Creating a Culture of Inquiry How to Make it Doable

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For you –
Is clinical inquiry something to do or a way of being?

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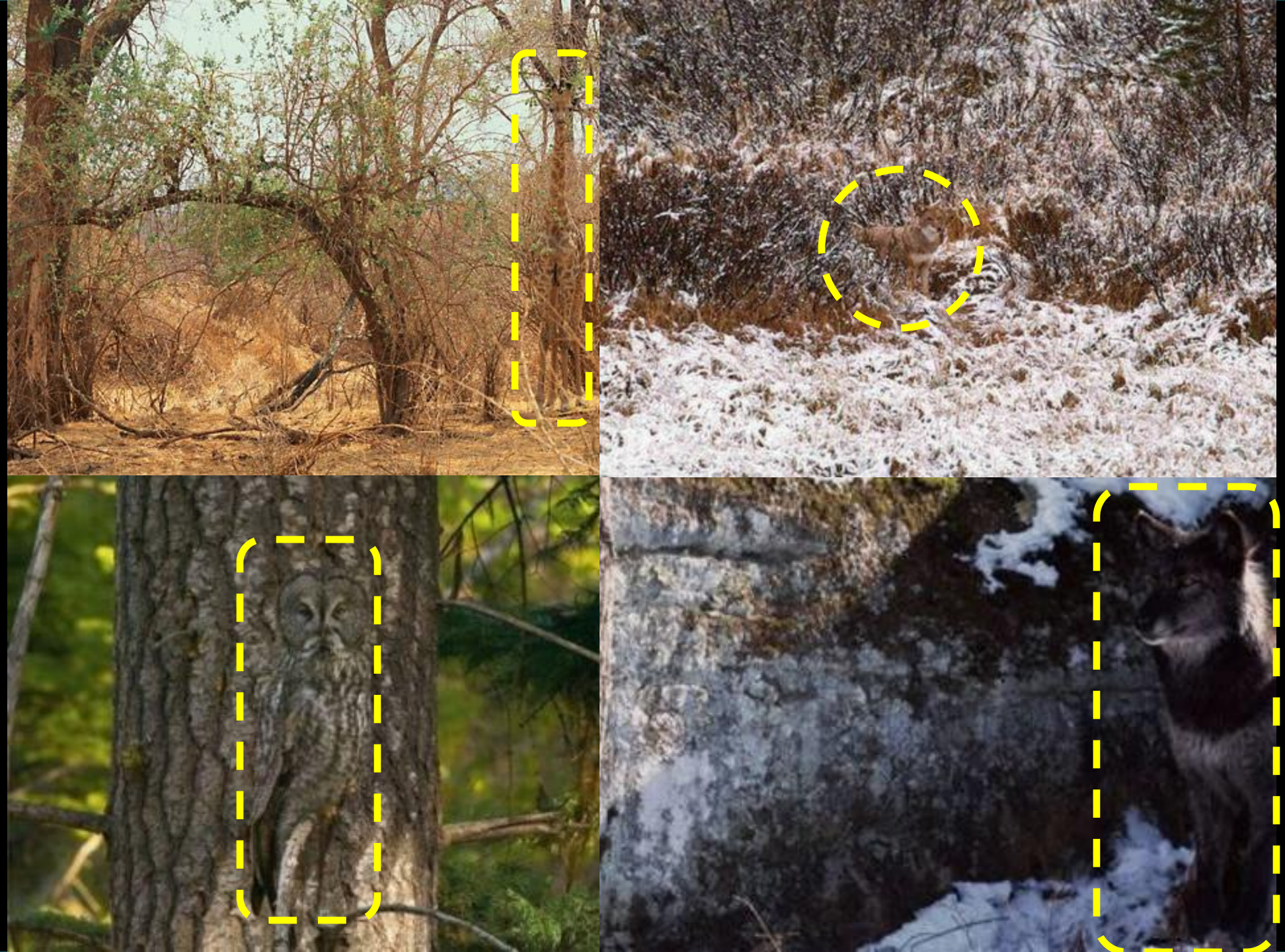
Culture of inquiry: the shared expectations, goals and practices, and structures woven through exemplary practice and professionalism that support and advance clinical inquiry
Clinical inquiry: The ongoing process of questioning and evaluating practice and providing informed practice; the creation of practice change through research, evidence-based practice and experiential learning (modified from AACN)
• Ongoing and iterative process of questioning and evaluating practice • Providing care informed by the best available evidence • Creating practice change through research and evidence-based practice • Building capacity and expectation for nurses to actively lead and participate in clinical inquiry
Assumptions • Inextricably woven through our patient/family care and professional practice • Requires that all nurses in the organization have a leadership role • Recognizes the various uses of research and evidence (instrumental, conceptual, symbolic)

Start with the End in Mind

What is the difference you want to make?



