters as these require decontextualisation and abstract knowledge.

The aim of this element of the study was to identify and test model/s to support the transfer of skills from hospital based services to (predominantly) home based services, in particular, those required to support people requiring palliative care and others requiring interventions such as IV analgesia, antibiotics, hydration, blood transfusions and bisphosphoneate administration

This paper will report on:

1) The frequency of exposure to the above skills from both the primary care practitioner and the community practitioner perspective.

2) Develop and test educational interventions which promote and support the safe, sustainable transfer of knowledge, skills and confidence over time.

24 Registered nurses from a range of nursing disciplines i.e Health Visitor, District Nurse, School Nurse, Community Hospital Nurses took part in individual telephone interviews. Thematic analysis reveals themes around: exposure, education, resources, self efficacy.

References:

Lave J (1988) Cognition in Practice: Mind, Mathematics and Culture in Everyday Life. Cambridge University Press, Cambridge.

Schunk DH (2003) Learning Theories: An Educational Perspective. Fourth edition. Prentice Hall, Upper Saddle River, New Jersey NJ.

Funding source:

Paper 3:

Community Practitioners with Special Interest

Brian James, University of Stirling, UK; Annetta Smith, University of Stirling, UK; Tessa Parkes, University of Stirling, UK; Cindy Gray, University of Stirling, UK; Caroline Wilson, University of Stirling, UK

The role of the specialist practitioner has been identified as someone with in-depth knowledge and skills who works within a specific contextually focused role (NES 2008). Specific context can include a client group, a skill set or an organisational context (NES 2008). This part of the study explores generalist and specialist roles for two specified client groups: child welfare and heart care.

The focus for this project is to help identify the level and scope of knowledge required for generalist and specialist practice in order to facilitate the development of practice tools. This also relates to those skills that enhance the patient experience through application of effective and collaborative teamwork.

The study was conducted with two focus group meetings of community nurses per specified client group (n=4 for child welfare and n=5 for heart care). Thematic analysis was carried out independently by two researchers from recordings before further thematic analysis using transcripts. At the first meetings, the practitioners were asked to explore aspects of specialist/generalist knowledge and skills. After analysis, at the second meeting the findings were fed back to the groups to identify implications for practice.

Early analysis indicates that the toolkit for specialist practice includes a way of being that takes account of a heightened professional awareness, arising from a sophisticated knowledge base practicum, notions of boundary and threshold, and deep insight into collaborative working with both clients and other professionals. Generalist working may have elements of specialist practice, but differs from specialist in the level of decisional support required, and this is fundamentally related to responsibility for decisions. The practitioners thought that there were implications for early in-service education for generalist practitioners.

References:

NHS Education for Scotland (2008) Visible, Accessible and Integrated Care

Capability Framework for the Advanced Practitioner: Nursing in the Community. NES

Funding source:

Obesity – bridging the theory practice gap: From measurement and holistic intervention development to practice implementation

Valerie Shephard, Visiting Research Fellow, Anglia Ruskin University, Faculty of Health and Social Care, UK

Abstract:

The World health Organisation (WHO) identified an international pandemic of obesity as classified by body mass index, (BMI) (WHO 1998). However this "gold standard" for classification of overweight and obese, body mass index (BMI) which is BMI 25-29.9kg/m2 and obesity BMI≥30kg/m2 respectively, does not identify abdominal obesity, which increasing epidemiological evidence links with cancer, cardiovascular and metabolic diseases (WHO 1998). UK Government statistics identify a rising tide of weight gain and the diseases associated with this, and recommended primary care as the most appropriate setting for management of this (National Institute for Health and Clinical Excellence 2006).

Much research in obesity requires the validation of methods in controlled research facilities. The work presented here attempts to bridge the theory – practice gap and develop and audit tools fit for purpose in routine primary care. The three papers reflect some of the challenges of accurate assessment and implementation of appropriate care for people who are overweight and obese.

This symposium will use a nursing process model, to enable delegates to:

- Consider the tools for assessment of people with excess weight.
- Identify components of partnership and self care in the holistic management of people who are at risk of the diseases associated with obesity.
- Discuss the challenges implementation of appropriate assessment and management in practice.

The presenters will give papers that consider assessment, planning, implementation and evaluation in the partnership of holistic care. The topics include tools for physical assessment of fat mass and distribution, the development of a tool for holistic assessment of the challenges for weight control for individuals, and the implementation of this tool in primary care.

Paper 1:

Assessment of obesity: Practical tools for primary care

Valerie Shephard, Anglia Ruskin University, UK

Assessment and monitoring of people who are overweight or obese presents a challenge to all health practitioners who need to be confident that the tools used are reliable when obtaining measurements on repeated visits. Fat distribution is as important as total fat mass, because intra-abdominal fat has been linked to cardiovascular and metabolic diseases as well as some cancers (World Health Organization, (WHO) 1998). While weight loss and gain can be reliably measured on scales this identifies neither the nature nor the distribution of the tissue. Body mass index (BMI) is the gold standard for classification of overweight (BMI 25-29.9kg/m2) and obesity (BMI≥30kg/m2) (WHO1998), but this does not identify the nature of the tissue weighed. Waist circumference (WC) and sagittal abdominal diameter (SAD) have been proposed as methods of measuring central adiposity (Pouliot et al 1994).

In primary care tools used for measurements need to be:

- Practical and easy to use
- Show relevant change
- Provide reliable results from different practitioners, and on subsequent occasions
- Inexpensive

This paper addresses the challenges of assessing changes in weight and adipose tissue distribution in primary care. It is based on long-term monitoring (1-4 years) of a small group of volunteers in one primary care surgery. The tools used had all been validated in the controlled conditions of clinical research facilities, so this study sort to evaluate them for routine use in a pragmatic realistic clinical setting, where stability of results and ease of use are essential.

The methods discussed will be:

- Weight
- Height
- Body Mass Index
- Bio-impedance analysis
- Waist circumference
- Sagittal abdominal diameter (or supine abdominal height)

Finally, conclusions, based on the statistical analysis of the data, will be drawn as to the suitability of these methods.

References:

Pouliot MC, Despés JP, Lemieux S, Moorjani S, Bouchard C, Tremblay A, Nadeau A, Lupien PJ. (1994) Waist Circumference and abdominal sagittal diameter: best simple anthropometric indexes of abdominal visceral adipose tissue accumulation and related cardiovascular risk in men and women. The American Journal of Cardiology, Volume 73; 460-468

WHO (1998) Obesity, Preventing and Managing the Global Epidemic. Report of a WHO Consultation on Obesity. Geneva WHO.

Funding source:

UK – Higher Education Institution

1,000 – 10,000

Paper 2:

The development and implementation of a Holistic Approach Towards Self-care for Obesity Management (HATSOM)

Jenny Brown, Aberdeen Royal Infirmary Honorary Clinic /Robert Gordon University, UK

Traditional approaches to obesity management which focus on dietary intervention have limited outcomes although the addition of physical activity and behaviour therapy are more effective (Avenell et al 2004). However, they all reflect the paternalistic approach to care. It is argued here that a holistic, person-centred approach would be more effective. Furthermore, it would encourage self care (DH 2006) as it:

- Puts 'patients' at the centre
- Fosters partnership working
- Encourages self-management
- Encourages greater confidence and a sense of control
- Is multi-component and is concordant with the NICE (2006) guidelines for obesity management:

- Helps individuals identify barriers to good weight management
- Includes behaviour change strategies
- Provides written goals and actions

This paper will explore how such a theoretically underpinned, evidence based approach was developed from the obese persons' perspective by involving them in the research at exploratory, development and intervention levels. Consideration will be given to the transfer of outcomes from the exploratory phase of this mixed method research to the development of the novel intervention. Furthermore, the materials, education and support provided for nurses will be reviewed.

The relevance of the resultant Holistic Approach Towards Self-care for Obesity Management (HATSOM) for both primary care nurses and obese individuals will be discussed. Differences from current approaches in practice will be demonstrated by providing views from both nurses and obese individuals.

The key findings of this study confirmed that a holistic, person centred approach to weight management can be effective. The materials and education provided in this novel, practical approach, facilitated the implementation of obesity management by Practice Nurses in primary care and adds to the body of nursing knowledge.

References:

Avenell, A., Broom, J., Brown, T.J., Poobalan, A., Aucott, L., Stearns, S.C., Smith, W.C.S., Jung, R.T., Campbell, M.K., Grant, A.M., 2004. Systematic review of the long-term effects and economic consequences of treatments for obesity and implications for health improvement. Health Technology Assessment, 8(21), pp. 1-194.

Department of Health, 2006. Supporting people with long term conditions to Self Care: A guide to developing local strategies and good practice. 270415. London, Department of Health.

National Institute for Health and Clinical Excellence. 2006. Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43.

Funding source:

UK – Higher Education Institution

10,001 – 50,000

Paper 3:

Bridging the theory-practice gap for obesity management in primary care

Christine Goldie, Banff and Gamrie Practice, UK

This paper discusses the challenges of putting theory into practice in the primary care setting.

Context: Practice nurses, are ideally placed to address obesity management (NICE 2006), in particular, those involved in chronic disease man-

agement. In addition to the need for practical interventions (Mulvihill and Quigley 2003) actual implementation may be made more difficult as nurses often lack the authority to instigate change (Foxcroft and Cole 2004). Furthermore, there is a dearth of appropriate tools and education especially from a nursing perspective.

This paper discusses the challenges of identifying and negotiating the use of suitable premises, keeping in mind the specific needs of obese individuals. Consideration is also given to the contextual issues of introducing a new area of practice within the primary care setting. This includes the need for obesity education for nurses and reflects on how this can be fulfilled.

The challenge of undertaking obesity management utilising the Holistic Approach Towards Self-care for Obesity Management (HATSOM) intervention will be addressed. In particular, consideration will be given to how it differs from usual care in practice especially for those who are obese. Both benefits and drawbacks will be deliberated upon, especially from a nursing perspective.

General results from the audit carried out following implementation of will be presented. In particular, highlighting the benefits of weight loss in both diabetes prevention and management of those already diagnosed with type II diabetes. A more in-depth case study will also be presented to demonstrate the utility of such an approach.

References:

National Institute for Health and Clinical Excellence. 2006. Obesity: guidance on the prevention, identification, assessment and management of overweight and obesity in adults and children. NICE clinical guideline 43.

Mulvihill, C., and Quigley, R., 2003. The Management of Obesity and Overweight: an analysis of reviews of diet, physical activity and behavioural approaches. Evidence briefing. London, Health Development Agency.

Foxcroft, D.R., Cole, N., 2003. Organisational infrastructures to promote evidence based nursing practice. Cochrane Database of Systematic Reviews 2003, Issue 4. Art. No.: CD002212. DOI: 10.1002/14651858.CD002212

Paper 4:

Theory into practice, a discussion

Following the presentations there will be an opportunity for the delegates to critically debate the challenges of providing holistic appropriate care in partnership with people who are overweight and obese. This will provide an opportunity to discuss the methodologies and theoretical aspects of the studies. This discussion will be of interest to practioners and researchers in the fields of primary care and obesity.

S 15

Art and science in health care research: Pushing at open doors or locked in institutions

Dawn Freshwater, Dean, School of Healthcare, University of Leeds, School of Healthcare, UK

Abstract:

Research methods are usually dictated and driven by the research question; however, in the context of research in environments and systems which are closed, for example, prisons and psychiatry, it is imperative that the research question takes into consideration the context and environment in which the research is located. In our experience, research that has action, transformation and creativity at its heart is a significant challenge in closed cultures for both the researcher and the researched.

In these three papers we question whether researchers should adopt a safe approach by using methods conducive to researching in these closed cultures or indeed to what extent they should engage in methodological and ethical dilemmas that prise open and illuminate, thus provoking and supporting reflection on change. By reflecting on previous studies we have undertaken, we aim not to answer this question, but to suggest that researchers give careful consideration and reflect on the methods appropriate to both the context of the research and the purpose. Where research methods espouse adaptability and flexibility, the researcher may find themselves in direct conflict with the closed systems; be they closed in through walls or scientific discourse.

Paper 1:

Using open methods in closed institutions

E Walsh, University of Leeds, UK; D Freshwater, University of Leeds, UK

This paper focuses on the complexities of undertaking reflexive action research in the prison setting where the purpose of the research is to examine and develop practice. The authors have frequently adopted practitioner based, reflexive, embodied methodologies in prison healthcare settings in order to develop practice. However within the context of secure environments and in particular, prison healthcare, reflexive action research presented the researchers with some significant and complex philosophical and practical conflicts and peculiar dilemmas. In this paper, we draw on our experiences of undertaking a funded national action research project in which we jointly developed, implemented and supported practice improvement through clinical supervision. In doing so we discuss the implications of conducting action research, which we perceive to be an 'open' methodology, in what we term 'closed' systems.

Paper 2:

Creative methods in scientific discourse

T Muncey, University of Leeds, UK; J Cahill, University of Leeds, UK

The prime purpose of user involvement is to improve the way research is commissioned, undertaken and disseminated because it helps to ensure that research is relevant to those people whose lives it affects. Within the NHS, user involvement is a statutory duty. Section 11 of the Health and Social Care Act 2001 established a duty to involve and consult patients and the public in service planning, operation and in the development of proposals for change. This does not include the voices of those currently outside psychiatric mental health services whose behaviour may be described as psychotic but who have chosen alternative explanations for their behaviour. However, there are tensions and anomalies in the practice of psychiatry in relation to the treatment of individuals with psychosis. As Johnstone notes "Psychiatry is required to be the agent of society while purporting to be the agent of the individual, and its main function is not treatment but social control". This tension permeates every aspect of the psychiatric system and impacts heavily on the individual who is being treated within such a system. A specific consequence is that 'psychiatry' in being dominated by the biosciences paradigm, fails to address the emotional/relationship problems and in fact reinforces them due to a lack of a whole person, whole system model of understanding which treats biological, psychological and social issues as systems of the body, similar to the traditional medical systems such as the respiratory and cardiovascular systems. This failure in turn leads to an obscuring of the personal meaning of people's distressing experiences and the psychological and social origins of their difficulties. This paper will address the elements that need to be restored to psychiatric practice-specifically with reference to the treatment of psychosis in the individual.

References:

Johnstone, L. (2000). Users and Abusers of Psychiatry. Routledge: London

Paper 3:

Researching vulnerability: Ethics and reflexivity

P Esterhuizen, Amsterdam School of Health, The Netherlands

Researching a vulnerable and marginalised group has ethical consequences for the researcher, and researchers have the obligation to provide their readers with transparency and rigor regarding their research methods, data analysis and representation of research findings. Those researchers undertaking qualitative research are challenged further, as their tools to provide this insight are directly related to self-reflection and reflexivity – their way of being as a researcher. The concept of reflexivity as transparency is often challenged by critics as being navel-gazing and self-indulgent. This is, however, an important element of undertaking exploratory research within a closed environment when there is a risk of preconceptions, bias and stereotyping.

Is the use of narrative auto-ethnography a legitimate means of providing transparency and research rigor when undertaking research within a closed environment? Although the issues facing the researcher using this approach to autobiographical narrative are often ethically, philosophically and pragmatically related to providing transparency in representing participants, there are specific discussions related to the ethics of personal and professional self-disclosure. This paper addresses the issue of research ethics and vulnerability from participant and researcher perspectives.

S 16

Notes on nursing knowledge: Philosophical inquiry and research in nursing

Davina Porock, School of Nursing, Midwifery and Physiotherapy, University of Nottingham, UK

Abstract:

International Nurses Day is celebrated on the anniversary of Florence Nightingale's birth and this year it falls within the dates of this conference. The aim of this symposium is to revisit elements of Florence Nightingale's seminal work, Notes on Nursing (1859), and take a critical look at contemporary nursing knowledge and the methods being favoured for its development. Together, the papers forming this symposium will argue that philosophical inquiry is essential to the development of research questions as well as methodology that will have a positive and lasting impact on nursing practice. Four papers will be presented and the symposium will be chaired by Professor Davina Porock. The presenters and chair are all members of the International Philosophy of Nursing Society (IPONS).

Paper 1:

Introduction and review of Nightingale's 'Notes on Nursing: What it is and what it is not'

Davina Porock, University of Nottingham, UK

In contemporary comments on Nightingale's most famous written work pundits will exclaim amazement that many of the ideas contained therein still hold true today. The reason for this is currency is that Nightingale's work was based on the premise is that sound knowledge is needed in order to nurse. Furthermore Nightingale bemoans that too little attention is paid to the logical and systematic development of knowledge in particular through observation and critical thinking. Using examples from Nightingale's Notes on Nursing, the purpose of the symposium is outlined and the presenters introduced.

The first paper addresses the question of the nature of the discipline of nursing and draws out the links between philosophy, research methods and the discovery of knowledge.

The second paper builds on the first by arguing for the importance of philosophical inquiry as a distinct stream of research in nursing in order to develop disciplinary knowledge.

The third paper develops this theme further by focusing on the measurement debate and the implications this has for practice.

The final paper completes the link with practice and the close connection between philosophical thought and the practice of nursing.

Paper 2:

What is nursing? Research methodologies and defining the discipline

Janet Holt, University of Leeds, UK

The conflict between describing nursing as an art or a science is discussed extensively in the literature, as is the qualitative/quantitative debate in nursing research. The arguments related to defining nursing do not necessarily relate to the research debate which is usually centred upon which type of methodology is most appropriate for discovering knowledge for nursing. However, there are other important questions to be addressed concerning the link between research methodology and defining a subject.

A central claim in any discipline is the need for research to add to the body of knowledge. In nursing, this may be explained not just simply as discovering knowledge that may be useful in nursing practice (and ultimately to improve care for service users), but also as necessary in the development of nursing knowledge as a discipline in its own right. This raises questions about what sort of knowledge constitutes nursing knowledge, how it is recognised as such, and how it may differ from other forms of knowledge. The methods used to derive this knowledge are not exclusive to nursing and are established research methods from both the sciences and the humanities with, in some circumstances, entirely different understanding of the subject under scrutiny. The knowledge discovered using a particular type of methodology therefore has implications for how nursing is defined and the significance of further research in nursing.

Using philosophical methods, this paper will examine the link between research methodology and the discovery of knowledge and explore the implications of this for the definition of nursing.

Paper 3:

Philosophical inquiry and the goals of nursing: The development and enactment of sound research

Pam Grace, Boston College, Massachusetts, United States

This paper posits that undertaking nursing research is a critical aspect of disciplinary knowledge development and thus is an obligation of the profession. However, valid questions for study are those predicated on nursing goals and perspectives. In this sense the questions posed and addressed by contemporary nursing scholars and researchers are ethical in nature. That is, we can be critiqued to the extent that our research endeavours are honestly focused on addressing critical nursing concerns. Contemporary nursing research endeavours however, like research undertaken in other areas of healthcare, are inevitably influenced by external forces such as funding priorities, and politically motivated initiatives. Thus, even when rigorously conceptualized, nursing research efforts can be undermined at many points in their course. However, as supported in the literature, nursing research is often not well conceptualized from the start. Among the reasons for this is that empirical research has become a benchmark of an individual's professional progress; it is expectation of those working in academic settings and as a result expedience, in designing a project and moving it forward, can triumph over value.

Philosophical inquiry is a necessary antecedent to deciding both good nursing research questions and apt methods for their address. Yet philosophical inquiry is often considered at best an anaemic method or at worst intellectual manipulation. This is a mistaken and impoverished view of the method. Philosophical inquiry offers critique, analysis and clarification and is an inescapable part of a sound research design. The author uses philosophical inquiry to exemplify the thesis that this method is an anchoring research tool in the project of nursing knowledge development.

Paper 4:

Nursing philosophy: why bother?

Catherine Green, Rockhurst University, United States

This paper argues that nursing, while it is a fully practical discipline, is essentially united with philosophy and its issues for several reasons, perhaps the most fundamental of which results from the intimacy and duration of the relationship between nurses and patients, people who are, in the context of the nursing relationship, always coping with a real or possible existential crisis. For both patients and nurses, the reality of this existential crisis and the intimacy of the relationship open up the horizon for the examination of the many truly philosophic questions raised by the business of facing one's mortality. This paper further argues that nurse theorists have been astonishingly successful at developing, explicating and evaluating important philosophical theories, discarding some that are inconsistent or poorly grounded while incorporating those that are helpful in giving an adequate account of the reality of nursing practice. I will argue that the reason for this success rests with their allegiance to the reality of nursing practice as a measure of the validity of a theory and with the strength of critical thinking that has been a hallmark of nursing education since its move into the academy.

S 17

Enabling human flourishing through the development of person-centred care in nursing: the challenge of personhood

Brendan McCormack, University of Ulster, Institute of Nursing Research, UK

Abstract:

Developments in person-centred care in nursing have been ongoing for many years. There is a general understanding in nursing that person-centred care is concerned with: treating people as individuals; respecting their rights as a person; building mutual trust and understanding, and developing therapeutic relationships. However it has been recognised that translating the core concepts of person-centredness into every day practice is challenging. The reasons for this come in many forms and are often indicative of the context in which care is delivered, and the fact that we are living in times of constant change, particularly within health and social care.

The promotion of 'person-centredness' is consistent with the policy direction of health and social care internationally and is reflected in approaches to the delivery of healthcare. In this symposium we will present five papers that deal with different aspects of the development and evaluation of person-centred nursing. Paper 1 will outline a framework for person-centred nursing. Papers 2, 3 and 4 will present an analysis of three different research and practice development programmes that focused on implementing different aspects of person-centred nursing in contrasting care settings and cultures (UK, The Netherlands & Ireland) using the theoretical framework presented in paper 1. Paper 5 will present an analysis of particular challenges associated with evaluating the outcomes derived from the development of person-centred nursing. There will be a particular focus on demonstrating how respecting and promoting the personhood of service users, others significant to them and staff/teams can be achieved in the context of facilitating the flourishing of all in care settings.

Paper 1:

The Person-centred Nursing Framework

Tanya McCance, University of Ulster, UK

Whilst there is increased understanding of person-centredness and other related concepts that underpin nursing, how they are operationalised in practice needs to be understood if improvements in care are to be realised. The Person-Centred Nursing Framework is described as a tool to facilitate nurses to explore the concept of person-centredness and provides a lens that enables the operationalisation of person-centred care in practice.

The Person-Centred Nursing Framework was developed for use in the intervention stage of a large quasi-experimental study. This study focused on measuring the effectiveness of the implementation of person-centred nursing in a tertiary hospital setting (McCormack & McCance 2006; McCormack et al 2008). In summary, the Framework comprises four constructs: prerequisites, which focus on the attributes of the nurses; the care environment, which focuses on the context in which care is delivered; person-centred processes, which focus on delivering care through a range of activities; and outcomes, described as the results of effective person-centred nursing. The relationship between the constructs suggest that in order to deliver positive outcomes for patients and staff, account must be taken of the prerequisites and the care environment, which are necessary for providing effective care through person-centred processes.

