Integrating Evidence-based Patient Decision Support in
Nursing Curriculum

Report: July 31, 2006

Updated January 18, 2007

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Introduction: Teaching and Learning Activities for Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Although providing patient decision support is within the scope of nursing practice, the quality of decision support by nurses in practice is variable and little is known about the degree to which patient decision support is addressed in the nursing curriculum.

An iterative process, working with 17 faculty members at the University of Ottawa led to the development of teaching and learning strategies to integrate patient decision support theories, nursing interventions, and resources in basic nursing programs. These learning activities are also relevant to continuing education programs for practicing nurses, faculty members, and other health professionals. Strategies, based on the needs identified by faculty members, include presentations for classes within each of the four years of the program, written assignments that involve critically evaluating available evidence-based patient decision support resources and problem-based case scenarios. Several of these teaching and learning strategies were implemented in the 2005-2006 academic year across the four-year undergraduate nursing program in English and French.

These resources are protected by copyright but free of charge, provided you cite the reference when you use it. We welcome you to choose from the various learning activities that we have created, modify them to suite your students' learning needs, and provide us with feedback (e.g., usefulness, accuracy, comprehensiveness, clarity of the learning activities, comments, or suggestions).

For more information, please contact:
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School of Nursing, Unviersity of Ottawa www.uottawa.ca
Or visit our website at decisionaid.ohri.ca for access to a global inventory of patient decision aids, systematic review, theoretical frameworks, outcome measures, and more.

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Overview of Teaching/learning strategies to enhance nurses' knowledge and skills in EB patient decision support

Modules	Overall Objective	Lectures	Problem-based Scenarios	Assignments
I (clinical focus: individuals as children, adults, seniors)	To introduce patient decision making and influence of values on clinical decisions	▪ Understanding the influence of values on nursing practice* ▪ Supporting clients to be effective consumers and decision makers for lifestyle choices* ▪ Healthwise Handbook and Knowledgebase workshop*	1.1c- Stress in adults* 1.2c- Childhood healthy body weight* 1.3c- Falls in seniors*	1.1a Exploring the influence of values on health decisions
II (clinical focus : obstetrics, seniors)	To identify the nurse's role in supporting families making decisions by using patient decision support tools	▪ Health decision making and the family for triage and values-sensitive decisions (English & French)*	2.1c- Circumcision; infant feeding 2.2c- Postpartum depression	2.1a-Utilization of patient decision aids: obstetrics focus(English & French)* 2.1b – Utilization of patient decision aids: birth control or tube feeding (English) 2.2a- Evidence-based clinical guideline (English & French)*
III (clinical focus: community health,surgery, medicine, mental health)	To explore the Ottawa Decision Support Framework and its relevance for clinical practice	▪ The Ottawa Decision Support Framework as a mid-range nursing theory* ▪ Breast cancer patient decision making within 3-hr cancer nursing lecture*	3.1c- Lung cancer end of life care 3.2c- Adolescent suicide	3.1a-Ottawa Decision Support Tutorial with knowledge test* 3.2a-Applying the Ottawa Decision Support Framework*
IV (clinical focus: complex care, consolidating knowledge & skills)	To build and appraise decision coaching skills for supporting patients facing decisions in a complex care environment	▪ Decision support skill building workshop* ▪ Addressing oncology patient information and decision support needs*	4.1c- Medication error 4.2c- Stroke rehabilitation	4.1a-Critical appraisal of Patient Decision Coaching 4.2a- Clinical practice guideline evidence-practice gap

*pilot tested with students

Additional resources:
- Guidelines for Creating Problem Based Learning case scenarios
- Summary of Evidence-based patient decision support Resources for posting on the University of Ottawa Library Website
- Conducting a Curriculum Needs Assessment: A workbook for assessing opportunities for integrating patient decision support within curriculum for health practitioners

Module I

Overall Objective:
>To introduce patient decision making and influence of values on clinical decisions

Theory and clinical practicum focus
- individuals as children, adults and seniors
- health promotion
- socialization into role of nurses

Teaching and Learning Strategies
>A. Lectures:
>>- Understanding the Influence of Values on Nursing Practice
>>- Supporting clients to be effective consumers and decision makers for lifestyle choices
>>- Healthwise handbook and Knowledgebase Workshop
>
>Learning is evaluated through use of questions on mid-term and final exanimations as well as through use of assignments.

>B. Assignments
>>1.1a Exploring the influence of values on health decisions
>>1.2a Individual patient decision needs assessment (pending)

>C. Problem-based Learning Case Scenarios
>
>The case scenarios can be used for small group case discussions. Each case is organized with the scenario, additional chart or other pertinent data, and references. It is then followed by additional information for tutorial facilitators that include concepts to be addressed, examples of trigger/discussion questions, and faculty resources that include websites, journal articles and books.
>
>1.1c- Stress in Adults
>
>This is a case scenario about a first year university student, Clark Kent, experiencing the stressors of post-secondary education. The concepts of plagiarism and learning styles are addressed. The students identify their own learning styles as well as being introduced to, values and ethical decision making.
>
>1.2c- Childhood healthy body weight
>
>This case scenario deals with the health concerns of overweight elementary children. The students are introduced to childhood growth and development concepts, nursing diagnoses, nurse's role in the school, nursing best practice guidelines and ethical issues surrounding childhood obesity.
>
>1.3c- Fall in seniors
>
>This is a case scenario that focuses on issues pertinent to the healthy senior. In this case Mr. Jones receives a visit from a student nurse who addresses his concerns regarding fall risks and prevention. Other concepts that are addressed include developmental stage, nurse's role, types of seniors' residences and ethical issues and best practice guidelines.

Lectures Module I

- Understanding the Influence of Values on Nursing Practice

- Supporting clients to be effective consumers and decision makers for lifestyle choices

- Healthwise Handbook and Knowledgebase workshop – computer lab

Lectures are available upon request to decisionaid@ohri.ca.

Assignment 1.1a
Exploring the Influence of Values on Health Decisions

Individuals' values influence how health and social decisions are made. As well, health professionals own values can interfere with exploring patients' values related to their options.

Objectives:

1. To understand the concept of values as it relates to decision making.

2. To explore values associated with a specific decision.

3. To describe how nurses' values can influence nurse-patient interactions.

Case Scenario:

You have just renewed your driver's license and notice a card in the envelope about organ donation.
Consider the following questions:

– *What are your views on organ donation?*

– *What personal values influence your decision?*

– *What are the views of other people/society?*

Instructions:

1. Using the Ottawa Personal Decision Guide (OPDG) online version at

   http://decisionaid.ohri.ca/decguide.html, print a copy and complete the questions in the guide.

2. Write a 2 to 3 page reflective paper following the assignment structure below. Submit your

   completed guide with your paper.

Assignment 1.1a Structure/Grading Scheme:

25%	**1.**	**Strengths of the tool**:
		- Discuss 3 strengths of the tool as a strategy for helping recognize and clarify values related to the decision. Remember to justify your answers
25%	**2.**	**Limitations of the tool:**
		- Discuss 3 limitations of the tool as a strategy for helping recognize and clarify values related to the decision. Remember to justify your answer
30%	**3.**	**Clinical Implications:**
		- Reflect and discuss on how rating your importance for outcomes (personal values) may influence how you discuss organ donation with a family member of a patient being taken off life-support.
10%	**4.**	**Conclusion:**
		- summarize the key highlights of your paper
10%	**5.**	**Format:**
		- your paper should be typed with 12 font Times Roman, 2 to 3 pages double spaced with spelling and grammar checked carefully.

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Case Scenario 1.1c: Stress in Adults

You are a nurse at the university health services centre. Today, a first year student, Clark Kent, comes into the clinic, asking for medication to help him relax. When you inquire about why he needs this medication he replies, "I think I'm stressed because the expectations of University is so different from high school. A second year nursing student told me that my learning style is probably not suited to nursing and now I'm worried that I might not be able to pass this year."

He also mentions that he recently submitted an assignment for his psychology course, and he copied part of the assignment from one that a friend submitted last year. He is now worried about whether he should tell his psychology professor what he did. He asks you what he should do. You also discover during the conversation that the psychology professor is a good friend of yours.

INFORMATION SHEET

New client data

Presenting: - admits that he is uncertain about his learning style and suitability for nursing
- states that he copied part of an assignment from another student

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Additional Tutor Information

Concepts to be addressed in this case: Examples of trigger/discussion questions

Adaptation to university (transition to first year)

- Explore the issues involved in transition to first year in university

Stress

- Explore the signs and symptoms of stress and the consequences of unresolved stress

Coping strategies

- Explore coping strategies that this student can use to deal with his stress.

Learning strategies and resources

- What is a learning style inventory and how could it be used to help this student?

Learning style assessment

- Did you learn anything new about yourself by completing the learning style inventory?
- How can you use this information to improve your learning?

Plagiarism

- What is the university's policy on plagiarism?
- Is copying another student's assignment considered plagiarism?
- What are the consequences of plagiarizing?

Client confidentiality and standards of practice

- What is client confidentiality? What would you do in this case?
- What services are available for students? What referrals might you make?
- What are the CNO client confidentiality standards?

Ethical decision making

- How could you relate the concept of ethical decision making to this case?

Personal values relevant to this situation

- What responsibilities does this student have in terms of preparing assignments?
- What are your own personal values relevant to this situation & how might they influence your interaction with the student?

Case Scenario 1.1c: Stress
Faculty Resources

Arnold, E. & Boggs, K. (2003). Interpersonal relationships: Professional communication for nurses, (4th ed.). Toronto, ON: W. B. Saunders. .

Bray, R., S. & Born, H., A. (2004) Transition to university and vigorous physical activity: Implications for health and psychological well-being. *Journal of American College Health.* 52(4), 181-188.

College of Nurses of Ontario. (2000). Compendium of standards of practice for nurses in Ontario. Toronto, ON: Author. Online at www.cno.org/pubs/compendium.html

Dimock, G. H. (1993). *How to observe your group*, (3rd ed.). North York, ON: Captus Press.

Fisher, S. & Hood, B. (1987). The stress of transition to university: a longitudinal study of psychological disturbance, absent mindedness and vulnerability to homesickness. *BR J Psychology.* 78, 425-441.

Gall, T. L., Hvans, D. R. & Bellerose, S. (2000). Transition to first-year university: Patterns of change in adjustment across life domains and time. *J Soc Clin Psychol*, 19, 544-547.

Lohri-Posey, B. (2003). Determining Learning style preferences of student. *Nurse Educator, 28*(2), 54.

O'Shea, E. (2003). Self-directed learning in nursing education: A review of the literature. *Journal of Advanced Nursing, 43*(1), 62-70.

Case Scenario 1.2c: Childhood Healthy Body Weight

Your clinical nursing group has been assigned to work in an elementary school with a class of Grade 1 students and another class of Grade 6 students on the topic of healthy body weight. The school is concerned about the number of students who are overweight and at risk of obesity.

Your clinical nursing group arranges for a visit to the classroom to meet the teachers and students. At your visit, you noticed that half of the children are overweight and at a risk for obesity.

The teacher shares the following issues with you:
1. Many of the children come from homes of new immigrant families.
2. Several children live in families of lower socio-economic status.
3. Children's lunches commonly include: chips, chocolate bars and cookies as their snacks with sandwiches are usually made with bologna.
4. Some girls who are quite thin have been overheard talking about their weight and discussing ways to lose weight.

Your group needs to design a teaching session(s) to address the needs of these children.

INFORMATION SHEET

Grade 1 student Assessment profile:

    Grade: 1

    Ages: 6 years (range 5 to 7)

    Gender: Males and Females

Grade 6 student Assessment profile:

    Grade: 6

    Age: ~ 11 years (range 10 to 12)

    Gender: Males and Females

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Additional Tutor Information

Concepts to be addressed in this case: Examples of trigger/discussion questions

Childhood developmental stages

- Explore various developmental models
- What developmental stage would these children be in according to these models?

Nutrition needs for school-aged children

- Explore the nutritional needs of school-aged children
- What are the recommendations from Health Canada?

Physical activity needs for school-aged children

- What are the recommendations from Health Canada?
- What learning activities would you create to address these issues related to healthy body weight?

Healthy eating and physical activity in children

- Explore the factors influencing healthy eating and physical activity in children.

Teaching strategies for school-aged children
- What do you need to do to prepare for educating students in these classes?
- How will you determine what grade 1 and 6 students know already and need to know?
- How would you present this information to the students using age appropriate strategies?

Nurses' role in schools
- Do you think that public health nurses should be involved in elementary schools; if so, how and why?

Nursing best practice guidelines
- Refer to the BPG on prevention of childhood obesity
- What recommendations would you use to address this case?

Self-esteem / body image and children

- Explore the relationship between self-esteem/body image with children (according to age and gender)

Ethical & legal issues related to healthy body weight in children

- Explore the ethical and legal issues related to healthy body weight in children (in particular considering low SES & ethically diverse home environments)

Roles of child, parent, school, community, health practitioners i

- Describe the roles of the child, parent, school, community and health practitioners in promoting healthy body weight in children.

Scholarliness of evidence sources used

Case Scenario 1.2c: Childhood Healthy Body Weight
Faculty Resources

Abbott, R & Davies. (2004) Habitual physical activity and physical activity intensity: their relation to body composition in 5.0-10.5-y-old children. *European Journal of Clinical Nutrition,* 58(2), 285-291.

Arnold, E. & Boggs, K. (2003). *Interpersonal relationships: Professional communication for nurses,* (4th ed.). Toronto, ON: WB Saunders.

Cole, T., Faith, M., Pietrobelli, A., & Heo, M. (2005).What is the best measure of adiposity change in growing children: BMI, BMI %, BMI z-score or BMI centile? *European Journal of Clinical Nutrition,* 59(3), 419-425.

Edmunds, L. D. (2005). Parents' perceptions of health professionals' responses when seeking help for their overweight children. *Family Practice*, 22(3), 287-292.

Hart, K. H., Bishop, J. A., & Truby, H. (2002). An investigation into school children's knowledge and awareness of food and nutrition. *Journal of Human Nutrition & Dietetics*, 15(2), 129-140.

Health Canada. (1997). Canada's Food Guide for Healthy Eating – Focus on Children 6 to 12 years. Available at: http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/index_e.html

Health Canada. (2002). Canada's Physical Activity Guide for Children. Available at: http://www.phac-aspc.gc.ca/pau-uap/paguide/child_youth/

Hesketh, K., Wake, M., &Waters, E. (2004). Body mass index and parent-reported self-esteem in elementary school children: evidence for a causal relationship. *International Journal of Obesity,* 28(10), 1233-1237.

Janssen, I., Katzmarzyk, P. T., Boyce, W. F., Vereecken, C., Mulvihill, C., Roberts, C., et al. (2005). The Health Behaviour in School-Aged Children Obesity Working Group* Comparison of overweight and obesity prevalence in school-aged youth from 34 countries and their relationships with physical activity and dietary patterns. *Obesity Reviews*, 6(2), 123-132.

Ontario Ministry of Education. (2005). Healthy Schools. Available at: http://www.edu.gov.on.ca/eng/

Ontario Ministry of Education. (2005). The Ontario Curriculum – Elementary – Health and Physical Education. Available at: http://www.edu.gov.on.ca/eng/

Registered Nurses Association of Ontario (RNAO) www.rnao.org

Registered Nurses Association of Ontario (2004). *Primary Prevention of Childhood Obesity*. Toronto, Canada: Registered Nurses Association of Ontario.

Sadler C. (2005). *A weight on their minds*. Nursing Standard. 19(52), 22-24.

Salmon, J., Ball, K., Crawford, D., Booth, M., Telford, A., Hume, C., et al. (2005). Reducing sedentary behaviour and increasing physical activity among 10-year-old children: overview and process evaluation of the 'Switch-Play' intervention. *Health Promotion International*, 20(1), 7-17.

Veugelers, P. J., & Fitzgerald, A. (2005). Effectiveness of school programs in preventing Childhood obesity: A multilevel comparison. *American Journal of PublicHealth.* Programs and Policies to Advance Public Health, 95(3), 432-435.

Warren, J. M., Henry, C. J., Lightowler, H. J., Bradshaw, S. M., & Perwaiz, S. (2003). Evaluation of a pilot school programme aimed at the prevention of obesity in children. *Health Promotion International*, 18(4), 287-296.

Yoshinaga, M., Shimago, A., Koriyama, C., Nomura, Y., Miyata, K., Hashiguchi, J., et al. (2004). Rapid increase in the prevalence of obesity in elementary school children. I*nternational Journal of Obesity*, 28(4), 494-499.

Zametkin, A., Zoon, C. K., Klein, H., & Munson, S.(2004). Psychiatric aspects of child and adolescent obesity: A review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(2):134-150, February.

Case Scenario 1.3c: Falls in seniors Part A

You are a group of nursing students assigned to a retirement residence as part of your clinical experience in the health assessment and promotion course. In a telephone call to book the visit, Mr. Jones, a 70 year old male informs you that he is concerned about the high number of falls within the last few months. "*I am worried that I will end up falling, breaking a hip and be stuck in hospital for months.*"

You need to develop an education plan tailored to Mr. Jones' needs.

INFORMATION SHEET

Client profile		Setting	
Age:	70 years old	Age:	65 and older
Gender:	Male	Gender:	Males and Females
Location:	Retirement home	Issues:	Multiple falls with seniors

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Case Scenario 1.3c: Falls in seniors Part B

On your visit, you conduct an individual assessment of Mr. Jones and find out that he has hypertension that is controlled with a medication called 'terazosin'. He is not taking any other medications. He had one fall a couple months ago when he awoke in the night to void. He had bruises to his legs and arms, but no cuts.

As Mr. Jones shows you around the Seniors Residence, you notice the tile missing at the entrance, the carpet rolls up on the sides, and a bulb is burnt out in the hallway to the elevators. He also tells you that his friend Ivy, fell and broke her hip while she was using his toilet, because one the grab bars had come loose. She will be in a nursing home until she is independent again. When he speaks of Ivy's situation, he sounds sad. As you examine the bathroom, you notice that it is quite small and would be difficult to use a walker in there.

INFORMATION SHEET

New client data
- Unsafe environment
- BP 165/110 pre medication; currently 130/80
- Medication: terazosin 10mg po daily at bedtime for the past 10 years
- Dizziness if he gets up too quickly from lying down
- Feeling a sense of loss

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Case Scenario 1.3c: Falls in seniors
Additional Tutor Information

Concepts that should be addressed in this case:

Part A	Part B
1. Relevant nursing diagnoses	10. Working with groups – factors to enhance group functioning
2. Fall risk assessment	11. Environmental factors
3. Fall Prevention strategies (e.g. strength training, Tai Chi, hip protectors)	12. Medications and its' relation to falls
4. RNAO "Prevention of Falls"	13. Osteoporosis prevention
5. Teaching strategies for the elderly	14. Senior's resident safety requirements
6. Safe mobility	15. Ethical & legal issues
7. Developmental stage	16. Restraints and alternatives
8. Nurses' role in Fall Prevention	
9. Types of seniors residences (nursing home, long-term care facilities, retirement)	

Case Scenario 1.3c: Falls in seniors
Faculty Resources

Bezon, J., Echevarria, K. H., & Smith, G. B. (1999). Nursing outcome indicator: Preventing falls for elderly people. *Outcomes Management for Nursing Practice*, 3(3), 112-117.

Bloem, B. R., Steijns, Janneke, A.G., Smits-Engelsman, & Bouwien C. (2003). An update on falls. *Current Opinion in Neurology*. 16(1), 15-26.

Bright, L. (2005). Strategies to improve the patient safety outcome indicator: Preventing or reducing falls. *Home Healthcare Nurse*, 23(1):29-36.

Close, J., Ellis, M., Hooper, R., Glucksman, E., Jackson, S., & Swift, C. (1999).Prevention of falls in the elderly trial (PROFET): a randomised controlled trial. *Lancet*, 353(9147), 93-97.

Cumming, R., G. (2001). Nurse home visits have no effect on falls or mobility impairment among the elderly, *Evidence-Based Healthcare*. 5(3), 74.

De Rekeneire, N., Visser, M., Peila, R., Nevitt, M. C., Cauley, J. A., Tylavsky, F. A., et al. (2003). Is a fall just a fall: Correlates of falling in healthy older persons. The health, aging and body composition study. *Journal of the American Geriatrics Society*, 51(6), 841-846.

Herwaldt, L. A., & Pottinger, J. M. (2003). Preventing falls in the elderly. *Journal of the American Geriatrics Society*, 51(8), 1175-1177.

Hill-Westmoreland, E. E., Soeken, K., & Spellbring, A. M. (2002). A Meta-Analysis of fall prevention programs for the elderly: How effective are they? *Nursing Research*, 51(1), 1-8.

Honeycutt, P. H., & Ramsey, P. (2002). Factors contributing to falls in elderly men living in the community. *Geriatric Nursing*, 23(5), 250-257.

Honkanen, L. (2004). An overview of hip fracture prevention. *Topics in Geriatric Rehabilitation. Functional Outcome*, 20(4), 285-296.

Lawlor, D. A., Patel, R., & Ebrahim, S. (2003). Association between falls in elderly women and chronic diseases and drug use: cross sectional study. *BMJ*, 327(7417), 712.

Lee, H. K., & Scudds, R. J. (2003). Comparison of balance in older people with and without visual impairment. *Age & Ageing*, 32(6), 643-649.

Mennick, F. (2005). Exercise for fall prevention in older adults: Sun-style Tai Chi offers an additional option. *American Journal of Nursing*, 105(10), 20.

Registered Nurses Association of Ontario (2005). *Prevention of Falls and Fall Injuries in the Older Adult*. Toronto, Canada: Registered Nurses Association of Ontario.

Rush, C. (2005). Development of older adult falls prevention educational materials. *Journal of Emergency Nursing*, 31(1), 19-20.

Sloan, H. L., Haslam, K., & Foret, C. M. (2001). Teaching the use of walkers and canes. *Home Healthcare Nurse*, 19(4), 241-246.

Van Haastregt, J., Diederiks, J., van Rossum, E., de Witte, L. P., Voorhoeve, P. M., & Crebolder, H. (2000). Effects of a programme of multifactorial home visits on falls and mobility impairments in elderly people at risk: randomised controlled trial. *BMJ*, 321(7267), 994-998

Vu, M. Q., Weintraub, N., & Rubenstein, L. (2005). Falls in the nursing home: Are they preventable?. *Journal of the American Medical Directors Association*, CME Digest. 6 SUPPLEMENT:S81-S87.

Module II

Overall Objective:
> To identify the nurses' role in supporting families making decisions by using patient decision support tools.

Theory and clinical practicum focus
- Obstetrics, family
- Seniors

Teaching and Learning Strategies

A. Lectures:
> Health decision making and the family for triage and values-sensitive decisions (English and French)

Learning is evaluated through use of questions on mid-term and final examinations as well as through use of assignments.

B. Assignments
> 2.1a Utilization of patient decision aids: focus on amniocentesis, vaginal birth after cesarean, breast feeding, or circumcision (English and French)
> 2.1b Utilization of patient decision aids: focus on birth control or tube feeding in elderly (English only)
> 2.2a Evidence-based clinical guidelines (English and French)

C. Problem-based Learning Case Scenarios

The case scenarios can be used for small group discussions. Each case is organized with the scenario, additional chart or other pertinent data, and references. It is then followed by additional information for tutorial facilitators that include concepts to be addressed, examples of trigger/discussion questions, and faculty resources that include websites, journal articles and books. The following is a description of each case scenario.

2.1c- Circumcision and infant feeding
This case examines two values-sensitive decisions for women postpartum and introduces decision aids as tools to support postpartum families making decisions. As well as, the case explores the nurse's role in decision support, evidence based guidelines, pain management, clinical pathways and discharge planning.

2.2c- Postpartum depression
This case scenario examines the role of the public health nurse in postpartum depression assessment and intervention. As well, it introduces the students to the Calgary Family Assessment Model, the Edinburgh Postpartum Depression Scale, and a best practice guideline on postpartum depression.

Lectures Module 11

- Health decision making and the family (French & English)

Lectures are available upon request to <u>decisionaid@ohri.ca</u>.

Assignment 2.1a
Utilization of Decision Aids:
Focus on amniocentesis, vaginal birth after cesarean, breast feeding or circumcision

Objectives:
1. To describe the concept of decisional conflict
2. To describe the nurse's role in providing information that helps clients make informed, values-based health decisions
3. To describe the role of other health team members for patient and family care
4. To write an academic paper with nursing interventions justified by the literature

Format: APA Publication Manual (5th ed) to be used for scholarly format. All papers are typed/word processed, double spaced with 2.54 cm (I inch) margins (top, bottom, left & right) margins, with type size of 12 CPI (or equivalent for MacIntosh computers). Times New Roman or similar fonts are recommended. No Table of Contents. **Do not place papers in folder, plastic cover, etc.** Staple pages only please.

Length: 4 pages maximum, excluding references.