What difference has the availability of EBP tools and resources made for you or your organization?

Symbolic/Instrumental/Persuasive Use

- **Used evidence** to lobby for change or inform a specific action
- **Outcomes/Audit results**
- **Legitimize pre-existing views (±)**

Conceptual Use

- **Desire** to continue to consider improvements to the fundamental aspects of nursing care
- **Personal and professional developments**
- **Increased morale, sense of team** (from working together to learn more about evidence use or think about practice provision)
- Improvements to knowledge and **understanding** evidence for practice
- **Increased confidence** in accessing evidence for practice

Wilkinson Impacts of evidence use- hard hitting or subtle change. Worldviews on Evidence-based Nursing, 2010
Nutley SM, et al. Using Evidence: How Research Can Inform Public Services (Ebook)

Importance of Conceptual Use

mental use or outcomes. However, these conceptual uses clearly have a wider reach in the longer term. For some staff, the longer term was actually quite short, and they moved on quickly to use evidence to change practice; their confidence in understanding EBP led to them accessing evidence and translating this into change to practice in a short space of time. For others, this was a first ever opportunity to use evidence to lobby for change (persuasive or symbolic use). Or at least to begin the negotiations at team or organizational levels, which were a necessary first step to highlighting the need for a change to current service delivery modes or provision.

Wilkinson Impacts of evidence use- hard hitting or subtle change. Worldviews on Evidence-based Nursing, 2010

A Multidisciplinary Approach To A Backbreaking Problem In Interventional Cardiology

Sue Hansen, MSN, RN[1], Sandeep K. Krishnan, MD[2], Frances Wang, MS[3]

[1]University of Washington Medical Center

[2]St. John Medical Center

[3]Johns Hopkins University

University of Washington Medical Center, Seattle, Washington

Clinical Issue

- Percutaneous coronary interventional (PCI) procedures are expected to grow by 27% within 7 years
- Insufficient evidence supporting & defining optimal bedrest duration following PCI

WE KNOW THAT:

- Prolonged bedrest contributes to an increase in back pain and a decrease in patient satisfaction
- Shortened bedrest may increase a patient's risk of vascular complications

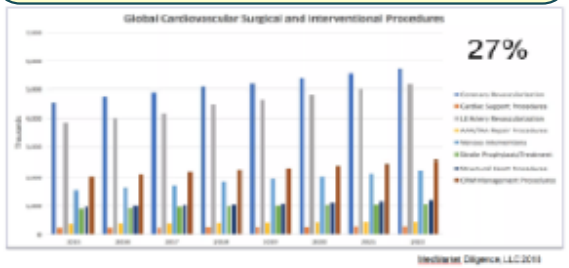


Figure 1. Global growth of cardiovascular procedures

Objectives

- To assess the effects of reducing bedrest duration after trans-femoral catheterization on pain, urinary retention, patient satisfaction, bleeding and hematoma incidence, post procedure opioid use, & patient satisfaction
- Create a standardized approach to bedrest duration following trans-femoral catheterization

Smart AIM

Reduce the amount of back pain associated with strict bedrest by 20% within 6 months of implementing a standard 2 hour bedrest period following trans-femoral catheterization for PCI.