The development of the Person-Centred Nursing Framework is rooted in practice and continues to be tested on an international stage with a wide range of professional groups from different settings. This activity has taken many forms and includes use of the framework: to facilitate reflection; as a framework for analysis of data; to guide developments in practice; and to gain feedback on the user experience. This symposium will draw on several international projects currently ongoing that are using the Person-Centred Nursing Framework in a range of different ways, to illustrate the utility and flexibility of the Framework in practice.

References:

McCormack, B., & McCance, T. V. (2006). The Person Centred Nursing Conceptual Framework. Journal of Clinical Nursing.

McCormack, B. McCance, T., Slater, P., McCormick, J., McArdle, C., and Dewing, J. Person-centred Outcomes and Cultural Change (2008): In International Practice Development in Nursing and Healthcare. (Manley, K., McCormack, B. and Wilson, V. eds). Blackwell, Oxford, pp. 189 – 214

Funding source:

No Funding

Paper 2:

Using the person-centred nursing framework in a Dutch context

Shaun Cardiff, Fontys University of Applied Sciences, The Netherlands

Background: Person-centred care is a new concept within Dutch nursing and in light of our realisation that Dutch nurses are reluctant to read articles written in English, we have had to explore new ways of making the knowledge embedded in this literature accessible to them.

Aim: To facilitate and research a team's journey from unconscious to conscious person-centred work, and care-relationships.

Method: In a Participatory Action Research study with staff on an acute (urban) gerontology unit, we choose to research and develop leadership, based on the assumption that people tend to treat others as they themselves are treated. Alongside the work of Plas & Lewin (2001) on person-centred leadership, we have been working with the person-centred nursing (PCN) framework of McCormack and McCance (2006) to explore and develop the leadership of six people in leadership roles within the unit.

Results: Facilitated critical reflective inquiry (Kim 1998) has provided the structure to surface leader stories for creative and collaborative reflection, from which learnings and actions have been derived, and plotted against the PCN Framework. Critically dialoguing the stories shared is revealing what these leaders feel is important to being person-centred. Currently, the leader roles are being re-structured and we are using participant observation with post-observation interviewing to further develop leadership practice.

Conclusions: Short, practice based story-telling sessions, facilitated by the leaders themselves, has been shown to be a successful strategy in helping staff to learn how to become more person-centred in their relationships with patients. The need to re-present the PCN Framework to make it applicable to a Dutch context raises important issues in the transferability of theories and frameworks to guide research. Contextual and cultural issues specific to the Dutch context and how these are influencing the use of the PCN Framework will be raised.

References:

Kim, H.S. (1998) Critical reflective inquiry for knowledge development in nursing practice. Journal of Advanced Nursing, 29(5), 1205-1212.

McCormack, B. & McCance, T. (2006) Development of a framework for person-centred nursing. Journal of Advanced Nursing, 56(5), 472-479.

Plas, J. & Lewis, S. (2001) Person-centered Leadership for nonprofit organisations, Sage Publications, Thousand oaks.

Funding source:

50,001 – 100,000

Paper 3:

The implementation of a model of person-centred practice in older person settings in the Republic of Ireland

Brendan McCormack, University of Ulster, UK; Jan Dewing, Canterbury Christ Church University/NHS East Sussex Community Health Services, UK

Background: This paper provides an overview of the findings from a two-year programme of work undertaken to develop person-centredness in residential care settings in the Republic of Ireland.

Aim: To implement a framework for person-centred nursing for older people across multiple settings in Ireland, through a collaborative facilitation model and an evaluation of the processes and outcomes.

Method: The programme was set within an emancipatory practice development framework. Processes and outcomes were evaluated within a framework of cooperative inquiry drawing upon reflective dialogue data between the facilitators, programme participants and the programme leaders; interview data with all participants and records of developments. In addition, a number of 'tools' were used to systematically evaluate the processes and outcomes of the development activity and the existence and growth of person-centred care. Data have been collected at three time-points. As well as the data collected through the practice development activities, between 800 and1200 questionnaires were analysed at each time-point (Total sample = 3118), 180 periods of observation were undertaken and 120 user narratives were collected.

Results: Findings demonstrate the positive role of the facilitator in changing practice context working collaboratively and in partnership with staff groups. The role of the Director of Nursing in different units is a significant factor in the way different settings achieved more or less change in culture. Resident-focused findings demonstrate, residents having more choice; more hopeful environments; more effective teamwork; better inter-professional rela-

tionships; settings being more open to change and innovation; and the development of more person-centred care environments.

Conclusion: The findings from this study demonstrate the impact of a systematically facilitated approach to culture change set within a person-centred nursing framework. The need for the embedding of the work in nursing and health strategy is highlighted and issues for the ongoing development of similar programmes raised.

Paper 4:

Delivering person-centred care: The reality of practice

Bernadette Gribben, Belfast HSC Trust, UK

Background: There is an increasing emphasis on the provision of person-centred care within healthcare systems that is broadly interpreted as treating people as individuals. Existing evidence would suggest that to work effectively in this way requires the formation of therapeutic relationships between professionals, patients and others significant to them in their lives. It has been recognised, however, that whilst there is a lot of emphasis on providing care that is person-centred, translating the core concepts into professional practice is challenging.

Aim: The overarching aim of the Person-centred Care Programme was to enable nursing teams to explore the concept of person-centredness within their own setting, to improve care delivery.

Method: The programme was underpinned by the principles of practice development and was guided by the Person-centred Nursing Framework (McCormack & McCance 2006). The programme comprised facilitated activities focusing on four themes, and a realistic evaluation framework was used to evaluate its effectiveness (Pawson & Tilley 1997). Ten nursing teams, representing a range of specialities, were recruited from across the Belfast Trust and participated in the programme over an 18 month period.

Results: Multiple qualitative data sources were analysed and findings from the evaluation provided insight into: the mechanisms of the programme; the contextual issues that impacted on the way the mechanisms were used; and outcomes experienced by patients/clients/carers and participants involved in the programme.

Conclusions: Using the Person-centred Nursing Framework to interpret the findings from the evaluation provides important insights into the impact of a facilitated programme that focuses on the delivery of effective person-centred care. Furthermore, it is evident that this programme represents a complex health care intervention and the findings provide useful indicators for areas requiring further exploration and testing.

References:

McCormack B & McCance TV (2006) Developing a conceptual framework for person-centred nursing. Journal of Advanced Nursing 56, 472-479.

Nolan M, Davies S, Brown J, Keady J and Nolan J (2004) Beyond 'person-centred' care: a new vision for gerontological nursing, International Journal of Older People Nursing [in association with the Journal of Clinical Nursing] 13(3A), 45-53.

Pawson R. & Tilley N., (1997) Realistic Evaluation. Sage, London

Paper 5:

Person-centred nursing outcomes and their evaluation

Brendan McCormack, University of Ulster, UK;
Tanya McCance, University of Ulster, UK

The literature on person-centred nursing is weak in terms of methods for evaluating outcomes, with little clarity about outcome focus, methodologies or methods. From the analysis of the studies presented in this symposium and the ongoing analysis of other person-centred research and development projects, we have identified three themes for outcome measurement – feeling involved in care; having a feeling of well-being; and the existence of a therapeutic environment, described as one in which decision-making is shared, staff relationships are collaborative, leadership is transformational and innovative practices are supported. Outcomes in these themes can be demonstrated from the perspectives of staff and patients/families. In this paper these three themes will be explored from the perspectives of challenges, approaches and tools.

The presentation will begin with an overview of outcome evaluation in nursing with a particular focus on how caring outcomes are reflected in the literature. The challenges associated with determining outcomes from person-centred nursing will be discussed drawing on the issues arising from the other papers presented in this symposium. A framework for evaluating outcomes from person-centred nursing will be proposed that takes account of the evaluation of processes and outcomes arising. It will be proposed that the adoption of methodological principles derived from realistic evaluation (Pawson & Tilley 1997)can overcome many of the challenges associated with critiques of outcome evaluation in person-centred nursing. The adoption of these principles enables the identification of context-specific mechanisms to be identified for the development of person-centredness and the application of methods to evaluate the three outcome themes. However, in order for these outcomes to be achieved, a continuous participatory and inclusive developmental approach needs to be adopted in the development and evaluation of person-centred nursing. Finally, the presentation will propose a variety of methods that can be used to evaluate person-centred nursing outcomes.

References:

Pawson R. & Tilley N., (1997) Realistic Evaluation. Sage, London

S 18

The senior clinical academic: Current experience and future vision

Debbie Carrick-Sen, Head of Nursing and Midwifery Research, Newcastle upon Tyne Hospitals NHS Foundtion Trust, Research Midwives Office, UK

Abstract:

There is a need to increase capacity in nursing research. The clinical academic training pathway for nurses, midwives and AHP's has been introduced within the UK to contribute to the development of clinical academic posts. Despite clear definition of the entry and exist points on the clinical academic pathway, there is a need to explore, debate, visualise and articulate the exact nature of substantive posts within the higher educational institute (HEI) and clinical setting.

The symposium will link together the current experience of two senior (post doctorate) clinical academics, one working within the higher education setting and the other working within the clinical setting. Each organisation has differing priorities, challenges and opportunities. There is a need to increase collaboration between the two organisations to maximise generation, funding, delivery and output of nursing research. The current proposal within the UK is to develop substantive joint research clinical appointments. Twenty years ago Australia and more recently New Zealand introduced joint research clinical posts, appropriately called professor/clinical chair.

The third presentation will outline the rationale and experience to date concerning the role of the clinical chair in Australia.

The fourth and final presentation will present updated information regarding the clinical academic training pathway awards and the progress to date of the implementation group.

The symposium will be chaired by Professor Alan Pearson and will propose and encourage debate to assist in the visualisation, description and key issues concerning the introduction and formalisation of substantive clinical academic posts.

Paper 1:

The senior clinical academic working in the clinical setting

Debbie Carrick-Sen, Newcastle Hospitals NHS Foundation Trust, UK

This presentation will focus on the context, opportunities and challenges as a post doctorate academic working within the clinical setting. Since 2006 I have been employed as Head of Nursing and Midwifery Research in a large Tertiary unit within North East England. Within my current post I undertake 45% personal research, 45% as Trust lead for nursing and midwifery research and 10% teaching. My career pathway has been unusual, complex and at times difficult. Previous posts have included substantial experience working in a support and leading role in research as well as in teaching and senior management.

Working in the clinical environment has many opportunities and challenges. Organisation priorities predominately focus on meeting clinical targets, winter pressures and hospital acquired infection. Until recently, research has been a low priority within the health care provider setting.

There are a number of growing opportunities in research within the clinical setting. Working closely with frontline health care professionals is of mutual benefit, enhances motivation and enthusiasm and provides an optimal opportunity to identify and develop research ideas. There are also increased opportunities to multidisciplinary collaboration.

Challenges include working with predominantly research native colleagues, limited research post opportunities and mentorship and decreased academic supervision opportunities. One of the most important challenges working as an academic within a clinical setting is to create and maintain effective collaboration with higher education institutes.

Three things that would be helpful for the senior academic working within the clinical setting include development of an established and credible research career pathway, increased opportunities for collaboration with HEIs and acknowledgement of a credible and equal partnership in the generation and delivery of research.

Paper 2:

Experience of being a post-doctorial academic within a university setting

Sharon Hamilton, Teesside University, UK

Over the last 25 years, nurse education has undergone a major transformation in the UK, moving from an apprentice style training to a university based education. This brought with it the opportunity for nurses to acquire the academic skills needed to start to develop an evidence-base for nursing practice. However, academic nursing is still a young discipline in the UK and while it offers many opportunities it also faces a number of challenges. This paper presents the experiences of a post-doctoral nurse pursuing an academic career in a university and highlights some lessons for others.

This particular post-doctoral researcher spent the majority of her career in the NHS, including a post as head of nursing research in a London Trust. Prompted mainly by the lack of a career pathway and permanent post in the NHS she left the NHS three years ago and was appointed to a Readership in Nursing at Teesside University. Teesside University was established as a new university in 1992. While education is the main business of the university, another key priority for the School of Health is the generation of research evidence that informs and underpins nursing practice. This offers a number of opportunities for post-doctoral academics including a career pathway that doesn't appear to be available in the NHS and linked with this are opportunities for career progression. However, challenges are evident. For example, managing teaching commitments while developing a research portfolio are particularly problematic for those in lecturing posts. For those in research posts the need to secure research grants and produce outputs of national and international standards are key challenges.

The main lesson learned from these experiences is the need for ongoing mentorship, particularly from a senior academic to facilitate the transition into the academic environment while offering guidance on career development.

Paper 3:

An international (antipodean!) perspective on role of the clinical chair in nursing

Professor Alan Pearson, The University of Adelaide, Australia

Clinical professors/chairs were first introduced into Australia in 1987 subsequent to the transfer of undergraduate nursing education from hospital schools to the Australian higher education sector in Australia. The transfer to the higher education sector was meant to create a balance between research, education and service, but it was very apparent at that time that educational rhetoric and outmoded views of science could drive nursing education and that the needs of health agencies could become decentralised. In an attempt to manage the tensions between nursing service, research and education, in 1987 the Faculty of Nursing at Deakin University, Geelong established two Professorial Nursing Units, headed by a Professor of Nursing, modeled on the Nursing Development Units established in Oxford and Burford. This represented Australia's first attempt to establish a clinical professorial role (or the first "clinical chair" in nursing). Subsequent to this, numerous clinical chairs have been established across Australia and, to a lesser extent, New Zealand, with varying degrees of success. There are now many clinical chairs with very different objectives and they are loosely seen as joint clinical/academic appointments with a variety of possible roles. Some clinical chairs have been very successful whereas others have struggled to develop and a number failed to survive longer than the initial contract period. In this session, the development of clinical chairs in Australia will be explored and possible precursors to success and failure will be addressed. Given that it is now well over 20 years since the clinical chair in nursing was first conceived, it is interesting to reflect on the rela-

tively slow progress in establish them as an integral part of nursing – as Ogden Nash so famously said: Progress might have been alright once but it has gone on far too long.

References:

Dignam, D; Honeyfield, J; Cooney, C (2000) Potential Outcomes of Joint Appointment/Clinical Chair Positions http://www.nurseducation.org.nz/documents/joint-apptpublishvers.doc Accessed 31st October 2009

Elliott, D. (1997). A conjoint appointment involving a nursing research management role. International Journal of Nursing Practice 3, 47-52.

Tamlyn, D., & Myrick, F. (1995). Joint appointments: A vehicle for influencing health care change. Journal of Advanced Nursing 22, 490-493.

Paper 4:

The clinical academic training pathway in England

Jo M Powell, National Institute of Health Trainees Coordinating Centre (NIHR TCC), UK

The author will present the Chief Nursing Officer (CNO) funded Clinical Academic Training (CAT) pathway for nurses, midwives and allied health professionals. This pathway is administered by the National Institute of Health Research (NIHR) and is available to applicants based in England.

Context: In 2007 the UKCRC Subcommittee for Nurses in Clinical Research (workforce), chaired by Professor Janet Finch, published a report 'Developing the best research professionals'. This report recommended a number of actions to support the development of clinical academic researchers. These are being implemented in England by the CAT pathway.

Content: A brief progress report of the CAT pathway, since its launch in 2008/9 will be provided, for each level:

- Seven Universities have each been awarded ten funded Masters places, each year 2009 – 2011
- Fifteen people were awarded CAT Doctoral Research Fellowships in September 2009
- Recommendations for Clinical Lectureships were made in November 2009

The first round of the Senior Clinical Lectureship was launched, with financial support from the Higher Education Funding Council for England (HEFCE), during 2010.

The remainder of the presentation will explore the various strategies needed to be considered to ensure that these roles are sustained. Discussion is likely to focus on the following:

The opportunities collaborative ways of working between Higher Education Institutions and the NHS present to support quality and productivity priorities.

The engagement of key decision making stakeholders in an emerging understanding as to what the post of a clinical academic might look like in practice and a recognition of the benefits it will bring to both NHS and HEI organisations.

Contribution: The CAT pathway contributes to the Modernising Nursing Careers framework, supports putting quality at the heart of the NHS and contributes to the overall vision of the NIHR, by building research capacity in England.

References:

Finch, J(2007) Developing the best research professionals, UK Clinical Research Collaborative

Darzi, A (2008) High Quality Care for All: NHS Next Stage Review final Report

Department of Health (research and development) (2006) Best Research for Best Health

S 19

Measuring compassion through a collaborative and appreciative approach

Morag Gray, Associate Dean (Academic Development), Faculty of Health, Life & Social Sciences, Edinburgh Napier University, UK
m.gray@napier.ac.uk

Abstract:

Recent evidence has highlighted nationally that patients and their families can experience care of an exceptionally poor standard (The Patients Association, 2009). There continues to be a striking increase in emphasis in policy, practice and research, about the importance of caring and compassion in healthcare (Scottish Government 2008, DoH 2008).

The Leadership in Compassionate Care Programme is an action research joint NHS and HEI initiative that aims to embed compassionate care as an integral aspect of all nurse education and practice in NHS Lothian. The initiative is in its third and final year.

This symposium comprises of four interlinking papers which aim to demonstrate the measurement of compassion, with a particular emphasis on collaborative and appreciative ways of working. The papers incorporate: findings from a leadership programme that identify how collaborative and supportive approaches to learning resulted in participants feeling empowered to act; work undertaken with Development Sites, that provided practitioners the opportunity to adopt an appreciative enquiry approach to develop and measure their compassionate care practices; utilising the teaching and assessment of students nurses' clinical skills provided a way of measuring their compassionate caring skills and the experiences of newly qualified nurses that indicated challenges

to providing compassionate care due to competing commitments and attitudinal differences amongst staff and patients.

The symposium will conclude with the recitation of a poem written collaboratively by the presenters that expresses their research experiences of measuring compassion whilst utilising collaborative and appreciative approaches.

References:

Department of Health (2008) "High Quality Care For All: NHS Next Stage Review Final Report" London, Department of Health

Scottish Government, (2008) "Leading Better Care" Edinburgh, Scottish Government

The Patients Association (2009) "Patients…not numbers, people…not statistics" The Patients Association http://www.patients-association.org.uk/DBIMGS/file/Patients%20not%20numbers,%20people%20not%20statistics.pdf

Paper 1:

Small changes big impact: Evaluating a leadership programme in compassionate care

Fiona Smith, Edinburgh Napier University, UK;
Gill McCrossan, Edinburgh Napier University, UK;
Stephen Smith, Edinburgh Napier University, UK

This research evaluated the impact of a leadership programme in compassionate care: focusing on participants, their clinical situations and the wider organisation. Recent policy documents emphasise the need to strengthen the climate for care through leadership by promoting models of practice that are centred on relationships, compassionate care and the need to nurture and sustain core fundamental caring skills and values (Finfgeld-Connett, 2007; Scottish Government, 2008; Smith, 2008).

This one year leadership programme is focused on personal development through innovative approaches to learning. The programme involves regular study days, action learning and individual coaching within participant's clinical areas. The aim was to facilitate participants to implement an action project pertinent to their clinical area. This compassionate approach to leadership development, aimed to provide learning related to theory which was also applicable to practice, whilst supporting the participant emotionally throughout this experience.

A multi method approach was used to explore the participant's (n=32) experience of the leadership programme and evaluate the effectiveness of their action project objectives. Data collection included; participant observation, questionnaires from action learning sets, 360° feedback process and evaluation of study days that utilised the SENSES framework as a measurement process.

We found, through specific examples cited by participants, that the knowledge gained, the sharing of good practices and the emotional support expe-

rienced, engendered a sense of confidence and empowerment to implement their action projects amidst the realities of providing services in challenging times (for example staff shortages). The combined impact of action learning and individual coaching addressed the emotional needs of participants.

During study days, the collaboration between participants resulted in sharing of knowledge, such as hints and tips of what was working to engage staff, and bring about change. Participants appreciated this collective and real time learning which enabled opportunities to try practices within their area.

References:

Finfgeld-Connett, D. (2007) "Meta-synthesis of caring in nursing". Journal of Clinical Nursing 17, 196 – 204.

Scottish Government, (2008) "Leading Better Care". Edinburgh, Scottish Government http://www.intute.ac.uk/cgibin/redir.pl?url=http://www.scotland.gov.uk/Publications/2008/05/30104057/0&handle=20080610-10442715 [accessed 15.10.09]

Smith, P., (2008) "Compassion and smiles: what's the evidence?" Journal of Research in Nursing 13, 367 – 370.

Funding source:

Paper 2:

How should we measure compassionate care and how do we know if initiatives to promote it lead to transformational change?

Belinda Dewar, NHS Lothian, UK; Ria Tocher, NHS Lothian, UK

In June 2008 the UK government, supported by the Royal College of Nursing, stated that nursing care would be measured for compassion (Bradshaw 2009). There is currently a lack of clarity about what to measure if we are to evidence compassionate caring. Compassion is a complex concept and measurement of this will require careful analysis and development if it is to measure what matters rather than what is easy to measure. This paper explores some key considerations for measurement of compassion and shares the extent to which action projects aimed at enhancing compassion achieved transformational rather than transactional change in 2 health care settings.

Within this action research study, the researchers acted as appreciative inquirers over a 1 year period, working with staff (n=40), patients(n=12) and families (n=14) to understand and develop processes to enhance compassionate care in 2 Beacon wards. The processes of appreciation and collaboration were fundamental to the approaches within the project.

The paper shares findings about processes that helped to begin to develop approaches to meas-

urement that were both appreciative and collaborative. These processes included:

• Facilitated discussions to articulate desired outcomes of a compassionate care change project for key stakeholders.

• Identification of positive care practices to inform the development of core statements that staff are willing to defend and measure themselves against.

• The art of appreciative questioning.

The project implemented a number of initiatives aimed at enhancing compassionate care. Did these initiatives lead to sustainable change? This will be explored.

The findings of this project have important implications for development of a tool for measuring compassion that has a strong evidence base and relevance to those who give and receive care.

References:

Bradshaw A (2009) "Measuring nursing care and compassion: the McDonaldised nurse" Journal of Medical Ethics 35, 465-468

Dewar B, McKay R, Smith Stephen, Pullin S and Tocher R (2009) in press "Use of emotional touchpoints as a method of tapping into the experience of receiving compassionate care in a hospital setting" Journal of Research in Nursing

Funding source:

Paper 3:

Teaching and measuring compassionate care in pre registration nurse training

Liz Adamson, Napier University, UK

It is evident from literature that compassionate care is welcomed by patients and influences their perception of the quality of care provided (Henderson et al., 2007; Cornwell & Goodrich 2009). Patient's experiences indicate, however, that compassionate care cannot always be taken for granted (NHS Confederation, 2008). It is therefore important to ensure that this fundamental aspect of nursing is included within the pre registration curriculum. However although compassionate care is acknowledged as foundational to nursing practice, making it explicit, embedding it throughout the programme of study and finding ways to measure it can be a challenge.