Case scenario:
You are assigned to visit the "Jones" family for your family visit. Mrs. Jones is a 40-year-old female, 11 weeks pregnant and has a 6-year-old daughter and 40-year-old husband living with her. Your visit takes place with both Mr. and Mrs. Jones. As you are collecting data for a family assessment, you observe that Mrs. Jones seems distracted. You then say to Mrs. Jones, "you seem preoccupied with something, is there anything you would like to share with me?" Mrs. Jones tells you that she has been very stressed lately. Her obstetrician recommended an amniocentesis because she is forty years old. She tells you that this worries her since she has heard that an amniocentesis is very dangerous.

Mr. Jones then tells you that during the labour for their first child that they had to rush his wife to the operating room because the baby's heart rate was decreasing quickly. Mrs. Jones ended up having a cesarean section. After the C-section she had problems breast-feeding because she was in so much pain and was so tired. Mrs. Jones said that she felt guilty and disappointed because she was not able to breast-feed successfully.

While they are hoping for another healthy child this time, they would really like to have a boy. Mr. Jones then questions you about the merits of circumcision.

Below is a list of the Jones family concerns:
1. ***Should an amniocentesis be done? Are there other tests that might be less dangerous?***
2. ***There is a saying that once you have a cesarean you cannot have a vaginal birth, is this true? What are the options?***
3. ***Should breast-feeding be tried again or should bottle-feeding be used right from the beginning immediately after the baby is born?***
4. ***Should we be considering circumcision?***

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Assignment 2.1a Structure/Grading Scheme:

20% 1.   Introduction:
        - describe one difficult decision and the potential decisional conflict.

25% 2.   Literature:
        - describe the risks and benefits of options supported by at least 3 references.

25% 3.   Clinical Interventions:
        - select a decision aid and justify your choice that you might use with this family
        - describe the role of nursing in providing information to help clients make
          informed, values-based health decisions
        - describe the potential role involvement by other health care providers (i.e.;
          geneticist, dietician, physician, social worker, etc.)

20% 4.   Summary and Conclusion:
        - describe the key highlights of your paper

10% 5.   Format:
        - your paper should be typed, checked carefully for spelling and grammar, and
          include citations within the text and a reference list formatted using APA format

Use recent professional literature **(most from past 2 years)** especially any research to support
your work. No citation to course notes.

Assignment 2.1b
Utilization of Decision Aids:
focus on birth control or tube feeding in elderly

Objectives:

1. To describe the concept of decisional conflict
2. To describe the nurse's role in providing information that helps clients make informed, values-based health decisions
3. To describe the role of other health team members for patient and family care
4. To write an academic paper with nursing interventions justified by the literature

Format: APA Publication Manual (5th ed.) to be used for scholarly format. All papers should be typed in 12 point font, double spaced with 2.54 cm (I inch) margins (top, bottom, left & right). Times New Roman or a similar font should be used. No Table of Contents. Please staple the pages and <u>do not</u> place the assignment in any type of folder, plastic cover, etc.

Length: 4 pages maximum, excluding references and a one page appendix (optional).

Case Scenario A:

   Mrs. Doucet is a 32 year old woman on a post-partum unit. She gave birth to a healthy daughter yesterday and plans to breastfeed. While conducting your routine postpartum assessment, she tells you that she is unsure about what birth control method to use. She shares with you that she has a history of infertility problems. However, after the birth of her first daughter 18 months ago (conceived with the help of fertility drugs), she became pregnant this second time without fertility drugs. Now, she and her husband are concerned that they may get pregnant again. Mr. and Mrs. Doucet are happy with the size of their family and do not plan to have more children. Mrs. Doucet would prefer not to take any daily pills for birth control but she is unsure about the reliability of other birth control methods. She and her husband are considering permanent methods of birth control: tubal ligation or vasectomy.

Case Scenario B:

   Mrs. Bola is a 78 year old client diagnosed with advanced Alzheimer's disease. She is living in a long-term care facility. She moved into the facility three years ago, after her husband died and her children decided that she could no longer live alone safely in her apartment. Mrs. Bola's children, Alisa and Ken, are her substitute decision makers. They both visit her regularly with their own young families. Although her disease has progressed to the point where she is almost always confused, she appears to enjoy their visits. Often the families try to visit during meal times so that they can help Mrs. Bola eat. However, over the past 4 months, Mrs. Bola's interest in eating has decreased to the point where she becomes agitated during meals and it is has become very stressful for the family to help her with eating. She has lost weight and the health care team has expressed concern about the adequacy of her nutrition & ingestion of medications. The team has suggested to Alisa and Ken that they consider placement of a G-tube for their mother. Although Alisa and Ken never discussed this procedure with their mother, they

think that it may improve her quality of life. However, they are concerned about the risks of the procedure and the feedings. They have also witnessed other clients in the facility become very agitated and have to be restrained so that they do not pull at their G-tubes.

Assignment Structure/Grading Scheme:

Choose either scenario A or B below and write a paper according to the following outline:

20%   1.   Introduction:
- describe one difficult decision and the potential decisional conflict from either case scenario A or B.

25%   2.   Literature:
- describe the risks and benefits of options supported by at least 3 references.

25%   3.   Clinical Interventions:
- select and describe a decision aid that you might use with this family.
- Justify your choice of this decision aid.
- describe the role of nursing in providing information to help clients make informed, values-based health decisions
- describe the potential role of other health care providers in decision making (i.e.: dietician, physician, social worker etc.)

20%   4.   Summary and Conclusion:
- describe the key highlights of your paper

10%   5.   Format:
- your paper should be typed, checked carefully for spelling and grammar, and include citations within the text and a reference list using APA format.

Use recent professional literature (**most from past 2 years**) especially any research to support your work. No citations to course notes.

Assignment 2.2a
Evidence-based Clinical Guidelines

Objectives:

1.   To analyze a case study and describe the gap between nursing practice and the recommendation in an evidence-based clinical guideline.
2.   To describe the research evidence supporting at least one clinical practice guideline recommendation.
3.   To propose ideas for reducing the gap, justified by clinical observations and/or the research literature.
4.   To describe nursing interventions that is applicable to family members and other health care providers in the multi-disciplinary team.
5.   To enhance student's critical thinking, problem solving and analytical skills

Cases: Select only one of the following

Assessment and Management of Stage 1 to IV Pressure Ulcers

You (a second year student nurse) have been assigned to care for an 85 year old man who has had a serious stroke, limited mobility and a poor appetite. His daughter is a nurse and asks you "what type of mattress should my father have to prevent any pressure ulcers? I am concerned that currently a regular hospital mattress is being used"

Promoting Continence Using Prompted Voiding

You are working as an unregistered care provider in a long-term care setting for the summer when a staff nurse asks you "what can we do about the incontinence problem for Mrs. Smith? Mrs. Smith is cognitively aware and interested in participating in unit activities but is embarrassed about her problem with incontinence. The staff nurse asks you "have you seen a clinical practice guideline describing recommendations for prompted voiding protocols?"

Interventions for Postpartum Depression

A community health nurse working on the maternal-child team has been providing individual daytime home visits to women with depressive symptoms after the birth of their new baby. The new mother's partner/spouse is rarely available during the visits because he is at work. Government funding has been announced to initiate new models of care. This nurse thinks that it would be a good idea to better involve the partner/spouse and other family members but is uncertain about what to do.

Woman Abuse: Screening

A young nurse with two years of experience in general surgery has been hired to work on the post-partum ward of a large tertiary care hospital with 4,000 births per year. From past clinical experience on the surgical unit, this nurse has seen some very serious cases of woman abuse resulting in considerable trauma. The young nurse observes that some of the new mothers on their unit are potentially in an abuse situation. This energetic, smart nurse wants to work towards the prevention of future abuse and trauma in families. The maternity unit does not have any routine screening questions related to woman abuse on either the admission or discharge forms.

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Assignment 2.2a structure/Grading Scheme:

20%   1.   Introduction:
Select one case and describe an evidence-based recommendation from a clinical practice guideline that is applicable to the issue. Describe the frequency of the issue. Provide Canadian data to support the frequency, relevance and importance of the issue.

25%   2.   Literature:
What is the level of research evidence supporting the guideline recommendation? How many and what type of studies are referenced to support the recommendation? What are the results of the studies supporting the recommendation? Be specific and provide the data with key references.

30%   3.   Clinical interventions and application to family nursing:
Describe what you would do to implement the recommendation in the case study setting. What other care providers need to be involved?   (e.g. physician, physiotherapist, dietary, social worker) How would you involve the patient/client and their family?

15%   4.   Conclusion:
Provide suggestions for the future to bridge the gap between the evidence-based guidelines and actual clinical practice.

10%   5.   Format:
APA Publication Manual (5th ed). Do not place papers in folder or plastic covers. Staple pages only. Include your name, course, date, and professor (Dr. B. Davies) on the cover page. Length maximum of 4 pages excluding references. At least 6 references are expected at a minimum.

Case Scenario 2.1c: Circumcision; infant feeding

Mrs. Jones has just delivered a baby boy. During her second day postpartum, you overhear a conversation between her and Mr. Jones. Mrs. Jones tells her husband that the doctor said that there was no need for them to get their son circumcised. Mr. Jones then states, "that's none of his business, I want my son circumcised. In my family male sons are always circumcised."

Later on that day you see Mrs. Jones holding her baby and crying softly. You sit beside Mrs. Jones and you ask her if she wants to share why she is crying. While sobbing, Mrs. Jones tells you that she is very tired, is concerned about the circumcision issue and is having difficulty breast-feeding and wonders if the baby would be better off with just being bottle-fed.

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Case Scenario 2.1c: Circumcision; infant feeding
Chart Information

Mrs. Jones, Age: 40yrs

Medical Hx: gravida 1, para 1, no previous health problems

Surgery: Emergency Cesarean section at 39 weeks, due to deceleration in fetal heart rate

Post partum day #2: Clinical Pathway

Medications: Epidural and IV PCA discontinued this morning, Tylenol 1-2 tabs PO every 4 hours prn. Laxative prn.

Tests: CBC, normal

Activity: Activity as tolerated

Nutrition: Regular diet, fluid intake adequate

Assessment:

Vital signs: T=37.0c, P=74, R=16, BP=106/70, O2 saturation=96%

Pain control: on a scale of 10= 8/10 with 10 being the worst pain

Breasts/nipples: soft/filling; tender on latching, breast milk in

Fundus: midline, firm at umbilicus

Lochia: moderate rubra

Perineum: no problems

Elimination: catheter removed, voiding sufficient quantity, passing flatus

Abdominal incision: staples intact, open to air and well approximated

Patient teaching: Knowledge base: able to verbalize signs and symptoms of infection, verbalizes understanding of and demonstrates independently, self care and baby care, verbalizes awareness re: timing/need for required health checks for self and baby.

Breastfeeding: complains of sore nipples, fatigue and incisional pain. Successfully breastfed at 4 attempts in the past 24 hours, Lactation consultant requested by nurse.

Circumcision: Mrs. Jones and husband discussing options.

Discharge Plans:

Coping skills; Some difficulty with breastfeeding and questions whether able to breastfeed. Refuses pain medications due to effects it may have on breast milk.

Financial status: Spouse employed full-time with the government. Patient is a manager at a clothing store. Willing to be off work as long as the baby needs her but must return to her job within a year in order to retain her seniority.

Support system; Describes spouse as a good support system. Currently has no family living in the area. PARKIN assessment done, Public Health Nurse referral form completed.

<u>Baby Jones</u> Age: 39 weeks gestation (male)

2days old.

At Birth: 3460.89 grams, 21inches, Apgar score, 8, 9, emergency C- section with no complications

Medications: None

Tests: bilirubin and glucose within normal limits

Assessment:

Vital sign: T=37.2c, P=140, R=50 rate and effort normal, no cyanosis, nasal flaring or grunting observed.

Weight: 7lbs 6oz 3347.49 grams

Colour=pink

Skin= clear

Cord= clamp removed, drying

Activity= Fussy

Nutrition:

Receiving bottle supplement as mother complaining of pain upon latching and feeling extremely fatigued. Demonstrates sucking and swallowing, voids within normal, and passing meconium to transitional stools

Case Scenario 2.1c: Circumcision; infant feeding
References

Alanis, M.C., & Lucidi, R. S. (2004). Neonatal circumcision : A review of the world's oldest and most controversial operation. *Obstetrical and Gynecological Survey,* 59(5), 379-395.

American Association of Pediatrics (2005). Breastfeeding and the use of human milk. *Pediatrics,* 115(2), 496-506, Retrieved February 5, 2006, from the American Association of Pediatrics website:
www.aap.org/advocacy/releases/feb05breastfeeding.htm.

Demirseren, M., & Gokrem, S. (2004). Circumcision in unqualified hands: A significant risk of complication [Electronic version]. *The Journal of the American Society of Plastic Surgeons,* 113(3): 1090 -1092.

Healthwise® Knowledgebase. (2013). *Breast-Feeding: Should I Breast-Feed My Baby?*
http://decisionaid.ohri.ca/AZsumm.php?ID=1149

Healthwise® Knowledgebase. (2012). *Circumcision: Should I keep my son's penis natural??*
http://decisionaid.ohri.ca/AZsumm.php?ID=1035

Informed Choice (2005). Breastfeeding or Bottlefeeding? (Leaflet). *Midwives Information and Resource Service.* Retrieved February 5, 2006, from the Informed Choice website:
http://www.infochoice.org/

Learman, L. (1999). Neonatal circumcision: A dispassionate analysis [Electronic version]. Clinical Obstetrics and Gynecology, 42(4): 849-859.

Nelson, C., Dunn, R., Wan, J., & Wei, J. (2005). The increasing incidence of newborn circumcision: Data from the nationwide inpatient sample [Electronic version]. *The Journal of Urology,* 173(3), 978-981.

Olds, S., London, M., Ladewig, P., & Davidson, M. (2004). *Maternal-Newborn Nursing & Women's Health Care* (7 th ed.). New Jersey: Pearson Education.

The Ottawa decisional support framework. (2005). Retrieved 02/05, 2006 from http://decisionaid.ohri.ca/odsf.html.

Registered Nurses Association of Ontario (2005). *Breastfeeding Best Practice Guidelines for Nurses*. Toronto, Canada: Registered Nurses Association of Ontario.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.* Mississauga, ON: Jones and Bartlett.

U.S. Preventive Service Task Force. (2003). Behavioral Interventions to promote Breastfeeding: Recommendations and Rationale. Retrieved Feb 5, 2006, from The Agency for Healthcare Research and Quality website:
http://www.guideline.gov/content.aspx?id=13255

Van Howe, R. S. (2004). A cost-utility analysis of neonatal circumcision. *Medical Decision Making,* 24(6), 584-601.

Weigert, E. M. L., Giugliani, E. R. J., França, M. C .T., De Oliveira, L. D., Bonilha, A., Do Espírito Santo, L. C., et al. (2005). The influence of breastfeeding technique on the frequencies of exclusive breastfeeding and nipple trauma in the first month of lactation. *Jornal de Pediatria,* 81(4), 310-316.

Case Scenario 2.1c: Circumcision; infant feeding

Additional Tutor Information
Concepts to be addressed in this case: Examples of trigger/discussion questions

Decisional support needs of postpartum families
- What do you need to do to prepare for educating these parents?
- In exploring the Ottawa Decision Support Framework; how could you support these parents in making a decision regarding circumcision and breast or bottle feeding?

Family nursing
- What factors would you have to take into consideration? (i.e. age of parent, type of delivery, babies health status, culture, support systems, income etc.)

Circumcision/Breast vs. bottle-feeding
- What resources could you refer to?

Decision Aid
- What are decision aids and how can they help these parents?

Value-sensitive decision
- What makes these decisions value-sensitive? What other decisions are there?

EBP guidelines
- What evidence based practice guidelines exist for circumcision and breast and bottle-feeding?

Nurses' role
- What is your role in these decisions?

Pain management
- Discuss pain management as it relates to this case (assessment, intervention, evaluation).
- Apart from the issues already discussed, do you see any other issues in the assessment data?

Clinical pathways
- What is a clinical pathway and why might this be useful in terms of documentation and client's progress?

Consultant roles
- What is the role of the lactation consultant and is it appropriate to consult at this time?

Discharge planning
- What is the importance of discharge planning and what do you anticipate in terms of discharge plans and follow up for this family?

Scholarliness of evidence sources used
- When discussing and researching the issues in this case, consider the sources you use by asking yourself, is this source reliable, how old is this material and what level of evidence is it?

Case Scenario 2.1c: Circumcision; infant feeding
Faculty Resources

Alanis, M.C., & Lucidi, R. S. (2004). Neonatal circumcision : A review of the   world's oldest and most controversial operation. *Obstetrical and   Gynecological Survey,* 59(5), 379-395.

Abstract: Untimely old, circumcision has elicited more controversy and war of words than any surgical procedure in history. Although previous claims of benefits like curing masturbation, gout, epilepsy, and even insanity were no doubt absurd, important research has shed light on real medical benefits of circumcision. In particular, the procedure has consistently shown to result in the decreased risk of debilitating and costly diseases such as HIV, cervical cancer, and infantile urinary tract infection. Because of advances in the understanding of the anatomy of the foreskin and pain conditioning in infants, prevailing attitudes have changed about anesthesia and analgesia during the procedure. This article objectively summarizes the bulk of significant medical literature over the last century to provide an accurate statement about what we know and what we do not know about neonatal circumcision, including its history, epidemiology, medical benefits, complications, contraindications, techniques, management for pain, and current controversies.

Demirseren, M., & Gokrem, S. (2004). Circumcision in unqualified hands: A A significant risk of complication [Electronic version]. *The Journal of the American Society of Plastic Surgeons,* 113(3): 1090 -1092. **No Abstract available**

Healthwise. (2012). *Circumcision: Should I keep my son's penis natural?* Retrieved 2013-Nov-7 from   http://decisionaid.ohri.ca/AZsumm.php?ID=1035

Learman, L. (1999). Neonatal circumcision: A dispassionate analysis [Electronic version]. *Clinical Obstetrics and Gynecology,* 42(4): 849-859.

Abstract: This review provides a dispassionate analysis of the evidence on the benefits and risks of neonatal circumcision. The evidence is considered within a clinically relevant framework in which decision-making relies on three interrelated factors: 1) clinical experience, 2) scientific evidence, and 3) patient preference. The roles of patient preference and clinical experience are outlined; then health benefits, risks, and economic costs of circumcision are explored. The most commonly proposed benefits of circumcision are prevention of penile inflammatory disorders, urinary tract infections, penile cancer, and sexually transmitted diseases. Meanwhile, the short-term risks of circumcision include surgical complications and the infliction of pain and distress on the neonate. A potential long-term consequence of the procedure is sexual dysfunction. In considering the cost-effectiveness of circumcision, the following areas are taken into account: 1) economic data on the direct and indirect cost of the procedure and subsequent care, 2) valid estimates of the probability of events prevented and events cause by the intervention, and 3) an accurate estimate of the circumcision's impact on health status. Evidence of the technical aspects of circumcision, namely, the surgical and anesthetic techniques, are also reviewed.

Little, D. C., Cooney, D. R., & Custer. (2002). Pediatric circumcision and release of phimosis *Operative Techniques in General Surgery,* 4(3), 251-259.

Abstract: Neonatal circumcision remains a common, yet controversial surgical procedure. On the one hand, existing scientific evidence demonstrates some potential medical benefits of newborn circumcision. On the other hand, the scientific studies and data to date have not demonstrated a clear risk: benefit ratio resulting in a consensus sufficient to recommend routine neonatal circumcision. Parental wishes should be respected and usually determine what is in the best interest of each individual child. To make an informed choice, parents should be given accurate and unbiased information as well as reassurance about the procedure's safety. It is legitimate for parents and physicians to take into account the cultural, religious, and ethnic traditions of the family in addition to the medical factors. Analgesia is safe and effective in reducing the procedural pain in children and should be used. Circumcision done in the newborn period should be performed only in healthy infants with no obvious genital abnormalities. When properly performed by qualified, well-informed practitioners, circumcision should be a safe procedure with a low risk (<1%) of complications.

Nelson, C., Dunn, R., Wan, J., & Wei, J. (2005). The increasing incidence of newborn circumcision: Data from the nationwide inpatient sample [Electronic version]. *The Journal of Urology,* 173(3), 978-981. **No abstract available**

Olds, S., London, M., Ladewig, P., & Davidson, M. (2004). *Maternal-Newborn Nursing & Women's Health Care* (7 th ed.). New Jersey: Pearson   Education.

Ottawa decisional support framework. (2005). Retrieved 02/05, 2006 from http://decisionaid.ohri.ca/odsf.html.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.* Mississauga, ON: Jones and Bartlett.

Van Howe, R. S. (2004). A cost-utility analysis of neonatal circumcision. *Medical Decision Making,* 24(6), 584-601.

Abstract: A cost-utility analysis, based on published data from multiple observational studies, comparing boys circumcised at birth and those not circumcised was undertaken using the Quality of Well-being Scale, a Markov analysis, the standard reference case, and a societal perspective. Neonatal circumcision increased incremental costs by $828.42 per patient and resulted in an incremental 15.30 well-years lost per 1000 males. If neonatal circumcision was cost-free, pain-free, and had no immediate complications, it was still more costly than not circumcising. Using sensitivity analysis, it was impossible to arrange a scenario that made neonatal circumcision cost-effective. Neonatal circumcision is not good health policy, and support for it as a medical procedure cannot be justified financially or medically.

Case Scenario 2.1c: Infant feeding
Faculty Resources

American Association of Pediatrics (2005). Breastfeeding and the use of human milk. *Pediatrics,* 115(2), 496-506, Retrieved February 5, 2006, from the American Association of Pediatrics website: www.aap.org/advocacy/releases/feb05breastfeeding.htm.

Chuang, C. K., Lin, S. P., Lee, H. C., Wang, T. J., Shih, Y. S., Huang, F. Y. et al. (2005). Free amino acids in full-term and pre-term human milk and infant formula. *Journal of Pediatric Gastroenterology & Nutrition,* 40(4), 496-500.

Abstract: Objective: Although the nutritional value of human milk has been thoroughly studied, few reports describing its free amino acid (FAA) content have been published. Although infant formulas are designed to approximate the nutrient composition of human milk, the content and concentration of free amino acids are unknown. We compared the FAA concentrations of milk from mothers of preterm and full-term infants with those in several infant formulas. Method: Human milk was obtained during three different stages of lactation (colostral, transitional and mature milk). Sixty-seven samples were collected from 44 healthy mothers of term infants and 23 mothers of premature infants 29 to 36 weeks gestation (mean 33 weeks). Two brands of powdered term formula (TF-A and TF-B) and two brands designed for preterm infants (PTF-A and PTF-B)were also studied. Ion exchange chromatography was used for free amino acid analysis. Results: The mean concentration of total FAA in human milk was significantly higher than any of the infant formulas (8139 μmol/L for pre-term human milk; 3462 μmol/L for full term human milk; TF-A, 720 μmol/L; TF-B, 697 μmol/L; PTF-A, 820 μmol/L; PTF-B, 789 μmol/L) ($P < 0.01$). FAA concentration in term and premature human colostral milk was significantly higher than in human transitional and mature milks ($P < 0.01$). In comparing individual FAAs, there were significant differences in concentrations between term human milk and preterm milk except for phosphoethanolamine, hydroxyproline, asparagine, and α-amino-η-butyric acid. There were significant differences in all FAA concentrations between all human milks and infant formulas ($P < 0.05$), but no significant differences were found among the study formulas. Conclusion: The concentration of FAA is high in human colostral milk and decreases through the transitional and mature milk stages. FAA is higher in all human milks than in infant formulas.

Fulhan, J., Collier, S., & Duggan, C. (2003). Update on pediatric nutrition: breastfeeding, infant nutrition, and growth. *Current Opinion in Pediatrics,* 15(3), 323-332.

Abstract: Recent studies continue to point out the critical nature of a patient's nutritional status in helping to determine important health outcomes in pediatrics. We review recent data concerning the composition of breast milk and its adequacy to support infant growth in the first six months of life, as well as trials that support breastfeeding as an important method to delay or reduce the incidence of atopic diseases such as eczema, allergies, and asthma. Studies have also been published that show how physician education and training about breastfeeding can be optimized. Studies showing how nutritional status is measured (using standard anthropometric techniques as well as more modern measures of basal metabolic rate) are highlighted, as well as the role of micronutrient supplementation of patients with the human immunodeficiency virus infection and diarrheal diseases.

Healthwise® Knowledgebase. (2013). *Breast-Feeding: Should I Breast-Feed My Baby?* http://decisionaid.ohri.ca/AZsumm.php?ID=1149

Informed Choice (2005). Breastfeeding or Bottlefeeding? (Leaflet). *Midwives Information and Resource Service.* Retrieved February 5, 2006, from the Informed Choice website: http://www.infochoice.org/ .

Osborn, D. A., & Sinn, J. (2004). Soy formula for prevention of allergy and food intolerance in infants. *Cochrane Database of Systematic Reviews,* 3, CD003741.