Methods

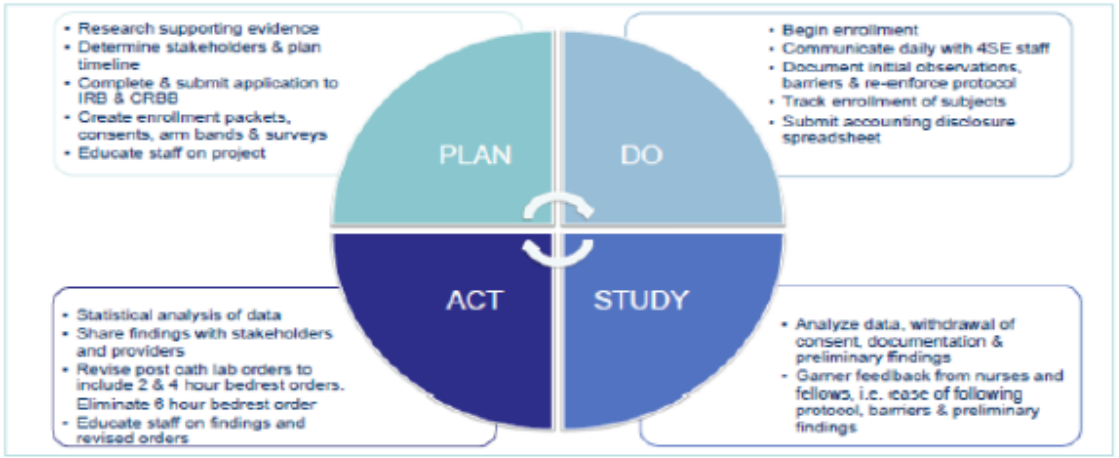


Figure 2. PDSA Cycle

Study Design

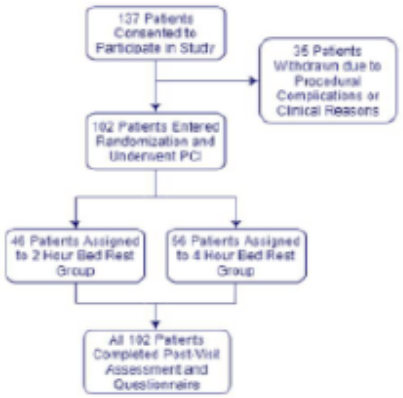


Figure 3. Randomized Bedrest Duration Study Design

Results

Table 1. Outcomes Comparison between Patients Undergoing 2 and 4 Hours Post-Catheterization Bedrest

	2 Hours Bedrest (n=46)	4 Hours Bedrest (n=56)	p
Backpain Rating during Bedrest (%)			0.779
1	11 (25.6)	15 (27.8)	
2	8 (18.6)	8 (14.8)	
3	3 (7.0)	8 (14.8)	
4	7 (16.3)	7 (13.0)	
5	14 (32.6)	16 (29.6)	
Medicines Requested for Back pain (%)	39 (85.0)	32 (57.1)	0.469
Back pain Reduced after Bedrest (%)			0.364
1	7 (17.5)	7 (14.6)	
2	0 (0.0)	3 (6.4)	
3	4 (10.0)	2 (4.3)	
4	9 (22.5)	7 (14.6)	
5	20 (50.0)	28 (59.6)	
Urinary Pain during Bedrest (%)			0.167
1	20 (54.1)	19 (34.6)	
2	4 (10.8)	6 (11.5)	
3	5 (8.1)	15 (35.0)	
4	2 (5.4)	6 (11.5)	
5	8 (21.6)	9 (17.3)	
Staff Reported Bleeding (%)	4 (20.0)	12 (33.3)	0.006
Bleeding Symptoms after Ambulation (%)	0 (0.0)	1 (1.8)	1

** Count and proportions reported are based on non-missing observations for each respective variable.

Conclusions

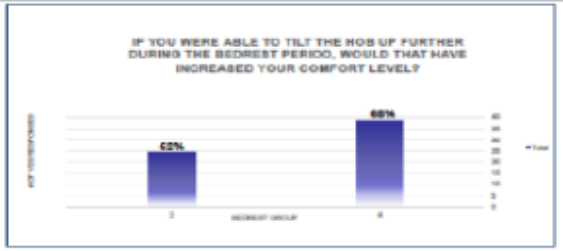


Figure 4. Patient survey question # 9

- There are no statistical differences between the 2 and 4 hour bedrest groups **(Table 1.)**
- Patients do believe that if they could have their HOB up further, it would reduce the degree of back pain they experience **(Figure 4.)**
- Patients on the 2 hour bedrest period are not at greater risk for vascular complications as compared to the 4 hour bedrest group **(Table 1.)**
- Early mobilization after PCI is safe, decreases patients' pain after bedrest, improves patient satisfaction and does not increase risk of vascular complications
- The limitation of this study was insufficient time which contributed to inadequate sample size and generalizability

Acknowledgments

The authors would like the thank the University of Washington Medical Center and Seattle Children's Certificate in Patient Safety in Quality Program for their mentorship and guidance on this project. We would also like to thank those below:

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- Kate Kearny, MD, Interventional Cardiology Fellow
- Christina Tan, MD, Interventional Cardiology Fellow
- 4SE Nurses-Special Procedures Unit

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UW Medicine
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Engaging Registered Nurses in Back-Breaking Research to Improve Patient Care

Authors: Wirt, A., Speckhardt, E., Abbott, S., Bergquist, B., Billman, J., Burns, J., Kim, D., Loechl, A., Zajac, E.