The Undergraduate strand of the Leadership in Compassionate Care Programme has provided an opportunity to begin to take this forward at Edinburgh Napier University through a number of actions developed from the initial phase of the programme.

A module that teaches recognition and management of patient deterioration to both undergraduate pre registration nursing students and regis-

tered nurses is one area where the initial actions have been implemented.

These actions include the following:

1. Patient stories gathered within the project Beacon wards are used to inform patient scenarios used in teaching and assessment through the use of simulation. The stories also inform the assessment criteria so that students are awarded marks for treating their patients with compassion.

2. Using a collaborative and appreciative approach students are encouraged to identify aspects of compassionate care during scenario debrief and critical reflection which inform the assessment criteria.

3. Actor patients are encouraged to feedback to students how compassionate they felt their care was during patient scenarios, what was important to them as patients and how their expectations could be met.

This paper will share examples of teaching and assessment initiatives and student views and experiences of engaging in compassionate care during simulation.

References:

Cornwell, J., Goodrich, J., (2009) "Exploring how to improve patients' experience in hospital at both national and local levels" Nursing Times, July Available at http://www.nursingtimes.net

Henderson, A., Van Eps M.A., Pearson, K., James, C., Henderson, P., & Osborne, Y., (2007) "Caring for behaviours that indicate to patients that nurses care about them". Journal of Advanced Nursing, 60 (2), pp.146-153.

NHS Confederation, (2008) "Future Debate: Compassion in healthcare, The missing dimension of healthcare reform?" London: NHS Confederation

Funding source:

Paper 4:

Developing competence and compassion: The experience of newly-qualified staff nurses

Dorothy Horsburgh, Napier University, UK

Little evidence exists about experiences of newly-qualified nurses in relation to compassionate care and a study exploring their perspectives is ongoing throughout the Leadership in Compassionate Care Programme. The study was approved by the University's Research Ethics and Governance Committee. Staff nurses volunteer to participate in focus groups or individual interviews during one or more of the four study days held at Edinburgh Napier University during their first post-registration year.

A constructivist grounded theory approach (Charmaz 2006) is being used. Four focus groups (total participants 26) and two individual interviews have taken place to date. The agenda focuses on support available to newly-qualified staff nurses

in NHS Lothian, whether this meets their needs and explores their perceptions of the meaning of 'compassionate care'. Collection and analysis of data are ongoing throughout the study.

Data analysis to date indicates that many staff nurses experience their immediate post-registration practice as 'being flung in at the deep end' and that support from colleagues is variable, dependent on 'the luck of the draw' rather than planned, structured and embedded within the culture of the NHS. Feedback on their performance is sometimes lacking, with some participants identifying that their post-registration experience highlighted how much support they received whilst students, compared with that available to them as staff nurses.

Participants are clear that, for activities to be labelled as 'caring', compassion is a prerequisite. Compassion involves active acknowledgement of patients as unique individuals but is challenging to deliver due to competing commitments and the sometimes negative attitudes of colleagues and patients. Compassion is not seen as confined to the nurse/patient relationship but should be evident also in interactions between staff and between patients. Findings from the study should enhance understanding of the experience and needs of newly-qualified staff nurses so that appropriate supportive measures may be implemented.

References:

Charmaz K (2006) Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis. London, Sage

Funding source:

Posters

Tuesday 11 May 2010

1

A phenomenological study exploring mothers' perceptions whilst establishing and maintaining breast feeding in the neonatal unit

Deb Wilson, St George's Healthcare NHS Trust, UK

Abstract:

There is a wealth of published data on breast-feeding and it is from this evidence that the World Health Organisation and the Department of Health have based their recommendations that every infant should be exclusively breastfed for the first six months of life. For babies that are born early or pre-term, it can take many weeks before they are ready to start feeding from the breast and for women who wish to breastfeed, maintaining lactation can be problematic.

It is noticeable in practice that a lot of mothers find their milk 'dries up' and they are unable to breastfeed their infant. This study was designed to explore the feelings and perceptions of mothers who deliver preterm infants towards expressing and maintaining breast milk whilst their child is being cared for in the Neonatal Unit.

A qualitative research design was chosen for this study incorporating a phenomenological methodology. A purposeful sample of eight mothers were consented to participate in a semi-structured interview, they had to have expressed breast milk for a minimum of 4 weeks to be included in the study. To provide structure and guidance, the analysis for this study used a method incorporating Colaizzi's procedural steps (Colaizzi 1978), interviews were transcribed, and themes once identified were placed into categories.

The findings although not contradictory to previous research, mostly reaffirm what is already known, however a perceived lack of support around expressing breast milk was obvious and the study highlights areas of practice that could be improved, particularly in relation to multidisciplinary working. The challenge for professionals is to ensure all mothers are supported to start expressing as soon as is practically possible and that this support is maintained whilst their child is on the Neonatal Unit including the transition to demand breastfeeding and the immediate period when home.

Recommended reading:

Colaizzi, P.F. (1978) In: Valle, R.S. King, M. (1978) Existential Phenomenological Alternatives for Psychology. Oxford University Press.

2

The effect of yoga on general wellbeing in Type 2 Diabetes Mellitus

Lorna Ingoe, North East & Cumbria Diabetes Research Network, Newcastle upon Tyne Hospitals NHS Foundtion Trust, UK

Co-authors: P Rao; G Hancock; R M J Robinson; J U Weaver

Abstract:

Background: There are no randomised controlled trials which examine the effects of yoga on physical and social wellbeing in Type 2 Diabetes Mellitus (T2DM).

Aim: To examine the effects of Hatha Yoga on physical and social wellbeing in patients with established T2DM and features of the metabolic syndrome.

Method: 100 adult males and females were recruited. 50 participants were each assigned to the intervention and control arms using a randomisation programme. Yoga classes were provided by trained instructors. Participants attended at least one class per week and were encouraged to practice yoga exercises at home using a DVD and written instructions for 6 months. An assessment of wellbeing was made using the SF-36® Health Survey Standard English (U.K.) Version 2 at randomization and study completion from January 2006 to September 2007.

Results: The withdrawal rate from the study was higher than expected. 22% of participants withdrew from the intervention arm and 8% from the control arm. In the mental wellbeing domain there was no statistical difference between the 2 groups for vitality (p=0.67), role emotional (p=0.43) and mental health (p=0.90). However social functioning was statistically different (p=0.02). In the physical wellbeing domain there was no statistical difference for physical functioning (p=0.48); role physical (p=0.61); bodily pain (p=0.19) and general health (p=0.52).

Discussion: After six months the participants practising yoga had a significantly improved level of social functioning compared to those in the control arm. Physical health or emotional problems did not interfere with normal social activities with family, friends, neighbours or groups both in terms of time spent on these activities and the extent to which they were enjoyed.

Conclusion: Patients with T2DM are encouraged to attend subsidised yoga classes run within the locality for the purposes of exercise, relaxation and social interaction as an adjunct to usual treatment options.

3

Multisensory stimulation strategies in treating older adults with pain

Mimi Tse, Assistant Professor, School of Nursing, Hong Kong Polytechnic University, Hong Kong

Co-author: S S K Ho

Abstract:

Background: Pain is very common in older adults and is often under reported, under accessed and under treated. As a result, older adults may have negative mood states and reduced quality of life.

Aims: To reduce pain using multisensory stimulation strategies.

Method and Procedure: The study adopted a quasi-experimental pre and posttest design. 77 older adults in a nursing home joined an eight-week multisensory stimulation programme (MSP). MSP used multisensory stimulation (sense of touch, smell, taste, hearing and sight) and participation in crafts (making paper flowers, paper cups, paper fans and key chains, and putting photos into their own albums).

MSP included broadcasting soft music and applying essential lotion to the faces and hands of the participating older adults. They were asked to close their eyes and practise deep breathing while listening to the music, and they were guided to feel their bodies and smell the fragrant lotion. Chinese tea was provided and older adults were invited to note the fragrance of the tea. In addition, attractive pictures of natural scenery and photos of movie stairs and historic buildings were shown to bring back memories of the past.

Results: Around 80% of the older adults had suffered from pain in the previous three months, pain intensity was 5.35 ± 2.79 (on a 10-point scale), and pain was mainly in the knee, back and shoulder.

Upon completion of the MSP, mean pain intensity had significantly decreased to 3.86 ± 1.95 (p<0.05). Psychological parameters (happiness, loneliness, life satisfaction and depression scale) were significantly improved (p<0.05). Older adults stated that they had been able to relax and enjoy MSP.

Discussion and **Conclusions:** MSP proved to be effective in reducing pain among older adults. To manage pain in a creative way, MSP is inexpensive, easy to use and welcomed by older adults.

4

Meeting phase one accreditation – A colaborative approach from the non commercial perspective

Polly Tarrant, Lead Research Nurse, Addenbrookes Clinical Research Centre, Cambridge University Hospitals NHS Foundation Trust, UK

Co author: S Kornelia-Hathaway

polly.tarrant@ntlworld.com

Abstract:

Following the events of March 2006 where a number of phase one First In Man clinical trial participants became critically ill following administration of a novel monoclonal antibody, TGN412, an Expert Scientific Group on Phase 1 Clinical Trials was set up by the Secretary of State for Health to identify strategies for improving participant safety in future trials of First In Human investigational products. The Medicines and Healthcare Products Regulatory Agency have subsequently put in place a number of recommendations for the conduct of Phase 1 clinical trials, and put in place a voluntary accreditation scheme for Units carrying out such trials.

To date the accreditation process has been implemented only in commercial units, but it is recognised as setting the benchmark for clinical practice in this area. Although the MHRA has not yet confirmed that the same criteria will be used to accredit non – commercial research units, the Wellcome Trust Clinical Research Facilities (CRFs) have been collaborating to establish strategies to meet the requirements outlined in the accreditation scheme. A Quality Assurance Working Group incorporating clinical, quality and laboratory managers from Southampton, Manchester, Birmingham, Edinburgh, Cambridge and Cardiff CRFs has produced a number of core measures including risk assessments, training criteria, standard operating procedures and audit tools, all of which will be outlined here. In addition, we discuss how one particular dilemma for a multi-user facility, ensuring Principal Investigator suitability and training, was approached and possible solutions identified. The presentation demonstrates how shared experience and knowledge has created a robust framework which demonstrates adherence to Good Clinical Practice and contributes to participant safety in high risk trials.

Recommended reading:

MHRA (2007) MHRA phase 1 accreditation scheme. MHRA, Nov 2007

Good Clinical Practice(2002) www.mhra.gov.uk/Howweregulate/Medicines/Inspectionandstandards/GoodClinicalPractice accessed June 2009

Funding source:

No Funding

5

Newcastle clinical research facility patient satisfaction audit

Victoria Bridgett, Clinical Research Facility, Newcastle upon Tyne Hospitals NHS Foundtion Trust, UK

Co-authors: J Wilson; M Walker

Abstract:

Aim: To undertake a satisfaction survey of study participants attending the Newcastle NIHR Clinical Research Facility (CRF) using a simple 10 item questionnaire.

Methods: 30 study participants were randomly selected over a four week period. They were asked to complete the questionnaire whilst attending the CRF. Participants were given full instructions on how to complete the questionnaire, which was based upon the Newcastle Hospitals NHS Foundation Trust Patient Satisfaction Questionnaire.

Results: A total of 30 participants completed the questionnaire.

On entering the unit all 30 participants (100%) reported that they were greeted in a friendly and professional manner and were seen within a reasonable time by a health care professional. Again 30 (100%) participants thought that the information they received about the clinical trial they were involved in was the right amount and instructions on how to get to the unit were clear.

All participants (100%) expressed that they were treated with, privacy, respect and dignity.

On leaving the unit 29 participants (99%) felt that were told whom to contact if they were worried about any aspect of their care and 1 participant responded yes, 'sometimes'

Overall, 28 (93%) participants rated the standard of care and service as 'excellent' and the other 2 (7%) rated it 'very good'.

Discussion: Although the questionnaire was conducted in a small group of study participants, it captured their overall views of the CRF and staff. The plan is to now modify the questionnaire for paediatric participants and to conduct the satisfaction survey annually as part of our NIHR CRF performance audit.

Funding source:

No Funding

6

Changing practice through action research: Three examples in children's nursing

Antonia Beringer, Research Fellow, Faculty of Health & Life Sciences, University of the West of England, UK

Co-authors: K Tomasino; P Mahendran

antonia.beringer@uwe.ac.uk

Abstract:

Background: Action research is recognised as an appropriate and effective approach to developing practice. Here we present three examples of how it was used by multi-disciplinary groups of staff to address specific aspects of care.

Aim: To describe the process and outcomes of three projects to develop practice in a children's hospital, paying particular attention to factors which promoted and hindered engagement.

Process: Workshops were held to identify which issues staff themselves wanted to improve and to emphasise the practitioner-led nature of the project. A facilitated action research approach provided the structure for group sessions of three project groups, which operated simultaneously between November 2008 and October 2009.

The groups chose to focus on i) the care of adolescents with mental health needs, ii) the dispensing of take home medicines from the ward, and ii) the provision of equipment for ongoing care in the community. The majority of group members were ward-based nurses who worked with colleagues from pharmacy , community nursing and play therapy to collect baseline measures, introduce changes and measure their effect.

Outcomes: Although proceeding at different rates and with varying levels of engagement, each group achieved changes in the area of practice they had chosen and developed a range of skills during the action research process. These included the development of a self harm risk assessment tool, the introduction of a process to dispense medicines direct from the ward and the production of discharge equipment packs.

Discussion: Two key features of the action research approach adopted facilitated change in practice – flexibility in pace and in scope. The former enabled staff to progress towards their chosen goals at a rate that accommodated clinical commitments. The latter allowed the project work to be responsive to changes within and outside the organisation, keeping it up-to-date and relevant .

Recommended reading:

Beringer, A.J. & Julier, H. (2009) 'Time Off the ward: an action research approach to reducing nursing time spent accompanying children to X-ray'. Paediatric Nursing, 21,2, pp31-33.

Coghlan, D .& Casey, M. (2006) 'Action research from the inside: issues and challenges in doing action research in your own hospital'. Journal of Advanced Nursing, 53,3,pp 304-310.

Williamson, G. R. & Prosser, S. (2002) 'Action research: politics, ethics and participation'. Journal of Advanced Nursing, 40,5, pp 587-593.

7

What can research nurses contribute to enhancing portfolio research in Primary Care

Louise Jones, Research Nurse in Primary Care, Research and Development, Northumberland Care Trust, UK

Co-authors: E Mckeith; L Walker

Abstract:

A few GP's have been involved in research for years however most medical research projects are carried out in secondary care settings. This has denied patients seeking healthcare in the Primary care environment from being involved in research. It also results in specific primary care questions not being answered and limiting research opportunities for primary care staff.

In Northumberland Tyne and Wear the Primary Care Working Group consisting of members from the Comprehensive Local Research Network (CLRN), Primary Care Trusts (PCT's) and Primary Care Research Network (PCRN) were keen to promote portfolio research in Primary Care and set up initiatives to address this. A pilot scheme recruiting NTW GP research practices began in 2008. 19 GP practices have been awarded funding for two years to carry out research projects from the NIHR portfolio. The scheme is tiered with support given depending on individual practice level of research ability. Some practices with research experience can deliver portfolio research however practices with only some capability and capacity but interest have access to CLRN funded research nurses to ensure portfolio research delivery.

As research nurses in Primary Care we will describe our role in terms of support, clinical interventions and database management providing a case study to illustrate how we work. This new role brings considerable barriers to overcome, one such barrier is the lack of NIHR projects with nurse involvement. We will discuss the need for nurse focused research training sessions to facilitate the development of nurse led research proposals. Other barriers will be highlighted and the learning from them shared. Suggested solutions of how this role may work in the future in Primary Care, how we can develop other nurses interest and skills in the delivery of portfolio research and the potential opportunities open to nurses will be discussed.

8

Nursing contributions to mobilising older adults following total hip replacement in Ireland

Mary OSullivan, Clinical Development Coordinator, Orthopaedics and Trauma, St Mary's Orthopaedic Hospital, Cork, Ireland

Abstract:

The aim of this study was to describe the nursing contribution to mobilizing patients following total hip replacement. The objectives were to describe nurses' perceptions of their contribution to the physical care of patients in promoting mobility following surgery, as well as their contribution to the psychological care and the education of patients undergoing hip replacement surgery. The study was quantitative with descriptive design. Data was collected by a 12-item questionnaire designed by the author. Sample consisted of (n=30) nurses. The response rate was 77%.

Results showed that the greatest contribution of nursing was in relation to the provision of physical care (65.2%) and patient education (34.8%). Physical care was represented by: pressure area care (78.3%), pain management (69.6%), meeting patient comfort needs (69.6%), and the prevention of wound infection (65.2%). Nurses however also identified that they contributed to patients' psychological well-being: Nurses competence (73.9%), observation of patients, (73.9%), acknowledgment of holistic needs (56.5%) and keeping patients informed (43.5%) were rated by nurses as the areas of psychological care that impact greatest on patients mobility. In relation to the process of educating patients undergoing hip replacement surgery nurses perceive that the areas of most importance are effective communication, providing patients with education reflective of their individual needs. Educational content on functional, biophysiological, cognitive, and social aspects were considered most important with that pre-admission was the optimum time for the provision of education.

A conclusion therefore is that nurses see their contribution to the rehabilitation of patients' mobility following total hip replacement as explicit in relation to physical care, psychological care and patient education. Recommendations are made for further developments in rehabilitative nursing for older people with musculoskeletal conditions.

Recommended reading:

O'Sullivan, M*. & Savage, E. (2008) Nursing contributions Nursing contributions to mobilising older adults following total hip replacement in Ireland. Vol.(12) 181-186

9

An "ageless" approach to translational research

Lucy Cooper, Professional Development Research Sister, Wellcome Trust Clinical Research Facility, Birmingham Children's Hospital NHS Trust, UK

Abstract:

Conditions such as inherited metabolic disorders and childhood cancers are unique to paediatrics whilst others such as childhood diabetes and obesity offer early indicators for future health outcomes. Research programmes within paediatric and adolescent populations offer the opportunity to identify novel therapies and to investigate disease mechanisms that could lead to cures and long-term health improvements. However, research across the paediatric/adult transition poses specific challenges to researchers.

The advent of a paediatric research facility marked a new era of translational research in Birmingham enabling an 'ageless' approach to our understanding of prevalent human disease across diverse ethnic communities. The new paediatric facility was established as a sister to the existing adult facility and whilst tailored to the paediatric setting was developed on the strength of their systems, procedures and management structures

In order for research to bridge the paediatric/adult transition and to ensure consistency, staff from both facilities work closely together in approving and implementing research studies. Patient pathways are tailored to the patients needs and are planned to accommodate the specific research requirements. Staff work flexibly between the two sites to provide continuity and age appropriate nursing care.

However there have been political challenges to overcome to enable adult and paediatric nursing staff to work outside of the normal procedures for caring for over/under aged patients. This is particularly important when caring for families taking part in genetic research studies and studies in late adolescence where patients progress to adult care during their involvement. These aspects were addressed by the development of new governance measures which include policies for risk assessment, honorary contracts, nursing supervision and education.

The collaborative approach provides a streamlined and patient-focussed model which supports research across all ages within the Birmingham population.

Posters

10

Researching complex patient experience: Using 'Pictor' to help cancer patients tell their story

Beth Hardy, Behavioural Sciences, University of Huddersfield, UK

Abstract:

Qualitative research in healthcare often demands research participants to describe complex situations and experiences. Service users may find it difficult to elucidate their experiences, and the challenge for health care researchers in these cases is to facilitate participants to tell their story effectively, whilst being both minimally intrusive and sensitive to the participants situations (Seymour & Clark, 1998).

Pictor is a research interview tool that was developed in research on collaborative working in health care (King, 2004). It has been adapted in a current study investigating the experiences of palliative cancer patients who are receiving support from multiple services in primary care, with the aim of a greater understanding of this experience from a service user perspective.

Participants are asked to bring to mind all the services that they have contact with and write these on separate arrow shaped 'post it' notes. The participant is then asked to place the 'post it' notes on a larger sheet of paper in a manner that helps them describe their experience with these services. They are advised to use the arrows to demonstrate their different relationships, for example, a very close relationship with a service or individual might be indicated by the close laying of the notes with the arrows facing each other. The only rule is that the participants must include themselves. The 'Pictor' diagram is not itself analysed, but forms the basis of further discussion with the participant about their experiences.

This method has proved successful in assisting participants to reflect on, and describe complex experiences. As a tool, Pictor has great possibilities for use in qualitative research in different contexts including complex situations and facilitating reflection on individual case studies.

Recommended reading:

King, N. (2004). Using templates in the thematic analysis of text. In C. Cassell & G. Symon (Eds.), Essential Guide to Qualitative Methods in Organizational Research (pp. 256-270): Sage.

Seymour, J., & Clark, D. (1998). Phenomenological approaches to palliative care research. Palliative Medicine, 12, 127 – 131.

11

Urban regeneration and health: Forming partnerships

Monique Lhussier, Community Health and Education Research Centre, Northumbria University, UK

Co-authors: S M Carr; L Geddes

Abstract:

The 2004 public health white paper (DoH 2004) sought to enable individuals to make healthier choices, with a particular focus on those living in disadvantaged communities. It builds on the vision of a 'fully engaged scenario', in which people take control of their own health and the wider determinants of ill health are addressed. (Wanless 2004) This presentation reports on a project in which academics, regeneration professionals and local residents were brought together to share their professional and lay experiences of health and well-being within an area of regeneration.

11 community members acted as peer researchers throughout the process. Their role was to gather 'stories' about people's experiences, using visual recording methods. Interviews were also carried out with key stakeholders (n=13) working or providing services in the area. Regeneration professionals and peer researchers were then brought together in a workshop aimed at sharing perspectives and identifying potential solutions to known problems.

The participatory action research methodology proved a valued alternative approach to research health and well being locally. Particular challenges were highlighted, such as the fact that relationship-building between academics and local residents proved resource-intensive, requiring trust and a sense of reciprocity to be developed. Nevertheless, residents have benefited from raised awareness about health and well-being in relation to regeneration and physical transformation. Regeneration professionals have benefited from gaining a broader understanding of the role of the community place and the environment as important indicators in the ways that local residents construct their health and well-being. Perhaps central to future regeneration practice, regeneration stakeholders also appreciated the benefits of active resident engagement in the research and extrapolated this to potential insights such engagement might bring to future regeneration practice. These messages are of particular relevance to public health and community practitioners in their partnership building endeavours.

Recommended reading:

Department of Health. Choosing Health: making healthy choices easier. London: The Stationery Office; 2004

Wanless D. Securing good health for the whole population. Final report. London: HM Treasury; 2004

12

Planning for end of life: The development of the 'child & family wishes' document using an action research approach

Antonia Beringer, Research Fellow, Faculty of Health & Life Sciences, University of the West of England, UK

Co-authors: J Fraser; N Harris

Abstract:

Background: Planning for end of life care is a sensitive but important part of providing comprehensive and individualised care for children with life-limiting conditions. The aim of the End of Life Planning project was to develop written guidance for staff that would support discussions with the child and family about end of life and clarify their wishes for the type, intensity, duration and location of care.