Abstract: BACKGROUND: Allergies and food reactions in infants and children are common and may be associated with foods including adapted cow's milk formulas. Soy based formulas have been used to treat infants with allergy or food intolerance. However, it is unclear whether they can be advocated for the prevention of allergy and food intolerance in infants without clinical

evidence of allergy or food intolerance. OBJECTIVES: In infants without clinical evidence of allergy or food intolerance, to determine whether feeding them an adapted soy formula compared to human milk, cow's milk formula or a hydrolysed protein formula prevents allergy or food intolerance. SEARCH STRATEGY: The standard search strategy of the Cochrane Neonatal Review Group was used including searches of the Cochrane Central Register of Controlled Trials (CENTRAL, The Cochrane Library, Issue 4, 2003), MEDLINE (1966 - January 2004), EMBASE (1980 - January 2004), CINAHL (1982 - December 2003) and previous reviews including cross references. SELECTION CRITERIA: Randomised and quasi-randomised trials that compare the use of an adapted soy formula to human milk, an adapted cow's milk or a hydrolysed protein formula for infant feeding in the first 6 months. Only trials with > 80% follow up of participants and reported in group of assignment were eligible for inclusion. DATA COLLECTION AND ANALYSIS: Eligibility of studies for inclusion, methodological quality and data extraction were assessed independently by each reviewer. Primary outcomes included clinical allergy, specific allergies and food intolerance. Meta-analysis was conducted using a fixed effects model where no heterogeneity of treatment effect existed, and a random effects model when heterogeneity was found. MAIN RESULTS: Five eligible studies were found, all enrolling infants at high risk of allergy on the basis of a family history of allergy in a first degree relative. All studies compared use of a soy to a cow's milk formula. Two studies also included a group fed a formula containing hydrolysed protein. No eligible study enrolled infants fed human milk. No study examined the effect of early, short term soy formula feeding. Three studies were of good methodology and did not have unbalanced allergy-preventing co-interventions in the treatment groups. Comparing soy to cow's milk formula, one study with unclear allocation concealment and 19.5% losses to follow up reported a reduction in cumulative incidence of childhood allergy, asthma and allergic rhinitis. No other study reported a significant benefit for any allergy or food intolerance. Analysis found no significant difference in allergy cumulative incidence in infancy (one study: RR 1.02, 95% CI 0.69, 1.49) or childhood (3 studies: typical RR 0.73, 95% CI 0.37, 1.44) and no significant difference in cumulative incidence or period prevalence of any specific allergy or food intolerance in infancy or childhood. Analysis of studies comparing soy to a hydrolysed formula found a significant increase in infant (one study: RR 1.67, 95% CI 1.03, 2.69) and childhood allergy cumulative incidence (one study: RR 1.55, 95% CI 1.02, 2.35), infant eczema cumulative incidence (2 studies: typical RR 2.34, 95% CI 1.51, 3.62) and childhood food allergy period prevalence (one study: RR 1.81, 95% CI 1.09, 3.02). REVIEWERS' CONCLUSIONS: Feeding with a soy formula should not be recommended for the prevention of allergy or food intolerance in infants at high risk of allergy or food intolerance

Registered Nurses Association of Ontario (2005). *Breastfeeding Best Practice Guidelines for Nurses*. Toronto, Canada: Registered Nurses Association of Ontario.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning*. Mississauga, ON: Jones and Bartlett.

U.S. Preventive Service Task Force. (2003). Behavioral Interventions to promote Breastfeeding: Recommendations and Rationale. Retrieved Feb 5, 2006, from The Agency for Healthcare Research and Quality website: http://www.guideline.gov/content.aspx?id=13255

Weigert, E. M. L., Giugliani, E. R. J., França, M. C .T., De Oliveira, L. D., Bonilha, A., Do Espírito Santo, L. C., et al. (2005). The influence of breastfeeding technique on the frequencies of exclusive breastfeeding and nipple trauma in the first month of lactation. *Jornal de Pediatria,* 81(4), 310-316.

Abstract: Objective: To investigate the influence of breastfeeding technique on the frequencies of exclusive breastfeeding and nipple trauma in the first month of lactation. Methods: We searched for unfavorable parameters of breastfeeding (five related to mother/baby positioning and three related to baby's latch on) in 211 mother-baby pairs in the maternity ward and at day 30, at home. We compared the frequencies of these parameters between mothers practicing or not exclusive breastfeeding at days 7 and 30, and between mothers with or without nipple trauma at the hospital. Results: The number of unfavorable parameters in the maternity ward was similar for mother-baby pairs practicing or not exclusive breastfeeding at day 7 and 30. However, at day 30, it was, on average, lower among those under exclusive breastfeeding, regarding positioning (1.7 ± 1.2 vs 2.2 ± 1.1; p = 0.009) as well as latch on (1.0 ± 0.6 vs 1.4 ± 0.6; p < 0.001). The number of unfavorable parameters related to latch on in the maternity ward was similar for women with or without nipple trauma, but women without trauma presented a higher number of unfavorable parameters related to positioning. (2.0 ± 1.4 vs 1.4 ± 1.2; p = 0.04). Conclusions: The frequencies of exclusive breastfeeding in the first month and of nipple trauma were not influenced by the breastfeeding technique in the maternity ward, but there was an association between a better technique at day 30 and the practice of exclusive breastfeeding. New studies may help to elucidate whether an improvement in breastfeeding practices over time helps the maintenance of exclusive breastfeeding or whether the introduction of bottlefeeding determines a negative effect on breastfeeding.

Case Scenario 2.2c: Postpartum depression

As a Public health nurse, you are scheduled to visit Mrs. Jones for a postpartum follow-up visit 2 weeks after discharge. As you walk up the driveway you notice that the entry way has not been shoveled. After ringing the door bell, you hear Mrs. Jones shout "I will be there in a minute." Mrs. Jones lets you in after 5 minutes and begins apologizing stating that "the baby was crying again." Mrs. Jones places the quiet baby into a portable baby seat. You look around to see that the house is dark, with all the window blinds shut and dishes piled up in the sink. You observe that Mrs. Jones looks tired with dark circles under her eyes, in her pajamas and her hair not brushed.

You begin your visit by asking Mrs. Jones how the past 2 weeks have been for her and the baby. Mrs. Jones starts crying, as she tells you that she has had very little rest since coming home. Mrs. Jones states that her husband has been working long hours and even when he is at home he tells her that he does not know how to care for the baby and it is better that she do it. "I have little energy to do anything else but take care of the baby. Some days I just cry for hours because I feel like a failure as a mother."

After consoling Mrs. Jones, you begin an assessment of both mom and baby and do an Edinburgh Postpartum Depression Scale with Mrs. Jones.

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Case Scenario 2.2c: Postpartum depression
Public Health Chart Information
Mother-Infant/Postnatal Assessment Record

Maternal assessment

Mrs. Jones, Age: 40yrs

Medical Hx: para 1, gravida 1, no previous health problems

Surgery: Emergency Cesarean section at 39 weeks, due to deceleration in fetal heart rate

Maternal physical condition:

No fever, cesarean section incision well-approximated, no redness or hematoma noted, minimal lochia alba, no reported problems with nutrition, no energy to do exercises and cold weather prevents taking the baby out for a walk, not sleeping well due to waking up to feed baby every 2 hours, breast/nipple normal, elimination no complaints, pain management not lifting anything heavier than the baby, incisional pain improving.

Emotional health:

Would like more support from husband, no family close by and friends are busy. Feeling very sad the past 2 weeks, feels guilty that she is unable to enjoy the baby the way she would like too.

Medical follow-up:

Has an appointment in 2 weeks to see OBGYN.

Breastfeeding assessment:

Position and comfort satisfactory

Infant latching, sucking and swallowing without audible/visible difficulties

Infant activity at breast is vigorous

No other devices used

Parenting:

Mrs. Jones voices that she would like more information on bonding, general parenting skills and baby development stages. She feels confident in the basic care of the baby as she has taken care of babies before.

Family adjustment to new baby:

Difficult adjustment for both parents. Mrs. Jones voiced being tired and needing more support from husband. Mrs. Jones states that Mr. Jones was an only child and he is not used to children.

Infant assessment

Baby boy Jones, birth weight: 3460.89 grams discharge weight: 3175.13 grams

Nutrition:

10-12 feedings/24h, no supplementation

Elimination:

3 BM/24h, yellow colour, urine output 8 diaper change in 24h

Infant Care/Routine:

Baby is colicky and bouts of crying after 5pm. Tried using pacifier with no success.

Medical follow-up:

In 2 weeks

Infant physical condition:

Weight, 3460.89 grams. no other health concerns

Head/Eyes/Hearing:

Cradle cap noted, otherwise, satisfactory

Umbilicus/Genitals/Circumcision

Satisfactory, no circumcision performed.

Mucous Membranes/Skin/Mouth:

Well hydrated, no jaundice present, all satisfactory

Neurological/Musculoskeletal:

Satisfactory

Injury Prevention:

Approved car seat and crib.

Case Scenario 2.2c: Postpartum depression
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Case Scenario 2.2c: Postpartum depression
Additional Tutor Information

Concepts to be addressed: Examples of trigger/discussion questions

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Postpartum depression
- What is postpartum depression?
- What are the prevalence, cause and issues involved in postpartum depression?
- What are the effects on the mother and family unit?

BPG on postpartum depression
- Consider reading and discussing the BPG on postpartum depression, how relevant is it to this case and which recommendations would you suggest that would be effective and why?

Edinburgh Postpartum Depression Scale
- What is the Edinburgh postpartum depression scale, have you used it before?
- Would this scale be useful in this case scenario and why?
- Explore the validity and reliability of this scale?
- What other scales might be used?

Public Health; healthy baby program
- What is the healthy baby program and how would it relate to this case?

Public Health nurse's role
- What is the role of the PHN in this case?

Community resources for postpartum moms
- What other community resources exist for postpartum moms

Calgary family assessment model (CFAM)
- What is CFAM and how could it be used in this case?

Support systems
- In examining family and support systems, how important do you think support systems are to new moms, and what does the literature say?
- Explore how the nurse could provide decision support to this family with regards to the breast versus bottle dilemma and the infant eating every 2hours?

Growth and development for infants
- What would be the expected stage in terms of growth and development for this infant is it within the norm?
- Explore the effects that mom's depression can have on an infant.

Case Scenario 2.2c: Postpartum depression
Faculty Resources

Boyd, R. C., Le, H N., & Somberg, R. (2005). Review of screening instruments for postpartum depression. *Archives of Women's Mental Health*, 8 (3),141-153.

Abstract: This paper presents a review and discussion of eight self-report measures used to assess for depressive symptoms in the postpartum period. Because postpartum depression is a significant mental health problem, there is a need for reliable and valid screening instruments. Published psychometric data (e.g., reliability, sensitivity, specificity, positive predictive value, concurrent validity) of each self-report instrument are presented and critiqued. Results suggest that the Edinburgh Postnatal Depression Scale is the most extensively studied measure with postpartum women with moderate psychometric soundness. This review illustrates the need for more research in this area. Issues involved in the selection of measures are considered. Implications for clinical practice, research, culture and language are discussed.

Dennis, C. L., & Creedy, D. (2006). Psychosocial and psychological interventions for preventing postpartum depression. [Systematic Review] *Cochrane Pregnancy and Childbirth Group Cochrane Database of Systematic Reviews*. 1.

Abstract

The cause of postpartum depression remains unclear, with extensive research suggesting a multi-factorial aetiology. However, epidemiological studies and meta-analyses of predictive studies have consistently demonstrated the importance of psychosocial and psychological variables. While interventions based on these variables may be effective treatment strategies, theoretically they may also be used in pregnancy and the early postpartum period to prevent postpartum depression.

Objectives:
Primary: to assess the effect of diverse psychosocial and psychological interventions compared with usual antepartum, intrapartum, or postpartum care to reduce the risk of developing postpartum depression. Secondary: to examine (1) the effectiveness of specific types of psychosocial and psychological interventions, (2) the effectiveness of individual versus group-based interventions, (3) the effects of intervention onset and duration, and (4) whether interventions are more effective in women selected with specific risk factors.
Search strategy:
We searched the Cochrane Pregnancy and Childbirth Group trials register (January 27 2004), the Cochrane Depression, Anxiety and Neurosis Group trials register (October 2003), the Cochrane Central Register of Controlled Trials (October 2003), MEDLINE (1966 to 2004), EMBASE (1980 to 2004) and CINAHL (1982 to 2004). We scanned secondary references and contacted experts in the field.
Selection criteria:
All published and unpublished randomised controlled trials of acceptable quality comparing a psychosocial or psychological intervention with usual antenatal, intrapartum, or postpartum care.
Data collection and analysis:
Both reviewers participated in the evaluation of methodological quality and data extraction. Additional information was sought from several trial researchers. Results are presented using relative risk for categorical data and weighted mean difference for continuous data.
Main results:
Fifteen trials, involving over 7600 women, were included. Overall, women who received a psychosocial intervention were equally likely to develop postpartum depression as those receiving standard care (relative risk (RR) 0.81, 95% confidence interval (CI) 0.65 to 1.02). One promising intervention appears to be the provision of intensive postpartum support provided by public health nurses or midwives (RR 0.68, 95% CI 0.55 to 0.84). Identifying mothers 'at-risk' assisted the prevention of postpartum depression (RR 0.67, 95% CI 0.51 to 0.89). Interventions with only a postnatal component appeared to be more beneficial (RR 0.76, 95% CI 0.58 to 0.98) than interventions that also incorporated an antenatal component. While individually-based interventions may be more effective (RR 0.76, 95% CI 0.59 to 1.00) than those that are group-based, women who received multiple-contact intervention were just as likely to experience postpartum depression as those who received a single-contact intervention.
Conclusions:
Overall psychosocial interventions do not reduce the numbers of women who develop postpartum depression. However, a promising intervention is the provision of intensive, professionally-based postpartum support.

Edwards, N. C., & Sims-Jones, N. (1997). A randomized controlled trial of alternative approaches to community follow-up for postpartum women. *Can J Public Health,* 88(2), 123-8.

Abstract: This three-group randomized controlled trial assessed the effectiveness of a postpartum public health nurse telephone visit on infant-care behaviours of primiparous women in Ottawa-Carleton. The impact of a clerk call on recruiting mothers to parent-baby groups was also described. Low risk primiparas were randomized into telephone visit, clerk call and control groups. At three months postpartum, there were no significant differences in infant-care behaviour scores among the study groups. Women who received the telephone visit had the highest parent-baby group attendance rates and among attenders, the highest rates of smoking during pregnancy, the least education, and lowest incomes. Analysis of variance revealed a significant interaction term between attendance at parent-baby groups and assigned study group. This effect disappeared after adjusting for age and education. The telephone visit was no more effective in producing the desired infant-care behaviour changes than a mailed out information package with or without a clerk phone call. However, the intervention did increase the utilization of parent-baby support groups by women who were more socioeconomically disadvantaged

Freeman, M. P., Wright, R., Watchman, M., Wahl, R. A., Sisk, D. J., Fraleigh, L., et al.(2005). Postpartum depression assessments at well-baby visits: Screening feasibility, prevalence, and risk factors. *Journal of Women's Health,* 14 (10), 929- 935.

Abstract: Background: Postpartum depression (PPD) is a disorder with broad public health implications and consequences that impact almost every aspect of child development. Methods: In this pilot study, study participants were 96 women who brought their babies to the University of Arizona Pediatrics Clinic for their 8-week well-baby visit. Participants completed a packet that consisted of questions about demographics, potential correlates of PPD, and the Edinburgh Postpartum Depression Scale (EPDS). English and Spanish versions were available. Results: Of a total of 172 women who brought their babies in for their 8-week well-baby visit, 96 women completed the packets, for an overall response rate of 56.9%. Observed EPDS scores ranged from 0 to 18, with a mean of 5.44 and a standard deviation (SD) of 4.83. Using the cutoff of EPDS $\geq$ 12, 14.6% of participants were likely suffering from clinically significant depression. Higher EPDS scores and also categorical depression classification were statistically associated with reported smoking and a family history of mental health problems. Conclusions: We conclude that screening for mothers at well-baby visits is feasible and that the data collected are of sufficient quality to identify reliable predictors even with small sample sizes.

Healthwise[®] Knowledgebase. http://www.healthlinkbc.ca/kb/content/actionset/tn9165.html

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Lasiuk, G. C., & Ferguson, L.M. (2005). From practice to midrange theory and back again: Beck's theory of postpartum depression. *Advances in Nursing Science,* 28(2), 127-136.

Abstract: This article presents a brief overview of theory as background for a more detailed discussion of midrange theory - its origins, the critical role for midrange theory in the development of nursing practice knowledge, and the criteria for evaluating midrange theory. We then chronicle Cheryl Tatano Beck's program of research on postpartum depression (PPD) and advance the thesis that her theory of PPD, titled Teetering on the Edge, is an exemplar of a substantive midrange nursing theory. We demonstrate Beck's progression from identification of a clinical problem to exploratory-descriptive research, to concept analysis and midrange theory development, and finally to the application and testing of the theory in the clinical setting. Through ongoing refinement and testing of her theory, Beck has increased its generalizability across various practice settings and continually identifies new issues for investigation. Beck's program of research on PPD exemplifies using nursing outcomes to build and test nursing practice knowledge.

Ray, K. L., & Hodnett, E. D. (2006). Caregiver support for postpartum depression. [Systematic Review] *Cochrane Pregnancy and Childbirth Group Cochrane Database of Systematic Reviews*. 1.

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Background:
Supportive relationships during the perinatal period may enhance a mother's feeling of wellbeing and control. Support to women during labour and after birth has shown benefits and this may also be the case for mothers with postpartum depression.
Objectives: The objective of this review was to assess the effect of professional and/or social support interventions for the treatment of postpartum depression.
Search strategy: We searched the Cochrane Pregnancy and Childbirth Group trials register. Date of last search: January 2001.
Selection criteria: Randomised and quasi-randomised trials comparing additional support from caregivers with usual forms of care in the postpartum period, in women who were clinically depressed in the six months after giving birth.
Data collection and analysis: Trial quality was assessed and data were extracted by both reviewers. Study authors were contacted for additional information.

Main results:
Two studies involving 137 women were included. There is potential for bias in at least one study, due to large numbers of women refusing to take part in the trial as well as significant losses to follow-up during the trial. Treatment of postpartum depression with support was associated with a reduction in depression at 25 weeks after giving birth (odds ratio 0.34, 95% confidence intervals 0.17 to 0.69).
Conclusions:
There is some indication that professional and/or social support may help in the treatment of postpartum depression. The types of support should be investigated to assess which models are most effective.

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Sit, D. K. Y., & Wisner, K.L. (2005). Decision making for postpartum depression treatment *Psychiatric Annals,* 35(7), 577-585.

Abstract: As clinicians, we tend to focus on facts. Which maternal pharmacotherapy is associated with the least amount of drug in the breastfed infants' sera? Are breastmilk levels related to infant serum levels? How frequently should psychotherapy be conducted, and how can the course of treatment be flexible with the patient's needs? What is the efficacy of alternative and novel therapies? How often does postpartum depression recur? These questions are important and lead to the data that we provide to women during the decision making process. However, these data are derived from grouped patient data sets. The application of information from these data sets to the individual in the office is an art that requires assignment of value by the patient based on her view from her own unique perspective. The mental health professional is the provider of information, structure, support, and guidance through the dynamic process of making treatment choices. Effective decision making for the treatment of postpartum depression ideally occurs in a context that values a woman's life experiences and her psychosocial environment, and must be a collaborative process between each patient and provider to be as successful as possible.

Module III
Overall Objective:
> To explore the Ottawa Decision Support Framework and its relevance for clinical practice.

Theory and Practicum focus
- Adult and Pediatric: community health, surgery, medicine and mental health

Teaching and Learning Strategies
A. Lectures:
> The Ottawa Decision Support Framework as a mid-range nursing theory
> Breast cancer patient decision making

Learning is evaluated through use of questions on mid-term and final exanimations as well as through use of assignments.

B. Assignments
> 3.1a Ottawa Decision Support Tutorial with knowledge test
> 3.2a Application of the Ottawa Decision Support Framework

C. Problem-based Learning Case Scenarios

The case scenarios can be used for small group discussions. Each case is organized with the scenario, additional chart or other pertinent data, and references. It is then followed by additional information for tutorial facilitators that include concepts to be addressed, examples of trigger/discussion questions, and faculty resources that include websites, journal articles and books. The following is a description of each case scenario.

3.1c- Lung cancer end of life care
This case scenario addresses the issues of end of life care. Mr. Heinz has been diagnosed with stage IV (metastatic) non-small cell lung cancer. The students are asked to address decision support needs for this family by examining family support and palliative care options. They are encouraged to consider interventions that include nurse coaching and decision aids.

3.2c- Adolescent suicide
 Pediatric mental health is the focus of this case scenario. Suicide and depression in adolescents are addressed. An examination of the nurse-client relationship is examined as well as the role of the home health nurse. The College of Nurse's of Ontario' standard of practice on therapeutic nurse-client relationship is explored. Chronic condition management of depression is analyzed.

Lectures

- The Ottawa Decision Support Framework as a mid-range nursing theory

- Breast cancer patient decision making (within 3-hour cancer nursing lecture)

Lectures are available upon request to decisionaid@ohri.ca.

Assignment 3.1a
Ottawa Decision Support Tutorial (ODST)

Target: Students and/or practitioners wanting to learn more about the concept of decisional conflict and the Ottawa Decision Support Framework. The Ottawa Decision Support Tutorial (ODST) is a learning strategy that can also be used in nursing theory courses or courses that requires students to explore 1 or more theories.

Access the ODST: https://decisionaid.ohri.ca/ODST/

Description: The ODST is divided into multiple sections with mini-quizzes at the end of each section that provide tailored feedback on learning. [*These are for personal feedback only and are not part of the ODST grade*]. At the start of the ODST, a hard copy of the ODST content is available for printing and can be used as a reference as one progresses through the ODST. The ODST takes approximately 3 hours to complete and may be completed within a single access or on multiple visits to the website.

The ODST was developed by:
AM O'Connor & MJ Jacobsen
University of Ottawa
Ottawa Health Research Institute
© O'Connor, Jacobsen 1999, updated 2003; 2006
Dr. Annette O'Connor holds a tier 1 Canada Research Chair award in consumer decision support and MJ Jacobsen is an educator with expertise in decision support.

Assignment 3.1a Continued
Ottawa Decision Support Tutorial (ODST)

People face decisions about health or social situations daily. Increasingly they want more involvement in decisions affecting their health. However, for more complex decisions many patients experience decisional conflict and need support to make these decisions. The ODST helps practitioners explore the concept of decisional conflict and learn about the Ottawa Decision Support Framework.

Learning Objectives:

Upon completing the ODST, participants will know how to:
1. recognize clients experiencing decisional conflict
2. identify modifiable factors that contribute to decisional conflict
3. select strategies to tailor decision support to a client's needs
4. differentiate between educational materials and materials useful to support client decision making
5. describe a framework for supporting client decision making
6. use tools for assessing client's decision making needs, providing decision support and evaluating impact
7. identify difficult decisions in your practice that create decisional conflict
8. distinguish between patient counseling and coaching approaches required for recommended care versus those useful for health care options with different strengths of evidence or magnitudes of benefit/harm ratios
9. identify communication skills useful in providing decision support and fostering client-centered communication.

Evaluation of Learning: At the end of the ODST there is a final test of knowledge that involves 12 multiple choice questions. The results of this test can be used for a percentage of the overall student's grade in the course (e.g., 10 to 20%). As well, there are review questions at the end of each section that provide the learner with feedback on the progress of their learning.

Note: Before starting the ODST, it is recommended that you use the on-line interactive Ottawa Personal Decision Guide at http://decisionaid.ohri.ca/decguide.html to make a personal or social decision for yourself. This will enable you to 'experience' strategies used in assessing and supporting decision making, before your learn about them from a purely theoretical perspective. We believe this will enhance your understanding of the concepts presented in the ODST.

Assignment 3.2a
Application of the Ottawa Decision Support Framework

This assignment is designed to help you better understand the Ottawa Decision Support Framework and apply it to a specific situation.

Consider a difficult health-related decision that you or a client is facing. This decision may be difficult for a number of reasons:

- there may be several options as well as uncertain outcomes
- other people may be involved in the decision making
- the decision making process itself may be difficult

The Ottawa Decision Support Framework can be used to assess the needs and decision support may be provided in the form of a specific decision aid.

Instructions
1. Go to http://decisionaid.ohri.ca/decguide.html.
2. On this Web page select- **an 1-page interactive PDF.** Complete and print this form for a difficult health related decision. All material submitted is confidential.
3. After completing the tool consider **some thoughts for action**. Is there an existing decision aid available? To find out, go to A-Z Inventory of Decision Aids (http://decisionaid.ohri.ca/AZinvent.php). Review the list of aids for one that might fit the situation. Select and name one that would be appropriate. If there is no suitable tool available, consider the following questions.
   Is this decision one that others may be facing and could also be encountering difficulty?
   Is this decision common or significant enough for the development of a decision aid?
   Would it interest you to pursue this topic at a later date as a research project?
   Is there another source of decisional support that partially addresses the issue?

Marks (total 20 marks)

a) Submit a completed **interactive online tool** (14 marks)
      Health related difficult decision   0 - 4
      Complete and thorough answers   0 - 10
b) Write a brief action plan that includes the name of the decision aid chosen, why and how it would be helpful OR if no suitable aid exists, reflection upon what might be useful. (6 marks)
      Thoughtfulness   0 - 3
      Originality/ creativity   0 - 3
Submit the completed online interactive tool and maximum of 2 double spaced typed pages for the action plan. The submission should be stapled together with your name and student number clearly written in the upper right hand side.