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Purpose

- Participate in clinical research project for assessing shortened bedrest time on patients who have undergone percutaneous coronary intervention (PCI)
- Evaluate the bedside nursing perspective on study participation and effect on clinical practice

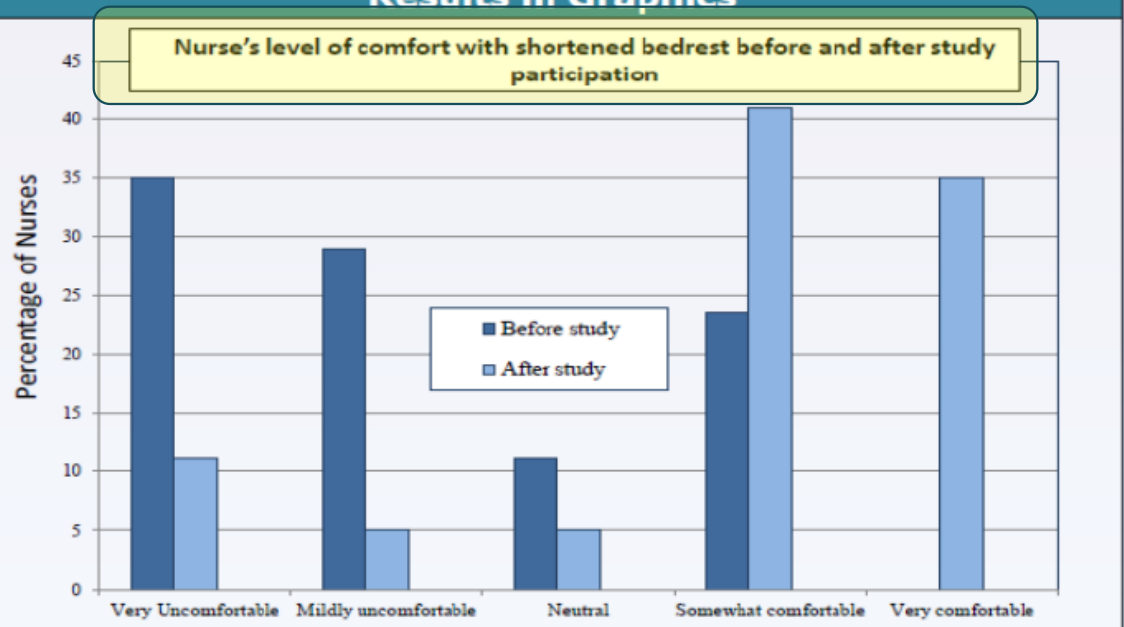
Relevance

- Prior to this study, all patients post PCI were placed on 6 hour bedrest time
- Researchers proposed shortened bedrest times of 2 hours or 4 hours

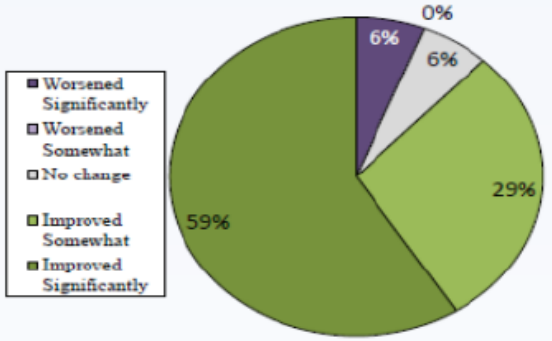
Strategy and Implementation

- Femoral arterial sheaths were removed by 4SE RNs
- 102 patients between September 2017 – April 2018 participated
- All patients were surveyed after bedrest and nurses documented all study factors in medical record for data abstraction
- Nurses were surveyed retrospectively on comfort level with 2 hour bedrest pre and post research participation and how the research impacted the RN-patient relationship

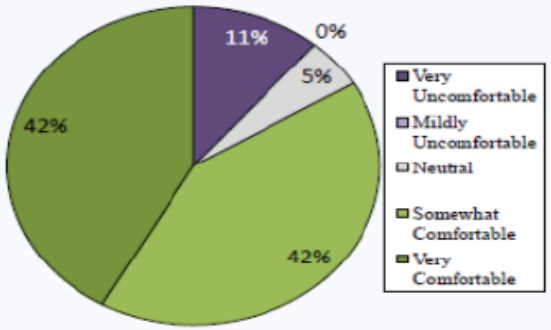
Results in Graphics



How did shortened bedrest time impact the RN-patient relationship?