Process: A facilitated action research approach was used by a multi-disciplinary project group whose members represented the full range of services that provide end of life care. The group met for 10 sessions over 18 months (Nov 2007 – June 2009). Current end of life planning practices in hospital, home and hospice settings were compared to establish the baseline for each service. Through a process of negotiation and reflection, a document was designed and piloted across the settings.

Outcomes: A 'Child & Family Wishes' document was produced which a) offered guidance for staff to encourage and support them in undertaking discussions with families about their wishes and, b) provided a template on which to record the outcome of discussions. After clinical governance approval the document was adopted locally by hospital and primary care trusts and nationally, through ACT – The Association for Children's Palliative Care.

Discussion and **Conclusions:** This project contributes to our knowledge about how end of life care planning can be supported and offers a practical way to achieve multi-disciplinary consensus on the design and usage of new documentation to support discussion about sensitive issues.

Further research is now planned to measure the impact the 'Wishes' document has had on end of life planning. A particular concern will be to explore whether the family's' wishes for the place of death have been recorded and acted upon.

Recommended reading:

ACT Association for Children's Palliative Care (2004) A framework for the development of integrated multi-agency care pathways for children with life-threatening and life-limiting conditions. Available at http://www.act.org.uk (accessesd 20th October 2009

Department of Health (2008) 'Better care: better lives. Improving outcomes and experiences for children, young people and their families living with life-limiting and life-threatening conditions'. DoH, London. Available at:

Fraser, J., Harris, N., Beringer, A., Prescott, H. & Finlay, F. (in press) 'End of life planning in children with life-limiting conditions – the Wishes Document'. Archives of Disease in Childhood (accepted for publication October 2009).

13

Generating evidence based nursing care guidelines for the treatment of pyrexia in adults

Irene Mabbott, Learning and Development Department, Sheffield Teaching Hospitals NHS Foundation Trust, UK

Co-authors: Catherine Jennings; Clare Warnock; Julie Foster; Cheryl Dixon

Abstract:

This presentation will describe the process used to generate evidence based nursing care guidelines related to the treatment of pyrexia in adults. The lack of guidance in this area was reported by a Trust wide body, the Evidence Based Council, which brings together nurses and other disciplines in order for them to share best practice.

A wide variation in the use of anti-pyrexial medication and techniques in practice were identified. No clear guidance existed regarding any specific temperature for these interventions and there was concern identified with inappropriate use medications and practices leading to the masking of clinical infections. The discussions at the Council led to a group being formed to examine the evidence related to the treatment of pyrexia and provide consistent evidence based guidance for practice. A literature search of the major electronic databases, including Medline, CINAHL etc, was conducted as well as internet resources such as SIGN, NICE and the Cochrane database.

Members of the group reviewed the citations and decided on their relevance based on specified inclusion criteria. The citations found three key areas of interest including the pharmacological / medical interventions, practical solutions to the problems and reassurance and assessment theories. Data from the studies were extracted and the evidence systematically appraised. Nursing care guidelines were developed based on this evidence which outlined a step by step approach to care.

Myths and healthcare rituals were discovered as part of this process but the guidance that was developed relied on up to date available evidence to provide active support for clinical staff and improve direct patient care. The dissemination of these guidelines has helped provide consistency in care throughout the organisation.

Recommended reading:

Aveyard, H, & Sharp, P, (2009) A beginners guide to Evidence Based Practice, Maidenhead, Open University Press.

Burgers JS, Grol R, Klazinga NS, Makela M, Zaat J, (2003) AGREE Collaboration. Towards evidence-based clinical practice: an international survey of 18 clinical guideline programs. International Journal of Qualitative Health Care. 2003 Feb;15(1):31-45

Connell, F, (1997) The causes and treatment of fever: A literature review, Nursing Standard, Vol. 12, No. 11, pp40-43

14

The relationship between perception of risks and lifestyle behaviours among selected male health care professionals in Trinidad and Tobago.

Oscar Ocho, Public Policy Unit, London School of Hygiene & Tropical Medicine, UK

Abstract:

Objective: The aim of this study was to identify the relationship between health professionals' knowledge and their lifestyle related behaviours.

Design and methods: A quantitative study design was used with a forty item questionnaire as the data collection instrument. A total of eighty-nine respondents including forty-five nurses and forty-four medical doctors were selected utilizing systematic sampling design. Respondents were chosen from the four major hospitals in Trinidad and Tobago.

Results: The study showed that there is a negative relationship between knowledge as a precursor to preventing lifestyle health problems and the frequency of exercise routines ($-.256$, $p<.05$). A negative relationship was observed between perception of vulnerability and selected health-related behaviours including frequency for eating fast foods ($-.257$, $p<.05$), frequency for consuming alcohol ($-.252$, $p<.05$), amount of cigarettes smoked daily ($-.297$, $p<.01$) and frequency for exercise routine ($-.391$, $p<.01$).

There was a moderate relationship between occupational status and the frequency with which male health care professionals ate fast foods ($.244$, $p<.01$), family history of coronary artery disease and the frequency of drinking alcohol ($-.230$, $p<.05$). Lifestyle health risks were significantly related to a potential diagnosis for coronary artery disease ($.413$, $p<0.01$), hypertension ($.484$, $p<0.01$), STI ($.433$, $p<0.01$) and HIV/AIDS ($.432$, $p<0.01$).

Conclusion: While male health care professionals are cognizant of the potential and actual deleterious effects of lifestyle behaviours their behav-

iours are not always consistent with their level of cognition. Consequently, knowledge does not always play a critical role in determining behaviour. While male health care professionals are conscious of the negative consequences of risk behaviours; the practice of potentially negative behaviours may not be construed as risks.

15

A study of parental stress and development of preschool-aged children of the immigrant mothers in Taiwan

Ya-Wen Lin, School of Nursing, China University, Taiwan, R.O.C

Co-authors: S F Su; Y H Tseng; J N Sheu

Abstract:

Transnational marriage has become a global phenomenon whereby the brides from less developed countries marry and move to live with the grooms from more developed countries. In Taiwan, the foreign marriage rate was 31.9% in 2003, and it decreased to be 14% in 2008. One of six children today was born by the immigrant mothers who might have difficulties in dealing with the transnational cultures and languages. However, limited studies have been conducted to investigate the immigrant mothers' stress and the development of their preschool-aged children.

The purpose of this study was to explore the relationships between parental stress and the development of preschool-aged children of the immigrant mothers. A cross-sectional correlational research design and convenience sampling were used. Participants were 120 immigrant mothers from southeast Asia living in Taiwan and their 3-6 year-old children, including 61boys and 59 girls. Subjects completed 3 questionnaires, Denver II Developmental Screening Test, Parenting Stress Index, and Demographic Questionnaire. Descriptive analysis, Correlation coefficient, Chi-square, Mann-Whitney U test, Post hoc test (Scheff test) were used for data analysis.

Results of this study showed that these mothers were from Vietnam and Indonesia in averagely 22.5 years old. The DDST II indicated that 85.8% of their children were normal and 14.2% was suspected of developmental delay. The major developmental delay was language. Findings also revealed that mothers' parenting stress was mainly coming from parenting distress and difficult child. Parenting distress scores in the delay development group was higher than the normal group. Although developmental delays were found in these children, their immigrant mothers did not perceive this big issue. We suggest that the immigrant mothers and their children need to be concerned. The health care system and education system should provide appropriate interventions and enough social

support for the immigrant women in promoting their mother roles.

Recommended reading:

Wong, C.C. & Tsou, K.S. (2005) ,Clinical Characteristics of Young Children with Developmental Delay. Taipei City Medical Journal, vol 6, no 6, pp535-544.

Bailey, D.B., Skinner,D.,& Warren S.R.(2005) Newborn Screening for Developmental Disabilities: Reframing Presumptive Benefit. American Journal of Public Health, vol 95, pp1889-1893.

Woolfson, L., & Grant, E. (2005) Authoritative parenting and parental stress in parents of pre-school and old-children with developmental disabilities'. Child Care Health and Development, vol32, no 2, pp177-184.

Funding source:

16

Current utilisation of rehabilitation services and assistive devices in Huntington's disease: Analysis of European-wide client service receipt inventory data

Joyce Kenkre, University of Glamorgan, UK

Abstract:

Background: The Client Service Receipt Inventory (CSRI) is designed to collect information about use of health and social care service and is routinely collected as part of the European Huntington's Disease Network (EHDN) Registry study. This study utilised CSRI data to evaluate physiotherapy input and assistive devices for aspects of Activities of Daily Living (ADL) in HD according to the Total Functional Capacity Scores (TFC).

Methods: Data from 1395 Registry visits for 793 participants (up to 5 separate visits between the years 2004 and 2008) in participating Registry countries were available for analysis. Descriptive data of demographics, scores for Unified Huntington's Disease Rating Scale (UHDRS) motor and Total Functional Capacity (TFC) scores, physiotherapy and speech therapy input, assistive devices and adaptations was obtained. Cross-tabulations according to TFC scores were undertaken.

Results: At visit 1,385 males and 408 females were assessed from 12 European countries. Mean (SD) age was 49.5 (13.3) years. Median (range) UHDRS motor and TFC scores were 54 (0-106) and 8 (0-13) respectively). Only 151(19%) had received physiotherapy at visit 1. Care was mainly provided by the general practitioner, followed by the physiotherapist, speech therapist and then the nurse. There was clear utilisation of assistive devices and a trend for more adaptations and care support with decreasing TFC scores.

Conclusion: Initial data analysis suggests an underutilisation of physiotherapy services and limited nursing input, particularly in the home environment.

Funding source:

17

Review of attainments of the Research Strategy for Nursing & Midwifery in Ireland, 2003-2008

Sarah Condell, National Council for the Professional Development of Nursing and Midwifery, Ireland

Abstract:

The Commission on Nursing (Government of Ireland, 1998) suggested that a national strategy be developed to guide and support the development of a research base for Irish nursing and midwifery. Following a subsequent consultation with key stakeholders, a strategy was published (Deparment of Health & Children, 2003) outlining 21 recommendations over a five year timeframe. These recommendations spanned the research continuum from research generation to its application in practice and included professional representation on key research bodies such as ethics committees and funding agencies. The challenges to implementation of the strategy are described elsewhere. (Condell, 2004)

This poster is based on a report to the Chief Nurse regarding the attainments of that strategy. It utilises information supplied by stakeholders, such as funding agencies and professional development units, in addition to subsequent research and policy reports and web-based searches. The information was gathered one year after the end of the strategy to outline the key attainments of the strategy, 19 of which were deemed to be attained. The poster will outline some of the key attainments.

Recommended reading:

Government of Ireland (1998) Report of the Commission on Nursing. Dublin, Government Publications

Department of Health & Children (2003) Research Strategy for Nursing and Midwifery in Ireland. Dublin, Government Publications

Condell SL (2004) Journeying to professionalism: the case of Irish nursing and midwifery research. International Journal of Nursing Practice, Vol 10 No 4 pp145-149

Funding source:

18

Realist approaches to data generation

Monique Lhussier, Community Health and Education Research Centre, Northumbria University, UK
Co-author: S M Carr

Abstract:

In spite of the inherent complexity of public health practice, practitioners are faced with both a requirement to demonstrate effectiveness and a dearth of tools to do so. The authors have been working on the development of realist approaches to evaluation for a number of years. This has proved a particularly successful methodological framework (Carr et al 2008a). The authors have used realist approaches in conjunction with appreciative enquiry (Carr & Lhussier 2008), with health impact assessment (Lhussier et al. 2008) and with soft system methodology (Carr et al. 2008b). This presentation aims to expose and encourage discussion about these methodological developments.

Realist approaches encourage practitioners to populate a 'context-mechanism-outcome' framework. This enables a surfacing of often implicit forms of knowledge, so that details of intervention mechanisms can be contextualised. From there, practitioners are encouraged to identify short, medium and long outcomes which they expect the intervention might achieve. This enables practitioners to establish evidence generating evaluation strategies to support intervention development.

– In conjunction with principles of health impact assessment, a realist approach enabled practitioners to become explicit about why their project worked in the particular circumstances (Lhussier et al. 2008).

– In conjunction with soft system methodology, realist methodology enabled practitioners to highlight the complexity of their combined intervention and potential synergies of action. (Carr et al. 2008b)

– In conjunction with appreciative inquiry, realist synthesis enables a co-creation of understanding that builds on past success and frames them in a way that will facilitate replication (Carr & Lhussier 2008).

Methodologically, these advances offer huge potential to practitioners faced with the necessity to generate evidence of effectiveness. They offer the possibility to frame past successes, to acknowledge local specificities and the often impossibility of achieving long term epidemiologically measurable impacts, and to frame and assess progress.

Recommended reading:

Carr S M & Lhussier M (2008) Replicating good practice: The 'flat-pack' approach Practice Development in Health Care 7(4):180-188.

Carr SM, Lhussier M, Wilkinson J, Gleadhill S. (2008a) Empowerment evaluation applied to public health. Critical Public Health 18(02): 161 – 174.

Lhussier M, Carr SM, Robson A (2008) The potential contribution of realistic evaluation to small-scale community interventions Community Practitioner 81(9): 25-28.

Wednesday

1

The obesity epidemic: Evaluating effective interventions

Monique Lhussier, Community Health and Education Research Centre, Northumbria University, UK

Co-authors: S.M. Carr; M Cook; D Ruta; T McKenna

Abstract:

Obesity is acknowledged to be a highly complex problem and there is limited understanding of effective interventions, although practice guidance is developing (DOH 2008). Public awareness of obesity may be increasing, yet this does not necessarily translate into the required behaviour change (Jebb, Steer & Holmes 2007).

This presentation reports on a multi-intervention coordinated approach to tackling childhood obesity. Its distinctiveness consisted of the combination of a variety of target groups (parents, overweight children, obese children, all children in a particular class), interventions (cooking, exercising with weight monitoring or engagement in exercise practices, community engagement in the healthy agenda) and outcomes (raising awareness, reducing weight, increasing fitness, improving exercising opportunities, changing family eating practices), all focussed upon a geographically circumscribed community. The context-mechanism-outcome (CMO) approach (Pawson & Tilley 1999) strongly guided the design of the evaluation in terms of providing a systematic approach to studying connections between activities, outcomes and contexts.

In the process of delivering their intervention, the providers gained a greater insight into obesity causal factors in the target population. These included; lack of appreciation of acceptable BMI, or of the need to engage in weight management, large portion sizes, lack of cooking skills and facilities, limited knowledge on healthy recipes and menu development, lack of access to structured and appealing physical activity, inadequate resources to participate in physical activity, lack of knowledge and skills to maintain equipment such as cycles. The intervention addressed a wide menu of outcomes pertinent to addressing lifestyle choices relevant to obesity development at short, medium and long term time lines. This is a very positive finding as it accommodates participants at various stages of need and readiness to become involved.

Recommended reading:

Department of Health (2008) Healthy weight, healthy lives: A cross-government strategy for England HMSO

Jebb S, Steer T & Holmes C (2007) The healthy living social marketing initiative: a review of the evidence MRC: Human Nutrition Research

Pawson R & Tilley N (1999) Realistic evaluation. Sage

2

Psychomteric validation of the Chinese version of the illness perception questionnaire-revised

Shiah-Lian Chen, Associate Director, Department of Nursing, HungKuang University, China

Co-authors: Jen-Chen Tsai; Wen-Lieng Lee

Abstract:

This paper is a report of a study to evaluate the psychometric properties of the Chinese version of the Illness Perception Questionnaire-Revised, using the technique of confirmatory factor analysis.

The Illness Perception Questionnaire-Revised is the most commonly used instrument for assessing patients' views of illness, and there is good evidence for the psychometric properties of the English version. However, there is inconsistency in the literature about how scores of the Illness Perception Questionnaire-Revised should be.

A cross sectional survey was conducted in three teaching hospitals in central Taiwan. The Chinese Illness Perception Questionnaire-Revised was administered to a purposive sample of 358 patients with hypertension.

Confirmatory factor analysis provided evidence of satisfactory factorial validity, convergent validity and discriminant validity of the Chinese Illness Perception Questionnaire-Revised. Internal consistency was supported by adequate Cronbach's alphas and composite reliability. The factor structures of the identity and cause subscales were found to be an acceptable fit to the data. The findings of model evaluation supported the seven-factor structure, after removal of six poorly fitting items. Second-order analysis indicated two factors (control and negative illness representation) representing latent constructs underlying the factors of personal control, treatment control, consequence, timeline-cyclic and emotional representation.

The Chinese Illness Perception Questionnaire-Revised is a reliable and valid instrument for the measurement of illness perceptions in patients with hypertension.

Recommended reading:

Moss-Morris R., Weinman J., Petrie K.J., Horne R., Cameron L.D.& Buick D. (2002) The Revised Illness Perception Questionnaire(IPQ-R). Psychology & Health, 17, 1-16.

Hagger M.S. & Orbell S. (2005) A confirmatory factor analysis ofthe revised illness perception questionnaire (IPQ-R) in a cervicascreening context. Psychology & Health 20,2, 161-173.

Weinman J., Petrie K.J., Sharpe N. & Walker S. (2000) Causalattributions in patients and spouses following first-time myocardialinfarction and subsequent lifestyle changes. British Journal of Health Psychology 5, 263-273.

3

Linking high quality nursing research and practice in the north-east: Emerging opportunities

Monique Lhussier, Community Health and Education Research Centre, Northumbria University, UK

Co-authors: S M Carr; C Chandler

Abstract:

Government policy drives health and social care providers to continually improve and innovate (as in the 'High Quality Care for All', NHS, 2008). This is particularly evident in public health, where there has recently been a multi-stakeholder commitment to developing research and practice, in the form of a £5m UKCRC award to the north-east to establish a centre of research excellence in public health (the Centre for Translational Research in Public Health, CTRPH). One aspect of the Centre is to build research capacity and there is, therefore, a considerable potential student population.

In the School of Community, Health & Education Studies we address the supervision of professional doctorate students by drawing on soft systems methodology (Carr, Lhussier & Chandler 2009).

At the core of practice-relevant research is the need for management of the interplay between individual students and the organisation in which they function. The Framework is influenced by Cowley's (1995) argument of the inappropriateness of separating organisational and professional learning. In order to avoid imposing inappropriate or unnecessary divisions or barriers between practice and the research/learning environments, each professional doctorate supervision team includes a practice advisor. Tackling some of the enduring health and social needs of the UK requires new approaches to how need is understood and responded to (Department of Health 2004). Addressing health inequalities demands a research agenda that is in tune with the knowledge required by practitioners and a mechanism to make the necessary evidence base easily available and accessible to those who require it to underpin practice development.

The CTRPH and the educational strategies at play in the Community, Health and Education Research Centre provide exciting opportunities for research and supervision collaboration, in a way most apt to influence practice.

Recommended reading:

Carr SM, Lhussier M & Chandler C (2009) The supervision of professional doctorates: methodological insights Nurse Education Today in press.

Cowley S (1995) Professional development and change in a learning organisation. Journal of Advanced Nursing 21: 965-974.

Department of Health. Choosing Health: making healthy choices easier. London: The Stationery Office; 2004

4

A retrospective study of burn injuries among children from a paediatric burns unit

Khalid Alnababtah, Faculty of Health, Birmingham City University, UK

Co-authors: R Ashford; C Jackson; M Filby; P Davis

Abstract:

Background: One can observe that the most frequent burns injuries occur at pre-school ages, in particular in the second and third year of life, and these injuries are most frequently sustained at home for children under the age of 5, where children spend the greatest part of their time (Ghosh, et al., 1996). To begin to understand the issues that surround burns in children it's important to investigate the factors involved in children being presented to a burns unit for treatment. One way of achieving this aim is to undertake a retrospective analysis of routinely collected hospital data over a specified period.

Aim: This study sought to conduct an audit of burns injuries in a children's hospital with a view to assessing the socio-demographic factors involved and highlight the other factors that may require further investigation.

Methods: A retrospective data retrieval process was used. Raw data was obtained from two hospital data resources: Both data was tabulated on the Excel 2003 spreadsheet.

Results: During the 5-year audit period 1249 cases were admitted to the burns ward, 1156 cases had clearly specified causes and 93 cases were unspecified. The total number of cases admitted per year ranged from 208 to 258. Most of the burns in this study were superficial and were less than 10% of body surface area. 743 cases were males (59.54%), while 505 cases (40.46%) were females, with the mean age of 4 years old. Spill was the cause of burns in 765 cases (61.2%), followed by contacts in 150 cases (12%).

Conclusion: As far as the authors are aware this is the first reported audit of burns admissions, which highlight the socio-demographic and related factors that may contribute to the occurrence of burns in children.

Recommended reading:

Istre R., McCoy A., Osborn L., Barnard J. and Bolton A. (2001). Deaths and injuries from house fires, New Engl J Med 344 (25) pp. 1911-1916.

Drago A (2005). Kitchen Scalds and Thermal Burns in Children Five Years and Younger. PEDIATRICS Vol. 115 No. 1 January, pp. 10-16.

Feldman K W, Schaller R T, Feldman A, McMillon M (1998). Tap Water Scald Burns in Children, PEDIATRICS Vol. 102 No. 1 Supplement July, pp. 256-258.

5

Care of chronic obstructive pulmonary disease patients receiving non-invasive ventilation: Evidence-based guideline development

Janita Pak Chun Chau, Nethersole School of Nursing, The Chinese University of Hong Kong, Hong Kong

Co-authors: A M L Kwok; J W H Liu; M W C Tong; A Y F Nip; D T F Lee; E Y H Lam; S W M Pang; K K W Wong

Abstract:

Background: Chronic obstructive pulmonary disease (COPD) is a major chronic condition and frequent COPD exacerbations are a major cause of hospital admission and mortality. Systematic review shows non-invasive positive pressure ventilation resulted in decreased mortality and decreased need for intubation in COPD patients with acute type II respiratory failure (Ram et al., 2004). Evidence also suggests that these patients need assistance with personal body care and the provision of psychological support. It is crucial that nurses are able to optimize their care and act in accord with research-based recommendations.

Aims: In this paper, we describe the process of evidence-based guideline development and the implementation strategies that were adopted. The guideline includes recommendations related to care of COPD patients receiving non-invasive ventilation.

Methods and Results: A working group was established to review the research evidence, develop the guideline, and plan strategies for its implementation. The guideline implementation is intended to help nurses more effectively manage patients in critical condition and to enhance professional nursing practice. To assist the implementation processes, a video on initiation of non-invasive ventilation and care of patients receiving non-invasive ventilation was produced. An evaluation cycle consisting of a pre-implementation audit to determine current practice and a post-implementation audit to evaluate the effectiveness of the guideline was adopted to determine if a change in practice leads to favourable outcomes. All reg-

istered nurses (n=45) working in the four infectious disease wards of an acute hospital in Hong Kong participated in the pre-implementation and post-implementation audits. Feedback about the pre-implementation audit were offered during the training courses in order to focus on best practice and emphasize those aspects that had been identified as requiring improvement.