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Case Scenario 3.1c: Lung cancer End-of-Life care

You are the palliative care nurse assigned to the Heinz family. In your initial assessment visit, Mrs. Heinz tells you about her frustration with the whole situation, she feels very tired and guilty because she is finding it harder to take care of her husband. Mrs. Heinz shares with you that the oncologist states that he is doing very poorly and she should be considering palliative care options. She also tells you that her daughter is pressuring her to convince the oncologist to enroll dad into a experimental chemo clinical trial. You then ask Mr. Heinz what he would like. Mr. Heinz states, that he is very tired, does not want to burden his wife anymore and just wants to go in peace.

Mrs. Heinz then starts crying.

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Case Scenario 3.1c: Lung cancer End-of-Life care
Chart Data

Diagnosis: Stage IV (metastatic) Non-small cell carcinoma (NSCC) left lung with metastasis to brain diagnosed 6 months ago.

Gender: Male

Age: 60

Martial status: Married

Code Status: Full Code

Prognosis: 1 year from initial diagnosis

Past Medical History:
Hypertension and hypercholesteremia

Medications: Altace 5mg every day. Baby aspirin every day. Lovostatin 10mg every night. Hydromorphone 5mg q4hours straight p.o. Hydromorphone 2mg for breakthrough pain every 2 hours as needed.

Pain assessment: Prior to taking Hydromorphone, his pain is 7 out of 10, after taking hydromorphone it goes down to 4 out of 10. Mr. Heinz states that his "pain is getting worse every day, it starts in my chest, then I get a headache and eventually everything starts hurting."

Activity of Daily Living assessment: He was managing well with some very minor assistance from his wife in bathing. He experienced some shortness of breath upon exertion. However, in the past week, Mr. Heinz has become increasingly weaker. Some days, he is not able to get out of bed. He has become more demanding, anxious, very fatigued, confused and complaining of increasing pain and increasing dyspnea on exertion.

Family & Support Assessment:
The Heinz's have 2 adult children who both live in other provinces and Mr. Heinz has 2 siblings that live in town. One of Mr. Heinz's children is a family physician and his one sister is a nurse. Mr. Heinz's 85 year old mother was diagnosed with dementia and a stroke 8 months ago and is currently residing in a nursing home. Mr. Heinz's sister suggested getting a referral to palliative care services. Mr. Heinz's daughter, the physician, suggested that her mother speak to the oncologist about the new experimental chemotherapy that promises some hope of a longer prognosis.

Family Physician visit:
After the suggestions from the family, Mrs. Heinz took Mr. Heinz to the family doctor. At the family doctor's appointment, the physician ordered an increase in Mr. Heinz's oral hydromorphone dose and made a referral for the palliative care nurse through home nursing services. He also suggested that the Heinz's discuss the experimental chemo with their oncologist.

Case Scenario 3.1c: Lung cancer End-of-Life care
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Case Scenario 3.1a: Lung cancer End-of-Life care
Additional Tutor Information

Concepts to be addressed in this case: Examples of trigger/discussion questions

Non-small cell lung cancer
- What is non-small cell lung cancer?

Metastasis
- What does metastasis mean?

Role of a Palliative care nurse
- What is the role of a palliative care nurse?
- What extra skills or education is needed to be a palliative care nurse?

End of life care
- What is end of life care and is it suitable in this situation?
- What is the role and scope of palliative care?
- When should palliative care be included in care?
- What are the principles of palliative care

Supportive care
- What is supportive care?

Decision Support for End of Life Decisions
- How can each of the health care providers provide decision support to the Heinz family (the family physician, the oncologist and the palliative care nurse)?
- Specifically, how could the nurse provide support by coaching the family through the decisions that they face?
- What are the decisions they are facing and who is involved?
- What could be sources of decisional conflict for the Heinz family?

Resources
- What resources can you offer this family?
- What members of the interdisciplinary team would you involve in care of the Heinz family and what would you expect them to contribute?

Patient Decision Aids
- Explore possible decision aids that you could offer to this family?

Home versus Hospice care
- What would be their options for home versus Hospice, chemo versus stopping treatment etc.?
- What are the typical determinants of place of care at the end of life?

Experimental chemotherapy
- Explore what experimental chemotherapy is and conduct some research to find out if this is a viable option for this client

Pain control
- Is Mr. Heinz's pain under control, if not what suggestions do you have to better pain control?
- Describe how you would complete a comprehensive pain assessment
- How would you document a pain assessment
- What are the most likely sources of pain for Mr. Heinz?
- Discuss the concept of "Total Pain"

Quality of life
- What is quality of life and how does it relate to this case?
- Have you seen any cases similar to this one in your practice, if so, what was similar or different?
- How is quality of life measured and defined?

Case Scenario 3.1c: Lung cancer End-of-Life care
Faculty Resources

Ben Diane, M.K., Peretti-Watel, P., Galinier, A., Favre, R., Obadia, Y., Granier, H., et al. (2005). Morphine prescription to terminal cancer patients suffering from severe pain: Results of a French survey. *Bulletin du Cancer,* 92(7-8), 733-740.

Abstract: This study aimed to determine factors associated with the prescription of morphine to terminal cancer patients suffering from severe pain. A phone survey was conducted among a sample of French GPs, neurologists and oncologists. Two short clinical cases described a terminally-ill patient with either a peritoneal carcinosis and intestinal occlusion, or a lung cancer, and in both cases suffering from severe pain. Overall, 917 agreed to participate among the 1,743 physicians contacted (global response rate 53%). About half of respondents did not support the prescription of morphine if the patient had an intestinal occlusion. Beliefs toward morphine, uneasiness with terminally-ill patients, age and female gender were independently associated with reluctance to prescribe morphine in presented cases. Specialised training has not completely remove reluctance toward morphine prescription in end-of-life care. Non-medical factors correlated to such reluctance, and especially gender, deserve more attention.

Browner, I., & Carducci, M.A. (2005). Palliative chemotherapy: Historical perspective, applications, and controversies. *Seminars in Oncology*, 32(2), 145-155.

Abstract: Despite advances in cancer detection and treatment, cancer continues to be a major public health burden in the United States, and patients with advanced or refractory cancers carry much of this burden. The primary goal of cancer treatment is cure. However, most patients with advanced, metastatic, or recurrent disease do not benefit from this intent. Recent research studies have documented the role of chemotherapy in providing symptom control, preventing complications, prolonging life, and improving quality of life (QOL) in patients with incurable cancers. Although chemotherapy under these conditions is palliative, patients receiving chemotherapy or participating in research trials are excluded from receiving much needed palliative services, such as Hospice, based on current definitions, limitations, and models of palliative care. Application of palliative services on a continuum from the time of diagnosis through the end of life (EOL) has been recognized as beneficial in the treatment of patients with terminal diseases and has been addressed through trials assessing mixed management models, providing palliative and therapeutic options.

Cancer Care Ontario http://www.cancercare.on.ca/

Casarett, D., Crowley, R, Stevenson, C., Xie, S., & Teno, J. (2005). Making difficult decisions about hospice enrollment: What do patients and families want to know? *Journal of the American Geriatrics Society*, 53(2), 249-254.

Abstract: OBJECTIVES: To define patients' and families' priorities for information about hospice. DESIGN: Cross-sectional interview. SETTING: Urban, not-for-profit, Medicare-certified hospice. PARTICIPANTS: Patients and families recruited from consecutive hospice information visits. MEASUREMENTS: Understanding of hospice, assessment of the relative importance of eight categories of information (by direct rating and ranking tasks), and nurse observation of shared decision making between patient and family (5-point scale). RESULTS: Interviews were conducted with 237 patients and families at a hospice information visit. Forty percent (n = 94) said that they knew anything about hospice. Most often, family members made the enrollment decision (n = 132, 57%). Of the eight categories of information, patients and families placed the greatest importance on visit frequency (n = 143, 60%), payment for hospice (n = 140, 59%), and the practical help that hospice provides (n = 123, 52%). Principal component factor analysis reduced the categories to three distinct factors reflecting concerns related to impending death, practical support, and changes from established patterns of care. CONCLUSION: Most patients and families who are referred for a hospice information visit know little about hospice and have substantial information needs. Referring physicians and hospice teams may be able to better support hospice enrollment decisions by anticipating common priorities for information.

Duggleby, W., & Berry, P. (2005). Transitions and shifting goals of care for palliative patients and their families. *Clinical journal of oncology nursing*, 9(4), 425-428.

Abstract: Terminally ill patients and their families experience many confusing and, at times, traumatic transitions. Examples of such transitions include transitions from cure to comfort care, transitions related to loss, changes in care settings, and psychosocial and spiritual transitions. The purpose of this article is to discuss the experiences of palliative patients and their families as they journey through transitions and how oncology nurses can provide support. Using a composite case study from actual clinical cases as a framework for discussion, the authors present examples of evidence-based strategies that can be used by oncology nurses. Critical points from the case study are Adjustment to death is a process and cannot be rushed. The needs of a palliative patient and family should be heard, honored, and not questioned or challenged. A patient and family should remain in control of decision making, with the hospice and palliative care team acting as guides and facilitators.

Evans, W.G., Cutson, T.M., Steinhauser, K.E., & Tulsky, J.A. (2006). Is there no place like home? Caregivers recall reasons for and experience upon transfer from home hospice to inpatient facilities. *Journal of Palliative Medicine*, 9(1), 100-110.

Abstract: Objective: To describe caregivers' reasons for transfer from home hospice to inpatient facilities, preferences for site of care and death, and their experiences during these transfers. Design: Retrospective qualitative analysis of interviews with caregivers of deceased hospice patients who had undergone transfer. Setting: A university-affiliated community hospice provider. Subjects: Caregivers of deceased hospice patients who transferred to an acute care hospital, a freestanding inpatient hospice facility, or a nursing home while enrolled in hospice and died between January 2003 and February 2004. Measurements: A semistructured interview protocol was developed and used for all interviews. Interviews were coded for reasons for transfer, preferences for site of care and death, and experience upon transfer using a grounded theory approach. Results: Patients transferred because of an acute medical event, an uncontrolled symptom, imminent death, or inability to provide needed care safely at home. Although all caregivers expressed a strong preference for care at home, other concerns such as pain and symptom control, safety, and quality and quantity of life became more important with time. We found significant variation in specific preferences regarding care and site of death. Satisfaction with care at the transfer facilities was determined by clarifying goals of care, following treatment preferences, providing personalized care, and the patient's environment. Conclusions: Hospice patients usually transfer to facilities to accomplish goals consistent with good end-of-life care. We can improve their experience by treating patients and their caregivers as unique individuals, exploring and respecting treatment preferences, and creating a pleasant physical environment.

Fiset, V., O'Connor, A.M., Evans, W., Graham, I., Degrasse, C., & Logan, J. (2000). Development and evaluation of a decision aid for patients with stage IV non-small cell lung cancer. *Health Expectations,* 3(2), 125-136.

Abstract: Although guidelines for treating stage IV non-small cell lung cancer suggest that the patient's values should be considered in decision-making, there are no practical tools available to assist them with their decision- making. Objective: To develop and evaluate a decision aid that incorporates patient values. Design and sample: (1) Before/after evaluation with patients referred to a regional cancer centre. (2) Mailed survey of thoracic surgeons and respirologists in Ontario. Intervention: An audio-tape guided individuals to review a booklet describing stage IV non-small cell lung cancer, its impact and possible coping strategies, treatment options, benefits and risks, and examples of the decision-making of others. Patients then used a worksheet to consider and communicate personal issues involved in the choice, including: personal values using a 'weigh-scale'; questions; preferred role in decision-making; and predisposition. Measures: (1) Patient questionnaires eliciting knowledge, the decision, decisional conflict and acceptability of the decision aid. (2) Physician questionnaires eliciting attitudes toward the decision aid. Results: (1) Twenty of 30 patients used the aid in decision- making. Users thought that the aid was acceptable and significantly improved their knowledge about options and outcomes (P < 0.001), and reduced their decisional conflict (P < 0.001). (2) The majority of the 29 physicians who reviewed the decision aid found it acceptable, were comfortable providing it to patients and said that they were likely to use it. Conclusion: The decision aid is a useful and acceptable adjunct to personal counselling.

Healthwise® Knowledgebase. http://www.healthlinkbc.ca/kb/content/major/hw183816.html

Heyland, D.K., Groll, D., Rocker, G., Dodek, P., Gafni, A., & Tranmer, J. (2005). End-of-life care in acute care hospitals in Canada: A quality finish? *Journal of Palliative Care,* 21(3), 142-150.

Abstract: Understanding patients' and family members' perspectives on the relative importance of elements of end-of-life (EOL) care and their satisfaction with those elements will help prioritize quality improvement initiatives. We administered a face-to-face questionnaire containing a selection of 28 elements of care to eligible inpatients with advanced lung, heart, or liver disease, or metastatic cancer, and available family caregivers (FCGs) in five tertiary care hospitals across Canada. 440 of 569 (78%) eligible patients and 160 of 176 (91%) FCGs participated. No respondent reported complete satisfaction with all elements of care. The average satisfaction score was 4.6 on a 26 point scale. Medical patients reported lower levels of satisfaction than cancer patients. Elements rated as "extremely important" and anything other than "completely satisfied" most frequently by respondents related to discharge planning, availability of home health services, symptom relief, not being a burden, physician trust, and communication. In conclusion, most patients and their family members in our survey were not completely satisfied with EOL care. Improvement initiatives to target key elements identified by patients and FCGs have the potential to improve satisfaction with EOL care across care settings.

McCall, K., & Rice, A.M. (2005). What influences decisions around the place of care for terminally ill cancer patients? *International journal of palliative nursing.*11(10), 541-547.

Abstract AIM: To explore what factors influence decisions around the place of care for terminally ill cancer patients in a rural area in West Highland, Scotland. DESIGN: This was a descriptive, explorative, qualitative study using taped semistructured interviews. SAMPLE: A purposive sample of eight terminally ill cancer patients. RESULTS: The determinants for the desired place of care were organized into three main themes: carer resource and support; past experiences with death; and communication of wishes. The study evidenced that individuals often changed their preferred place of care at the end of life as the need for care increased. Those involved in the study found a therapeutic and

emotional benefit by being able to discuss end-of-life care in a safe and secure environment. CONCLUSION: For many, the preference for place of care at the end of life was conditional on how the process of their disease advanced. It was not a clear and positive choice, but it did include the desire to be cared for in a place other than home. Carer availability and ability were influencing factors; however, decisions reflected the patient's perceptions of resources rather than those of the carer, even when the carer was available and able. The challenge to those who work with the terminally ill is to develop effective interventions to facilitate discourses around end-of-life care, and thereafter, where possible, to facilitate those preferences.

McMillan, S.C. (2005). Interventions to facilitate family caregiving at the end of life. *Journal of Palliative Medicine* 8(1), S-132-S-139.

Abstract: Informal family caregivers provide care in a variety of situations, including care for patients receiving active curative treatment for cancer and other life-threatening diseases, for Alzheimer's patients over the long trajectory of their disease, and for hospice patients who are near the end of life. Especially at the end of life, these caregivers are essential because they provide needed help with activities of daily living, medications, eating, transportation, and emotional support, as well as communicating with health care professionals about the patients' condition. As health care increasingly moves out of acute care settings and into homes, the role of the caregiver becomes more critical and the burden becomes heavier. There is a paucity of data regarding which caregivers are at greatest risk for distress and which interventions are likely to relieve that distress. Although both educational and supportive interventions have been tested, including both telephone and face-to-face meetings, it still is not clear which approach is best for which groups of caregivers. Much of the research that has been done has been descriptive and evaluative, and only a very limited number of clinical trials have been conducted with caregivers of patients near the end of life. There is limited evidence about whether caregiver interventions at the end of the patient's life have the potential to provide long-term benefits to caregivers. In addition, issues exist in adapting such interventions to work with culturally diverse populations. Sadly, there appears to be a limited number of investigators doing this important work. More research is needed to provide complete evidence on which to base practice and policy decisions.

Murray, M.A., Miller, T., Fiset, V., O'Connor, A., & Jacobsen, M.J. (2004). Decision support: helping patients and families to find a balance at the end of life. *International journal of palliative nursing,* 10(6), 270-277.

Abstract: Terminally ill patients and their families face many decisions at the end of life that can sometimes be overwhelming. Nurses play a key role in providing decision support so that patients and their families can make timely decisions about their health care that reflect their individual needs and circumstances. The Ottawa Decision Support Framework can help nurses to assess patients' decision-making needs, provide tailored decision support and evaluate the effect of their interventions. The theoretical underpinnings of the model and its implications for palliative care clinical practice are discussed.

Murray, M.A., O'Connor, A.M., Fiset, V., & Viola, R. (2003). Women's Decision-Making Needs Regarding Place of Care at End of Life. *Journal of Palliative Care,* 19(3), 176-184

Abstract: Little is known about the decision-making needs of terminally ill women who are considering options for place of care at the end of life. A pilot study was conducted with a sample of 20 terminally ill women with advanced cancer to identify factors taken into consideration in making this decision. Participants were interviewed using a semistructured questionnaire incorporating the domains of quality of end-of-life care and based on the Ottawa Decision Support Framework. Results suggested a gap between the preferred (home, n=13) and the actual (palliative care unit, n=16) place of care. Discrepancies about place of care may be related to conflicting subjective factors such as being a burden to family versus having the opportunity to strengthen relationships with family and friends. Participants who were actively engaged in making the decision scored the highest levels of decisional conflict. Previous studies have shown an association between high decisional conflict scores and decision delay. Although findings from this small study are preliminary, they suggest that the decision regarding place of terminal care is complex with multiple competing factors being considered.

Nolan, M.T., Hughes, M., Narendra, D.P., Sood, J.R., Terry, P.B., & Astrow, A.B. (2005). When patients lack capacity: The roles that patients with terminal diagnoses would choose for their physicians and loved ones in making medical decisions. *Journal of Pain and Symptom Management*, 30(4), 342-353.

Abstract: Current approaches to end-of-life decision making are widely considered inadequate. We explored these complexities by examining how patients with terminal diagnoses would choose to involve their physicians and loved ones in making medical decisions, assuming they were able and unable to participate. Cross-sectional interviews of 130 patients recently diagnosed with fatal conditions were conducted. Patients were recruited from two academic medical centers using a modification of the Decision Control Preferences Scale, ranging from independent decision making to decision making that relies upon others. Patients were asked how they would balance their own wishes relative to the input of physician and loved ones in making medical decisions, and to weigh the input of loved ones relative to physician. Most patients (52%), assuming they had the capacity, would opt to share decision making with their physicians, but 15% would defer to their physicians and 34% would make decisions independently. Similarly, 44% would share decision making with their loved ones, but fewer (6%) would defer to their loved ones.

Thirty-nine percent would rely upon their physicians' judgments about what would be best for them rather than their own wishes if they became unconscious, compared with 15% who would do so if they were conscious (P < 0.001). Nonetheless, patients were more likely to weigh their loved ones' input more heavily than their physicians' input if they were unconscious (33%) than if they were conscious (7%, P = 0.05). Race, religion, gender, diagnosis, and health status were largely unassociated with patients' decision control preferences. Patients with terminal diagnoses report a wide diversity of decision control preferences, but most would opt to share decision making with their physicians and loved ones. If unable to decide for themselves, they shift toward greater reliance on physician input relative to their own wishes but would weigh loved ones' input more heavily than physician input. Deciding for patients who cannot speak for themselves may be more complex than has previously been reflected in law, policy, or clinical ethics.

Ottawa patient decision aids, http://decisionaid.ohri.ca/decaids.html.

Ottawa Decisional Support framework, http://decisionaid.ohri.ca/odsf.html.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.* Mississauga, ON: Jones and Bartlett.

Spiro, S.G., Rudd, R.M., Souhami, R.L., Brown, J., Fairlamb, D.J., Gower, N.H. et al. (2004). Chemotherapy versus supportive care in advanced non-small cell lung cancer: Improved survival without detriment to quality of life. *Thorax*, 59(10), 828-836**.**

Abstract: Background: In 1995 a meta-analysis of randomised trials investigating the value of adding chemotherapy to primary treatment for non-small cell lung cancer (NSCLC) suggested a small survival benefit for cisplatin-based chemotherapy in each of the primary treatment settings. However, the meta-analysis included many small trials and trials with differing eligibility criteria and chemotherapy regimens. Methods: The aim of the Big Lung Trial was to confirm the survival benefits seen in the meta-analysis and to assess quality of life and cost in the supportive care setting. A total of 725 patients were randomised to receive supportive care alone (n = 361) or supportive care plus cisplatin-based chemotherapy (n = 364). Results: 65% of patients allocated chemotherapy (C) received all three cycles of treatment and a further 27% received one or two cycles. 74% of patients allocated no chemotherapy (NoC) received thoracic radiotherapy compared with 47% of the C group. Patients allocated C had a significantly better survival than those allocated NoC: HR 0.77 (95% CI 0.66 to 0.89, p = 0.0006), median survival 8.0 months for the C group v 5.7 months for the NoC group, a difference of 9 weeks. There were 19 (5%) treatment related deaths in the C group. There was no evidence that any subgroup benefited more or less from chemotherapy. No significant differences were observed between the two groups in terms of the pre-defined primary and secondary quality of life end points, although large negative effects of chemotherapy were ruled out. The regimens used proved to be cost effective, the extra cost of chemotherapy being offset by longer survival. Conclusions: The survival benefit seen in this trial was entirely consistent with the NSCLC meta-analysis and subsequent similarly designed large trials. The information on quality of life and cost should enable patients and their clinicians to make more informed treatment choices.

Steele, L.L., Mills, B, Hardin, S.R., & Hussey, L.C. (2005). The quality of life of hospice patients: Patient and provider perceptions. *American Journal of Hospice and Palliative Medicine,* 22(2), 95-110.

Abstract: The purposes of this study were to describe the quality of life (QOL) of terminally ill patients in a home-based hospice program and to examine the relationship between QOL data and patients' symptom distress, ability to function, interpersonal communication (support from family and friends), well-being (their affairs in order), and transcendence (religious comfort/support) as recorded in their charts. QOL was measured by the Missoula-Vitas Quality of Life Index (MVQOLI), an instrument designed specifically for use with terminally ill patients. The study was conducted over a three-year period with 129 terminally ill patients enrolled in a home-based hospice program of care. The MVQOLI was administered to patients within 20 days of their admission to hospice. A retrospective chart review was conducted to determine patients' levels of symptom distress, ability to function, social support, whether or not their affairs were in order, and religious comfort/support. The mean age of participants in this study was 67, with 54.3 percent male and 45.7 percent female. Cancer was the primary diagnosis for 92.2 percent of the sample, and 35 percent of these patients had a diagnosis of lung cancer. Of the 7.8 percent non-cancer diagnoses, five were diagnosed with AIDS, four with chronic obstructive pulmonary disease, and one with chronic heart failure. The results of this study revealed positive scores on the five dimensions of the MVQOLI QOL scale, indicating that within 20 days of admission to hospice, patients rated their QOL as good to very good. Data obtained from the chart review also indicated that patients did not experience a great deal of symptom distress (e.g., pain, nausea, shortness of breath, and restlessness). A significant correlation existed between age and QOL; number of interventions and pain levels; and marital status, well-being, interpersonal relationships, and transcendence. Shortness of breath and well-being were significantly correlated with QOL. There was no significant correlation between gender, race, or closeness to death and the five dimensions of the MVQOLI and chart review assessments.

Temel, J.S. Pirl, W.F and Lynch, T.J. (2006). Comprehensive symptom management in patients with advanced-stage non-small-cell lung cancer. *Clinical Lung Cancer,* 7(4), 241-249

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Abstract: Although we have made steady improvements in the survival rates of patients with advanced-stage lung cancer, the majority of patients still experience distress and suffering. Although the symptom burden is greatest in patients in the end stages of life, many patients living with lung cancer suffer from troubling symptoms and side effects of therapy. Even long-term survivors with early-stage non-small-cell lung cancer (NSCLC) often experience respiratory symptoms, such as dyspnea and cough. Because of the high prevalence of NSCLC and the frequency with which it presents in an incurable stage, symptom management is a large component of the care of these patients. Dyspnea, cough, fatigue, anorexia/cachexia, and pain are the most common symptoms in patients with advanced-stage NSCLC. Cancer-directed therapy can improve some of these symptoms bid often incompletely and temporarily. Therefore, comprehensive care of patients with advanced-stage NSCLC must include therapies targeted at these difficult and distressing symptoms.

Von Gunten, C.F. (2005). Interventions to manage symptoms at the end of life. *Journal of Palliative Medicine* 8(1), S-88-S-94.

