

Minutes from SNERC 5/13/08

Taken by Shannon Moore

Present: Sheryl Buckner, Susie Jones, Cynthia Yarberry, Brenda Skaggs, Sharon Coon, Shannon Moore, Kristen Webb, Jamie Loomis, Rita Worthington, Toni Starkey, Judy Chapman, Candace Becker

### **Operation Morale**

Shannon Moore talked about a study she did at OUMC called Operation Morale concerning nurse morale before and after Magnet process. She would like to connect to other sites that are potentially going through Magnet to do a multi-site study. She will write up and abstract that will be distributed through SNERC.

**Review of Turning Study:** Study will occur in 13 hour period, q 1hour to look at patients, initial observation, then hourly. One of the purposes of this study is to help people learn process or research. Research question: Are patient's getting turned? Inclusion criteria: Clients who are unable to reposition themselves, 18 years of age and over, score less than an 18 on the Braden Scale. Don't want to move to exotic intervention if basic intervention is not being met. Study is looking a one "spot in time, like a chest x-ray." In terms of standard of care, we don't know what is being done. This will be a purely observational study. Eventually (not now) may want to look at difference in staffing. This study may help each institution figure out where they are; are their patients getting turned? With upcoming issues of CMS, no pay and pressure issues becoming more prevalent, need to look at quality issues: where are we in regard to this problem?

### **LOG**

- ◆ Decided to create log/agency to log all clients within that agency on it. Will ID clients through a numerical system such as: Integris 1000, VA 2000, OUMC, 3000, etc. The log would include patients name, room # and date and a unique identifier (include initials) or room #, eg. 1001-JP, pt would be patient #1 at Integris, JP initials.

The log is a way to go back and match particular record to a data sheet. Keep an on-going log when do continuing review (have to tell them how many studied and how many lost because they left). The log is to match data collection sheet. Each patient has a unique ID so can match with data entered so no duplication or errors.

**ACTION:** *Brenda Skaggs* will develop log and bring to next meeting

### **ETHICAL ISSUES**

- ◆ Briefly discussed Dr. Bowers concerns from last meeting that it might be bothersome to a client if you are going into their room hourly to stare at them. How is that going to be handled? No decision on this.

- ◆ Does researcher have authority to speak up, if a client is in same position for 8 hours? Need to be careful about assumptions that they aren't turned. It's possible patients were turned but are non-compliant and turning back or could have refused a turn. At end of 12 hours, we might develop a protocol script ("these patients were in the same position for 12 hours when we observed them") to handle situations where a patient is not turned. You would go to the charge nurse and say for 12 hrs, he was in same position or provide some sort of debriefing.

**ACTION:** Need to determine/resolve this at next meeting.

## TOOL

- ◆ Reviewed Tool

- **Unit Name:** Maybe ICU or non-ICU? Or Critical Care, Non-critical care, LTAC? Need to be careful to use consistent nomenclature. Someone mentioned using JCAHO nomenclature, but then thought JCAHO didn't use standardized nomenclature. Facilities to participate possibly: Baptist, Southwest (?), VA, OUMC, Lawton, Duncan (has more beds than Enid, but couldn't hear a number), Enid (70-80 acute care beds).

**ACTION:** Each hospital needs to define unit names and level of care occurring on units so we can compare one hospital to another.

- **Other demographic data:** Still discussed including staff mix: how many RN's, LPN's, CTA's, etc. Does staffing make a difference? Who owns the turning of patients? Define staffing patterns-descriptive variable for organizations. Define staffing at unit level for every organization. Collect information about staffing, but we might not have large enough sample size for statistical analysis.

**ACTION:** Each facility needs to give estimate of how many they think might be included on a particular day at their facility.

- **Possible numbers at each hospital that might be included (one day snapshot).** The census at Baptist could be 400, but how many of those patients are unable to reposition themselves? We think the number is larger than expected. How will those patients be identified? At OUMC, Medi-Tech will generate a custom report to see Braden scale scores and print out location.