Conclusions: Positive outcomes from this study served as a decision point to proceed with wider implementation of the guideline to other clinical areas.

Recommended reading:

Ram FSF, Picot J, Lightowler J, Wedzicha JA. (2004) Non-invasive positive pressure ventilation for treatment of respiratory failure due to exacerbations of chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2004, Issue 3. Art.

Funding source:

No Funding

6

The effects of Tai Chi exercise and auricular acupressure in rheumatoid arthritis patients

Claire Hale, Professor of Clinical Nuring, Schol of Healthcare, University of Leeds, UK

Co-authors: H Y Lee; B Hemmingway; M Woolridge

Abstract:

Background: In recent years Tai Chi has been suggested as a suitable exercise for people with arthritis and other musculoskeletal problems and outside the UK specific programmes have been developed. Tai Chi consists of a series of slow purposeful movements that involve turning, shifting weight from one leg to the other, bending and unbending the legs with various arm movements. Auricular acupressure is a therapeutic method by which specific points on the ear are stimulated to treat various disorders including pain.

Aims:

1. To compare the effects of Tai Chi exercise alone – with Tai Chi exercise and auricular acupressure.

2.To ascertain if people with arthritis in Yorkshire would be able and willing to attend an intensive programme.

3.To obtain the views of participants of the benefits of the programme.

Methods: In April 2009, 21 people with a confirmed diagnosis of rheumatoid arthritis were recruited and allocated into two groups according to address. Both groups followed a Tai Chi exercise programme, twice a week for 12 weeks, but one group (n=14) had, in addition, the auricular acupressure. Physical symptoms, physical function, pain, quality of life and self-efficacy were measured in both groups before and after the exercise programme.

Results: At 12 weeks, analysis showed that both groups achieved significant improvements in balance, grip strength, pinch strength and 50 foot walk time (p ⇐ 0.05 Wilcoxon test). Initial analysis suggests that the Tai Chi and auricular acupressure group showed greater improvements in function and pain than the group that received Tai Chi alone.

Discussion: This paper will discuss the findings of this study compared with those from similar studies and consider the benefits of this kind of exercise for people with similar mobility problems.

Conclusion: This study indicates that in this country recruitment to a larger study is feasible.

Recommended reading:

Han A, Judd M, Welch V, Wu, Tugwell P, Wells GA (2004). Tai Chi for treating rheumatoid arthritis (review) Cochrane Database of Systematic Reviews no 3.

Hall A, Maher C Latimer J Ferreira M (2009) The Effectiveness of Tai Chi for Chronic Musculskeletal Pain Conditions: A systematic Review and Meta Analysis Arthritis Care and Research 61,6,717-724

Fransen M, Nairn L Winstanley J Lam P, Edmonds J (2007) Physical Activity for Osteoarthritis Management: a randomised controlled Clinical Trial Evaluating Hydrotherapy or Tai Chi Classes, Arthritis Care and Research 57,3,407 – 414

Funding source:

1,000 – 10,000

7

Evaluation of the Super-Link System Theory for spinal cord injury patients using participatory action research in rehabilitation hospital

Hsiao-Yu Chen, Nursing, National Taichung Nursing College, Taiwan, R.O.C.

Abstract:

Aim: The purpose of this study was to improve the quality of nursing care for patients with spinal cord injury in a rehabilitation ward through implementing and evaluating the Super-Link System Theory (JAN 2007; 57:639).

Background: Super-Link System Theory is a theory of spinal cord injury rehabilitation nursing, which has been developed using the grounded theory research method. One of the challenges of nursing today is to narrow the gap among nursing research, theory and practice.

Methods: Using a participatory action research approach, data were collected from October 2007 to September 2008 in a rehabilitation hospital in Taiwan by means of group discussions, interviews, participant observations, documentary resources, case reports and participants' self-reflective enquire. The Super-Link System theory was introduced to 31 rehabilitation nurses working in a rehabilitation ward. The nurses selected a key reference group including the researcher to facilitate the participatory action research process to implement and evaluate the theory. Data were analysed using content analysis.

Findings: The Super-Link System theory was revised and this study significant identified the nursing implementation of physiological effects and care, human sciences, collaborative care, promoting hope, social care and liaison care. Furthermore, developing an integrated link system from hospital to community through both rehabilitation nurses and discharge planned.

Conclusion: The theory was evaluated and nurses became more involved with their individual patient's care, developing a patient-centred care relationship based on the revised Super-Link System Theory.

Recommended reading:

Chen, H.Y. & Boore, J.R.P. (2007). Establishing a super-link system: spinal cord injury rehabilitation nursing. Journal of Advanced Nursing 57, 639-648.

Hart, A. & Bond, M. (1995). Action research for health and social care: a guide to practice. Buckingham: Open University Press.

Worral, P.S. Randolph, C., & Levin, R.F. (2008). Evidenced-based practice: bringing evidence to the point of care. Research and Theory for Nursing Practice: An International Journal, 22 (4), 225-227.

Funding source:

10,001 – 50,000

8

Developing and delivering a Basic Research Skills course for nurses and midwives in a hospital trust

S. Kornelia Hathaway, Education & Training Manager, Addenbrookes Clinical Research Centre, Cambridge University Hospitals NHS Foundation Trust, UK

Abstract:

Background: The Finch Report (UKCRC, 2007) demonstrated the Government's interest in increasing healthcare research conducted by nurses. Nursing research in the clinical setting has lagged behind nursing research from academia (Kim, 2009). NIHR funding (NIHR, 2009) encouraging research education for Nurses, Midwives and Allied Health Professionals (NMAPs) has resulted in a proliferation of postgraduate courses in clinical research.

The Cambridge University Hospitals Foundation NHS Trust (CUHFT) has considerable numbers of clinical nurses interested in research, but who require much smaller steps than a postgraduate degree before they feel confident and ready to take on a research-based role.

Aim: To provide an introduction to local clinical nurses and midwives in the essential skills and issues relating to the scientific, safe and ethical conduct of research, and to encourage them to engage in such research themselves.

The Original Project: In 2003 the RCN East of England Research Society designed and delivered an annual, small scale, non-accredited, two-day course on 'Basic Research Skills' for clinical nurses, in response to a lack of local provision of introduction to research. After funding proved to be problematic, the course concept was taken on by the Nursing, Midwifery& AHP Research Steering Group of CUHFT in 2008.

Current project:

The new stakeholders reviewed the course by:

- scoping potential local users,
- re-identifying the course objectives,
- determining the essential and desirable components of the course and their required mode of delivery,
- identifying and approaching a suitable faculty.

Three two-day courses have been delivered since October 2008.

I will present an overview of the resulting successful course, its evaluations, ensuing changes and future directions.

Future Application: The framework if this course is generic to healthcare professionals and as such transferable to many settings. It has already informed the creation of a similar course for medical trainees.

Recommended reading:

UK Clinical Research Collaboration Sub-committee for Nurses in Clinical Research (2007) Developing the best research professionals. London: UKCRC

Kim M J (2009) Clinical academic research careers for nurses in cllinical research: towards global nursing. Journal of Research in Nursing 14 (2) 125 – 132

National Institute for Health Research Training Coordinating Centre (2009) NIHR Clinical Academic Training Pathways for Nurses, Midwives and Allied Health Professions. http://www.nihrtcc.nhs/nurs-esmidwivesandahp/ last up-dated 09 Sept 2009, accessed 0

Funding source:

No Funding

9

One small step or a giant leap? Role development for clinical research nurses

Gordon Hill, School of Nursing, Midwifery and Social Care, Napier University, UK

Abstract:

Over the last 20 years the role of the Clinical Research Nurse (sometimes referred to as a Research Co-ordinator) has changed greatly. From an early position of 'hand-maiden' to the investigators, they have now become an integral part of the investigative team, often with a significant role in all aspects of a trial; from protocol development to analysis and dissemination (Raja-Jones 2002). The number of these nurses/co-ordinators has increased dramatically and extremely conservative estimates that the number in the region of 11,700 worldwide (Rickard and Roberts 2008).

Has there now come a time for research nurses to make a logical step and leap into the realms of being a Principal Investigator in their own right? Some may argue that this is not the raison d'être of the research nurse, and that to do so would be devaluing the role of the research nurse. However, it has to be recognised that research nurses have a wide range of skills that would be easily converted to initiate research projects of their own. This poster will explore the benefits and drawbacks of this position and recommend routes that research nurses might consider as part of their career development.

Recommended reading:

Raja-Jones H. (2002) Role boundaries – research nurse or clinical nurse specialist? A literature review JOURNAL OF CLINICAL NURSING 11 (4): 415-420

Rickard C., Roberts B. (2008) Commentary on Spilsbury K, Petherick E, Cullum N, Nelson A, Nixon J & Mason S (2008) The role and potential contribution of clinical research nurses to clinical trials. Journal of Clinical Nursing 2008. Oct. 17(19) p2664-6

Funding:

10,001 – 50,000

10

An evaluation of the impact of introducing a new model for recognising and responding to early signs of deterioration in patients at The Rotherham NHS Foundation Trust

Angela Mary Tod, Principal Research Fellow, Centre for Health and Social Care Research, Sheffield Hallam University, UK

Co-authors: K Bray; D Adsetts; D Bainbridge; A McDonnell

Abstract:

Background: The recognition and management of patients with potential or established critical illness is a key challenge for nurses (NIHCE 2007, NPSA, 2007).

This project (funded by Yorkshire and Humber SHA) evaluates the impact of a new 'two tier' scoring system to facilitate nurses in detecting and responding appropriately to signs of deterioration in patients in an acute hospital.

This poster presents selected findings from the first two stages of the evaluation.

Aims:

- To evaluate the impact of the new system on nurses' knowledge, attitudes and confidence to recognise and manage acutely ill patients
- To understand the reasons for any observed changes

Method: Stage 1 – A before and after survey of nursing staff (n = 328)

To have an 80% chance of detecting a 0.5 point change in confidence to recognise a critically ill patient (on a 1 to 10 scale) at 5% significance level, 128 paired responses were needed.

Stage 2 – A before and after qualitative consultation with nurses identified using purposive sampling.(n = 15).

Results: 84% (n = 271) of staff attended a training session and completed baseline questionnaires. The final number of paired responses was 213.

Confidence to recognise a critically ill patient increased from 7.5 (SD 1.8) to 8.2 (SD 1.4), 95% CI 0.55 – 0.92, p $<$ 0.01.

Level of knowledge increased from 7.3 (SD 1.8) to 8.0 (SD 1.5), 95% CI 0.52 – 0.91, p $<$ 0.01.

Total number of concerns (out of 10) decreased from 4.3 (SD 2.68) to 3.7 (SD 2.3), 95% CI – 0.91 – -0.26, p $<$ 0.01.

Qualitative data provides insights to explain this impact including the nature of the training and the scoring system itself.

Conclusions: The findings support the use of early warning scoring systems and raise important issues regarding training.

Recommended reading:

Featherstone B, Smith GB et al (2005). Impact of a one day inter-professional course (ALERT) on attitudes and confidence in managing critically ill adult patients. Resuscitation, 65: 329-336.

National Institute for Health and Clinical Excellence (2007) Acutely ill patients in hospital NICE Guideline 50. London, NICE.

National Patient Safety Agency (2007) recognising and responding appropriately to early signs of deterioration in hospitalised patients. London, NPSA.

Funding source:

UK – Health Service (Local)

10,001 – 50,000

11

The exploration of the impact and needs of immigrant mothers when they bring their critically ill children to the emergency department

Hsiu-Mei Wang, ER senior nursing staff, Department of Nursing, ER, Taichung Veterans General Hospital, Taiwan
Co authors: S F Su, JD Wang

Abstract:

Emergency department (ED) is often the first unit for people as their critically ill family members need urgent treatments. In ED, mothers are always the main care givers for the critically ill children. However, when mothers' expectations of medical needs are not met or communications with medical staff are insufficient, high degrees of anxiety or distrust of doctors or nurses reveal, especially for the immigrant mothers. However, limited research has been conducted to explore immigrant mothers' needs of cares or impact while their children suffering from critical situations in the ED.

This aim of this study was to investigate immigrant mothers' impact and needs in sending their critically ill children to the ED. A total of 26 South-East Asian immigrant mothers with basic listen, speak, literacy, and communication skills, participated in this study. Semi-structured interviews were used to collect the data and the methodology of grounded theory was applied for data analysis. Constant comparison, theoretical sampling, and reviewing references were utilised until theoretical saturation was achieved.

Finding in this study demonstrated that the immigrant mothers felt fearful, stressed, and anxious because of the unknown critical situations happened to their children. During the process of waiting to see the doctors, participants worried that the symptoms of their children became deteriorated. However, due to their language barriers, the immigrant mothers had difficulties in understanding or communicating with the ED doctors or nurses. They felt confused, frustrated, and helpless in dealing with the ED environment. They perceived that their needs of medical care or explanation were ignored because of their poor skills in expressing themselves. Poor attitudes of doctors or nurses in the busy time and no time of teaching cares were noted. We suggested that more social and language help, patience, and concerns for the immigrant mothers were necessary.

Recommended reading:

Redley, B. & Beanland, C. (2004) Revising the critical care family needs inventory for the emergency department. Journal of Advanced Nursing, vol 45, no 2, pp 95-104.

Al-Hassan, M. A. & Hweidi, I. M. (2004) The perceived needs of Jordanian families of hospitalized, critically ill patients. International Journal of Nursing Practice, vol 10, no 2, pp 64-71.

Sterling, Y. M. & Peterson, J. W. (2003) Characteristics of African American Women Caregivers of Children With Asthma. American Journal of Maternal/Child Nursing, vol 28, no1, pp 32-38.

12

Homeless intermediate care – An economic evaluation

Chiara Hendry, Lambeth Primary Care Trust, UK
Co-authors: S Dorney-Smith; A Scammell

Abstract:

In January 2009 the Homeless Intermediate Care Pilot Project commenced at St. Mungo's Cedars Road hostel in Clapham, South London. The project has a caseload of 6 – 10 clients that are the residents most at risk of death or disability at any one time. The project is aimed at reducing mortality and morbidity in these chosen clients, whilst also reducing secondary care usage. Lane (2005) reported a 93% incidence of substance misuse problems, 61% incidence of mental health problems, and 56% incidence of serious physical health problems. There is also evidence of sever tri-morbidity in this client group. Wright et al (2003) identifies that the use of illicit intravenous drugs in homeless persons results in a high incidence of viral hepatitis (B and C), HIV infection, deep vein thrombosis, pulmonary embolism, septicaemia, encephalitis, endocarditis, cellulitis and abscesses. Wright (2003) also identifies that homeless alcohol dependent clients suffer with gastrointestinal, hepatobiliary, neurological, cardiovascular and metabolic conditions as a direct result of drinking. Bines (1994) found 51% of homeless people reported a chronic health problem compared with 24% of the general population.

The small caseload also reflects the ongoing research activity also taking place. All clients are having 'before and after' EQ-5D, SF12, SOCRATES, and nurse dependency scores undertaken as part of the research process. Detailed data regarding secondary care usage is also being obtained. Time and motion data is being collected, to identify recommended case load and define appropriate skill-mix. An interim evaluation identified initial benefits of this pilot but the final economic evaluation is to be released in March 2010 and as a nurse led pilot and economic evaluation it is envisaged that the findings will have relevance for wider health audiences. This pilot also highlights the importance of partnership working across, social, health, statutory and non-statutory services.

Recommended reading:

Lane, R. (2005) 'The Road to Recovery – A feasibility study into homeless intermediate care' On behalf of the Homeless Intermediate Care Steering Group. Guy's and St. Thomas' Charitable Foundation, London.available on www.threeboroughs.nhs.uk

Wright N. (2003) Homelessness and primary care. Br J Gen Pract. Jul;53(492):568-9.

Bines (1994) reported on a Centre for Housing Policy / British Household Panel Survey

13

"See-and-treat" management of facial skin malignancy

Alasdair McKechnie, Consultant Maxillofacial Surgeon, United Lincolnshire Hospitals NHS Trust, UK
Co-authors: S Daniels; T Taylor

Abstract:

Background: Skin cancer is common in older people and 80% of lesions occur on the face, head or neck. Treatment is most often surgical. Conventional treatment protocols demand a long, anxious wait between initial consultation and definitive treatment. "See-and-treat" clinics offer a bridge between primary and secondary care, streamlining treatment and reducing waiting times. It's role in management of other conditions such as cervical carcinoma in situ has been studied. The suitability of "see-and-treat" surgery for management of facial skin malignancy has not yet been established.

Aim: To assess patient satisfaction and anxiety in relation to a newly established "see-and-treat" clinic for facial skin malignancy.

Methods: Patients referred for management of facial skin malignancies were offered "see-and-treat" surgery. One week after surgery a post questionnaire was issued. Patients were asked about their anxiety levels and their opinion of the service.

Results: Fifty consecutive patients were canvassed. Mean age was 78 yrs (44-98 range) 88% of questionnaires were returned. 60% of patients reported little or no anxiety. 96% felt that "see-and-treat" reduced their anxiety levels. 98% felt that they were given enough choice about surgery, would have it again if necessary and would recommend it to a friend or a family member. 94% of patients felt completely satisfied with the service.

Discussion: Social taboos dictate that facial surgery is associated with high anxiety levels and patients must weigh options carefully when considering treatment of facial lesions. Our results suggest that patients are capable of deciding very quickly whether to proceed with surgery and appreciate the opportunity to have surgery sooner rather than later.

Conclusions: "See-and-treat" is an effective and acceptable means of providing surgery for patients with facial skin malignancy.

Recommended reading:

Kietpeerakool C, Cheekkriangkrai C, Suprasert P, Srisomboon J. (2009) Feasibility of the

Clancy E, Mayo A. (2009) Launching a social enterprise see-and-treat service. Emergency Nurse. 17(3), 22-4

Wright PK, Geary PM, Jose RM, Chou C, Berry RB. 2005. See-and-treat plastic surgery: experience at the Univeristy Hospital of North Durham.Plastic and Reconstructive Surgery. 116(1):342-4

Funding source:

No Funding

14

Mapping the international evidence-base for a relationship between nurse staffing and quality of nursing home care for residents and informing future research

Karen Spilsbury, Senior Research Fellow, Health Sciences, University of York, UK

Abstract:

Background: Care homes (nursing) have an important role in the provision of care for dependent older people. Ensuring quality of care for residents in these settings is the subject of ongoing international debates. Poor quality care has been associated with inadequate nurse staffing and poor skills mix.

Aims: To review the evidence-base for the relationship between care home nurse staffing (proportion of RNs and support workers) and how this affects quality of care for nursing home residents and to explore methodological lessons for future international studies.

Methods: A systematic mapping review. A total of 13,411 references were identified (using search strategy, seven databases). References were screened to meet inclusion criteria. 80 papers were subjected to full scrutiny and checked for additional references (n=3). Of the 83 papers, 50 were included. Paper selection and data extraction completed by one reviewer and checked by another.

Results: A growing body of literature is examining the relationships between nurse staffing levels in nursing homes and quality of care provided to residents, but predominantly focuses on US nursing facilities. The studies present a wide range and varied mass of findings that use disparate methods for defining and measuring quality (42 measures of quality identified) and nurse staffing (52 ways of measuring staffing identified).

Discussion and Conclusion: A focus on numbers of nurses fails to address the influence of other staffing factors (e.g. turnover, agency staff use), training and experience of staff, and care organisation and management. 'Quality' is a difficult concept to capture directly and the measures used focus mainly on 'clinical' outcomes for residents. This systematic mapping review highlights important methodological lessons for future international studies and makes an important contribution to the evidence-base of a relationship between the nursing workforce and quality of care and resident outcomes in nursing home settings.

Funding source:

UK – Health Service (National)

100,001 – 500,000

15

Approaches to prevent the recurrence of ischemic heart disease in patients after coronary artery bypass graft surgery

Mio Machimoto, Adult Nursing, Mie University, Japan

Abstract:

Background: The recurrence rate of ischemic heart disease (IHD) in patients who have received coronary intervention was reported as 38% in Japan. Therefore, secondary prevention is a significant issue and post operative patients are required to self-manage their lifestyle. Although patients are motivated to maintain healthy lifestyle habits, they often experience difficulties in continuing health management by themselves.

Aims: To describe the process of effort preventing a recurrence of IHD in patients undergoing CABG until 1 year after discharge.

Methods: Qualitative and descriptive design was employed in this study. We conducted semi-structured interviews with ten patients who underwent coronary artery bypass surgery, three times for each person (one, six, and twelve months after discharge).

Finding: Regarding approaches to prevent ischemic heart disease recurrence, seven categories of which five were common to the three interviews were identified: 'Find and practice one's own methods', 'Have time to relax to continue the efforts', 'Shake off temptations', 'Seek support from others' and 'Maintain a positive mental state'. Following two categories were identified from the first interview data: 'Accept and endure a necessity of changing lifestyle' and 'Prepare an ideal environment to prevent recurrence'. 'Rediscover feelings by changing view of life' and 'Be sensitive to burdens placed on the family' were the categories identified from the second interview data, and 'Seek ones own life and focus on the life from now' and 'Evaluate the positive effect obtained from self-management' were the categories identified from the third interview data.

Conclusions: Patients' approaches to self-management were largely categorized into four stages: 'preparation', 'seeking', 'maintenance', and 'extension'. To help patients prevent ischemic heart disease recurrence and provide effective support, it is important to grasp their stage and level of effort.

Recommended reading:

Ai AL, Dunkle RE, et al. (1998) Self-care and psychosocial adjustment of patients following cardiac surgery, Social Work in Health Care, 27(3),75-95.

Gaw BL. (2004) Motivation to change life-style following PTCA, Dimensions of critical care nursing, 11(2), 68-74.

Kawakami C., Matsuoka M., e al. (2006) Analysis of factors influencing self-management behavior of the patients with Ischemic heart disease after coronary interventions, Japan society of nursing research, 29(4), 33-40.

Funding source:

1,000 – 10,000

16

Early nutrition in the recovery room in a Danish hospital

Louise Bang Grode, Department of Anaesthesiology, Regional Hospital of Horsens, Braedstrup and Odder, Denmark
Co-author: L Uhrenfeldt

Abstract:

Background: Pre-operative fasting and peri and postoperative starvation results in surgical patients fasting for solid food in up to 20% of the hospital stay, and this causes nutritional deficiency. Our hypothesis is that early oral feeding in the recovery room has a positive influence on nutritional status and prevents Post Operative Nausea and Vomiting (PONV).