Abstract: The aim of this article is to summarize the current evidence base about interventions that improve symptoms at the end of life. Moderate to severe symptoms are highly prevalent in the weeks and months before death: 1.4 million individuals have dyspnea; and 1 million have pain. Of those with pain, 300,000 want more pain relief. 700,000 may need more relief, but do not receive it because of the myth of opioid addiction; their physicians do not know how to manage the adverse effects of pain relieving therapies, or they don't know the various options that are available for pain relief. Of the 1 million Americans who die in hospitals, 324,000 had fatigue, 280,000 anorexia, 244,000 dyspnea, 232,000 xerostomia, 208,000 cough, 196,000 pain, 148,000 confusion, 148,000 depression, 140,000 nausea, 92,000 insomnia in 23, and 88,000 vomiting. This is caused in part by clinician ignorance. In a representative sample of oncologists, the most important source of information about symptom control was trial-and-error in practice. In addition, large, well-designed, well-controlled studies of patients at the end of life have not been performed. Clinical practice is guided by extrapolation of data from other populations and from anecdote. The system of care provided by hospice programs in the U.S. provides improved symptom control as compared with hospitals, home health agency, and nursing home systems. Population-based studies of prevalence are needed to gauge outcomes of the implementation of measures to relieve symptoms. Well-powered, definitive studies of both existing and new approaches in terminally ill patients with the most common symptoms are needed. The health care system interventions that are effective in hospice care must be studied so that they can be broadly applied to the care of all dying Americans.

Wilson, S.A., Coenen, A., & Doorenbos, A. (2006). Dignified dying as a nursing phenomenon in the United States. *Journal of Hospice and Palliative Nursing,* 8(1), 34-41.

Abstract: The purpose of this study was to validate the concept of dignified dying and to identify nursing interventions to promote dignified dying. US nurses (N = 281) who participated in the 2000-2001 End of Life Nursing Education Consortium were surveyed via e-mail. Subjects rated characteristics for representativeness of dignified dying and identified nursing interventions to promote dignified dying. Examples of major characteristics of dignified dying identified through quantitative analysis included "verbalizes relief of pain," "expresses control of symptoms," and "participates in decisions for care and treatment." Examination of construct validity resulted in a two-factor solution accounting for 60% of the variance. The factors supported issues beyond the physical concerns of illness, including psychosocial and spiritual dimensions of end-of-life care. Qualitative analysis was used to cluster interventions identified by nurses to promote dignified dying. Interventions focused on increasing comfort and included, for example, listening, pain control, life review, and family support.

Case Scenario 3.2c: Adolescent suicide

You are home health nurse and are visiting 16 year old Jane for an admission intake today. You read what little you do have of her referral and see that she was discharged from a psychiatric hospital 2 days ago having been admitted for 3 weeks with a suicide attempt and a diagnosis of depression. Your instructions are to do an admission assessment and to do wound care to her left wrist.

You are now on your 8th visit to Jane's and have developed a trusting relationship with her. You are able to speak to her about what led her to the suicide attempt and her personal problems.

You have given her some pamphlets and reading material on suicide prevention and gave her various resources for support groups. In your last visit you assessed whether she had contacted any of the resources. Jane told you that she was not feeling up to it yet. She also tells you that her parents and her psychiatrist want her to take a medication called "Prozac" to help her moods. Jane tells you that she took a medication before for her depression and it just made her feel sick. She is unsure if she wants to take any more pills.

Usually Jane is out on the steps waiting for you and today, no one is answering the door. After ringing the door bell several times and calling from your cell phone, you see the neighbor and ask her if she knows where Jane is. The neighbor tells you that it was such a mess here early this morning. The fire engines, police car and ambulance made so much noise. Apparently someone was taken to the hospital.

You finish up your last 2 cases and decide to go check at the hospital to see what has happen to Jane. At the hospital, you tell the triage nurse who you are and ask if Jane was indeed here and if you could speak to her. The triage nurse tells you that information is confidential.

You leave the hospital wondering if you could not have done more to help Jane.

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Case Scenario 3.2c: Adolescent suicide
Chart Data

<u>Referral information</u>
Diagnosis: Attempted suicide and depression
Gender: Female
Age: 16

Past Medical History:
History of Depression diagnosed 9 months ago. No family history of depression noted. Past suicide attempts x2 (6 months ago and 9 months ago); both Tylenol overdoses that required a hospitalization stay of 1 week each time. Client has been seeing a psychiatrist as an outpatient since her first suicide attempt.

Social Service discharge notes:
Home health notified to start wound care ASAP. Will fax order. Parents to call and set up outpatient visits to psychiatric clinic. Child protective services informed. Will request case manager for visit.

Wound care discharge note:
Cleanse Left wrist wound with N/S daily and apply dry dressing and Kerlix.
Psychiatric discharge summary:
16 year old female admitted one month ago with a laceration to the left wrist. Found by mother in the bathroom unconscious. Has a history of depression diagnosed 9 months ago where medical treatment was terminated 3 months ago. She was an outpatient and was taking antidepressants. Parents describe her as a top student and a model daughter. Client is an only child of Asian decent and both parents have jobs that require international travel. Up until 3 months ago, client always had a nanny but parents stated that she was old enough to manage on her own now.

During counseling session client admits that she was being bullied in school by a group of girls. She expresses that she has been afraid to tell anyone, especially her parents. She explained that she went out with one of the girl's boyfriend and became pregnant and had an abortion 10 months ago. She also expresses that she deeply regrets what she has done and feels very sad to the point where she believes that she does not deserve to live.

After 1 week on the acute care ward she developed an infection in the left wrist wound and then had a successful D & C was placed on IV antibiotics and wound care. Transferred to psychiatric unit 2 weeks later where she improved emotionally and was no longer deemed a risk for self-harm. After consultation with client and parents; client was discharged.

Case Scenario 3.2c: Adolescent suicide
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Sanci, L.A., Sawyer, S.M., Kang, M.S.-L., Haller, D.M., & Patton, G.C. (2005). Confidential health care for adolescents: Reconciling clinical evidence with family values. *Medical Journal of Australia*, 183(8), 410-414.

Skegg, K. (2005). Self-harm. *Lancet*, 366(9495), 1471-1483.

Spady, D.W., Schopflocher, D.P., Svenson, L.W., & Thompson, A.H. (2001). Prevalence of mental disorders in children living in Alberta, Canada, as determined from physician billing data. *Archives of Pediatrics and Adolescent Medicine,* 155(10), 1153-1159.

Tan, J.O.A., & Fegert, J.M. (2004). Capacity and competence in child and adolescent psychiatry. *Health Care Analysis*, 12(4), 285-294.

Weist, M.D. (2005). Fulfilling the promise of school-based mental health: Moving toward a Public Mental Health Promotion approach. *Journal of Abnormal Child Psychology,* 33(6), 735-741.

Case Scenario 3.2c: Adolescent suicide
Additional Tutor Information

Concepts to be addressed in this case: Examples of trigger/discussion questions:

Nurse-client relationship
- Describe the nurse-client relationship in this case and discuss if it is appropriate.

Role of Home health nurse
- What is the role of a home health nurse?

Adolescent suicide
- Is adolescent suicide different from adult suicide and what is the prevalence?

Adolescent depression/chronic condition management
- What is depression and is it related to suicide?
- Explore the concept of decision support for chronic condition management

Self-harm
- What is self-harm and is it the same as suicide?

Causes
- What are the causes of each of the above and is there a gender difference noted?

Prevention strategies
- What are prevention strategies?

Treatment options & decisional conflict about treatment decisions
- What are the different treatment options and their effectiveness?
- Explore the decisional conflict in this case
- Explore if there are decision tools that could be offered to this family support their decision making

Age of consent
- What is the age of consent in your province and what does this mean?

Family involvement/responsibilities
- To what extent should the family be involved and would you consider this family nursing as oppose to individual client nursing?
- What are the responsibilities of parents or guardians in this case?

Adolescent pregnancy
- What is the significance of adolescence pregnancy and do you see any relationship to the depression/suicide that this client experienced?

Bullying in adolescents
- What is the prevalence of bullying at this age and what is its significance?

Growth and development stage
- What is the normal growth and development stage for this client?

School responsibilities
- What is the school's responsibility in this case scenario?

Community resources for adolescents
- What community resources are there for adolescents who are depressed and/or suicidal?
- How effective are they?

Funding for these resources & Political stance
- What type of funding do they receive?
- Explore the political aspects of funding for mental health illness

Hospital inpatient treatment for adolescents
- What is the process of hospital care for these clients and how effective is it?

Case Scenario 3.2c: Adolescent suicide
Faculty Resources

Ackard, D.M., Neumark-Sztainer, D., Story, & M., Perry, C. (2006). Parent-child connectedness and behavioral and emotional health among adolescents. *American Journal of Preventive Medicine*, 30(1), 59-66.

Abstract: Background: This study sought to examine teen perceptions of mother-child and father-child connectedness, with focus on valuing parental opinions and perception of parental communication and caring, and associations with behavioral and emotional health. Methods: A population-based sample of 4746 students in public schools completed the 2001 Project EAT (Eating Among Teens) survey. Results: Overall, the majority of girls and boys reported valuing their parents' opinion when making serious decisions and believing that their parents cared about them. Yet, one fourth of girls and boys felt unable to talk to their mother about problems, and over half of girls and one third of boys felt unable to talk to their father. Valuing friends' opinions over parents' opinions, and perceiving low parental communication and caring were associated with unhealthy weight control, substance use, suicide attempts, body dissatisfaction, depression, and low self-esteem. Of significant concern, compared to their peers who reported feeling that their mother cared quite a bit or very much, youths who reported feeling as though their mother cared very little or not at all about them reported particularly high prevalence rates of unhealthy weight control behaviors (63.49% girls, 25.45% boys); suicide attempts (33.51% girls, 21.28% boys); low self-esteem (47.15% girls, 24.56% boys); and depression (63.52% girls, 33.35% boys). Conclusions: Adolescents' perceptions of low parental caring, difficulty talking to their parents about problems, and valuing their friends' opinions for serious decisions were significantly associated with compromised behavioral and emotional health. Interventions aimed at improving the parent-child relationship may provide an avenue toward preventing health risk behaviors in youth.

Ashmore, R., Cutcliffe, J.,& Collier, E. (2002). An examination of the last 10 years of mental health nursing. *British journal of nursing,* 11(7), 503-505.

Abstract: This article offers an examination of the mental health nursing articles published in the British Journal of Nursing during the last 10 years, and a commentary on how these reflect developments within this specialism. It identifies a number of clinical and professional issues, which have emerged over the last decade, including: community care; concerns over the quality of acute inpatient services; clinical supervision; and the integration of schools of nursing into higher education. Finally, the article identifies some clinical areas which it suggests warrant attention in the next decade such as child and adolescent mental health and mental health care for older people.

Beck, C.A., Williams, J.V.A., Jian, L.W., Kassam, A., El-Guebaly, N., Currie, S.R., Maxwell, C.J., & Patten, S.B. (2005). Psychotropic medication use in Canada. *Canadian Journal of Psychiatry,* 50(10), 605-613.

Abstract: Background: Psychotropic medication use can be employed as an indicator of appropriate treatment for mental disorders. The Canadian Community Health Survey: Mental Health and Well-Being (CCHS 1.2) offers the first opportunity to characterize Canadian psychotropic medication use on a national level within diagnostic groups as assessed by a full version of the Composite International Diagnostic Interview (CIDI). Method: We assessed the prevalence of antidepressant, sedative-hypnotic, mood stabilizer, psychostimulant, and antipsychotic use over 2 days overall and in subgroups defined by CIDI-diagnosed disorders and demographics. We employed sampling weights and bootstrap methods. Results: Overall psychotropic drug utilization was 7.2%. Utilization was higher for women and with increasing age. With any lifetime CIDI-diagnosed disorder assessed in the CCHS 1.2, utilization was 19.3%, whereas without such disorders, it was 4.1%. Selective serotonin reuptake inhibitors (SSRIs) were the most commonly used antidepressants for those with a past-year major depressive episode (17.8%), followed by venlafaxine (7.4%). Among people aged 15 to 19 years, antidepressant use was 1.8% overall and 11.7% among those with past-year depression; SSRIs made up the majority of use. Sedative-hypnotics were used by 3.1% overall, increasing with age to 11.1% over 75 years. Conclusions: International comparison is difficult because of different evaluation methods, but antidepressant use may be higher and antipsychotic use lower in Canada than in recent European and American reports. In light of the relative lack of contemporary evidence for antidepressant efficacy in adolescents, it is likely that antidepressant use among those aged 15 to 19 years will continue to decline. The increased use of sedative-hypnotics with age is of concern, given the associated risk of adverse effects among seniors.

Bergeron, E., Poirier, L.-R., Fournier, L., Roberge, P., & Barrette, G. (2005). Determinants of service use among young Canadians with mental disorders. *Canadian Journal of Psychiatry,* 50(10), 629-636.

Abstract: Objective: To identify the determinants of service use by young Canadians with mental health problems. Methods: Data were drawn from a recent large Canadian mental health survey. The analyses were conducted on a subsample of 1092 Canadians aged 15 to 24 years and identified as presenting a mood disorder, an anxiety disorder, or a substance-related disorder in the 12 months preceding the survey. We classified variables potentially associated with any type of service use for a mental health problem over a 12-month period according to predisposing, enabling, and need factors. We conducted weighted multivariate logistic regressions to determine the association of each factor with service use. Results: In the final model, being female and living alone were the predisposing factors associated with service use. None of the enabling factors predicted help seeking. In regard to the perceived need factors, those who had difficulties with social situations were more likely to use services. Having a mood disorder and (or) having a diagnosed chronic illness were the evaluated need factors associated with service use. Conclusion: Certain groups of young Canadians are less likely to seek help for mental health problems and could be the target of interventions aimed at increasing service use.

Best, R. (2006). Deliberate self-harm in adolescence: A challenge for schools. *British Journal of Guidance and Counselling,* 34(2), 161-175.

Abstract: Acts of deliberate self-harm (DSH) by adolescents are thought to be on the increase. Many of those who self-harm are of school age and it is to be expected that schools (and their teachers) will be aware of the problem and will respond appropriately as part of their pastoral-care provision. However, a recent survey of research in pastoral care and personal-social education undertaken by the author found virtually no reference to DSH. It appears that empirical evidence about schools experience of, and responses to, DSH does not exist. This paper reports some of the findings of a Nuffield Foundation-funded study undertaken in England in 2003/2004. A variety of self-harming behaviours, from cutting to unnecessary risk-taking, were reported by the 34 teachers and other professionals interviewed in schools, pupil referral units and support agencies such as child and adolescent mental health services (CAMHS). The findings indicate that teachers awareness of DSH is patchy and that their reactions are often those of shock, panic and anxiety. The implications of the findings for those in education are considered in the context of a discussion of the literature. The contested status of the concept of deliberate self-harm, the need for a cautious raising of awareness, and the importance of supervision for front-line workers in schools are amongst the issues considered.

Bristow, K., & Patten, S. (2002). Treatment-seeking rates and associated mediating factors among individuals with depression. *Canadian Journal of Psychiatry*, 47(7), 660-665.

Abstract: Objective: To systematically review the literature with respect to treatment-seeking rates for depression and associated mediating factors. This review focuses on adolescents and adults of all ages. Methods: A structured literature review using Medline and PsychInfo databases revealed 38 relevant papers. Two trained reviewers independently and blindly assessed each study according to 4 inclusion criteria. A total of 17 papers met all 4 criteria. Results: Between 17.0% and 77.8% of individuals with depressive episodes or disorders sought treatment in these studies. We could explain the range in rates by diverse measures of depression, mediating factors that influence treatment-seeking, varied years in which the studies were done, and different time periods over which treatment-seeking was assessed. Conclusions: Treatment-seeking rates for major depression appear to have increased over the years. Age, race, social supports, and clinical and psychiatric factors seem to influence treatment-seeking rates most. Public health initiatives can use this information to facilitate service access and delivery.

Butler, R.J., & Gasson, S.L. (2005). Self esteem/self concept scales for children and adolescents: A review. Child and Adolescent Mental Health, 10(4), 190-201.

Abstract: There remains a flourishing interest in self esteem/self concept both in academic and clinical circles and popular literature. This paper elaborates various notions of the self and discusses the principles underpinning ways of measuring self esteem/self concept with children and adolescents. A review over the last 20 years indicates a raft of scales currently employed. The 14 most frequently cited are considered, with the top six measures and the latest British scale discussed in detail. The paper highlights issues and themes emerging from a comprehensive analysis of these scales, with a conclusion framed around assisting the reader to make an informed choice.

College of Nurses of Ontario. (Revised 2006). The standard of care. Therapeutic nurse-client relationship. Retrieved July 16, 2006, from http://www.cno.org/docs/prac/41033_Therapeutic.pdf

Dopheide, J.A. (2006). Recognizing and treating depression in children and adolescents. *American Journal of Health-System Pharmacy,* 63(3), 233-243.

Abstract: Purpose. The clinical presentation and neurobiology of depression in youth and its appropriate treatment, as well as strategies for improving therapeutic benefit and preventing adverse outcomes, including suicide, are reviewed. Summary. Functionally impairing depression occurs in 2-10% of children and adolescents. A diagnosis of depression should be considered when a physically healthy child exhibits depressed mood or anhedonia, multiple somatic complaints, or behavioral changes, such as bullying, aggression, and social withdrawal. Risk factors for depression include childhood trauma, genetic susceptibility, and environmental stressors. Antidepressants and cognitive behavioral therapy are the most effective treatments for adolescents with depression. Youth are at risk for the same adverse effects as adults but have an increased risk of behavioral activation, or switch, to mania and suicidal thoughts and behaviors early in treatment. Compared with other antidepressants, fluoxetine has the most evidence for safety and efficacy, particularly in adolescents 12 years or older. There is very little evidence for the effectiveness of any antidepressant in children 11 years and younger. Youth receiving antidepressants should be monitored closely for new-onset or worsening suicidality, particularly during the first two weeks after starting medication, and for three months of therapy. Behavioral activation, aggression, worsening depression, anxiety, insomnia, or impulsivity can herald a switch to mania or suicidality. Conclusion. Depression in youth is common and treatable and responds best to multimodal treatment combining patient and family education, cognitive behavioral therapy, and antidepressant medication. The potential benefits of antidepressants outweigh the risks for adolescents. Family and psychotherapeutic interventions are most effective for prepubertal children.

Essau, C.A. (2005). Frequency and patterns of mental health services utilization among adolescents with anxiety and depressive disorders. *Depression and Anxiety*, 2(3), 130-137.

Abstract: The main aim of this study was to examine the frequency and patterns of mental health services utilization among 12- to 17-year-old adolescents with anxiety and depressive disorders. Another aim was to examine the factors associated with the use of mental health services. The study population comprised 1,035 adolescents randomly recruited from 36 schools. Anxiety and depressive disorders were coded based on DSM-IV criteria using the computerized Munich version of the Composite International Diagnostic Interview. Only 18.2% of the adolescents who met DSM-IV criteria for anxiety disorders, and 23% of those with depressive disorders, used mental health services. Among adolescents with anxiety disorders, mental health services utilization was associated with past suicide attempt, older age, the presence of comorbid disorders, as well as parental anxiety and depression. The only factor that predicts the use of mental health service among adolescents with depressive disorder was a history of suicide attempt. The implication of the results in terms of tailoring services for children and adolescents with anxiety and depressive disorders are discussed.

Folse, V.N., Eich, K.N., Hall, A.M., & Ruppman, J.B.(2006). Detecting suicide risk in adolescents and adults in an emergency department: A pilot study. *Journal of Psychosocial Nursing and Mental Health Services,* 44(3), 22-29.

Abstract: The investigators conducted a pilot study to detect suicide risk in adolescents and adults seeking treatment in an emergency department, as well as to test the reliability and validity of the 4-item Risk of Suicide Questionnaire (RSQ). This study expanded the implementation of the RSQ beyond its initial use with children and adolescents with psychiatric symptoms who were seeking treatment in an pediatric emergency department to include adolescent and adult patients in a Level I trauma center. An advanced practice psychiatric nurse verbally administered the RSQ to a convenience sample of 104 emergency department patients ages 12 to 82. Psychometric analysis demonstrated an adequate degree of reliability and criterion-related validity for the RSQ. Approximately 30% of all patients who participated screened positive for suicide risk. The results support the continued use of the 4-item RSQ with all adolescents and use of a reduced 2-item form of the RSQ with adults exhibiting psychiatric chief complaints to determine imminent risk of suicide in patients who seek treatment in the emergency department. Nurses in all health care settings need to initiate suicide screening and implement nursing interventions directed toward suicide prevention.

Geanellos, R. (2002).Transformative change of self: the unique focus of (adolescent) mental health nursing? *International journal of mental health nursing*, 11(3), 174-185.

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Abstract: In mental health nursing, inadequate nursing practice research has resulted in a deficit of knowledge concerning the nurse-client relationship; an area seen as the heart of practice. In turn, the specialty has experienced difficulty in identifying its unique domain of practice. Findings from a hermeneutic study into adolescent mental health nursing explicated its practice knowledge. These findings include: (i) 'engaging in therapeutic relationships'; (ii) 'guiding the potential for change'; and (iii) 'facilitating positive outcomes'. A higher order finding was named 'fostering a functional self'. These findings are discussed. Findings point to the nature, purpose and processes of the nurse-client relationship, and to outcomes from that relationship. It is suggested they also represent a beginning understanding of the specialty's unique contribution to nursing; that mental health nursing fosters transformative change of self.

Grossoehme, D.H., & Gerbetz, L. (2004). Adolescent perceptions of meaningfulness of psychiatric hospitalization. *Clinical Child Psychology and Psychiatry*, 9(4), 589-596.

Abstract: Positive patient outcomes are related to patient satisfaction and the meaningfulness of their hospital experience. Limited attention has been paid to how adolescent psychiatric in-patients experience their treatment course. This study was developed to examine how hospitalized adolescents experience the treatment milieu during an acute hospitalization in a crisis stabilization unit. The study consisted of a survey administered to 105 in-patients at the time of their discharge from the unit. The most meaningful experiences were those in which adolescents focused on issues related to hospitalization and learned skills for breaking problems down into manageable pieces which included setting realistic and achievable goals. Males and females did not significantly differ in their experience of the unit. Identifying the adolescents' needs and teaching them goal-setting appears to be very important in acute in-patient care. Adolescents reported peer contact and goal-setting work to be the most meaningful experiences.

Hallfors, D., Brodish, P.H., Khatapoush, S., Sanchez, V., Cho, H., & Steckler, A. (2006). Feasibility of screening adolescents for suicide risk in "real-world" high school settings. *American Journal of Public Health*, 96(2), 282-287.

Abstract: Objectives. We evaluated the feasibility of a population-based approach to preventing adolescent suicide. Methods. A total of 1323 students in 10 high schools completed the Suicide Risk Screen. Screening results, student follow-up, staff feedback, and school responses were assessed. Results. Overall, 29% of the participants were rated as at risk of suicide. As a result of this overwhelming percentage, school staffs chose to discontinue the screening after 2 semesters. In further analyses, about half of the students identified were deemed at high risk on the basis of high levels of depression, suicidal ideation, or suicidal behavior. Priority rankings evidenced good construct validity on correlates such as drug use, hopelessness, and perceived family support. Conclusions. A simpler, more specific screening instrument than the Suicide Risk Screen would identify approximately 11% of urban high school youths for assessment, offering high school officials an important opportunity to identify young people at the greatest levels of need and to target scarce health resources. Our experiences from this study show that lack of feasibility testing greatly contributes to the gap between science and practice.

Healthwise® Knowledgebase. http://www.healthlinkbc.ca/kb/content/symptom/suicd.html

Khanlou, N. (2004). Influences on adolescent self-esteem in multicultural Canadian secondary schools. *Public Health Nursing*, 21(5), 404-411.

Abstract: This study examined the global and current self-esteem levels of adolescents in a community sample of 550 secondary school students in Canada. A cross-sectional design and the survey method were used. Respondents' individual (age and gender) and environmental (cultural background, acculturating group, family circumstances, and perception of support) attributes were considered. Influences that promoted or challenged their current self-esteem were examined. Eighteen percent of respondents and 43.4% of respondents' parents were immigrants. When the Rosenberg Self-Esteem scale was used, 27.6% of respondents had the highest global self-esteem level; when the Current Self-Esteem scale was used, 12.7% had the highest current self-esteem level. A significant gender difference was found, with male adolescents having higher self-esteem. The results indicate that, although self-esteem promotion can benefit from lifestyle-oriented activities, its growth takes place in the larger context of adolescents' relationships, school-related experiences, achievements, and attitudes toward themselves. The study findings can contribute to mental health promotion strategies in multicultural and immigrant-receiving community settings.

Kools, S. (1998). Prevention of mental health problems in adolescence. *Annual review of nursing research,* 16, 83-116.

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Abstract: Mental health problems in adolescence are noteworthy in that they are outside of the normative adolescent developmental experience. Twenty percent of adolescents in the United States experience significant and persistent mental disorders, which indicates the need for prevention and early intervention. The purpose of this chapter is to review research on the prevention of mental health problems in adolescence. Various sociocontextual factors that place an adolescent at risk for mental health problems are examined. In particular, studies that identify risk factors for problems common to adolescence, including depression, suicide, and disorders of conduct and eating are reviewed. Evaluative research on prevention and early intervention programs in this substantive area are also critically reviewed. A summative report and critique on the state of research in this area is given along with suggestions for future research. A call for the active involvement of nursing in this research agenda is made.