**ACTION:** Each facility needs to develop a way to identify patients.

- **Braden Scale:** Will be on back of tool for Baptist and Lawton since they use different wound assessments. Both Baptist and Lawton will need to look at how they will convert clients over from their current scales (Williams and Norton, respectively) to a Braden. Who will score Braden? Susie felt like the observer should, but then Cynthia pointed out that then the observer would have to do an assessment on the patient. Someone suggested using the Braden scores the patient has recorded by staff. At some facilities, the Braden is done upon admission and then 4 days later.

**ACTION:** Individual hospital need to define what their current policy is on completing wound risk assessments and what type they use. If using

something other than Braden, suggest a protocol that might be used to convert the client information into a Braden scale.

- **Inclusion/Exclusion Criteria:** Will be on tool to remind people. Decided to use only two inclusion criteria: 18 years and older and less than an 18 on the Braden Scale (since Cynthia pointed out that the Braden already allows for not being able to turn independently). Added to exclusion criteria: Exclude those on isolation unless can make visual without going in to room.
- **Mattress Types:** What is the benefit as far as turning? False belief by nurses that automatic turning beds are adequate for turning (when in reality they are good for ARDS, not adequate for turning). Also, common belief that if a client is on a specialty mattress, even, they don't have to be turned. **ACTION:** Each facility needs to identify what kind of mattress types/beds are used at their facility and categorize.
- **Data Collection Points:** Decided that we want to circle the position they are in but change Prone and Supine around. HOB if it makes a difference with the pilot, then include it for the study. Add comments section for each hour on data point. Also, have an N/A or not observed column (in case they are in x-ray).
- **Data Analysis:** How are we going to analyze data? 13 data points for each patient. Use cumulatively (point 1, point 2 are different?). From this time to this time is position different? For descriptive, look at individual for repeated measures (chi squared). For each person, how many times were they in a different position? Be clear with research question and how to analyze to put on IRB application. Are patients being turned? Are patients in a different position? What percentage of time? What percentage of time are patients in a different position at 2hrs? When patients go prone, do they stay that way for 10-12 hrs?

SPSS helpful to start?

Code the positions:

Not available	= 0
Left	=1
Right	=2
Supine	=3
Prone	=4

Hour = initial observation, change to time (military) then place an empty time block and then hr 1, hr 2.....

Another column to ask if pt in a different position than previous 2 hrs  
yes = 1, no = 2

Each site will be responsible to clean the data before giving to the multi-site coordinator.

**ACTION:** Susie Jones to update tool and put on Excel or Access.

## MULTI-SITE COORDINATOR

- ◆ Discussed role/responsibilities: Dr. Coon to clarify with Kathy Jost that she is multi-site coordinator, not just for OUMC; if it is a problem she is to let Sheryl

Discussed role of Multi-Site Coordinator:

- Clarified that coordinating site will take lead on data analysis.
- Multi-site coordinator responsible for all participating sites to make sure have IRB approval
- Ensure Human Subjects training
- Monitor performance of all participating sites.
- Ensure data bases are consistent among sites.
- Adhere to IRB proposal/submit changes to IRB as needed.

**Next Steps:**

- ◆ Each hospital to review **ACTION** steps and define (as above).
- ◆ Brenda to do log, Susie to update tool.
- ◆ If hospital does not have human subject training then the Citi program at OUHSC can be used (see April minutes). To get in, just select *University of Oklahoma Health Sciences Center*. There is also a free NIH Human Subjects training available on the internet: <http://phrp.nihtraining.com/users/login.php>  
**ACTION:** Everyone participating will need to have Human Subjects Training completed.
- ◆ Cynthia and Brenda will share work on annotated bib they have done for another project that we may be able to use for the beginning of the lit review for this study.  
**ACTION:** Brenda will bring to next meeting.

**TIMELINE:**

**June**

- ◆ Complete IRB at next meeting (review and makes changes according to above changes)
- ◆ By next meeting, identify sites that are going to be in study. Will need rep from each site at meeting.

**July**

- ◆ Run a pilot before full study

**August**

- ◆ Make changes

**September**

- ◆ Collect data