Aim: The purpose of this study was to investigate information documented on:

• Patients oral intake in recovery room

• PONV

Method: A systematic literature search on nutrition in recovery rooms revealed few studies. We conducted a retrospective study analysing nursing records, of 314 of 316 patients admitted to our recovery. Records from three random weeks in year 2007, – 08 and – 09. Data on nutrition, fluids and PONV in recovery were collected. Statistical analysis by SPSS.

Results: The prevalence of PONV was 5%. 23% of patients received solid food, 63% received oral fluids (containing glucose) and 1% received oral nutrition supplements in the recovery room.

A chi-squared test showed no evidence that solid food affected the probability of PONV (p = 0.432)

Results revealed an increase over the three years in the use of solid food and fluids containing glucose to patients in recovery.

Discussion: PONV is not a huge issue in our recovery (literature reports a prevalence of 15-30%). Surprisingly few patients received oral nutrition supplements. A systematic nutritional intervention, with oral nutrition supplements given in recovery, might increase overall energy intake

during hospital stay and minimize postoperative starvation.

Conclusion: Further studies are needed. We designed a RCT on a nutritional intervention in the recovery. In this next study we investigate the effects of oral nutrition supplements given in recovery (measured on energy intake, PONV, mobilisation, bowel movements, and subjective well-being).

17

Patients' satisfaction with nursing interventions – Preliminary results from Bydgoszcz, Poland

Robert Slusarz, Neurological and Neurosurgical Nursing Department, Collegium Medicum Nicolaus Copernicus University in Bydgoszcz, Poland
Co-authors: M Skrzypek-Czerko; M Biercewicz; J Szrajda; L Grzelak; R Jab o ska

Abstract:

Introduction: Patient's satisfaction is inseparably connected with quality of medical care. The aim of study was to determine the patient's satisfaction on the basis of the assessment of the nursing interventions.

Materials and Methods: The study included 220 patients of the Neurosurgical Department. Anonymous questionnaire – Patient's Satisfaction Questionnaire – based on standardized tools was used as a survey instrument. The survey was conducted twice (in 2004 and 2006). The work of a nursing team was assessed.

Results: The study shows that:

1) There is a statistically significant relation between time the nurse devotes to the patient and providing information about nursing interventions and procedures (p=0.0001)

2) Respecting patient's rights and dignity by the nursing staff (p=0.0001)

3) There is a statistically significant relation between the nursing interventions and patient's preparation for the surgical procedure (p=0.0001).

Conclusions: The time devoted to the patient is an important factor that influenced on the amount and quality of information given to the patient by a nurse and the attitude of the nursing team towards a patient. The assessment of work of a nursing team is an important factor, which influenced on the quality of preparation of patient for operation.

Recommended reading:

Gutysz-Wojnicka A, Dyk D. 2007. The adaptation of the Polish version of The Newcastle Satisfaction with Nursing Scale (NSNS), Nursing Topics, 2, pp. 133-138

Zastowny TR. 2000. Patient satisfaction and experience. In Yeomans SG. The clinical application of outcomes assessment. Appleton & Lange 2000, pp.113-129

Thomas L.H., et al. 1996. Newcastle Satisfaction with Nursing Scale: an instrument for quality assessments of nursing care, Quality in Health Care, 5(2), pp. 67-72

18

The exploration of decision making in fever management for critical patients among nurses

Chiung-Fen Shih, Department of Nursing, ICU-2, Taichung Veterans General Hospital, Taiwan
Co-author: S F Su

Abstract:

Various studies have revealed that fever is a common symptom for critical care patients during hospitalisation, resulting in physical and psychological effects, such as tachycardia, decrement of oxygen supply, or anxiety. Although indoor temperature controlling, ice pillow using, or antipyretic taking are the common strategies for fever management, limited studies were conducted to show the most appropriate nursing interventions for intensive care unit (ICU) fever patients. In fact, very few studies indicated how to make proper decisions in dealing with patients' fever for nurses.

This study aimed to explore nurses' perceptions of decision-making process in fever management for adult fever ICU patients. Twenty-five nurses recruited from adult medical and surgical ICUs participated in the semi-structured interviews, with questions focused on how they made decisions in dealing with patients' fever conditions. Qualitative data were analyzed using the methodology of grounded theory. In order to maintain research trustworthiness, constant comparison, theoretical sampling, reviewing references, and member checking were used throughout the data collection until theoretical saturation was achieved.

Findings of this study showed that a critical piece of knowledge in managing fever is missing from ICU nurses' decision making process. Nurses' fever management strategies were various due to their knowledge of fever might be insufficient or influenced by their unit rules, routine medical orders, senior colleagues' experiences, or family requests. Although ICU nurses tried to assess their patients' fever, lack of enough knowledge in fever pathophysiology as well as the early signs and symptoms detections was found. Therefore, in order to minimize complications and improve ICU patient care, we suggest that nurses need to enhance their knowledge of pathophysiology and management skills in fever cares. Early nursing interventions for ICU patients in preventing fever are essential. This study has highlighted the areas of fever interventions for further research and professional debate.

Recommended reading:

Ferguson, A. (2007) Evaluation and Treatment of Fever in Intensive Care Unit Patients. Critical Care Nursing Quarterly, vol 30, no 4, pp 347-351.

Clack, G. (2009) Decision making in nursing practice: a case review. Paediatric Nursing, vol 21, no 5, pp 24-27.

Walsh, A. M., Edwards, H. E., Courtney, M. D., Wilson, J. E., & Monaghan, S. J. (2005) Fever management: Paediatric nurses' knowledge, attitudes and influencing factors. Journal of Advanced Nursing, vol 49, no 5, pp 453-464.

19

Using realistic synthesis to review the literature in infection control: A welcome approach for the real world of nursing?

Lynne Williams, Lecturer in Adult Nursing, Bangor University, School of Healthcare Sciences, Bangor University, UK

Abstract:

Background: The realistic synthesis approach to literature reviewing focuses on outcomes which serve to directly inform commissioners or stakeholders of the potential of certain interventions (Rycroft-Malone et al, 2007). In addition to the traditional systematic review, this approach acknowledges how different contexts can influence the success or failure of mechanisms (McCormack et al, 2007), and places emphasis on the involvement of relevant stakeholders. This has implications for the nursing and healthcare community where decisions to introduce/implement interventions need to consider the practical question – 'How will it work here?' as well as the soundness of the evidence to support the intervention.

Objective: The poster will focus on the methodological issues of using the realist synthesis approach in a realistic evaluation research study of intermediaries and their functions in infection control, and will reflect on the utility of this approach for nursing research.

Approach: The study in question will provide an evaluation of intermediary roles as interventions in infection control, how they work and in what contexts. The realist synthesis will examine the existing evidence for this complex intervention through an iterative process (Pawson et al, 2004). In particular, the approach outlines the importance of stakeholder/commissioner involvement throughout the process.

Discussion: This poster will outline the potential contribution to the existing body of evidence about the use and benefits of this approach for both researchers and practitioners in healthcare services. In particular, the poster will discuss how the realist synthesis approach can be utilized

to develop knowledge for clinical practice, and enhance understanding of complex interventions.

Recommended reading:

McCormack, B., Wright, J., Dewar, B. et al (2007) A realist synthesis of evidence relating to practice development: Methodology and methods Practice Development in Health Care 6(1) 5-24

Pawson, R., Greenhalgh, T., Harvey, G., Walshe, K (2004) Realist synthesis; an introduction. RMP Methods paper 2/2004. Centre for census and survey research, University of Manchester, Manchester

Rycroft-Malone, J.,Fontenia,M.,Bick, D.,Seers,K (2007) Protocol based care evaluation project – Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R&D (NCCSDO) SDO/78/2004

Funding source:

50,001 – 100,000

20

Management of visual problems after stroke: A survey of current practice in Scotland

Christine Hazelton, Nursing, Midwifery and Allied Health Professions Research Unit (NMAHP RU), Glasgow Caledonian University, UK
Co-authors: A Pollock; M Brady

Abstract:

Background: Stroke affects the vision of approximately 30% of survivors, yet services available to patients with visual problems are presently inconsistent.

Aims: To investigate how visual problems are currently assessed and managed in Scottish stroke care settings.

Methods: Building on previous successful work in this area we developed a postal survey to gather information from each acute or rehab hospital ward in Scotland that has stroke-dedicated beds. The questions establish basic information about this setting, and specific information about the management of visual problems (including assessments, interventions, health professionals involved and referrals). Employing procedures known to maximise response rates we identified by name, and contacted, the most appropriate Occupational Therapist on the ward. Pre-notification and reminder letters were circulated.

Results: To date, the response rate is 89% (54/61).

Preliminary analyses have highlighted some key factors relating to current practice:

- Only 7% of wards have a protocol for visual assessment.
- The most frequent visual assessments relate to visual attention and scanning ability (89% of OTs performed these regularly or with every patient). Visual fields are tested regularly in 67% of patients.

- Every OT has at least one management option for visual neglect and visual field loss, varying from onward referral to treatment by the OT.
- 16% of OTs reported no management options for patients with eye movement problems.

Data analysis will be completed by the end of November 2009, and final results presented.

Discussion and Conclusion: The results of this survey will detail current practice across Scotland relating to the management of visual problems after stroke and provide information on where further service provision is required.

Recommended reading:

Pambakian, AL, Kennard, C (1997) Can visual function be restored in patients with homonymous heminaopia? British Journal of Ophthalmology,81, pp324-328

Talbot, A, Brady, M, Furlanetto, DLC, Frenkel, H, Williams, BO (2005) Oral care and stroke units. Gerodontology, 22, pp77-83.

Edwards, P, Roberts, I, Clarke, M, DiGuiseppi, C, Pratap, S, Wentz, R, et al (2001) Methods to influence response to postal questionnaires. The Cochrane Library, Issue 4. Oxford: Update Software; (Cochrane Methodology Review). Cochrane library number: MR00

Funding source:

UK – Research Charity/Foundation

1,000 – 10,000

21

Integrating the service user/ care agenda in health and social care education: An evaluation of student's experiences

Kelly Sisson, School of Health and Social care, Teesside University, UK
Co-author: J Sedgewick

Abstract:

Background: Inter-professional learning (IPL) is a key component of health and social care education. The NHS plan (2000) outlined a vision for an NHS service designed around patient need; and encouraged professionals to work together to meet the needs of service users. While IPL programmes across the globe focus on the needs of service users and carers few directly engage multidisciplinary groups of students with service users and carers. This presentation reports the results of an evaluation of an innovative approach to IPL at a large UK University that does just that. Year one students from eight disciplines listen to the live stories of service user/carers experiences of health and social care, to help them explore concepts of patient centred care and collaborative practice.

Aims: To evaluate first year students experiences of Inter-professional learning.

Methods: A study specific questionnaire was designed to capture evaluative data and sent to all 565 first year students, 36 IPL facilitators and 18 Service user/carers in November 2008. The questionnaire was analysed using descriptive statistics and captured both quantitative and qualitative data. The results reported focus upon the student experience of their year one IPL week.

Results: 244 students (42.9%) completed the questionnaire. The overall experience of the programme was overwhelmingly positive with students reporting that working with service user/carers helped them to understand the importance of patient centred care and collaborative practice. Attention is however needed regarding student and service user/carer preparedness for the IPL week and in developing the learning activities.

Discussion and Conclusion: Combining the IPL and Service user/carer agendas has created a positive learning experience for students and integrates two important areas of health and social care policy. Further research based evaluation is however needed to confirm this and help develop IPL in pre-registration education.

Recommended reading:

Department of Health (2000) The NHS plan: A plan for investment, a plan for reform. London: The Stationary Office.

Funding source:

No Funding

Thursday

1

Engagement: An indicator of difference in the perceptions of antenatal care for pregnant women from diverse socioeconomic backgrounds

Angie Docherty, Health, Nursing & Midwifery, University of the West of Scotland, UK
Co-author: C Bugge
angie.docherty@uws.ac.uk

Abstract:

Background: Socioeconomically deprived women are at greater risk of adverse pregnancy outcomes. Research tends to focus on access (equality) of services. Yet access may not equate with the meaningfulness (equity) of services for women from different socioeconomic backgrounds. Without understanding equity we are not in a position to plan appropriate and equitable care.

Aims: To determine: pregnant women's perceptions of the current antenatal provision; and, if women from the extremes of socioeconomic background perceive their antenatal care differently

Methods: Longitudinal interviews were undertaken with multiple, comparative antenatal case studies between January 2007 and April 2009. Cases were primigravida women from 'least deprived' (n=9) and 'most deprived' (n=12) geographical areas as identified by the Scottish Index of Multiple Deprivation (2006). Data were analysed using case study replication analysis.

Results: Access to antenatal services showed little difference between the 'least' and 'most' deprived groups but perception of care differed. A key difference concerned the level of 'engagement' (defined as personalisation and active involvement in care, power and relationships and health literacy). Engagement was present in most of the least deprived group and almost none of the most deprived group. In comparison to women from more affluent areas, more deprived women described less evidence of: personal connection to their own care; shared decision making and perceived value of the educational aspects of antenatal care.

Discussion: For women from socioeconomically deprived areas, access may be a less useful indicator than engagement when assessing antenatal service quality. The lack of engagement perceived by those who are most deprived may indicate that equity of service is yet to be attained for those who are most in need.

Conclusion: Equity of service may need to be strengthened. Future research needs to be directed to the potential reasons that may undermine equity and engagement in women from lower socioeconomic areas.

Recommended reading:

Scottish Executive (2006) The Scottish Index of Multiple Deprivation Edinburgh: Scottish Executive

2

Should health leaflets be one size fits all? A comparative study of accident prevention leaflets

Sarit Carlebach, Centre for Health and Social Evaluation (CHASE), Teesside University, UK
Co-author: S Costello

Abstract:

Background: Nurses disseminate health related leaflets to patients regularly to supplement or reiterate verbal information or to transmit new information. Little however is known about the effectiveness of such leaflets.

Aim: To investigate whether different presentations of leaflets have an impact on people's preferences and do these preferences differ according to literacy levels.

Method: Two leaflets in national use (one low-cost monochrome A4; one tri-fold A4 colour) and a service-user designed interactive colour third leaflet were distributed to a convenience sample (n=117) in North-Eastern England. A questionnaire was designed to elicit views and perceptions of the different leaflets and analysed using logistic regression against literacy levels.

Results: 59.6% of the respondents preferred leaflet three, based on quantity of information, dimensions, visual impact, anticipated ease of reading and perceived usefulness.

The most consistent predictor of whether respondents would pick up or read a leaflet or think that the leaflet was written for someone like them was perceived usefulness.

Respondents classified as having literacy skills below level 1 were least likely to either pick up (OR=0.32, 95% CI:0.14-0.90, p=0.03) or read (OR=0.35, 95% CI:0.13-0.97, p=0.04) leaflet 1.

Discussion: This study found a difference between the leaflet preference and level of literacy. Additionally, the most reliable predictor of leaflet preference was perceived usefulness. These results question the value of many researchers' focus on readability formulae and of governmental focus on improving literacy without looking, in the shorter term, at the perceived usefulness of the leaflets employed.

Conclusion: Healthcare professionals and others involved in the creation of written materials should be prepared to provide written information at various levels and to implement the advice of diverse service users in the development of such information. Leaflets should be colourful, engaging and above all appear to be useful to the target audience.

Recommended reading:

French KS, Larrabee, JH. Relationship among educational material readability, client literacy, perceived beneficence and perceived quality. Journal of Nursing Care Quarterly. 1999;13: 68-82.

Selander S, Troein M, Finnegan J & Rastam L. The discursive formation of health. A study of printed health education material used in primary care. Patient Educ Couns. 1997:31:181-189.

Raynor DK, Blenkinsopp A, Knapp P, Grime J, Nicolson DJ, Pollock K, Forer G, Gilbody S, Dickson D, Maule AJ & Spoor P. A systematic review of quantitative and qualitative research on the role and effectiveness of written information available to patients

3

'Forgotten shopping, lost keys and hearts which forget to beat': Exploring nurses' conceptualisation of dementia

Sarah J Rhynas, Nursing Studies – School of Health in Social Science, University of Edinburgh, UK

Abstract:

This paper reports on a small qualitative study exploring how nurses conceptualise dementia and how these conceptualisations relate to the care that they give to patients living with dementia. While literature on specific approaches to dementia care, treatments and relationships between patients, carers and family members form a substantial and growing body of dementia literature, information about nurses and their understandings of dementia have previously been unexplored. This study demonstrates the range of views held by nurses and the influences of education, structures of the clinical setting and ward culture in shaping those understandings.

Using a reflexive sociological approach, the study reflects the views and understandings of nurses from a range of inpatient areas both within medical and mental health settings. Data were collected in clinical areas in Central Scotland using focus groups, individual interviews and observation.

Nurses were found to conceptualise dementia in four main ways; as a disease, as a memory problem, as confusion and finally as a journey. These four conceptualisations are explored in turn and the ways in which they inform and relate to nursing practice are discussed.

Nurses were found to demonstrate limited overview of the trajectory of dementia. This lack of overview has implications for patient care with nurses being unable to envisage the care of individuals throughout the course of their dementia. Early

diagnosis provides opportunity for individuals and their families to receive support and to meet the challenges of dementia. However, the realisation of these opportunities is threatened by the fragmented way in which some nurses conceptualise dementia. The importance of understanding nurses' conceptualisations of dementia and the ways that these relate to nursing practice are discussed and their potential to inform and enhance practice and nurse education is highlighted.

4

Effectiveness of a sleep-sling in comforting and soothing young infants

Fiona Kaley, Research Student, Psychology Department, Durham university, UK
Co-authors: V M Reid; E G Flynn

Abstract:

Colic or persistent infant crying occurs in approximately 20% of infants. It is the most common parental concern, for which parents seek medical advice, during an infant's first year (Lobo, 2004). Numerous studies have investigated the effectiveness of pharmacological, herbal and behavioural interventions but none, has been found to be reliably effective.

The aim of the present study was to investigate the effectiveness of a newly developed sleep-sling in soothing and comforting infants.

In 2009, 65 infant-parent dyads participated for a period of three weeks, when infants were between four and nine weeks of age. During the first week parents kept a record of infant cry, feed and sleep routines. During the second week participants were allocated during one of three conditions, namely: a sleep-sling, commercially available carry-sling or no-sling condition. Parents again recorded infant routines and also recorded settling times for their method of comforting. During the third week participants kept a record of routines, post intervention. Data collection will be complete in November 2009.

Preliminary results indicate that there was no significant difference between conditions in two infant temperament dimensions, mood and distractibility, thought to be related to persistent crying (Lehtonen et al, 1994), (F $(2,58)$ = 1.217, p= .304 and F $(2,58)$ = 0.114, p= .892 respectively). Results also indicate a significant reduction across conditions in mean daily crying between week 1 and week 3 (F $(1,46)$ = 12.42, p=.001), with the greatest reduction in crying in the sleep-sling condition. Analysis is currently ascertaining the factors underpinning this reduction. Further analyses will be complete by December 2009.

Morris et al (2001) estimated the cost to the NHS of infant crying and sleep problems to be £65 million/ annum. Clearly a device which helps alleviate per-

sistent infant crying will be of significant value to both parents and paediatric services .

Recommended reading:

Lehtonen, L. (1994). Infantile colic. Turku, Finland: Turun Yliopisto, Turku University Library.

Lobo, M.L., Kotzer, A.M.., Keefe, M.R., Brady, E., Deloian, B., Froese-Fretz, A., and Barbosa, G. 2004. Current beliefs and management strategies for treating infant colic. Journal of Pediatric Health Care, 18, 115-122.

Morris, S., St James-Roberts, I., Sleep, J. and Gillham, P. 2001. Economic evaluation of strategies for managing crying and sleep problems. Archives of Disease in Childhood, 84 (1), 15-19.

5

Enhancing pain assessment practice on an acute medical unit using action research

Julie Gregory, Pain Management, Bolton Hospitals NHS Trust, UK

Abstract:

This reflexive study examined the assessment and management of pain on an acute medical unit at a DGH in the North West of England. Action research spirals of assess-plan-act-evaluate-reflect-plan-act have been used to impact upon practice.

Acute Pain Services have been established in over 86% of hospitals in the UK (Powell 2004) and they continue to improve pain management for surgical units. Pain resources have been concentrated on what are considered high risk patient groups and medical patients have not been considered high risk for pain (Loder and Witkower 2002, Dix et al 2003 Whelan et al 2004). Yet there continues to be suboptimal and inadequate pain management in clinical settings (Schafheutle et al 2004).

There have been some suggestions that the APS should evolve to include all patients throughout the hospital experiencing pain (CSAG 1999, Notticutt 1995), in particular there is a need to recognise and quantify the problem within medical wards (Dix et al 2003).

This paper will present the initial measures taken prior to the action research interventions which have been used to initiate changes in the unit and the final evaluation, four years later. It will describe the activities that have led to a change in attitudes about the management of pain on the unit. The evaluation measures have demonstrated an increased number of referrals to the APS from 39 a year initially to over 188 and the recording of pain scores from 16% to 93% at the final measure.

The study has demonstrated that pain is not isolated to the surgical areas of the hospital and

supports the recommendation that APS's need to develop to include medical patients.

Recommended reading:

Clinical Standards Advisory Group (CSAG) (1999) Services for patients with pain. Clinical Standards Advisory Group.

Powell AE, Davies HTO, Bannister J, McCrae WA (2004) Rhetoric and reality on acute pain services in the UK: a national postal questionnaire survey. British Journal of Anaesthesia. 92 , 5, 689-693.

Whelan CT, Jin L and Meltzer D (2004) Pain and satisfaction with pain control in hospitalized medical patients. Archives of Internal Medicine. 164, 2, 175-180

6

A literature review of current evidence for promoting a good night's sleep in the hospital environment

Irene Mabbott, Learning and Development Department, Sheffield Teaching Hospitals NHS Foundation Trust, UK
Co-author: Joanne Marsden

Abstract:

Background: It is well established that sleep has a restorative effect on the human body, (Dogan et al, 2005, Tranmer, 2003) but in hospital there are a number of factors which prevent patients from sleeping. These can include: pain, anxiety, noise and care interventions. Problems with sleep have been reported in the National NHS Patients surveys and also at a local level via the Clinical Assurance Toolkit: a survey of both patients and staff within the Trust. This presentation will detail the methods and results of a literature search and make recommendations for improving the patients sleep experience.

Aims and Methods: A systematic literature search was performed of the major electronic databases including CINAHL, NHS Evidence, and Medline. Other internet based resources were accessed including patient information sites, charities and daily news sites. The identified citations were reviewed by members of a Trust-wide multi-disciplinary group â " the Evidence Based Council. Data was extracted regarding the type of study, level of evidence and key interventions and ideas.

Results: The searching exercise brought forward approximately 50 citations. These citations highlighted a number of areas that could not be changed such as existing patient conditions, marital status and established sleep patterns which would not change as an in patient. Other interventions that could have a positive effect on promoting a good nights sleep emerged including: reducing patient

stress, reorganisation of care practices and the use of measuring devices to identify the noise levels in certain clinical practices. The literature did highlight a lack of systematic evidence with many interventions based on anecdote.