Lesser, J., & Koniak-Griffin, D. (2000). The impact of physical or sexual abuse on chronic depression in adolescent mothers. *Journal of Pediatric Nursing*, 15(6), 378-387.

Abstract: This longitudinal investigation explored the impact of a childhood history of physical and sexual abuse on perinatal depressive symptomatology, suicide attempts, and maternal behavior in an ethnically diverse sample of 95 adolescent mothers. Maternal role attainment theory and the cognitive-interpersonal theory of depression provided the conceptual framework for this study. This investigation helps to expand theory on adolescent maternal role attainment by identifying a relationship between history of abuse, depressive symptoms over time, and maternal role behavior problems. Findings do not indicate that a history of childhood maltreatment alone increases a young mother's risk for maternal-child interaction problems.

Levine, L.J., Schwarz, D.F., Argon, J., Mandell, D.S., & Feudtner, C. (2005). Discharge disposition of adolescents admitted to medical hospitals after attempting suicide. *Archives of Pediatrics and Adolescent Medicine*, 159(9), 860-866.

Abstract: Objective: To test the hypothesis that discharge disposition for adolescents admitted to medical hospitals after attempting suicide varies as a function of hospital type and geographic region. Design: Retrospective cohort analysis. Setting: The nationally representative Kids' Inpatient Database for 2000. Participants: Patients aged 10 to 19 years with a diagnosis of suicide attempt or self-inflicted injury. Main Outcome Measure: Likelihood of transfer to another facility vs discharge to home. Results: Care for 32 655 adolescents who attempted suicide was provided in adult hospitals (83% of hospitalizations), children's units in general hospitals (10%), and children's hospitals (4%). More than half (66%) of medical hospitalizations ended with discharge to home, 21% with transfer to a psychiatric, rehabilitation, or chronic care (P/R/C) facility, 10% with transfer to a skilled nursing facility, intermediate care facility, or short-term acute care hospital facility, and 2% with death or departure against medical advice. After adjustment for individual patient characteristics, children's units were 44% more likely than adult hospitals to transfer adolescent patients to a P/R/C facility (odds ratio [OR], 1.44; 95% confidence interval [CI], 1.07-1.94). Patients cared for outside the Northeast were significantly less likely to be transferred to a P/R/C facility (South: OR, 0.79; 95% CI, 0.65-0.97; Midwest: OR, 0.63; 95% CI, 0.49-0.80; West: OR, 0.29; 95% CI, 0.22-0.38). Conclusions: Most adolescents admitted to a medical hospital after a suicide attempt are discharged to home, and the likelihood of transfer to another facility appears to be influenced by the geographic location of the admitting hospital and whether it caters to children.

McClain, N. (2003). Adolescent suicide attempt: undisclosed secrets. *Pediatric nursing* 29(1), 52-53.

Mills, C., Guerin, S., Lynch, F., Daly, I., & Fitzpatrick, C. (2004). The relationship between bullying, depression and suicidal thoughts/behaviour in Irish adolescents. *Irish Journal of Psychological Medicine* 21(4), 112-116.

Abstract: Objectives: This study examined the prevalence of depressive symptoms, including suicidal ideation/ behaviour, among bullied and non-bullied young people. Methods: Participants were 209 students, 97 male and 112 female, attending eight urban post-primary schools and aged between 12 and 15 years. Participants were interviewed using the Schedule for Affective Disorders and Schizophrenia for School Aged Children - Present and Lifetime Version, the Hopelessness Scale for Children, the Scale for Suicide Ideation, and the Suicide Intent Scale. Results: Data were analysed using a series of non-parametric comparison tests. Being a victim of bullying was found to be significantly associated with depression (χ^2 = 10.986; df = 1; p = 0.001) and suicidal ideation (χ^2 = 5.811; df = 1; p = 0.022). Results also indicated that victims were more likely to have reported a suicide attempt (χ^2 = 5.995; df = 1; p = 0.022). Finally, those bullied were significantly more likely to have been referred to psychiatric services (χ^2 = 6.661; df = 1; p = 0.011). Conclusions: These findings suggest that the issue of bullying needs to be re-addressed within Irish schools, with particular emphasis placed on further investigation into the psychological consequences thereof.

Parsons, C. (2003). Caring for adolescents and families in crisis. *Nursing Clinics of North America,* 38(1) 111-122.

Abstract: Nurses are likely to see adolescents and their families in a variety of practice settings. Recognizing the youth and family at risk is significant in helping them resolve a stressful situation by mobilizing resources and strengthening coping and problem-solving skills. This article has focused on several areas, including suicide and depression, sex-related issues, substance abuse, and poor academic performance. Helping the youth and family in crisis challenges the nurse to use astute assessment skills that support a patient-centered crisis intervention model. During a time when cost-effective mental health care is a necessity, this model offers nurses an opportunity to provide quality health care.

Palmer, S., Maiter, S., & Manji, S. (2006). Effective intervention in child protective services: Learning from parents. Children and Youth Services Review, 28(7), 812-824.

Abstract: Sixty-one parents, mainly mothers, in two mid-size Ontario (Canada) cities were interviewed about their experiences with Child Protective Services (CPS) agencies, one in each city. The interviewers took a semi-structured approach that focussed on learning about the challenges in the parents' daily lives (to be reported in a future paper), and their perceptions of CPS interventions. Four researchers, including the three authors, developed a coding scheme to analyze the interviews, using the qualitative software package QSR NUD*IST Vivo. The findings indicated that parents valued good referrals, concrete help, and emotional support, although the latter was mentioned by only a minority of parents. Their most negative experiences were: having their initial requests for help turned down; being accepted for service, but not receiving much help; being unfairly treated or harrassed; and being traumatized by the sudden, police-like removal of their children. The paper discusses how the context of these two agencies may have contributed to the findings: increasing poverty among families with children, and the effects of an ultra-conservative government, who introduced a legalistic, investigative agenda for CPS beginning in 1995. The paper discusses how workers and agencies could modify services to maximize the parents' positive experiences and minimize their negative experiences.

Power, T.J., Eiraldi, R.B., Clarke, A.T., Mazzuca, L.B., & Krain, A.L. (2005). Improving mental health service utilization for children and adolescents. *School Psychology Quarterly,* 20(2), 187-205.

Abstract: Approximately 10% of children and adolescents have mental health problems necessitating intervention, but well below 50% of these children receive needed services, and far fewer receive the quality of care required to effectively reduce their impairments. Although system reform is needed to improve service utilization and quality of care for all children, preschoolers, girls, individuals of minority status, and the uninsured are most at risk for being underserved. Factors contributing to poor service utilization can be classified into two broad sets: sociopolitical factors referring to issues related to funding and access, and cultural/familial factors including beliefs about mental health services, providers, and treatments. This article describes the help-seeking process and focuses on cultural and familial factors that contribute to movement through these stages, with a particular focus on variables that are amenable to change by practitioners in the school and community, including school psychologists. Guidelines for understanding and changing the help-seeking behavior of families, including suggestions for creating service options, providing family education, and offering individualized family services, are described.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.* Mississauga, ON: Jones and Bartlett.

Reder, S., & Quan, L. (2004). Emergency mental health care for youth in Washington State: Qualitative research addressing hospital emergency departments' identification and referral of youth facing mental health issues. *Pediatric Emergency Care,* 20(11), 742-748.

Abstract: Objectives: The purpose of this formative research was to gain a better understanding of how Washington State hospital emergency departments (EDs) identify and refer children and adolescents with mental health concerns. Increased understanding of emergency mental healthcare for youth will lead to the development and implementation of strategies and policies that enhance the system of providing mental health services to children and adolescents. Methods: We conducted structured group interviews, a form of qualitative research, with ED, social work, and mental health administrators and providers in 9 hospitals in Washington State. Results: Interviews reflected a systemwide lack of emergency mental health services for youth, as well as a lack of coordination between the larger mental health system and hospital ED. In addition, we identified issues

specific to the hospital/ED such as insufficient availability of social work and mental health staff, lack of mental and behavioral health screening tools, lack of knowledge of available mental health services, and lack of clarity about the ED's role in identification of mental health concerns. Conclusions: Specific interventions should be developed, implemented, and evaluated to increase coordination between the ED and the larger mental health system. This should include methods for increasing ED staff knowledge of available and accessible mental health services for youth, perhaps through an online system. In addition, the role of the ED in identifying youth facing mental health issues should be clarified, and a brief, nonintrusive screening tool for identifying emergency mental health concerns should be developed.

Rose, L.E., Mallinson, R.K., & Walton-Moss, B. (2004). Barriers to family care in psychiatric setting. *Journal of Nursing Scholarship,* 36(1), 39-47.

Abstract: Purpose: To identify barriers to family care in psychiatric settings and to describe family and provider perspectives about what constitutes effective family care. Design and Methods: A qualitative exploratory approach with focus groups. Seventy-eight people participated in 11 focus groups conducted with families, patients, and health professionals. Findings: Families identified poor quality care, conflict with health professionals about treatment, and lack of a role for families in the treatment. African American families also identified isolation of their communities from the mental health care system. Adolescents emphasized their role as caregivers and their needs for support. Health professionals conveyed concerns about system-based barriers, professional practice-based barriers, and family-based barriers to care. Patients stated the need for their families to be better educated about mental illness. Conclusions: The lack of family care in psychiatric settings is a multifaceted problem. Current health policies do not show endorsement of a family care approach. Responses from families and health professionals indicated conflicting opinions about content of family care. Health professionals reported they often lacked training and resources to deal with complex family issues. Families believed that lengthy and intensive interventions were neither necessary nor desired to address their concerns. Family care can be improved by focusing on building rapport and communicating problems and concerns between families and health professionals.

Sanci, L.A., Sawyer, S.M., Kang, M.S.-L., Haller, D.M., & Patton, G.C. (2005). Confidential health care for adolescents: Reconciling clinical evidence with family values. *Medical Journal of Australia*, 183(8), 410-414.

Abstract • Community debate about confidential health care for adolescents was triggered recently by the federal government's proposal to allow parents of teenagers aged 16 years and under access to their children's Health Insurance Commission data without their consent. • Extensive research evidence highlights the importance of confidentiality in promoting young people's access to health care, particularly for sensitive issues such as mental and sexual health, and substance use. • Involving parents is important, but evidence for any benefit from mandatory parental involvement is lacking. • The law recognises the rights of mature minors to make decisions about their medical treatment and to receive confidential health care; however, the doctor must weigh up certain factors to assess maturity and ensure that confidentiality around such treatment will be in the young person's best interests. Evaluation of maturity must take into account characteristics of the young person, gravity of the proposed treatment, family factors, and statutory restrictions.

Skegg, K. (2005). Self-harm. *Lancet*, 366(9495), 1471-1483.

Abstract: The term self-harm is commonly used to describe a wide range of behaviours and intentions including attempted hanging, impulsive self-poisoning, and superficial cutting in response to intolerable tension. As with suicide, rates of self-harm vary greatly between countries. 5-9% of adolescents in western countries report having self-harmed within the previous year. Risk factors include socioeconomic disadvantage, and psychiatric illness - particularly depression, substance abuse, and anxiety disorders. Cultural aspects of some societies may protect against suicide and self-harm and explain some of the international variation in rates of these events. Risk of repetition of self-harm and of later suicide is high. More than 5% of people who have been seen at a hospital after self-harm will have committed suicide within 9 years. Assessment after self-harm includes careful consideration of the patient's intent and beliefs about the lethality of the method used. Strong suicidal intent, high lethality, precautions against being discovered, and psychiatric illness are indicators of high suicide risk. Management after self-harm includes forming a trusting relationship with the patient, jointly identifying problems, ensuring support is available in a crisis, and treating psychiatric illness vigorously. Family and friends may also provide support. Large-scale studies of treatments for specific subgroups of people who self-harm might help to identify more effective treatments than are currently available. Although risk factors for self-harm are well established, aspects that protect people from engaging in self-harm need to be further explored.

Spady, D.W., Schopflocher, D.P., Svenson, L.W., & Thompson, A.H. (2001). Prevalence of mental disorders in children living in Alberta, Canada, as determined from physician billing data. *Archives of Pediatrics and Adolescent Medicine,* 155(10), 1153-1159.

Abstract: Background: The prevalence of mental disorders is often assessed using survey techniques. Although providing good estimates of prevalence, these techniques are time-consuming and expensive. Objective: To estimate the prevalence of mental disorders among children aged 0 to 17 years living in Alberta, Canada, using health care administrative data. Design: This was a cross-sectional study. International Classification of Diseases, Ninth Revision, Clinical Modification chapter 5 diagnostic codes from physician billing data were used. Codes were grouped into 10 categories. Prevalence rates for each category were calculated, stratified by age, sex, and premium subsidy status (a proxy for socioeconomic status). The age pattern, times of greatest risk, and the effect of sex on type and prevalence of mental disorder were estimated. Setting: All fee-for-service health care venues in Alberta between April 1, 1995, and March 31, 1996, providing services to children registered with the Alberta Health Care Insurance Commission on March 31, 1996. Results: Prevalence of mental disorders varied by disorder category, age, sex, and premium subsidy status. For boys, maximum prevalence of 9.5% occurred at age 10 years; for girls, maximum prevalence of 12.0% occurred at age 17 years. Mental disorders were most common in young boys and adolescent girls and among children receiving welfare. Distinct patterns of disorder were evident and comorbidity was common. Conclusions: Administrative data can be used to estimate the prevalence of mental disorders in a pediatric population. The estimates made are lower than those obtained by using surveys of similar populations, perhaps indicating the difference between treated and untreated prevalence. Strengths of this study are that the estimates reflect the entire population, are more easily and obtained at less cost, and are useful for the planning of mental health services.

Tan, J.O.A., & Fegert, J.M. (2004). Capacity and competence in child and adolescent psychiatry. *Health Care Analysis*, 12(4), 285-294.

Abstract: Capacity and competence in the field of child and adolescent psychiatry are complex issues, because of the many different influences that are involved in how children and adolescents make treatment decisions within the setting of mental health. This article will examine some of the influences which must be considered, namely: developmental aspects, the paradoxical relationship between the need for autonomy and participation and the capacity of children, family psychiatry, and the duty of care towards children and adolescents. The legal frameworks relevant to consideration of consent and competence will be briefly considered, as well as some studies of children's consent, participation and competence. A case vignette will be used as a focus to consider the complexity of the issue of competence in child and adolescent psychiatry, in the particular mental disorder of anorexia nervosa.

Weist, M.D. (2005). Fulfilling the promise of school-based mental health: Moving toward a Public Mental Health Promotion approach. *Journal of Abnormal Child Psychology,* 33(6), 735-741.

Abstract: School-based mental health (SBMH) programs and services are growing progressively in the United States for many reasons. However, the SBMH field is young and tenuously supported, and challenges are being confronted on many levels. There are major needs to continue to bring research-supported interventions into schools, and to better equip educators and mental health programs and staff in schools to function effectively. Articles in this special issue present the many challenges well and point to important directions for advancing SBMH. To truly advance the field a Public Mental Health Promotion approach is needed. Elements of this approach, in advancing training, quality assessment and improvement (including empirically supported practice), and advocacy and policy influence are discussed, as are strategic connections to the Community Science perspective and to the development of a growing Community of Practice in SBMH.

Module 1V

Overall Objective:

To build and appraise decision coaching skills for nursing students supporting patients facing decisions in complex care environment.

Theory and Clinical Practicum focus

- complex care, consolidating knowledge & skills

Teaching and Learning Strategies

B. Lectures:

Decision support skill building workshop

Addressing oncology patient information and decision support needs

Learning is evaluated through use of questions on mid-term and final exanimations as well as through use of assignments.

B. Assignments

4.1a Critical appraisal of Patient Decision Coaching

4.2a Clinical practice guideline evidence-practice gap

C. Problem-based Learning Case Scenarios

The case scenarios can be used for small group discussions. Each case is organized with the scenario, additional chart or other pertinent data, and references. It is then followed by additional information for tutorial facilitators that include concepts to be addressed, examples of trigger/discussion questions, and faculty resources that include websites, journal articles and books. The following is a description of each case scenario.

4.1c Medication error

This case focuses on medication errors and issues related to documentation. Students are asked to reflect on the process and consider the following; CNO standards of medication administration, elderly population and medication errors, nurses, physicians and pharmacy's role, CQI and documentation.

4.2c Stroke rehabilitation

This case focuses on the issues that can arise from a nursing shortage. It also introduces the students to different models of care in nursing. Patient decision support is explored for a family considering the option of home versus a nursing home facility for their loved one.

Lectures

- Decision Support skill building workshop

- Addressing oncology patient information and decision support

Lectures are available upon request to decisionaid@ohri.ca.

Assignment 4.1a
Decision Coaching for a Patient Facing a Values-Sensitive Decision

Nurses through their close and frequent interactions with patients and families, are well positioned to identify clients in decisional conflict and provide decision coaching tailored to their needs.

Learning Objectives:

1. To explore with a patient their experience making a values-sensitive decision

2. To identify factors contributing to decisional conflict (innate and modifiable).

3. To appraise the quality of decision coaching provided to the patient guided by the DSAT – Decision Support Analysis Tool.

Instructions:

1. Identify a patient making a values-sensitive decision related to a clinical condition (e.g. treatment, screening) or social situation. There needs to be 2 clear options, that can include maintaining status quo. Clarify the decision being made BEFORE the interview and find evidence-based resources that would be useful in providing decision support, to bring with you to the interview.
2. Provide decision coaching facilitated by the Ottawa Personal Decision Guide http://decisionaid.ohri.ca/decguide.html
3. Write a 3-4 page scholarly paper following the assignment structure below. Submit your completed guide with your paper.

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Assignment 4.1a Structure/Grading Scheme:

10%   **1. Introduction**
briefly introduce the case example that you will be discussing and the flow of the paper.

25%   **2. Case Exemplar**
a. Describe the clinical situation and decision making needs of your client (e.g., information needs, values clarity, influence of others, resources).
b. Discuss evidence-based patient decision support resources that were or could be helpful for patients facing this decision.
c. Describe the stage of decision making at the end of your coaching session.

25%   **3. Quality of decision coaching:**
- Using the Decision Support Analysis Tool (DSAT); http://decisionaid.ohri.ca/quality.html, consider the areas of strength and areas requiring improvement in the way you coached the patient facing this decision.

25%   **4. Clinical Implications:**
- Reflect upon the process of using the Ottawa Personal Decision Guide for coaching patients facing health decisions and discuss implications for use in nursing practice.

10%   **5. Conclusion:**
- summarize the key highlights of your paper

5%   **6. Format:**
- your paper should be typed with 12 font Times Roman, 2 to 3 pages double spaced with spelling and grammar checked carefully; follow APA format for correct citing of reference within the paper and in the reference list.

Assignment 4.2a
Clinical Practice Guideline Evidence-Practice Gap Assignment

Objectives:

1. To address the concept of the research-practice gap
2. To describe an RNAO practice guideline
3. To compare the recommendations of the RNAO guideline to a practice issue
4. To write an academic paper with nursing interventions justified by the literature

Format: APA Publication Manual (5th ed) to be used for scholarly format. All papers are typed/word processed, double spaced with 3 cm (left) 2.5 (top, bottom & right) margins, with type size of 12 CPI (or equivalent for MacIntosh computers). Times New Roman or similar fonts are recommended. No Table of Contents. **Do not place papers in folder, plastic cover, etc.** Staple pages only please.

Length: 4 pages maximum, excluding references.

Assignment 4.2a Structure/Grading Scheme:

15% 1. Introduction:
- Describe an issue that you observed in your clinical practice that is not consistent with an RNAO guideline (www.rnao.org)

25% 2. Literature review:
- How common is the discrepancy that you observed? Please provide two to three suggested articles about the frequency that this issue occurs.

45% 3. Clinical interventions:
- Describe the recommendations for this guideline, which are being implemented into practice.
- Suggest reasons why you have observed the implementation of some practice recommendations and not others?
- Are these reasons suggested in the nursing literature?
- Justify with two or three key references.

15% 4. Recommendations:
- Provide suggestions for the future to bridge the gap between the evidence-based guidelines and actual clinical practice

Use recent professional literature **(most from past 5-10 years),** especially any research to support your work. No citation to course notes.

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Case Scenario 4.1c: Medication Error

Mr. Jones is a 75 year old who was admitted from a nursing home to your acute care unit 8 days ago. He was admitted with shortness of breath and chest pain and later diagnosed with a pulmonary embolism. Your hospital has started an anti-thrombolytic protocol for pulmonary embolism, deep vein thrombosis and acute coronary syndrome. The attending physician prefers to be called with the patient's lab results to adjust the dosages. Mr. Jones was on Heparin IV for 4 days and has been switched to Enoxaparin 5000 units SC every 12 hours. He has also been prescribed Coumadin PO.

The Coumadin order reads "Daily INR, start Coumadin 10mg PO qhs. Call for INR <2.0 or >3.0." As you receive Mr. Jones, he has been on this regime for the past 3 days. Prior to giving him his Coumadin, you check the lab results and noted that the last measured INR was 4.0 two days ago. You then check the nurse's notes to see if any of this was documented and you find no reference to the INR. You then go back to the physician's order 2 days ago and see that one of your colleagues had taken a verbal order from the physician on call to hold Coumadin and recheck INR in am.

You call the pharmacy to see if they had received this order and the pharmacist claims that they had not, so they just kept sending the daily coumadin dose. You then notice that the order was not transcribed. On your unit the clerks transcribe the orders and then the nurse is to verify it after. You noticed that the order was written at the change of shift and are told that the unit was short one nurse that day. You notify the physician STAT as Mr. Jones has been receiving 10mg of coumadin for the past 3 days. He gives you an order to hold coumadin and draw a stat INR. Mr. Jones INR comes back at 8.0.

In documenting this error, you write in the patient's chart. "Patient was given 3 days dose of 10mg of coumadin, as order for a hold was not transcribed. Physician notified STAT, orders received and incident report filled out".

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Case Scenario 4.1c: Medication Error
Chart Data

Diagnosis: Pulmonary Emboli
Gender: Male
Age: 75
Marital status: Widowed
Code Status: Full Code

Past Medical History:
Atrial fibrillation, Inferior Wall MI, Coronary Artery Bypass Graft x2, 15years ago, Hypertension, Asthma

Current vital Sign: T= 36.6, P= 68 and irregular, R= 22, BP= 140/80

Current medications: Enoxaparin 5000 units SC BID., Digoxin 0.125mg PO qam, Coumadin 10mg PO qhs, Altace 5mg PO once daily and inhalers prn.

Admission Notes:

Mr. Jones is a 75 year old male transferred from a nursing home after experiencing increase shortness of breath and chest pain. States chest pain feels like a sharp stabbing pain when he breathes in and rates it as 9 out of 10. Patient has been on coumadin for 15 years as part of his antiarrythmic control interventions. According to the nursing home notes his last INR was .08 where at this time his coumadin was increased from 1mg to 2mg daily.

Admission Plan

1. *STAT chest x-ray & ECG
2. Arterial Blood Gases (ABG's)
3. INR, PTT, Troponin 1, CKMB, SMAC, CBC, Dig level and *D-Dimer
4. *VQ scan
5. Start heparin IV

* All lab work normal except, chest x-ray, ECG (old inferior wall myocardial infarction (IWMI) and Atrial fibrillation), D-Dimer (positive), VQ scan (moderate probability of Pulmonary embolism)

Case Scenario 4.1c: Medication Error

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Greenfield, S., Whelan, B., & Cohn, E. (2006). Use of dimensional analysis to reduce medication errors. *Journal of Nursing Education,* 45(2), 91-94

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Hullin, C., Nelson, S., Dalrymple, J., & Hart G. (2005). Interfacing clinical practice and error prevention. *Stud Health Technol Inform,*116, 587-92.

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Case Scenario 4.1c: Medication Error
Additional Tutor Information
Concepts to be addressed in this case: Examples of trigger/discussion questions

College of Nurses of Ontario standards of medication administration
- After reviewing the College's standards on medication administration, what steps could have been taken to prevent this problem?

Medication errors
- Why do errors occur, what are the major causes?

Incident reports
- What is the purpose of an incident report?
- How would you fill one out, i.e. what is the necessary information that must be included?

Underreporting
- Is there an underreporting of medication errors, if so, what factors may contribute to this other than having to fill out an incident report?

Continuous quality improvement (CQI)
- What is continuous quality improvement (CQI) and what role does it play in this case?

Continuing education regarding documentation and medication practices
- Should there be continuous education on medication errors and documentation, if so, should be mandatory and why?

Medication dispensing
- Are there other methods of medication dispensing, if yes, what are they and what does the research show in terms of decreasing medication errors?

Patient health and safety
- What do you know regarding patient health and safety in terms of medication errors? How detrimental is it to the patient? What has research shown?

Elderly population and medication errors
- What do you know about the elderly population and medication errors and does it compare to other populations such as pediatrics?

Documentation
- Do you see any issues with the nursing documentation in this case? What are they, and according to the college how should have the nurse documented?

Transcription
- Who commonly transcribes orders on the units that you have been on? If it is anyone other than nursing do you see any potential problems with this?