How comfortable are you participating in research now?



Evaluation

- Prior to the bedrest study, 64% of RNs felt uncomfortable with a 2 hour bedrest time
- Post bedrest study, 76% of RNs are comfortable with 2 hours bedrest time
- Patient participants in the 2 hour bedrest group reported less pain and an improved RN relationship
- Majority (88%) of RNs felt that the patient relationship was improved with 2 hour bedrest

Implications for Practice

- Shortened bedrest time improves RN-patient relationships
- Nurses are more comfortable with a 2 hour bedrest time
- 4SE RNs have more confidence to participate in future research studies

Limitations:

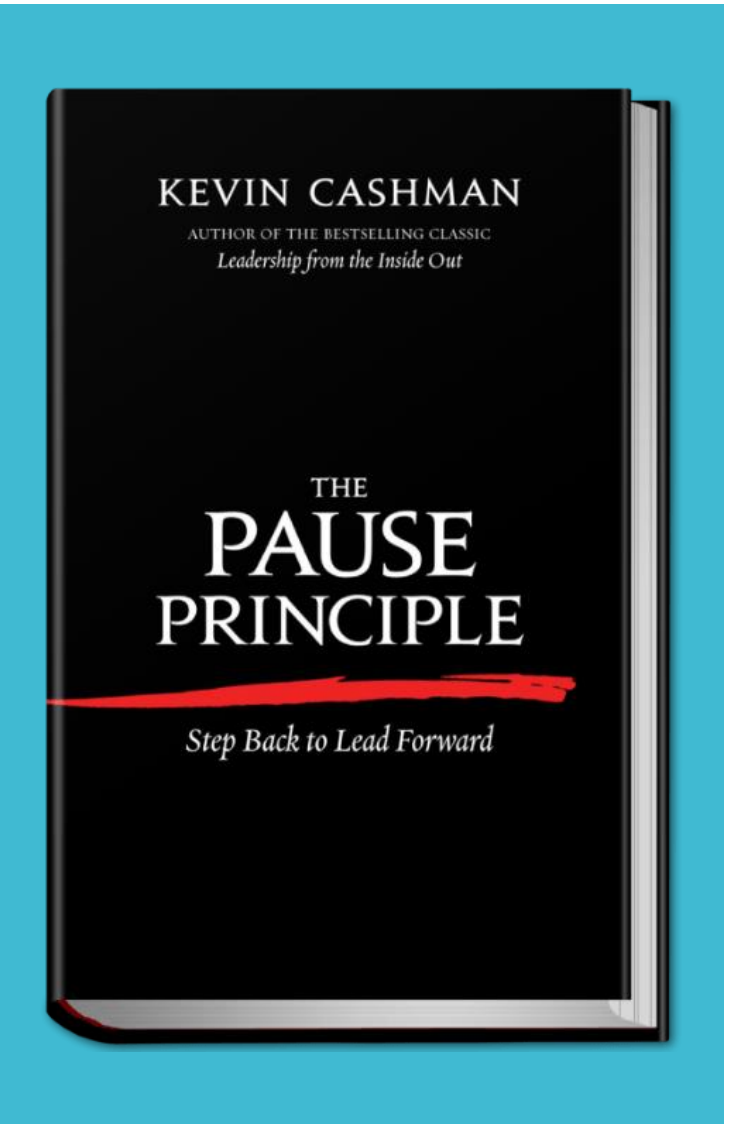
- Specific medical record documentation was not explicitly explained prior to beginning the study
- RN survey was retrospective

How confident are you in presenting your work?

How confident are you in engaging with a presenter?