Conclusions: As the evidence identified that disrupted sleep in hospitals can extend the hospital stay, further research is required in this area to evaluate the interventions identified in the literature search and to examine how these interventions can improve the patient experience.

Recommended reading:

Dogan, O, Ertekin, S, & Dogan, S, (2005) Sleep quality in hospitalised patients, Journal of Clinical Nursing, Vol. 14, pp107-113.

Tranmer, J, E, Minard, J, Fox, L, A, & Rebelo, L, (2003) The sleep experience of medical and surgical patients, Clinical Nursing Research, 12(2) pp159-173

Funding source:

7

Labelling patients difficult: Perspectives of nurses

Jacinta Kelly, Lecturer, School of Nursing and Midwifery, Trinity College Dublin, Ireland
Co author: R Wilson

Abstract:

Background: Adverse outcomes can be devastating for patients in terms of human suffering and can represent a costly burden to the finances and reputation of any healthcare organization. It is argued that patients, whom clinicians label 'difficult', are likely to sue, to utilize the healthcare system more and to have poor outcomes. Conflicting evidence exists in the international literature as to why a patient is designated 'difficult'. There are no available studies within an Irish context regarding the phenomenon of the 'difficult patient'.

Aims and Objectives: The aim of this study is to gain an understanding of the phenomenon of the designation of the patient as 'difficult' so as to inform educational and best practice strategies which could remove the possibility of associated adverse patient and organization outcomes.

Method: A qualitative research method will be employed as this is an appropriate inductive method when present knowledge to describe, explain and understand phenomena is inadequate. A purposeful sample of 12 nurses will be chosen by the primary researcher and will be invited to participate in audiotaped interviews of their experiences of the 'difficult' patient. Data will be transcribed and analyzed using Colaizzi's (1978) seven step framework.

Findings: Following approval by ethics committee it is anticipated that rich and indepth data on this topic will be collected in November 2009 and analyzed in December and January 2010.

Conclusions: The benefit of this study is that participants have opportunity to offer insights on the phenomenon of the designation of the patient as 'difficult' within the acute Irish healthcare setting.

Funding source:

8

Exacerbations of severe asthma: Psychosocial factors and the impact of a nurse-led clinic

Alison Pooler, School of Nursing and Midwifery, Keele University, UK

Abstract:

Body: The aims were to examine if psychosocial variables could predict levels of lung function and the number of exacerbations of severe asthma. Secondly, if attendance to a specialist clinic could mediate between these predictor variables and the number of exacerbations.

Methods: There were 102 participants all with severe asthma. The data on total number of exacerbations was collected retrospectively before and after the clinic intervention. Standard multiple regression was used to analyse the relationship between the predictor variables and the two criterion variables. Paired sample t tests were used to examine the effect of regular attendance to the clinic on the number of exacertbations

Results: Multiple regression analysis showed that high levels of depression and moderate levels of social deprivation had significant relationships to high numbers of exacerbations (R2=0.458, beta value=0.636, p=0.009 and R2=0.581, beta value=0.280, p=0.009 respectively). It was also apparent that the total number of exacerbations fell significantly following regular attendance to the specialist clinic (t=6.919, p=0.000. Eta squared of 0.33). No relationship was found between the predictor variables or the clinic intervention and the level of lung function.

Conclusion: There are predictor variables which have a significant influence on the morbidity of severe asthma, which cannot be treated by conventional management techniques. It has also shown the benefits of a structured severe asthma clinic. Collaborative working across health and social care boundaries needs to determine alternate startegies to tackle social deprivation and high levels of depression in people.

Funding source:

9

The sick child's 'journey' to high dependency care: A comparison of three children's wards

Maggie Doman, Lecturer in Nursing, Faculty of Health, University of Plymouth, UK
Co-authors: R Endacott; J Richardson

Abstract:

Background: Arrangements for the provision of high dependency care are a requirement in all hospitals that provide care for children in England (Department of Health, 2002). Despite inclusion in the framework for paediatric critical care, high dependency care has received limited attention and is usually provided on children's wards. Definitions and recommendations lack clarity, leading to difficulties in determining the most appropriate environment, staffing and equipment for care provision.

Aims: To explore the provision of high dependency care in children's wards and to identify influencing factors.

Methods: Fieldwork was conducted in three children's wards in 2002/3, using observation and individual interviews. Data from each ward were analysed separately, then combined to enable thematic analysis across settings.

Findings: Three themes were identified: the child's 'journey' to high dependency care, obstacles to high dependency care, and facilitators.

Discussion: Despite nurses recognising deterioration, a sick child's 'journey' to high dependency care could be problematic, especially if transfer to a high dependency unit was required. Factors such as nurses' communication skills and multi-disciplinary team working facilitated a child's 'journey', but the need to negotiate various obstacles had the potential to delay this.

Conclusions: The findings add to our understanding of the effects of delivering high dependency care on a children's ward. Such provision could adversely affect care for less acutely ill children and their families and had consequences for nursing staff due to the competing demands of the normal workload and the delivery of HD care.

This poster presentation will provide details of the study, with particular focus on the findings and implications for practice, especially in a district general hospital. Different configurations of the child's 'journey' and the facilitators and obstacles that could influence their access to high dependency care will be presented and discussed.

Recommended reading:

Datt, C. and Robinson, K. (2007) "Improving paediatric high dependency provision at a district general hospital". Paediatric Nursing, vol 19, no 7, pp 23-27.

Department of Health (2002) High Dependency Care for Children: Report of an Expert Advisory Group for Department of Health 2001: http://www.dh.gov.uk/en/Publicationsandstatistics/

Publications/PublicationsPolicyAndGuidance/DH_4010058

Rushforth K (2006) A Study of Paediatric High Dependency Care in West, North and East Yorkshire. A Report of Paediatric Staffing and Patient Activity. January – December 2005. Leeds, University of Leeds. ISBN: 0 85316 171 0

10

The influence of concept map taching on student nurses's critical thinking abilities

Shiah-Lian Chen, Associate Director, Department of Nursing, HungKuang University, Taiwan

Abstract:

Demonstration of effect of concept map teaching on students learning.

Recognize the factors that affect development of students'critical thinking over time.

There are no consistent findings suggesting how critical thinking can be taught. The purposes of the study was to investigate the predicted growth of critical thinking ability in response to concept map as a interventional strategy for nursing students in a two-year baccalaureate program.

The study was a quasi-experimental, control group, longitudinal follow-up design. A convenience sample was drawn from a nursing program in central Taiwan. The intervention of concept map teaching was given at the second semester in the two-year program in a 16-week course of the Medical-Surgical Nursing. Six scenarios related to the course content were designed for group discussion at the end of classes. Data were collected at four different time points at the beginning of each semester using structured questionnaires including the Critical Thinking Scale, Approaches to Learning and Studying, and Learn Style Inventory.

Data were analyzed using the Hierarchical linear modeling program. The student started with a mean critical thinking score of 41.14 and the score decreased at a rate of 0.79. Yet, the concept map group gained score at a rate of 0.9 across time. The conditional growth model has showed that best predicted growth in the total score of critical thinking included less use of surface approach and the concept map group. Growth in evaluation of argument was predicted best by age, entrance status, organized study, effort management, and assimilator. While, inference was predicted best by variables of the concept map group, age, clinical experience, surface approach and assimilator.

Our study confirms that concept map is an important teaching strategy to enhance student critical thinking.

Recommended reading:

Senita, Julie (2008) The use of concept maps to evaluate critical thinking in the clinical setting,Teaching and Learning in Nursing,3,1,6-10.

Chiou, Chei-Chang (2008) The effect of concept mapping on students' learning achievements and interests,Innovations in Education & Teaching International,45,4,375-387.

Taylor, J. Wros, P. (2007) Concept mapping: a nursing model for care planning, J Nurs Educ,46,5,211-217.

11

The changing skills of ward leaders: Using focus groups to explore ward leaders experiences implementing the productive ward

Susan Haines, Nursing Development Centre, Nottingham University Hospitals NHS Trust, UK

Abstract:

Background: The delivery of high quality patient care is key from 'ward to board'(DH,2008). Productivity and quality metrics are new concepts within the NHS. This study reports on a small scale qualitative study, utilising focus groups to gather narratives of ward leaders implementing an improvement initiative 'Releasing Time To Care – The Productive Ward '(PW)(NHS Institute,2008).

Aims: The study aimed to gain greater insight in to participants 'lived experiences' implementing the PW in practice and explore if skills required by ward leaders are changing as a result of the PW.

Methods: Two focus groups were utilised to gather narratives of nine participants. Mind mapping (Buzan,1983) was utilised in an innovative approach, exploring its use within the research process presenting focus group data back to participants as part of analysis, aiming to enhance accuracy in representation of the lived experience and empower participants further in the research process.

Results: The mind map tool allowed a cacophony of voices to be represented and readily presented back to participants, enabling opportunity for validation of their voice. Themes identified included recognition of patient focused improvements, but also perceptions of increased stress on leaders due to workload, increased administration and data collection and implications for sustainability of change.

Discussions: Using the RCN Clinical Leadership Progamme as a framework for analysis, it is proposed that leadership skills are evolving to meet changing expectations of ward leadership. Personal reflexivity and recognition of methodology limitations in the research process are outlined, potential for further study of mind maps within the qualitative research domain as another

creative option and a supporting method for data collection is suggested.

Conclusion: Findings provide a window into the human dimensions of a change process. Recommendations are made for further study into the experiences of, and skills required by, ward leaders implementing the PW.

Recommended reading:

Department of Health (2008)

NHS Institute for Innovation and Improvement (2008)

Buzan,T.(1983) Use Both Sides Of Your Brain – revised and updted edition. EP. Dutton Inc., New York

12

Writing for publication: A successful peer and mentor support, longitudinal programme

Debbie Carrick-Sen, Head of Nursing and Midwifery Research, Research Midwives Office, Newcastle upon Tyne Hospitals NHS Foundtion Trust, UK
Co-author: A Richardson
debbie.carrick-sen@ncl.ac.uk

Abstract:

Nurses frequently lack confidence but not ability to write for publication (WfP).

A number of organisations promote and encourage WfP by providing a single session focused on developing the idea, the writing process, selection of journal and the review process.

Antedoctal evidence suggests that nurses working within NHS organisations feel motivated to write at the end of the session, however sustaining the motivation is difficult when competing with clinical work pressures.

During 2008/9 two WfP programmes were developed and delivered in a large acute Teaching Hospitals organisation. The primary objective was to achieve 25% attendee to submission of a peer review publication within each programme.

A multi method evaluation, including self completion evaluation forms and a focus group was undertaken. Each programme consisted of eight monthly two hour sessions held early evening. A mixed method teaching and learning approach was utilised including taught sessions, 1:1 mentorship, peer support and group discussion.

In total 45 nurses, midwives or AHPs participated. Half attendees attended at least five sessions. By the end of the programmes, ten had submitted a paper, all were accepted for publication. Attendees requested an extension to the number of sessions. One year after programme commencement publication submissions had increased to sixteen.

The evaluation suggested that the program was highly valued. Timing, venue and content of sessions was appropriate, although a small number reported some level of assumed knowledge at the start of the programme. Most valued was peer support and 1:1 mentor sessions.

Suggestions for improvements included increased; a) use of writing targets, b) line management awareness, support and approval c) number of sessions to twelve. The WfP longitudinal support programme was a successful and novel approach to increase the number of WfP submissions within the clinical setting. Word count 289

Recommended reading:

Happell B. (2005) Disseminating nursing knowledge--a guide to writing for publication Int J Psychiatr Nurs Res. 2005 May;10(3):1147-55.

Lawrence, M; Folcik, MA. (1996) Writing for Publication. Journal of Nursing Staff Development, volume 12, Number 6, 289-293

Funding source:

UK – Health Service (Local)

1,000 – 10,000

13

Older people's management of persistent pain: A pilot study

Kate Kilgallon, School of Health & Social Care, Teesside University, UK

Abstract:

Background: Almost half of older people living in the community suffer from persistent pain but few studies focus on how older people define or cope with pain.

Aim: To identify the experiences of a group of older people with pain.

Participants: Five women and three men aged 83 to 89 years with persistent pain living in the community.

Methodology: The participants were invited to join a focus group. The discussion was tape-recorded and transcribed. A thematic approach was used to analyse data.

Results: Two themes, defining pain and approaches to pain management and sub-themes were analysed.

• Pain was seen as a nuisance taking over life, catching individuals unawares.

• A hurt affecting sleep, it made participants feel awful, depressed, tearful and weary.

• Pain was debilitating, rendering them reluctant to move.

Pain Management depended on:

• Personal coping, including cultural remedies influenced by childhood.

• Prayer.

• Cultural hardiness, this generation was more stoic – 'We lived through the war, and when I was a lad I gashed my leg, it cost five shillings for four stitches, didn't numb it or anything. I walked back to school with my leg bandaged'.

• Social contacts, for learning coping from others in pain and as a distraction – 'When my grandchildren come I don't seem to have any aches or pains'.

• Distraction, using television, music, reading or a glass of wine.

• Talking to friends about pain sometimes. Talking largely about other things helps, it's the fact that someone is listening to you and you're doing the same for them.

• Support from health workers.

• Drug management .

• Supporting Personal Coping 'I see the doctor every 6 months'

• Complimentary Therapy.

• Education. My doctor said take pain killers regularly.

Discussion: Older people rely on their own resources, family and friends to manage their pain.

Recommended reading:

Crome P., Main C.J., Lally F. (editors), (2007), Pain in Older People. Oxford University Press

Schofield P.(2007), Care Homes and Other Settings IN Schofield P. (editor), Pain In Older People. Wiley.

Funding source:

No Funding

14

A randomised study to compare the pelvictoner device against standard pelvic floor exercises in the treatment of stress urinary incontinence in women

Debbie Delgado, Senior Research Nurse, North Bristol NHS Trust, UK

Co-author: M Drake

Abstract:

Background: Pelvic floor muscle training (PFMT) is first line treatment for female urinary incontinence. PFMT typically involves helping the woman confidently identify her pelvic floor, and a regime of unresisted contractions. We hypothesised that introducing resistance against the pelvic floor contraction may facilitate PFMT, improve muscle strength and aid the woman gain confidence in successfully complying with PFMT.

Aims: To examine the efficacy, acceptability and patient satisfaction with the PelvicToner Device (PTD) as an adjunct to pelvic floor muscle training – with the objective of broadening the evidence based treatment options available to women who experience stress urinary incontinence (SUI).

Methods: Subjects with SUI were recruited and taught a standardised PFMT regime to be carried out over a 16 week period. Half the subjects were randomised to standard treatment (STD) i.e. PFMT alone, the remainder were assigned to the PelvicToner group (PTG) i.e. to use the PTD concurrently whilst executing this regime.

Outcome measures included International Consultation on Incontinence (ICIQ) quality of life questionnaires. Subjective opinions regarding satisfaction and acceptability were also sought.

Results: Results are based on 40 subjects who completed the treatment phase (STD: n=19, PTD: n= 21).

In analysing the primary outcome measure 52.4% (n=11/21) in the PTG and 52.6% (n=10/19) receiving ST reported symptom improvement following the treatment phase.

100% Subjects when questioned at treatment completion, reported the PTD easy to use, with 86% (n=18) giving the device a satisfaction rating ⋯⋯ 7/10 ('0' = 'dissatisfied', '10' = 'very satisfied').

Common reported themes (from study subjects) were that the PTD helped to isolate and focus on contracting the correct muscles, motivating the person to continue exercising.

Conclusions: The PTD is not inferior to standard PFMT. It is a safe and well tolerated adjunct to PFMT, which increases patient choice and may promote subsequent compliance and sustained efficacy.

Recommended reading:

Milsom, I., Altman, D., Lapitan, M.C. et al.(2009) : Epidemiology of Urinary (UI) and Faecal (FI) Incontinence and Pelvic Organ Prolapse (POP). IN: Incontinence. Edited by P. Abrams, L. Cardpza, S. Khoury et al. United Kingdom, pp36-111.

Kegel, A. H. (1948) :Progressive resistance exercise in the functional restoration of perineal muscles. American Journal of Obstetric Gynaecology. 56:238-48.

Hay-Smith, J. and Dumoulin, C. (2006): Pelvic floor muscle training versus no treatment or inactive control treatments for urinary incontinence in women. Cochrane Database of systematic reviews Issue 4

Funding source:

UK – Industry

10,001 – 50,000

Posters

Bridging the gap: The impact of a generic neurology nursing service on patients and carers

Barbara Jack, Professor, Head of Research and Scholarship, Director EPRC, Faculty of Health, Edgehill University, UK

Co-authors: J Kirton; M O'Brien; B Roe

Abstract:

Background: Neurological conditions are estimated to affect 10 million people across the UK. The National Service Framework for long term neurological conditions identified a more coordinated service was required, including better care planning, prompt advice, support and information for patients and carers (DH 2005). Specialist disease specific nurse led services are widely established in neurology and are an effective way of providing enhanced care particularly for complex cases. However, there are many patients with long term neurological conditions patients do not receive this input, and it was identified that there are similar generic issues that affect most neurological conditions. To address this a generic neurology nursing service was piloted in one locality in the North West of England. The aim of this study was to evaluate the impact of the service, and this paper focuses upon the impact on patients and carers.

Methodology: A stakeholder evaluation encompassing qualitative methodology was utilised for this element of the study. A non-probability sampling approach was implemented and 20 semi structured audio taped interviews were undertaken with patients and carers, who had experienced the service. Data was analysed using thematic analysis.

Results and Discussion: Patients and carers all indicated a high degree of satisfaction with the service. The increased time for the consultation, continuity of care and ready access to the service were all widely reported. An increased knowledge of the disease including medication review and management were also indicated. This paper discusses the results and explores potential reasons for the findings. Recommendations for the development and expansion of this service are made.

Recommended reading:

Department of Health (2005) The National Service Framework for Long term Neurological Conditions. Department of Health, London. .

Clinical practice facilitators perceptions of a Placement Learning Support System (PLSS): An evaluative study

Menna Harland, Health, Liverpool John Moores University, UK

Abstract:

Background: Quality assurance of health care practice placements is a key issue for all stakeholders. In one region in the North of England, the responsibility for monitoring, evaluating and improving the quality of practice placements rests with Clinical Practice Facilitators (CPFs) who use a web based Placement Learning Support System (PLSS) to assist them.

Aim: This study sought to evaluate whether CPFs believed that PLSS efficiently and effectively supported them to monitor and manage placements.

Methods: The study took the form of descriptive, non-experimental research with a cross sectional design. Data were collected in Spring 2008 using self administered questionnaires. Eighteen questions were included for statistical analysis and participants were invited to comment further on a number of items.

Results: Thirty five (35) CPFs returned questionnaires, giving a response rate of 51.4%. PLSS was perceived to have had a number of positive effects, including improved communication, a small increase in the number, range and type of learner placements available and improved quality assurance processes. Thirty three (94.3%) participants believed that the mentor database met the relevant NMC Standards. (NMC, 2006, 2008)

Discussion: Analysis demonstrated that overall PLSS was well received by CPFs although their favourable perceptions were perhaps not wholly unexpected as they were closely involved in the development of the system. The mentor database was seen as the most effective PLSS component and CFPs believed that managing the needs of mentors would be impossible without the facility. CFPs also saw the positive effect on communication as a benefit of using the system.

Conclusion: PLSS in general, and the mentor database in particular, appear to offer CFPs a useful and effective tool for managing and monitoring practice placements. It is anticipated that as PLSS gathers momentum these benefits will increase.

Recommended reading:

Nursing and Midwifery Council (2006). Standards to support learning and assessment in practice: NMC standards for mentors, practice teachers and teachers. London: NMC.

Nursing and Midwifery Council (2008). Standards to support learning and assessment in practice: NMC standards for mentors, practice teachers and teachers. London: NMC.

Factors that affect decision making to not having sterilization among couples with sufficient children

Jaruwan Kownaklai, Lecturer in Faculty of Nursing, Mahasarakham University, Family Nursing, Mahasarakham University, Thailand

Abstract:

This research was to find prediction factors of decision making to not having male and female sterilization among couples with sufficient children and it had been passed and approved on researching ethics in humans already. Data were collected by using questionnaire to ask husbands and wives who came for using service at Childbirth Department of Roi-et Hospital, Thailand. It took three months to collect data and sample of 57 persons were obtained. Data were analyzed to find relationship by using Pearson's correlation to find multiple regression prediction factors. It was found from the research that ages of couples after having the last child were positive with the current number of children (r=0.60**), the number of children was negative with decision making to not having sterilization (r=0.39**), ages when having the last child were negative with decision making to not having sterilization (r=0.41*), and factors that influenced the prediction of decision making to not having sterilization of couples included ages of couples with first child and last child, the number of children, and support from couples and relatives together to predict the decision making to not having sterilization for 46 percent.

Recommended reading:

Shain et all. Factors associated with married women,s selection of tubal sterilization and Vasectomy. Fertility and Sterility. February 1985; 43(2): 234-244

Westoff CF., McCarthy J. Sterilization in USA. Fam. Perspect.1979; 11: 147

18

Aiming at culture conscious and tailored nursing. An ethnographic study on the development process towards quality transcultural nursing

Raija Kokko, Nursing, Tampere University of Applied sciences, Tampere, Finland
Co-authors: M Leininger, M McFarland

Abstract:

The purpose of this ethnographic study is to describe the development process towards quality transcultural nursing from nursing education perspective. Leininger's Culture Care Model was used as a framework of this study.

Data were gathered 1997-2006 in Britain, Spain and Greece on student exchanges. The data consisted of interviews with key informants (N=12), interviews with general informants (N=9), research assistants' diaries (N=6), student nurses' travel reports (N=45), and additional material. Qualitative content analysis method was applied to the data.

The organizational and educational prerequisites of Finnish nursing education provided a chance for student nurses to learn transcultural nursing on exchange. The cultural knowledge gathered from the exchange countries increased the student nurses' cultural knowledge base and in addition, their personal knowledge base increased. All the student nurses went through a cultural change and growth (learning) process and both the increased cultural and personal knowledge bases were utilized in this process. The student nurses wanted to accommodate their own nursing on the bases of their learning experiences in order to improve the quality of it. The cultural change and growth (learning) process produced a new type of knowledge, which is called transcultural nursing knowledge. The use of this knowledge leads to nurses' cultural competence and preparedness to meet the cultural needs of the patient, and therefore nurses will be able to provide culture conscious and tailored nursing to their patients. Culture conscious and tailored nursing means here quality transcultural nursing to patients because the cultural knowledge and experiences are utilized when assessing and implementing the patient's care.

The development process towards quality transcultural nursing described in this study provided one option to meet the challenges of the globalization of nursing.