Communication
- Was there a breakdown in communication in this case, if so, where was it and how could it of been prevented?

Nurse's role
- What is the nurse's role in terms of medication errors and documentation?

Physician's role/Pharmacy role
- What are the physician's roles and the pharmacist's roles related to medication errors?
- Is there any one particular person at fault or do you see it as a multidisciplinary problem? Justify your answer.

Pulmonary Embolism/Anticoagulants
- Explore Pulmonary embolism, signs and symptoms, causes, tests and treatment options
- What are anticoagulants and why are they so important?

Case Scenario 4.1c: Medication Error
Faculty Resources

Austin, S. (2006). "Ladies & gentlemen of the jury, I present ... the nursing documentation". *Nursing,* 36(1) 56–63.

Make sure you don't leave any mysterious gaps in the medical record that would permit someone to speculate about what happened. Your charting should never cover up an incident or document care that wasn't provided.

Don't leave space so you can add more documentation later. Documentation that's later squeezed into the space available could look like a cover-up or, more generally, raise questions about why documentation was done after the fact. If you need to add more information later and your facility permits entries up to a limited time, follow its policies for making an addendum. It's best to include the reason when an entry is made more than a few days later.

Failing to accurately and completely document the events of an adverse incident and subsequent treatment can result in an unsolved mystery. The plaintiff's attorney will try to solve it by creating a theory about what happened. Based on speculation, this theory may not be accurate. But without solid documentation, you'll have trouble refuting it.

What you should do is document all medically relevant facts related to an incident in the medical record, according to your facility's policies. Document the investigation of an incident in the incident report or the form your facility uses. Don't add to your documentation in the patient's medical record that "an incident report was filed."

Balas, M., C., Scott, L., D., & Rogers, A., E. (2004). The prevalence and nature of errors and near errors reported by hospital staff nurses. *Appl Nurs Res*, 17(4), 224-30.

ABSTRACT: The purpose of this article is to describe the nature and prevalence of errors and near errors reported by 393 full-time hospital staff nurses. One hundred nineteen nurses (30%) reported making at least one error, and 127 nurses (33%) reported at least one near error, for a total of 199 errors and 213 near errors in the 28-day data collection period. Although the majority of errors and near errors identified in this study involved medication administration, the number of procedural, transcription, and charting errors that occurred suggests the need for further examination of the way we currently deliver health care.

Benner, P., Sheets, V., Uris, P., Malloch, K., Schwed, K., & Jamison, D. (2002). Individual, practice, and system causes of errors in nursing: a taxonomy. *J Nurs Adm,* 32(10), 509-23.

Practice errors by nurses can cause harm to patients, families, practitioners, systems, and the profession. Because the nursing errors reported to the State Boards of Nursing are typically serious, analyzing their data has great potential for developing new strategies to reduce dangerous errors. With the guiding rationale being identification of categories central to the nurse's role and function in healthcare delivery errors, 21 case studies of nursing errors from 9 State Boards of Nursing files were analyzed to develop a taxonomy of nursing errors. Eight categories of nursing errors representing a broad range of possible errors and contributive or causative factors were identified: lack of attentiveness; lack of agency/fiduciary concern; inappropriate judgment; lack of intervention on the patient's behalf; medication errors; lack of prevention; missed or mistaken MD/healthcare provider's orders; and documentation errors. Causes for the error, at the system and practice responsibility levels, were identified in each case. The categories, an assessment of causes of errors, and an examination of the remediation actions taken were the first steps in devising a taxonomy of nursing error, designed with prevention in mind. The authors discuss their work and present the taxonomy.

Caspi, A., Rozenfeld, V., & Kleyman, J. (2005). Prevention of medication in the hospital setting: The role of pharmacy students. *P and T*, 30(3), 183-186.

Abstract: According to a well-known report by the Institute of Medicine in 1999, medical errors accounted for 44,000 to 98,000 deaths per year, and many of these errors could have been avoided. Preventable drug-related morbidity and mortality represent a serious medical problem for which expert and immediate attention is urgently required. The challenge that we face is to provide systems and individuals who can identify these errors and stop them before they occur. The disciplines of medicine, nursing, and pharmacy all play a major role in preventing medication-related errors. To that end, we designed a project to explore the role of pharmacy students in preventing medication errors in the hospital setting. These students, collaborating with both a teaching

hospital and a college of pharmacy and using set guidelines, were responsible for identifying preventable medication errors in the acute-care inpatient setting. Preceptors from both the hospital and the college reviewed the findings for their impact on patient care. Medication errors were prevented in 82 patient-cases. The results of this study demonstrate the positive role that pharmacy students can and do play in preventing these errors.

Cohen, M., M., Eustis, M., A., & Gribbins, R., E. (2003). Changing the culture of patient safety: leadership's role in health care quality improvement. *Jt Comm J Qual Saf* , 29(7), 329-335.

Abstract: BACKGROUND: For two decades health care workers have been struggling, with varying degrees of success, to use the principles of continuous quality improvement (CQI) to improve the quality of patient care. The Institute of Medicine report To Err Is Human prompted most hospitals to turn their attention to the pandemic of medical errors and to the realization that without changing the culture of blame, and thus releasing an avalanche of information, major improvement would not be possible. This article describes one community hospital's approach to changing its organizational culture and the critical role of leadership in that transformation. THE REALITIES: The places to look for trouble when diagnosing organizational problems are purpose, structure, rewards, helpful mechanisms, relationships, and leadership. Hospitals are professional bureaucracies in that the real power resides with clinical staff. Improvement requires that effective relationships be built within the executive suite. Relationship and team building must be part of the organizational culture. Quality improvement will not occur unless it is clearly aligned with the organization's core objectives. CONCLUSIONS: Managing the five realities is essential to creating a suitable environment for sustaining clinical or more general CQI efforts within health care organizations. This is particularly crucial if the basic culture of the organization is to be changed. All five realities must be addressed on a continual basis, which takes time, and positive outcomes can be expected only over a longer rather than shorter time frame.

College of Nursing standards, medication and documentation. Retrieved June 16, 2006, from administrationhttp://www.cno.org/pubs/publist.html

Deans C. (2005). Medication errors and professional practice of registered nurses. *Collegian,* 12(1), 29-33.

This Australian study identified and described the incidence of medication errors among registered nurses, the type and causes of these errors and the impact that administration of medications has on the professional practice of registered nurses. Mostly, medication errors were attributed to documentation issues, including: illegible handwriting, misunderstanding abbreviations, misplaced decimal point, misreading and misinterpreting written orders. Several human factors were attributed to potential causes of medication errors, including: stress, fatigue, knowledge and skill deficits. Environmental factors, namely, interruptions and distractions during the administration of medications, were also attributed to potential errors. The study found professional nursing practice involving administration of medications had a strong education, patient and ethical focus. Over a quarter of the respondents indicated that further training in medication administration would positively impact on their nursing practice. The registered nurses also highlighted they would appreciate more time to spend with patients when administering medications. Medication errors are not the sole responsibility of any single professional group, therefore, collaboration with other health professionals is central to establishing processes, policies, strategies and systems that will reduce their occurrence. The organisation and those nurses employed within it share an accountability to ensure safe administration of medications to patients. Based on study results, several recommendations are directed towards preventing or reducing medication errors and supporting nurses in providing best practice.

Dunn, D. (2003). Incident reports--their purpose and scope. *AORN J,* 78(1), 46, 49-61, 65-6; quiz 67-70.

Accidents in the health care setting may be inevitable, but their frequency can be decreased with a dedicated focus on patient safety. Risk reduction naturally flows from a positive approach to risk containment and control that includes learning from past errors. Part One of this two-part series on incident reports talks about identifying and correcting errors, which results in decreased harm to patients and personnel, decreased facility risk liability and regulatory sanctions, and less negative publicity. Although it may be human nature to make mistakes, it also is human nature to create solutions, identify alternatives, and meet future challenges.

Greenfield, S., Whelan, B., & Cohn, E. (2006). Use of dimensional analysis to reduce medication errors. *Journal of Nursing Education,* 45(2), 91-94

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Abstract: The purpose of this pilot study was to determine whether using dimensional analysis as the method of mathematical computation could reduce nursing medication calculation errors. The sample for this study consisted of second-year baccalaureate nursing students in a required clinical skills course. Students in the control group were taught medication calculations using the traditional math method during one semester, whereas students in the experimental group were taught the same material using dimensional analysis during the next semester. Analysis of the collected data from a medication dosage calculation examination revealed the dimensional analysis group scored with greater accuracy than the traditional math group.

Healthwise® Knowledgebase. http://www.healthlinkbc.ca/kb/content/special/meder.html

Hullin, C., Nelson, S., Dalrymple, J., & Hart G. (2005). Interfacing clinical practice and error prevention. *Stud Health Technol Inform,*116, 587-92.

Medication error is a major source of preventable harm to patients in hospitals and is an area in which, it is suggested, information technology will have a positive impact. This paper presents findings from part of a study that examined current information utilisation patterns during nursing medication rounds. Nursing working patterns in medication administration are poorly understood despite being one of the most likely sources of medication error. Methods used were drawn from principles of Human Computer Interaction (HCI), using a semi-structured observational tool for analysing system requirements and data elements. Results from this study indicated that clinical and contextual factors impact on nursing patterns of information handling in many ways, including documentation quality, location of information sources and current patterns of computer utilization. Numerous extraneous interruptions also impact on the ability of nurses to assimilate and use clinical information effectively. These results were used to develop a conceptual framework for interfacing error prevention in clinical practice. These insights into the human factors that are the reality of clinical practice allow us to design and develop effective information technology systems to help prevent nursing medication administration errors.

Mawby, J. (2006). Accurate documenting of a patient's drug allergy status will promote informed therapy decision-making. *Pharmacy in Practice,* 16(1), 24-25.

Abstract: To avoid serious medication errors from being made accurate drug allergy information must be available - and acted upon - at the time medicines are prescribed, dispensed and administered. This can be achieved by recording allergy documentation on patient drug charts and within their medical notes. But this is only useful if the information is both correct and consistent in the charts and notes. We therefore audited the drug allergy records in two oncology wards at Southampton University Hospitals Trust to evaluate the accuracy of drug allergy documentation. In one ward we found the drug allergy documentation on drug charts and in medical notes to be 100% consistent. However, in the other ward only 82.4% of drug charts had an allergy entry on the drug chart, and of these only 68.8% (57.2% of the total) corresponded to information in the medical notes. This raises cause for concern because inaccuracies could lead to potentially serious and unnecessary allergic drug reactions. To circumvent this we now display a medication risk poster alerting all nursing and medical staff to the risks of drug allergies on wards. We have also introduced a new drug chart that allows more detailed recording of information and states that drugs may not be administered until the allergy status of the patient has been assessed

McBride-Henry, K., &Foureur, M. (2006). Medication administration errors: understanding the issues. *The Australian journal of advanced nursing,*23(3), 33-41.

Abstract: OBJECTIVE: This paper surveys current literature related to medication administration errors, the role of nurses in such errors, and current initiatives that are underway within New Zealand to address this aspect of patient safety. SETTING: The literature review focused on research that primarily addresses the issues related to medications that arise in tertiary care facilities. PRIMARY ARGUMENT: Medication administration errors are reported to occur in one in five medication dosages. Such events have long been scrutinised, with the primary focus being the practice of nurses and their role in medication error. Analysis of such events frequently identifies the nurse as the deliverer of unsafe practice. However, over the past few years a shift in how medication errors are understood has led to the identification of systems-related issues that contribute to medication errors. CONCLUSION: Initiatives such as the 'Quality and Safe Use of Medicines' raise the opportunity to address some of the safety related issues with a view to enhancing patient safety. A call for nurses to pre-emptively drive and contribute to these initiatives, along with the development of nursing led research, is offered.

Midlöv, P., Bergkvist, A., Bondesson, A°., Eriksson, T., & Höglund, P. (2005). Medication errors when transferring elderly patients between primary health care and hospital care. *Pharmacy World and Science,* 27(2), 116-120.

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Abstract: Objective: The aims were to evaluate the frequency and nature of errors in medication when patients are transferred between primary and secondary care. Method: Elderly primary health care patients (> 65years) living in nursing homes or in their own homes with care provided by the community nursing system, had been admitted to one of two hospitals in southern Sweden, one university hospital and one local hospital. A total of 69 patient-transfers were included. Of these, 34 patients were admitted to hospital whereas 35 were discharged from hospital. Main outcome measure: Percentage medication errors of all medications i.e. any error in the process of prescribing, dispensing, or administering a drug, and whether these had adverse consequences or not. Results: There were 142 medication errors out of 758 transfers of medications. The patients in this study used on an average more than 10 drugs before, during and after hospital stay. On an average, there were two medication errors each time a patient was transferred between primary and secondary care. When patients were discharged from the hospital, the usage of a specific medication dispensing system constituted a significant risk for medication errors. The most common error when patients were transferred to the hospital was inadvertent withdrawal of drugs. When patients left the hospital the most common error was that drugs were erroneously added. Conclusion: Medication errors are common when elderly patients are transferred between primary and secondary care. Improvement in documentation and transferring data about elderly patients' medications could reduce these errors. The specific medication dispensing system that has been used in order to increase safety in medication dispensing does not seem to be a good instrument to reduce the number of errors in transferring data about medication.

Paparella, S. (2005). A safe haven for nurses to report medication errors? Clarian and spectrum health systems prove it is possible! *Journal of Emergency Nursing,* 31(4), 373-375.

A transformation in medical error reporting has begun in hospitals across the United States. That is good news, because in the past, error reporting was taboo. It was an unwritten rule that we (nurses) did not talk about our mistakes or air our "dirty laundry" for many reasons. Not only did we fear the reprimand we would receive from our nurse manager, but we also feared losing the respect of our nursing colleagues. After all, we came to believe that really "good" or "vigilant" nurses never made mistakes and thus, logically, only "bad" or "careless" nurses made mistakes.

Often the degree of punishment following an error was directly tied to the level of harm that resulted or to how frequently we had been involved in other errors. That is, if the error resulted in patient harm, it was more likely that we could expect a note in our file, a bad performance evaluation, suspension, job loss, reporting to our state board, or even liability issues. More importantly, having been involved in a previous error would most surely be considered a negative finding when determining our fate. For those of us not directly involved, we would only find out about the error through the hospital grapevine, or by learning about it the hard way…*when we too made the same mistake.* In this punitive environment of unspoken problems, patients continued to be harmed by *preventable* mistakes.

But things are changing. Organizations are beginning to see what other complex, "high-reliability" organizations learned years ago: There is no way to fix a "problem" when it is dismissed, forgotten, or swept under the rug. Organizations have started to appreciate the enormous value of error reporting—that is, the ability to understand that with each error comes a "lesson learned." We now recognize that error reporting can be used as an early warning system and can help prevent similar errors (or divert serious sentinel events) in the future.

Potter, P., Wolf, L., Boxerman, S., Grayson, D., Sledge, J., Dunagan, C., & Evanoff, B. (2005). Understanding the cognitive work of nursing in the acute care environment. *Journal of Nursing Administration,* 35(7-8), 327-335.

Abstract: Objective: To combine human factors engineering techniques with qualitative observation of nurses in practice to analyze the nature of nurses' cognitive work and how environmental factors create disruptions that pose risks for medical errors. Background: Few researchers have examined the nature of nurses' cognitive work while in practice with patients. Researchers have described the broad range of thinking processes required in the acute care work setting, but have failed to examine how such processes are conducted and influenced by the complex care environment. A combined research methodology enables researchers to better understand how the nursing process becomes disrupted and the potential influence of this disruption on the safe and effective care of patients. Methods: An ethnographic study, using mixed-methodological approaches, involved 7 staff registered nurses. The quantitative and qualitative data collection included field observation and summarative interviews. Findings: A high number of cognitive shifts and interruptions, and a nurse's cumulative cognitive load, create the potential for disrupting a nurse's attention focus during care of patients. A majority of interruptions occurred as nurses performed interventions, particularly medication preparation. Conclusion: New attention must be given to how care systems and work processes complement or interfere with nurses' cognitive work.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.*

Mississauga, ON: Jones and Bartlett.

Romero, A.V., & Malone, D.C. (2005). Accuracy of adverse-drug-event reports collected using an automated dispensing system. *American Journal of Health-System Pharmacy*, 62(13), 1375-1380.

Abstract: Purpose. The accuracy of adverse-drug-event (ADE) reports collected using an automated dispensing system was evaluated. Methods. ADE reports were collected by requiring nurses on five units in a tertiary care facility to select a reason for removing two tracer drugs (dextrose injection 50% [D50] and naloxone) from an automated dispensing system (Medstation 2000, Pyxis, San Diego, CA). The accuracy of the ADE reports during a period of 4.5 months was evaluated through retrospective chart review. The sensitivity, specificity, positive predictive value, and negative predictive value of the reports were calculated. Results. A review of 61 D50 transactions found that the appropriate reason for removal was selected by nursing staff 62% of the time. Twenty-seven transactions were recorded as occurring due to an ADE, and 70% of these were confirmed in the medical record. The sensitivity and specificity of the ADE reports for D50 were 55.9% (95% confidence interval [CI], 39.2-72.6%) and 70.4% (95% CI, 53.2-87.6%), respectively. A review of 32 naloxone transactions found that nurses correctly selected the reason for removal 88% of the time. Twenty-three transactions were recorded as occurring due to an ADE, and 87% of these were confirmed in the medical record. The sensitivity and specificity of the ADE reports for naloxone were 95.2% (95% CI, 86.1-104.4%) and 72.7% (95% CI, 46.4-99.1%), respectively. Conclusion. A Pyxis ADE reporting mechanism using the tracer drugs D50 and naloxone increased the overall reporting of ADEs.

Schneider, P.J., Pedersen, C.A., Montanya, K.R., Curran, C.R., Harpe, S.E., & Bohenek, W. et al. (2006). Improving the safety of medication administration using an interactive CD-ROM program. *American Journal of Health-System Pharmacy,* 63(1), 59-64.

Abstract: Purpose. The impact of an interactive CD-ROM program on the rate of medication administration errors made by nurses was studied. Methods. This randomized, controlled, nonblinded study was conducted at three community hospitals. Study participants included 30 registered nurses who had at least one year of nursing experience in acute care and who worked on medical or medical-surgical units. Nurses were randomized to an intervention group that completed an interactive CD-ROM program on safe medication practices or to a control group. Direct observation was used to determine the baseline (preintervention) and postintervention error rates for both study and control groups. Three categories of errors were defined: deviation from safe administration practices (core 1), preparation and administration errors (core 2), and deviations from prescribed therapy (core 3). An error rate was calculated for each nurse, and the error rates for the study and control groups were based on the average error rate for the nurses in each group. Results. The majority of errors made were core 1 errors. The nurse-level data showed a significant decrease in core 1 error rates between baseline and postintervention periods. Core 2 error rates were higher in the postintervention period, but the increase was not significant. Very few core 3 errors were made by either group during either period. Conclusion. An interactive CD-ROM enabled nurses to apply the information learned to identify errors in medication administration and improved adherence to safe medication administration practices.

Seago, J.A., Williamson, A., & Atwood, C. (2006). Longitudinal analyses of nurse staffing and patient outcomes: More about failure to rescue. *Journal of Nursing Administration,* 36(1), 13-21.

Abstract: Background: Numerous studies have examined cross-sectional data to determine the relationships between nurse staffing and patient outcomes. Questions have been raised about some of the studies now in the literature regarding the use of the hospital as the unit of analysis and the cross-sectional design of the studies. Additionally, there is a concern that the primary outcomes being studied are negative. Objective: Objectives of this study are to (1) compare the relationships between nurse staffing and positive patient outcomes for 3 adult medical-surgical nursing units in one university teaching hospital across 4 years (16 fiscal quarters); and (2) explore the use of 2 new failure-to-rescue (FTR) rates as outcomes, specifically FTR from medication errors and FTR from decubitus ulcers. Design: This study uses secondary analyses of data viewed retrospectively with a longitudinal repeated-measures design to estimate the relationships between nurse staffing and the outcomes of interest. Results: Accounting for total dollars and case mix, all patient satisfaction measures increased as total hours of care per patient day increased, and as the skill mix became richer (more RN hours/total hours) there was a higher satisfaction with pain management and physical care requests. There was an increase in FTR from medication error as the non-RN (Other) hours of care per patient day increased and there was an increase in FTR from decubitus ulcers as patient severity increased. Conclusion: The overall conclusion is that it will likely be necessary to vary staffing hours and staffing mix depending on which positive patient outcome or outcomes you wish to achieve.

Simonson, W., & Feinberg, J.L. (2005). Medication-related problems in the elderly: Defining the issues and identifying solutions. *Drugs and Aging*, 22(7), 559-569.

Abstract: The elderly population is at great risk for medication-related problems as a result of age-related physiological changes, the presence of multiple chronic diseases and conditions, and the types and numbers of prescription and nonprescription medications they consume. Medication-related problems have received international attention. In the US, as many as 200 000 people may die of medication-related problems each year. Studies from other developed nations where patients have access to medications have determined that various types of medication-related problems occur in the elderly population in healthcare environments ranging from nursing homes to community dwelling settings. A variety of initiatives have been developed in an attempt to reduce the likelihood of medication-related problems in the elderly. The role that a pharmacist can play in identifying and preventing the negative health outcomes and costs of medication-related problems is being increasingly recognised. Indeed, numerous studies have now documented the positive impact that pharmacists can have in this area, and ongoing research is being conducted. With the growing numbers of elderly, and the increase in the numbers and types of medications available, it is imperative that awareness of medication-related problems be increased and that further initiatives be developed to optimise the positive outcomes of drug therapy in the elderly.

Taylor, J., A, Brownstein, D, Christakis, D., A, Blackburn, S, Strandjord, T., P, Klein, E., J., & Shafii J. (2004).Use of incident reports by physicians and nurses to document medical errors in pediatric patients. *Pediatrics,*114(3), 729-35.

ABSTRACT: OBJECTIVES: To describe the proportion and types of medical errors that are stated to be reported via incident report systems by physicians and nurses who care for pediatric patients and to determine attitudes about potential interventions for increasing error reports. METHODS: A survey on use of incident reports to document medical errors was sent to a random sample of 200 physicians and nurses at a large children's hospital. Items on the survey included proportion of medical errors that were reported, reasons for underreporting medical errors, and attitudes about potential interventions for increasing error reports. In addition, the survey contained scenarios about hypothetical medical errors; the physicians and nurses were asked how likely they were to report each of the events described. Differences in use of incident reports for documenting medical errors between nurses and physicians were assessed with chi(2) tests. Logistic regression was used to determine the association between health care profession type and likelihood of reporting medical errors. RESULTS: A total of 140 surveys were returned, including 74 from physicians and 66 by nurses. Overall, 34.8% of respondents indicated that they had reported <20% of their perceived medical errors in the previous 12 months, and 32.6% had reported <40% of perceived errors committed by colleagues. After controlling for potentially confounding variables, nurses were significantly more likely to report >or=80% of their own medical errors than physicians (odds ratio: 2.8; 95% confidence interval: 1.3-6.0). Commonly listed reasons for underreporting included lack of certainty about what is considered an error (indicated by 40.7% of respondents) and concerns about implicating others (37%). Potential interventions that would lead to increased reporting included education about which errors should be reported (listed by 65.4% of respondents), feedback on a regular basis about the errors reported (63.8%) and about individual events (51.2%), evidence of system changes because of reports of errors (55.4%), and an electronic format for reports (44.9%). Although virtually all respondents would likely report a 10-fold overdose of morphine leading to respiratory depression in a child, only 31.7% would report an event in which a supply of breast milk is inadvertently connected to a venous catheter but is discovered before any breast milk goes into the catheter. CONCLUSIONS: Medical errors in pediatric patients are significantly underreported in incident report systems, particularly by physicians. Some types of errors are less likely to be reported than others. Information in incident reports is not a representative sample of errors committed in a children's hospital. Specific changes in the incident report system could lead to more reporting by physicians and nurses who care for pediatric patients.

Case Scenario 4.2c: Stroke Rehabilitation

You are a new graduate nurse on a busy 64-bed rehabilitation unit. Your unit has a primary care model of nursing. There are 3 Personal Support Worker's that help with the activities of daily living. It is your 6th month working as a nurse and you are starting to feel more comfortable.

Today your floor is short of two nurses, as 4 nurses have quit in the past month and one nurse called in sick today. As a result your assignment includes a total of 11 patients instead of 8. The nurse in charge tells the staff that two agency nurses will be coming in, but in the meantime provide the best care possible and in a safe manner. Some of the nurses start complaining, stating that "since they change to this model of nursing the unit has deteriorated and any new nurse that knows what's good for them would leave the nursing profession."

As Judy called in sick today, you are assigned to her client Mrs. Heinz. As you walk into Mrs. Heinz's room, the daughter immediately starts asking questions. The daughter tells you that she is a nurse and that she is really concerned about the care her mother has been receiving since she came to this floor. The daughter states:

I told the other nurse yesterday that my mother needs a better mattress as this one is too hard for her and her skin is breaking down around her hip. There also seems to be no one around to help her to the toilet and she ends up wetting herself. She has not been able to hold her urine since the stroke. I am really upset because I told the previous nurse all of this and nothing has been done about it and now I am repeating it again.

After assessing Mrs. Heinz and listening to the daughters concerns, you decide to check Mrs. Heinz chart to come up with a plan of care for her.

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Case Scenario 4.2c: Stroke Rehabilitation
Chart Data

Diagnosis: Left CVA
Gender: Female
Age: 80
Martial status: Widowed
Code Status: Full Code

Past Medical History:
Dementia, Type II Diabetes, mild Congestive Heart Failure (CHF), Atrial Fibrillation, Hypertension and Peripheral Vascular Disease (PVD)
Vital Sign: T= 36.6, P= 62 and irregular, R= 22, BP= 140/80
Medications: NPH insulin 20 units daily, Altace, Digoxin and Coumadin.

Admission Notes:
Mrs. Heinz was transferred from an acute care medicine unit to rehab unit room # 222. Client came to rehab 1 week ago after suffering a stroke. Client is alert and oriented to place but unsure of date and time. Mrs. Heinz had a left CVA that has left her with some residual paralysis on her right side. Prior to her stroke, she was admitted with newly diagnosed dementia.

Admission Plan
   1. Start Stroke rehab pathway

Physiotherapist Notes:
Client able to transfer from chair to bed with assistance with a front wheel walker. Needs one person to help transfer from bed to chair. Was able to walk 3 meters today with walker then became short of breath. Oxygen saturation at 94%, no oxygen required.
Physiotherapy Plan Continue with present schedule; try a 3 meter walk tomorrow.
Encourage client to use walker for transfers

OT Notes:
Diet: No swallowing difficulties noted. Client is right handed, which is affected by her stroke. Having some difficulty in using left hand to feed self. Spills her food and expresses embarrassment such as "feeling like a baby again."
OT Plan Encourage and support client with eating as independently as possible. Offer client assistance prn.

Social Worker: Family would like to meet with physician to discuss discharge plans. They are very concerned about their mother returning home. Family requested information on nursing home options for their mother. They state that even if she does recuperate from this stroke, she is still forgetful and would not be safe at home.
Social Worker Plan Arrange a multi-disciplinary meeting. Provide a list of nursing homes options to the family.

Judy's Nurse's notes: Daughter called nurse into room and stated that she was trying to call someone to help her mom to the bathroom and no one came. Daughter reassured. Nurse helped client to commode. Daughter stated that client's bed is too hard and is causing a skin breakdown on her hip. Nurse to conduct a skin assessment, will arrange for new mattress.

Case Scenario 4.2c: Stroke Rehabilitation References

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Case Scenario 4.2c: Stroke Rehabilitation

Additional Tutor Information

Concepts to be addressed in this case: Examples of trigger/discussion questions

Nursing shortage
- Explore if there is a current nursing shortage in Canada? If so, what are the consequences to society?
- What are some of the causes for this shortage?
- What is the history of nursing shortage in Canada?
- Do you have any suggestions to decrease the shortage?

Role stress/strain
- What are the various stressors involved in the nursing role?

Primary care model of nursing
- What is a primary care model of nursing?
- What are the pro's and con's of this model?

Other nursing models of care
- Explore other nursing models of care.

Stroke and rehabilitation
- What is a stroke?
- What plan of care would you see for a stroke client in a rehab unit?
- What would a stroke pathway look like?

BPG's

Ulcer prevention/Promoting continence/Client centred care
- Explore the client's daughter justification in requesting another mattress for her mother?
- Explore the RNAO BPG guidelines in relation to client's incontinence, and ulcer prevention and suggest recommendations that you might consider using.
- What is client centred care?
- Explore client centred care as it relates to this case.

Decision Support: Home versus nursing care facility
- What are the options for Mrs. Heinz regarding home versus other nursing care facility?
- How could the nurse provide decision support to this client and her family in making this decision?

Decision aid for home versus nursing care facility
- Is there a decision aid that could help this client and family make an informed decision regarding home versus a nursing care facility?

Integrating Evidence-based Patient Decision Support in Nursing Curriculum

Case Scenario 4.2c: Stroke Rehabilitation

Faculty Resources

Budd, K.W., Warino, L.S., and Patton, M.E. (2004). Traditional and non-traditional collective bargaining: strategies to improve the patient care environment. *Journal of issues in nursing,* 9(1), 9.

Abstract: Acquiring organizational autonomy and control over nursing practice, through a combination of traditional and non-traditional collective bargaining (CB) strategies, is emerging as an important solution to the nursing shortage crisis. For the past 60 years, nurses have improved their economic and general welfare by organizing through traditional CB, particularly during periods of nursing shortages. During the past decade, however, the downsizing of nursing staffs, systems redesign, and oppressive management practices have created such poor nursing practice environments that improvement in wages no longer is viewed as the primary purpose of CB. Much more essential to nurses is assuring they have a safe practice environment free of mandatory overtime and other work issues, and a voice in the resource allocation decisions that affect their ability to achieve quality health outcomes for patients. The thesis presented in this article is that traditional and non-traditional CB strategies empower nurses to find such a voice and gain control over nursing practice. This article describes the current shortage; discusses how CB can be used to help nurses find a voice to effect change; reviews the American Nurses Association's (ANA's) history of collective action activities; explains differences between traditional and non-traditional CB strategies; and presents a case study in which both strategies were used to improve the present patient care environment.

Cullum, N., McInnes, E., Bell-Syer, S.E., and Legood, R. (2004). Support surfaces for pressure ulcer prevention Cochrane database of systematic reviews (Online: Update Software), 3, CD001735

Abstract: BACKGROUND: Pressure ulcers (also known as bedsores, pressure sores, decubitus ulcers) are areas of localised damage to the skin and underlying tissue due to pressure, shear or friction. They are common in the elderly and immobile and costly in financial and human terms. Pressure-relieving beds, mattresses and seat cushions are widely used as aids to prevention in both institutional and non-institutional settings. OBJECTIVES: This systematic review seeks to answer the following questions: to what extent do pressure-relieving cushions, beds, mattress overlays and mattress replacements reduce the incidence of pressure ulcers compared with standard support surfaces? how effective are different pressure-relieving surfaces in preventing pressure ulcers, compared to one another? SEARCH STRATEGY: The Specialised Trials Register of the Cochrane Wounds Group (compiled from regular searches of many electronic databases including MEDLINE, CINAHL and EMBASE plus handsearching of specialist journals and conference proceedings) was searched up to January 2004, Issue 3, 2004 of the Cochrane Central Register of Controlled Trials was also searched. The reference sections of included studies were searched for further trials. SELECTION CRITERIA: Randomised controlled trials (RCTs), published or unpublished, which assessed the effectiveness of beds, mattresses, mattress overlays, and seating cushions for the prevention of pressure ulcers, in any patient group, in any setting. RCTs were eligible for inclusion if they reported an objective, clinical outcome measure such as incidence and severity of new of pressure ulcers developed. Studies which only reported proxy outcome measures such as interface pressure were excluded. DATA COLLECTION AND ANALYSIS: Trial data were extracted by one researcher and checked by a second. The results from each study are presented as relative risk for dichotomous variables. Where deemed appropriate, similar studies were pooled in a meta analysis. MAIN RESULTS: 41 RCTs were included in the review.Foam alternatives to the standard hospital foam mattress can reduce the incidence of pressure ulcers in people at risk. The relative merits of alternating and constant low pressure devices, and of the different alternating pressure devices for pressure ulcer prevention are unclear.Pressure-relieving overlays on the operating table have been shown to reduce postoperative pressure ulcer incidence, although one study indicated that an overlay resulted in adverse skin changes. One trial indicated that Australian standard medical sheepskins prevented pressure ulcers. There is insufficient evidence to draw conclusions on the value of seat cushions, limb protectors and various constant low pressure devices as pressure ulcer prevention strategies.A study of Accident & Emergency trolley overlays did not identify a reduction in pressure ulcer incidence. There are tentative indications that foot waffle heel elevators, a particular low air loss hydrotherapy mattress and an operating theatre overlay are harmful. REVIEWERS' CONCLUSIONS: In people at high risk of pressure ulcer development, consideration should be given to the use of higher specification foam mattresses rather than standard hospital foam mattresses. The relative merits of higher-tech constant low pressure and alternating pressure for prevention are unclear. Organisations might consider the use of pressure relief for high risk patients in the operating theatre, as this is associated with a reduction in post-operative incidence of pressure ulcers. Seat cushions and overlays designed for use in Accident & Emergency settings have not been adequately evaluated.

Eustice, S., Roe, B., and Paterson, J. (2002). Prompted voiding for the management of urinary incontinence in adults. *Cochrane*, 2, CD002113.

Abstract: BACKGROUND: Prompted voiding is a behavioural therapy used mainly in North American nursing homes. It aims to improve bladder control for people with or without dementia using verbal prompts and positive reinforcement. OBJECTIVES: To assess the effects of prompted voiding for the management of urinary incontinence in adults. SEARCH STRATEGY: We searched the Cochrane Incontinence Group trials register (to February 2000) and reference lists of relevant articles. We contacted investigators in the field to locate extra studies. Date of the most recent searches: February 2000. SELECTION CRITERIA: All randomised or quasi-randomised trials which addressed prompted voiding

for the management of urinary incontinence. The trials included adult men and women, with or without cognitive impairment, diagnosed as having urinary incontinence as identified by the trialists, either by symptom classification or by urodynamic investigation. DATA COLLECTION AND ANALYSIS: The identified reports were assessed for eligibility. Two reviewers independently reviewed the selected studies for methodological quality. Data describing six pre-specified outcomes were extracted independently by each reviewer and consensus reached when there was disagreement. Trial investigators were consulted when clarification or further detail was required. A third reviewer was recruited to proof read the review at different stages. MAIN RESULTS: Five trials were included in the review. These involved 355 elderly people, most of whom were women. One other trial was excluded because no relevant outcome data were reported, and one trial is awaiting assessment. Prompted voiding was compared with no prompted voiding in four trials. The limited evidence suggested that prompted voiding increased self-initiated voiding and decreased incontinent episodes in the short-term. There was no evidence about long-term effects. A single small trial suggested that adding the muscle relaxant, Oxybutinin, reduced the number of incontinent episodes in the short-term: This study used a cross-over design and so did not address long-term effects. REVIEWER'S CONCLUSIONS: There was insufficient evidence to reach firm conclusions for practice. There was suggestive, although inconclusive, evidence of short-term benefit from prompted voiding and from adding the muscle relaxant, Oxybutinin to prompted voiding.

Florin, J., Ehrenberg, A., Ehnfors, and M. (2005). Patients' and nurses' perceptions of nursing problems in an acute care setting. *Journal of Advanced Nursing*, 51(2), 140-149.

Abstract: Aim. This paper reports a study to determine the degree of agreement or disagreement between nurses and patients in their perceptions of the presence, severity, and importance of nursing problems. Background. Patient experiences, values and preferences are increasingly acknowledged as important factors underpinning healthcare decision-making. The ability to identify patient problems accurately is an important prerequisite for planning and implementing individualized high quality care. Methods. A convenience sample of patients (n = 80) and Registered Nurses (n = 30) in an acute care setting responded to a 43-item questionnaire. Findings. Nurses identified patients' problems with a sensitivity of 0-53 and a positive predictive value of 0-50. Patients identified several severe problems that were not identified by nurses, particularly problems with nutrition, sleep, pain, and emotions/spirituality. Nurses underestimated the severity in 47% of mutually-identified problems. An overall level of agreement of 44% was found on the importance of patient problems. Low levels of agreement on severity and importance were related more to individual differences than to systematic differences. Conclusions. Nurses need to be more aware that patients and nurses often hold disparate views of the priorities in nursing care. To plan individualized nursing care effectively, nurses need to elicit and use individual patients' preferences more systematically in care planning.

Giaquinto, S. (2005). Do nurses exercise power in rehabilitation wards? *Europa Medicophysica*, 41(2), 141-147.

Abstract: Aim. Nowadays, there is a change in nursing policy. The nurse-centred model is shifting to the patient-centred model. Decision-making is therefore transferred to the customer (Power to the Patient). Data from literature mainly deals with acute care and long-term care facilities. The aim of the study was to evaluate whether: i) a nurse-centred model is still effective in rehabilitation wards; ii) patients' dignity is nevertheless considered; iii) nurses experience role satisfaction in a rehabilitation setting. Methods. A cross-sectional design was applied. Forty-eight nurses of our rehabilitation centre were invited to compile -in an anonymous way- a questionnaire developed by Finnish researchers from both acute care and geriatric units. More questions dealt with personal data. Results. The sum of variables describing the nurses' exercise of power showed that power was most commonly exercised in obligatory daily activities. Power was less in activities necessitated by obligatory daily activities and in voluntary activities. Nurses' power was due to the necessity of organising the individual rehabilitation programs, which are tailored for each patient and require the observance of time-schedules. Nevertheless, patients had a say in many choices and their dignity was maintained. The nurses also answered that work in rehabilitation wards was more stressful than in both medical or surgical acute care. A third of them felt themselves not involved in the rehabilitation of the patients. Conclusion. The exercise of power is not a negative phenomenon in situations requiring safety, control, quick decisions, coping with time-contingencies, as it daily happens in rehabilitation wards. However, subject's dignity is compatible with that exercise of power. Rehabilitation staff should be aware of the nurse role, which can be only partially perceived. Better communication between nurses and other components of the rehabilitative staff would improve self-esteem and hasten motivation. Apparently, when the association between the "experience" variable and the sum variable was considered, it was found that the group of low clinical experience believed that power was exercised more often.

Healthwise® Knowledgebase. http://www.healthlinkbc.ca/kb/content/special/zp3369.html

Holroyd-Leduc, J.M., and Straus, S.E. (2004). Management of Urinary Incontinence in Women: Scientific Review. *Journal of the American Medical Association,* 291(8), 986-995

Abstract: Context: Urinary incontinence is a common health problem among women that negatively impacts quality of life. Therefore, it is important that primary care physicians have an understanding of how to manage urinary incontinence effectively. Objective: To review the most recent, high-quality evidence regarding the etiology and management of urinary incontinence in women. Data Sources and Study Selection: Searches of MEDLINE, EMBASE, The Cochrane Library, and the ACP Journal Club were performed to identify English-language articles published between 1998-2003 that focused on the etiology or treatment of urinary incontinence in adult women. The references of each retrieved article were reviewed and an expert in the field was contacted to identify additional relevant articles. Data Extraction: Using a combination of more than 80 search terms, we included articles of etiology that were cohort studies, case-control studies, cross-sectional studies, or systematic reviews of cohort, case-control, and/or cross-sectional studies. Studies of treatment had to be randomized controlled trials or systematic reviews of randomized controlled trials. The quality of each article was assessed independently by each author and inclusion (n = 66) was determined by

consensus. Data Synthesis: Multiple factors have been found to be associated with urinary incontinence, some of which are amenable to modification. Factors associated with incontinence include age, white race, higher educational attainment, pregnancy-related factors, gynecological factors, urological and gastrointestinal tract factors, comorbid diseases, higher body mass index, medications, smoking, caffeine, and functional impairment. There are several effective nonpharmacological treatments including pelvic floor muscle training, electrical stimulation, bladder training, and prompted voiding. Anticholinergic drugs are effective in the treatment of urge urinary incontinence. Several surgical interventions are effective in the management of stress incontinence, including open retropubic colposuspension and suburethral sling procedure. Conclusion: Urinary incontinence in women is an important public health concern, and effective treatment options exist.

Jacobs, B.B., Fontana, J.S., Kehoe, M.H. Matarese, C., and Chinn, P.L. (2005). An emancipatory view of nursing practice. *Nursing Outlook*, 53(1), 6-14.

Abstract: Changes in health care facilities have created the necessity for individual nurses to change, eg, change jobs, pursue additional education, become independent entrepreneurs. There is a shortage of nurses that places stress on those who remain to care for an increasing number of persons with too few resources. The purposes of this study were to explore nurses' perceptions of the circumstances of their work lives and to describe the processes by which they can create change in these circumstances. The methodology was an emancipatory design combining tenets of critical inquiry and feminist research. The method used was a dialectical process of reflection and action (praxis). Three diverse groups of nurses met weekly over 6-10 weeks. Using the group process method, each group reflected on, discussed, and analyzed the phenomenon of practicing nursing today. The outcome of an emancipatory study is reflected in the power of the process. The group interaction increased awareness, promoted reflection on the status quo, and energized the groups to derive possible solutions to changing that status quo. It is not the solutions themselves that are as relevant as is the obvious cogency of the process to achieve individual and group emancipation. Six codifications reflected the themes that emerged and 5 processes for exploring untested feasibilities for change were identified. The participants perceived themselves more as subjects in their history than objects to be manipulated, capable of transforming a rather dismal situation of nursing practice into one that was critical, creative, and freer from constraints. The implication of this study is that nurses are encouraged to adopt and adapt this process of group interaction because of its demonstrated credibility to empower and validate the role that nurses have to derive and implement solutions to change their unsatisfactory status quo.

Jones, M., O'Neill, P., Waterman, H., and Webb, C. (1997). Building a relationship: Communications and relationships between staff and stroke patients on a rehabilitation ward. *Journal of Advanced Nursing*, 26(1), 101-110.

Abstract: Communications among staff and patients on a stroke rehabilitation ward form the focus of this article, which reports on some aspects of a larger study using a grounded theory approach. Tape-recorded interviews were transcribed and analysed concurrently according to recommendations for the approach. A main theme entitled building a relationship was identified, and this process was found to occur in a context varying from participative at one end of a continuum to hierarchical at the other. Building a relationship was found to be influenced by role, personal qualities and organizational context. Appropriate relationships between role-holders were subject to negotiation, leading to a resulting congruence or incongruence between participants' expectations of each other and their roles. Personal qualities were brought into play in the process, with patients' views of staff and staff views of patients both being influential. Some of these views seemed to parallel what has been described in earlier literature as 'the sick role' and the labelling of patients as 'good' or 'bad'. Responses to personal qualities led to nurses ascribing meaning to patients' behaviour in terms of adjustment to their stroke, giving time to them to help them to adjust, and withdrawal and handing over to other staff if this strategy failed. Organizational context also had an influence on building a relationship, with time constraints being identified particularly by nurses, and the need to fit in the most essential aspects of care. Place was also important, in that nurses were confined to the ward as a work location, whereas other therapists and doctors worked in other places and sometimes had the facility to take patients off the ward to concentrate on therapy. The findings are discussed against the background of related literature and the conclusion is drawn that the crucial role of nurses in rehabilitation is not recognized and valued, and that shortages of resources - especially suitably qualified and trained nursing staff - are a negative influence on building the relationships which are vital to successful rehabilitation.

Making Choices: Care at Home or Admission to a Care Facility,
http://decisionaid.ohri.ca/decaids.html

McKevitt, C., Redfern, J., Mold, F., and Wolfe, C. Qualitative studies of stroke: A systematic review. *Stroke*, 35(6), 1499-1505.

Abstract: Background and Purpose-Qualitative studies are increasingly used to investigate social processes and phenomena influencing health behaviors and service provision. We aimed to identify the scope of published qualitative studies of stroke, consider their relevance to development and delivery of services for people with stroke, and make recommendations for future work. Methods-Literature review of published articles was identified by systematically searching online literature databases using keywords from the start of each database until 2002. Articles were reviewed by 2 authors, using a standardized matrix for data extraction. The 2003 European Stroke Initiative recommendations for stroke management were used to categorize the literature for consideration of its contribution to stroke research. Results-We included 95 articles. Their empirical contribution includes an emphasis on recording the "human" experience of stroke; identification of needs as perceived by patients and their families, differences in priorities between patients and professionals, and barriers to best-quality care. We identified 12 papers that were specifically undertaken to develop or evaluate interventions. Conclusions-Qualitative studies have addressed a wide range of issues related to the impact of stroke on individuals and caregivers, and to the organization and delivery of services. Significant problems

remain in ensuring the delivery of best-quality stroke care, which such studies have the potential to address. Maximizing this potential requires greater collaboration between nonclinical and clinical scientists, service providers, and users to formulate research questions of interest as well as new research strategies, such as meta-analysis, to pool qualitative research findings and multisited investigations.

Østbye, T., Hunskaar, S., and Sykes, E. (2002). Predictors and incidence of urinary incontinence in elderly Canadians with and without dementia - A five-year follow up: The Canadian Study of Health and Aging. *Canadian Journal on Aging,* 21 (1), 95-102.

Abstract: Based on the national Canadian Study of Health and Aging, the objective of this study was to determine the importance of socio-demographic and medical factors, cognitive and functional status as predictors of the development of urinary incontinence, and to estimate five-year incidence by sex and age group. Participants from the Canadian Study of Health and Aging who underwent a clinical examination in 1992 and were continent for urine at the time were followed up and their continence status was again determined in 1997. Multivariate logistic regression models with daily incontinence and daily or less than daily incontinence as the outcomes were developed separately for male (n = 306) and female (n = 520) survivors. Predictor variables were introduced in the following chunks: socio-demographic factors; cognitive status; functional status, diabetes and stroke. Five-year cumulative incidence of daily and less than daily incontinence by sex and age group was also estimated. Results indicated that the incidence of urinary incontinence was higher in women than in men, and increased by age in both men and women. Especially among men, those in institutions were much more likely to develop urinary incontinence than those in the community. Incontinence increased dramatically with severity of dementia, less so with physical immobility. Diabetes mellitus was related to the development incontinence in men but not in women, prior stroke was related to development of incontinence in both sexes. It is concluded that urinary incontinence is common in older persons, and enquiries about its presence should be part of routine medical and nursing assessment of older persons. Those who develop incontinence commonly have dementia and are physically impaired. The extent of assessment and management should be carefully tailored to each individual patient.

Registered Nurses Association of Ontario (2006). *Client centred care.* Toronto, Canada: Registered Nurses Association of Ontario.

Registered Nurses Association of Ontario (2005). *Prompted continence using prompted voiding.* Toronto, Canada: Registered Nurses Association of Ontario.

Registered Nurses Association of Ontario (2005). *Ulcer prevention.* Toronto, Canada: Registered Nurses Association of Ontario.

Rideout, E. (2001). *Transforming nursing education through Problem-Based Learning.* Mississauga, ON: Jones and Bartlett.

Swanson, J.G., Skelly, J., Hutchison, B., and Kaczorowski, J. (2002). Urinary incontinence in Canada. National survey of family physician's knowledge, attitudes, and practice. *Canadian Family Physician*, 48, 86-92.

Abstract: Objective. To determine current knowledge, attitudes, and management of urinary incontinence among family physicians in Canada. Design. Cross-sectional mailed survey. Setting. Family physicians in Canada. Participants. A random sample of 1500 members of the College of Family Physicians of Canada. Main Outcome Measures. Self-assessed knowledge, self-reported attitudes, and rating of various tests and treatments in the investigation and management of incontinence. Results. The overall unadjusted response rate was 43.3% (650/1500). Although most respondents reported that urinary incontinence was common in their practices, less than half (46.0%, 284/617) indicated that they clearly understood incontinence and just 37.9% (232/612) had an organized plan for incontinence problems. Only 35.0% (214/612) of respondents felt very comfortable dealing with incontinence. Physical examination, urodynamic studies, urinalysis, and testing blood sugar levels were all considered important investigations by more than 90% of respondents. Conclusion. There are wide variations in knowledge, attitudes, practices, and comfort level among family physicians dealing with urinary incontinence.

Woodbury, M.G., and Houghton, P.E. (2004). Prevalence of pressure ulcers in Canadian healthcare settings. *Ostomy/wound management*, 50(10), 22-24, 26, 28, 30, 32, 34, 36-38

Abstract: Although statistics regarding the number of pressure ulcers in the US and other countries are available, little information is known about the number of individuals in Canada who have pressure ulcers. Such information is important to assess the scope and healthcare costs of pressure ulcers and develop public policies. To obtain estimated pressure ulcer prevalence rates in Canada, existing data (gathered between 1990 and 2003) from different healthcare settings across the country

were obtained from peer-reviewed published studies and from unpublished studies provided by individuals and pressure ulcer support surface manufacturers. Methods used to gather and report prevalence data in each study were critically appraised using a modified version of published criteria. Retrospective chart audit studies that did not involve direct patient assessment were excluded. The data included information from 18 acute care facilities involving 4,831 patients, 23 non-acute care facilities with 3,390 patients, 19 mixed healthcare settings with 4,200 patients, and five community care agencies that surveyed 1,681 patients. Estimates of pressure ulcer prevalence were 25.1% (95% Confidence Interval, 23.8% to 26.3%) for acute care settings, 29.9% (95% Confidence Interval, 28.3% to 31.4%) in non-acute care settings, 22.1% (95% Confidence Interval, 20.9% to 23.4%) in mixed health settings, and 15.1% (95% Confidence Interval, 13.4% to 16.8%) in community care. The overall estimate of the prevalence of pressure ulcers in all healthcare institutions across Canada was 26.0% (95% Confidence Interval, 25.2% to 26.8%). The Canadian prevalence estimates differed among the healthcare settings and were higher than those reported in the US and the Netherlands. Although additional studies are needed, the data suggest that pressure ulcers are a significant concern in all healthcare settings in Canada.