Recommended reading:

Sandin, I., Grahn, C., Kronvall, E. 2004 Outcomes of Swedish Nursing Students' Field Experieces in a Hospital Tanzania. Journal of Transcultural Nursing, vol 15, no 3, pp 225-290.

Ruddock, H. 2007 Developing cultural sensitivity: nursing students' experiences of a study programme abroad. Journal of Advanced Nursing, vol 59, no 4, pp 361-369.

Koskinen, L. 2003 To survive you have to adjust. A study abroad as a process of learning intercultural competence in nursing. Kuopio University Publications, Kuopio.

19

Learning in the Workplace

Pat Watson, Centre for Health and Social Evaluation, Teesside University, UK
Co-author: J Shucksmith

Abstract:

Background: This paper describes the ongoing evaluation of a complex intervention – the Learning in the Workplace Programme – a partnership between two PCTs and Teesside University designed to address the learning needs of primary care and community nursing staff. The programme aims to identify learning needs from the workforce, to design relevant programmes and to deliver them in innovative ways, principally in the workplace, to encourage application of learning.

Aims of the Evaluation: To evaluate a complex and dynamic programme using a 'realist' evaluation framework (Pawson and Tilley 1997) that responds to change and contributes to service development.

Methods: A 'theory of change' or realist evaluation framework is being used. An overarching study (pursued through observation and interviews with key stakeholders) has plotted the logic or theory that drives the programme across several authorities and multiple structures. Evaluations have taken place of component training programmes. A final overarching theme will be examination of the impact of the programme as a whole on ways of working amongst the clinical staff of the area.

Results: Results from the first stage charting of the logic model showed significant areas where goals were not originally matched by planned actions or resources. For the second stage we will be feeding this information back into the planning cycle through study days, committee structures and personal contacts.

Discussion: Mackenzie and Blamey (2005) highlighted the difficulties in applying theory of change approaches to a complex community evaluation but concluded that the evaluation style allowed sharpened decision-making, encouraged a focus on impact and removed some of the difficult attributional problems associated with 'black box' evaluation styles. This study sheds further light on that process.

Conclusions: Evaluation in this style involves confidence building with those delivering the programme but can deliver benefits in terms of programme planning.

Recommended reading:

Mackenzie M and Blamey A (2005) The practice and the theory: lessons from application of a Theories of Change approach. Evaluation 11, 2: 151-168

Pawson R and Tilley N (1997) Realistic Evaluation. London: Sage

20

An 'ageless' approach to clinical research

Nicola Anderson, Wellcome Trust Clinical Research Facility, University Hospital Birmingham NHS Foundation Trust, UK
Co-authors: N Anderson; J Plumb; P Stewart

Abstract:

Traditionally there has been under representation of participation in clinical trials and research within large sectors of society: women, ethnic minorities and those at both ends of the demographic spectrum. Reasons for reduced access include lack of specialised facilities and ineligibility because of wide age related protocol exclusions (Lewis J H, 2003)

This poster outlines an 'ageless' programme of research that can investigate new disease mechanisms, treatments and outcomes in adults and children from differing ethnic backgrounds who have a wide range of diseases. This programme is delivered through the establishment of dedicated clinical research facilities (CRFs) supported by the Wellcome Trust in two of the largest Trusts in the UK, in collaboration with a world class University. Furthermore, community links and access to research participation is extended through the utilisation of a mobile CRF and infrastructure that links the CRF's to the primary care research network.

The CRF's share common management and operational structures and closely cooperate in shared activities, particularly education and training. Cell based therapy suites and a dedicated gene therapy pharmacy allows development of novel therapy programmes for cancer and immune mediated diseases. Studies can be crossed over from adolescence to adulthood seamlessly instead of stop/starting studies that may have proved effective and of benefit to the patients. This is made possible with the collaboration of the CRF's and paediatric/adult PI's/researchers working up study protocols with this in mind at the start of a paediatric study subject to all the necessary regulatory approvals.

This partnership across clinical and academic establishments enables a new era of translational research encompassing an 'ageless' approach to understanding of prevalent human diseases across diverse ethnic communities thereby negating the limitations of traditional 'age-based' research methodologies thus complying with the drive to

provide 'quality care for all' (Department of Health 2006,2008)

Recommended reading:

Department of Health (Research and Development Directorate) (2006). Best Research for Best Health: A new national health service research strategy. London: Crown.

Department of Health. (2008). Quality Care for All. London: Department of Health.

Lewis J H, K. M. (2003). Participation of Patients 65 years of age or older in cancer clinical trials. Journal of Clinical Oncology , 1383-1389.

Funding source:

No Funding

Recommended reading:

UK Clinical Research Collaboration. (2006) Developing the Best Research Professionals. Report of the UKCRC Subcommittee for Nurses in Clinical Research (Workforce) Chair Janet Finch. UKCRC: London

Funding source:

No Funding

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The clinical research nurse as an expert resource in protocol development and implementation

Polly Tarrant, Lead Research Nurse, Addenbrookes Clinical Research Centre, Cambridge University Hospitals NHS Foundation Trust, UK

Co-authors: CRF Quality Assurance Workstream

Abstract:

There has historically been a clear distinction between the role of the nurse as a researcher and that of the clinical research nurse. This case study demonstrates how the expert knowledge of the clinical research nurse can have a direct formative effect on the development and implementation of research protocols .

A team of researchers from the department of psychiatry had applied to the Clinical Research Facility (CRF) to carry out a study investigating the effects of intravenous amphetamine on cognitive function. However, despite having received a favourable ethical opinion and approval from the R & D department, a number of aspects of the study were unclear, and consequently the clinical research nurse coordinating the study from within the CRF had vital input in guiding the research team through the process of ensuring safe practice, particularly with regard to the preparation and administration of the study drug, and in ensuring that safe monitoring of the participant was incorporated into the practical application of the protocol. The poster outlines how the ongoing process of liaison in order to carry out the study and refine the study protocol drew extensively on the specialist clinical and research knowledge and resources of the clinical research nurses facilitating the study. The collaboration between research team and CRF nurses was recognised by both parties to have been of benefit to the integrity of the research and the safety of the research participants. The case reflects the need to further consolidate the role of clinical research nurses with a clear career structure as suggested by Finch (2006), in order to ensure good practice in supporting high quality research in all aspects of health care provision.

Tuesday 11 May 2010

Workshop 1

Researchers and service evaluation: The twilight zone

Daniel Wolstenholme, Sheffield Teaching Hospitals NHS Foundation Trust, UK
Co-authors: J Taylor; A Topping

Abstract:

Background: In the UK, over recent years, there have been wholesale changes to the system of gaining ethical and research governance approvals. These have taken place under the auspices of bureaucracy busting, one of the goals of Best Research for Best Health (DH 2006). The decision to seek ethical committee approval is based on the principle that the investigation is defined as research.

Research interventions that are undertaken with patients (such as Randomised Controlled Trials) undisputedly require ethical approval. Small scale desk based research does not. But in between are a range of projects that fall into a 'grey area' often referred to as service evaluation, service improvement or practice development. Projects that are classified evaluation, for example, may not require National Health Service National Research Ethics Service (NHS NRES) approval, but are managed through other systems within their host organisations. We argue that in some cases, the nomenclature of design can bypass NRES approval entirely, or can enforce it unnecessarily. This workshop will debate whether either stance in fact matters.

One argument is that the processes, inherent in ethical and governance review, offers crucial and critical external scrutiny to a project. This also ensures lay review of the project and ensures that the organisation is fully aware of the implications of the project taking place in terms of data protection, employment and finance. It also allows the investigators to state the generalisability of the research across the desired context. These are surely positives for any project. So why should service evaluation be excluded from such robust processes? Alternatively, is that level of scrutiny necessary for investigations that present little ethical concern and lack scientific reliability and validity albeit while potentially delivering real value for organisations.

Focus of Workshop: To explore through facilitated examples the different paths projects are handled within the NHS, attendees will be encouraged to draw on their own experiences of submitting projects to add to the debate.

Specific attention will be drawn to:

1. How and who arbitrates the decision making process to determine if a project is or isn't defined as research, this will reference guidance such as that created by NRES (2008) and HQIP (2009).

2. How projects proceed once this decision has been made, and the differences between processes.

3. Common factors of all projects around ethical principles and legal requirements.

4. Current and future challenges of the processes as described, specifically looking to innovative approaches to address the complex issues described.

We propose, in this workshop, to debate the issues surrounding the significance of ethical approval as defining what is the status of a project, the impact of that decision on dissemination and impact, and game playing surrounding the twilight zone of service evaluation.

Recommended reading:

Department of Health 2006 Best Research for Best Health: A new national health research strategy, London: HMSO

Defining Research, 2008, National research Ethics Service, National Patient Safety Agency http://www.nres.npsa.nhs.uk/EasySiteWeb/Gateway-Link.aspx?alId=355, Accessed 02 Nov 09 23:30

A Guide for Clinical Audit, Research and Service Review: An educational toolkit designed to help staff differentiate between clinical audit, research and service review activities, 2009, http://www.hqip.org.uk/assets/Downloads/Audit-Research-Service-Evaluation.pdf, accessed 02 Nov 09, 22:00

Workshop level:

Postdoctoral level

Funding source:

No Funding

Wednesday 12 May 2010

Workshop 2

Peer review of research papers: A workshop for reviewers, authors and editors

Alison Tierney, Journal of Advanced Nursing, Wiley-Blackwell, UK

Abstract:

Aims: This workshop is aimed at the doers and the recipients of peer review – i.e. reviewers and authors – and also journal editors whose responsibility it is to manage and monitor the process. The overall aim of this workshop is to explain and discuss the process and value of peer review and, specifically, to:

1. Explain the rational and process of peer review.

2. Demonstrate the practical task of reviewing a paper, using Journal of Advanced Nursing as an example.

3. Identify some of the challenges of peer review for reviewers, authors and journal editors.

4. Discuss how common criticisms made by reviewers can provide insight for authors into what makes a sound research paper.

5. Examine an example of open review of a Nursing Research paper.*

6. Highlight some of the debates relating to peer review in nursing and other disciplines, and associated research.

Background: Most nurse academics and advanced practitioners will be asked at some stage of their career to become a reviewer. Being a reviewer is an excellent way of learning about good (and bad) research reporting, as well as gaining privileged access to the latest new research in your field. For journals, and for the discipline, peer review is arguably important for maintaining and improving standards of research publishing. It also can expose authors to new ideas and perspectives, and provide guidance about how to improve their writing. Most nurses, however, are not taught formally about peer review and how to go about the task of reviewing a manuscript. As a result, not all reviews provide expert appraisal and constructive guidance for the author; and, equally, authors who do not appreciate the role of a reviewer may be dismissive of advice or unnecessarily upset by criticism. This workshop will focus on the question 'What makes for good peer review?'.

Peer review is a far from perfect process, but it can provide valuable guidance for authors when reviewers have commitment to work in the author's interest. In this Workshop, members of JAN's editorial team will stimulate discussion about the challenges of peer review for reviewers, authors and editors.

Format: The topics of the Workshop will be covered in a PowerPoint slide-show presentation and workshop attendees will be provided with a handout of that as well as a copy of JAN's

reviewer guidelines and a list of useful references and resources. The examination of the selected example of an open review from Nursing Research [see Aim 5 *] will be interactive in style and, assuming equipment can be made available, it will be shown onscreen, online. Throughout the workshop it is hoped that participants will make it lively and interactive by sharing their own experiences of the peer review process, whether as authors, reviewers or editors.

Workshop level:

Postgraduate(Doctoral level)

Funding source:

No Funding

Wednesday 12 May 2010

Workshop 3

Creating autoethnographies

Tessa Muncey, Institute of Health and Social Work, University of Leeds, UK

Abstract:

Background: I have a fascination for the uniqueness of individuals and am a subscriber to Hillman's (1996) idea that 'a single anecdote lights up the whole field of vision'. I also recognize the enormous gap between experiences of normal life and the public narratives offered to make sense of that life. Autoethnography is a research method that privileges the individual, by presenting experiences in a thoughtful and imaginative way so that the reader is required to think about dominant discourses in a new light.

The challenge of mutual understanding among people is arguably one of the greatest dilemmas of the 21st century. Lack of shared understanding permeates political, cultural, artistic and scientific practices and leads us into war, unrealistic healthcare practice, misunderstood groups of excluded people and much more besides. One aim of research is to find general explanations for defining people's behaviour. By rigorously defining the sample in each study, attempts are made to understand populations and through this the individuals who make up the populations. Attempts are made to identify why people may be excluded from research studies, but these are not always well documented. Those eliminated may be people whose complexity would contribute so many intervening variables that they would distract the purpose of the study and are therefore gently cast aside. It is the complexity of individuals that autoethnography seeks to address; the muddled, idiosyncratic, florid eccentricities that make us unique as opposed to part of a population. The unexamined assumptions that govern everyday life, behaviour and decision making are as strong as any overt beliefs. The shape and size of these unexamined assumptions can be considered the staple diet of the autoethnographer. If we consider that the dominant voice of the research world is not representing our experience, then we have to find ways of redressing the balance. One only has to consider the whole discourse about adherence to medical regimens and the inherent problems in getting individuals to comply with professional advice to know that something happens when individuals interpret that advice using their own specific set of assumptions, or when the individual's set of assumptions overrides the opinion of an expert. In order to contribute to or subvert the dominant discourses that underpin much of our research, strategies and techniques need to be found for portraying experiences that don't rely on the affinity of shared assumptions.

There are several emerging trends in qualitative research within the humanities and social sciences that correspond with the expansion of autoethnographic texts. One is the growing acceptance of the individual in research, albeit often described as deviant cases. Potter (1996, p. 138) uses the term 'deviant case' to highlight 'exactly the kind of problem that shows why the standard pattern should take the form that it does'. Typically this is research wherein an individual is identified who doesn't appear to fit within the researcher's emergent themes and is singled out for detailed scrutiny. Second, there is the therapeutic or emancipatory element associated with participating in research. In order to reconstruct a narrative or 'lived experience', the researcher provides the participant with a cathartic experience during the collecting of the data. Third, there is a growing trend for the authority of the recipients or end users of research to have a voice within the research process, and narratives have become a common source of evaluative material. Autoethnography attempts to unite these trends in imaginative and insightful ways. However, because the author and the subject are the same, most published work – which can be text, performance, poetry, songs or art – is the 'story' itself, rather than an account of how it can be produced. There is a growing appeal for researchers in the disciplines of humanities and social sciences to work together, and this workshop should appeal to you if you are interested in using creative methods in research and come from disciplines, such as healthcare, education, communications and sport sciences, that draw on the social sciences. (Muncey 2010)

Workshop Content: This workshop will consider what criteria might be used to select an experience to develop and what writing tactics can transform it into an autoethnography and unpicks some of the assumptions implicit in the autoethnographer's mind, as they craft an autoethnography; identifies and addresses some of the tensions and criticisms that the concept attracts and provides some criteria for assessing the credibility of the autoethnographic contribution. Whether wishing to create autobiography or biography the use of snapshots, artefacts and metaphor will be utilised as adjuncts to the creative process.

Target audience: This introductory workshop is aimed at novices to the method but will appeal to all researchers who are considering the implications of portraying the experience of individuals in their work or who need to contextualize their own experience within the study. This includes both postgraduate students and experienced researchers seeking to use creative methods to explore their research questions in imaginative ways.

Recommended reading:

Hillman, J. (1996) The Soul's Code: In search of character and calling, Bantam Books, London.

Muncey, T (2010) Creating Autoethnographies, Sage Publications, London

Potter, J. (1996) Discourse Analysis and Constructionist Approaches: Theoretical background. In J. Richardson (Ed.) Handbook of Qualitative Research Methods for Psychology and the Social Sciences. BPS Books, Leicester.

Workshop level:

Postgraduate(Doctoral level)

Funding source:

No Funding

Wednesday 12 May 2010

Workshop 4

Crossing the finishing line: How to successfully complete your doctorate

Barbara Jack, Faculty of Health, Edgehill University, UK

Co-author: A E Topping

Abstract:

This workshop is aimed at delegates who are currently or about to embark on the final stages of doctoral study.

Undertaking a doctorate is undoubtedly a challenging time. In nursing many candidates undertake a doctorate on a part time basis juggling work, study and life. One of the key hurdles is the final period leading to successful completion – the 'End Game'. This is the period that includes writing up of the thesis, the viva voce examination and responding to corrections.

The aim of this workshop is to explore the particular challenges the End Game presents and discuss practical solutions for overcoming them.

Learning Outcomes: At the end of the workshop participants will be enabled to:

• Have examined the writing up process and identified strategies to aid successful completion.

• To understand the purpose of viva voce and examine the purpose, roles and possible outcomes.

The workshop will be divided into two parts:

A) The writing up process.

This will explore the inevitable challenges of the writing up process including time management, self-motivation, overcoming writers block and managing important others. The role of the supervisory team in supporting you. What examiners are looking for in a thesis and devices for helping your reader.

B) The Viva Voce Examination.

Preparation for the viva voce examination including pros and cons of a mock viva. The purpose and possible outcomes from the viva voce will be explored. Including ways of dealing with difficult questions.

Lastly, practical steps approached for dealing with corrections will be discussed.

It is envisaged that this workshop will be interactive and participants will be encouraged to discuss their own challenges and identify possible solutions. At the end of the workshop, it is anticipated that participants will be able to develop a personal action plan to help them successfully navigate crossing the 'Finishing line'.

Recommended reading:

Jack BA (2002) The Final Hurdle: Preparation for the PhD Viva Examination Nurse Researcher 10 (2) 66-75

Jack BA (1999) Staying the course: the supervisee's personal experience of the supervision relationship. Nurse Researcher 6 (4) 19-28

Workshop level:

Postgraduate (Doctoral level)

Funding source:

No Funding

Wednesday 12 May 2010

Masterclass

Translating research into action: The role of multi-methods systemic reviews and the impact of research practice

Professor Alan Pearson, Executive Director, The Joanna Briggs Institute, University of Adelaide, Adelaide, Australia

Abstract:

The dominant approach to the systematic review of evidence favours the meta-analysis of the results of Randomised Controlled Trials (RCTs); indeed, the RCT is conceptualised as the "gold standard" in evidence of effectiveness, with other quantitative methods ranked as lower in quality in terms of evidence, and the results of interpretive and critical research are not regarded as high quality evidence. Critics of the prevailing privileging of the RCT and quantitative research cite the arguments inherent critiques of traditional science and the emergence of new paradigms for knowledge. Whilst the RCT is probably the "best" approach to generating evidence of effectiveness, nurses, medical practitioners and other health professionals are concerned with more than cause and effect questions, and this is reflected in the wide range of research approaches utilised in the health field to generate knowledge for practice.

Although its proponents would argue that evidence-based practice is not limited to the utilisation of the results of traditional research, there has been considerable emphasis on RCTs and meta-analyses, especially in medicine and by the Cochrane Collaboration. This has drawn criticism from those professions who regard qualitative research methods as equally valid forms of research and, thus, generators of legitimate evidence for practice. The result is that qualitative research is rendered invisible in many systematic review databases.

Pearson (1999) argues for a pluralistic approach when considering "what counts as evidence" for health care practices and Evans and Pearson (2001) suggest that reviews that include both (or either) qualitative evidence and quantitative evidence are of importance to most practitioners.

Just as multi-method approaches to primary research are currently of increasing interest to researchers, so to is interest in multi-method systematic reviews. This master class will consider emerging approaches to the systematic reviews of evidence generated through diverse research methods and traditions.

Thursday 13 May 2010

Workshop 5

An introduction to writing a systematic review of the literature for nursing practice: A step by step practical workshop

Josette Bettany-Saltikov, School of Health and Social Care, Teesside University, UK; Katherine Sanderson, School of Health and Social Care, Teesside University, UK

Abstract:

This workshop aims to provide an overview of what constitutes a systematic review and the research process that produces such a review. It is targeted towards the novice reviewer. The scope of the workshop will be to introduce participants to systematic reviewing of the literature and highlight key aspects involved in the process.

A summary of the steps involved in conducting this type of review and the research process that produces such a review will be discussed. This will be followed by an interactive discussion of what constitutes 'appropriate' research questions and participants will be invited to discuss the research question for their own review. A presentation of the individual steps involved in undertaking this type of review will follow. The process will be illustrated through the use of a quantitative and a qualitative case-study. The workshop is designed to facilitate a longer term enquiry and the development of a technique that will necessarily involve work over several weeks or months. This workshop will enable participants to:

- Discuss the meaning of a 'systematic' review and explain the difference between a narrative review and a systematic review.

- Identify and write an answerable research question for their own systematic review.

- Relate their research question to the research design: What types of study designs should you look for to answer your research question?

- Understand the principles of writing the background for their own review; this will include the preparation of a rational for the systematic review indicating why it is necessary.

- Write the objectives for their review.

- Summarise how the reviewer selects criteria by which to choose which papers are reviewed.

- Understand the importance of writing a peer-reviewed protocol (or plan) for their own review.

- Understand the principles of undertaking a comprehensive and systematic search.

- Understand the methodology involved in writing a systematic review.

- Summarise the key principles involved in writing up the results and discussion sections of a systematic review.

Participants will be provided with workshop materials which will be distributed in class. Participants are strongly advised to attend with a specific question from practice in mind. The workshop will then demonstrate a qualitative and quantitative case-study and then give time for participants to fill in the systematic review worksheets that will enable them to develop their own question from practice.

Recommended reading:

Centre for Reviews and Dissemination. Systematic reviews: CRD's guidance for undertaking reviews in health care [Internet]. York: University of York; 2009. Chapter 1, Core principles and methods for conducting a systematic review of health interventions; [accessed 2nd October 2009]. Available from: http://www.york.ac.uk/inst/crd/systematic_reviews_book.htm

The Cochrane Collaboration (2008) Cochrane handbook [online] http://www.cochrane-handbook.org/ [Accessed 1 Oct 2009].

Petticrew, M. and Roberts, H. (2006) Systematic Reviews in the Social Sciences: A Practical Guide. Oxford: Blackwell Publishing.

Workshop level:

Undergraduate

Thursday 13 May 2010

Workshop 6

Pain measurement into practice: Tools for implementing the RCN guidelines on the recognition and assessment of acute pain in children

Chris Watts, RCN Learning and Development Institute, UK
Co-author: Jenny Gordon

Abstract:

The RCN has recently completely revised and updated its guideline on the recognition and assessment of acute pain in children. Through a systematic review and appraisal of the available literature, the revised guideline identifies reliable and valid tools for measuring pain intensity in children, and includes a new section for measuring pain in children with cognitive impairments.

Since the launch of the guideline, the RCN Learning and Development Institute has worked in partnership with professionals, parents and carers to develop online learning materials to support the implementation of the guidelines. This workshop is an opportunity for nurses and other related professionals to learn about these implementation resources, and how they can support getting the evidence from the guidelines into practice.

Recommended reading:

RCN (2009) The recognition and assessment of acute pain in children: Clinical Practice Guidelines. RCN: London.

Workshop level:

Undergraduate

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