1 = Not Confident 2 = Somewhat Confident; 3 = Confident; 4 = Very Confident

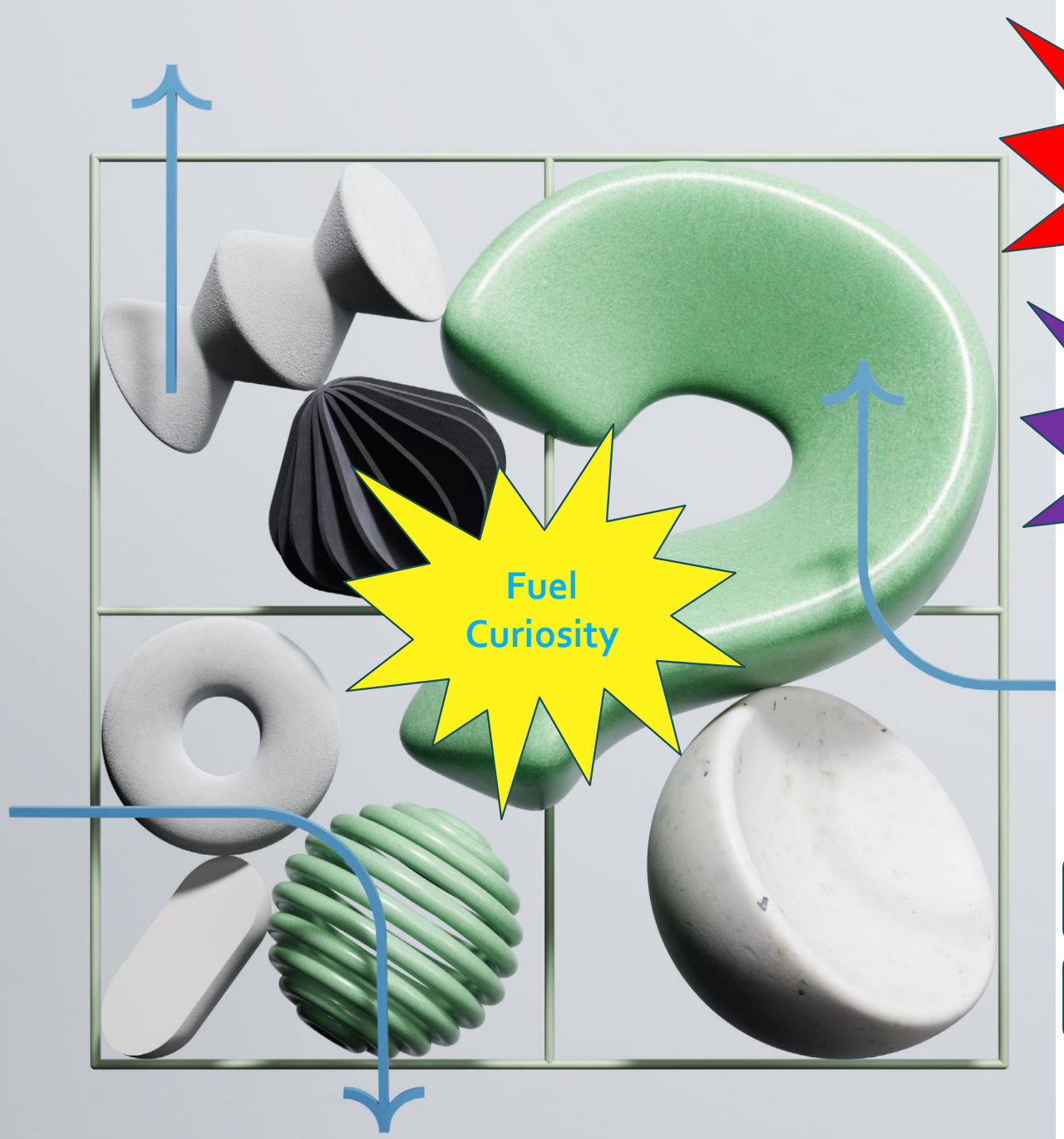

• Here is wha
f problem)
m statement)
outcomes)
• Here is what we
2 minu
• Here
• Here is what we are going
POSTER S
N
Three main points
point
er
Contact info
Tell me about your work
Listen to learn (not to answer)



Squint with your ears -Kevin Cashman

Listen with the intent to understand

https://f-4-c.blogspot.com/2012/10/lessons-from-kevin-cashman-on.html



Chevalier The art of asking smarter questions HBR, May-Jun 2024

Get out and look around

Listen with the intent to learn

You don't have to have the answer

Why x 5?

Now what?

What's Unsaid

What if?

So what?

Argue like your right – listen like your wrong

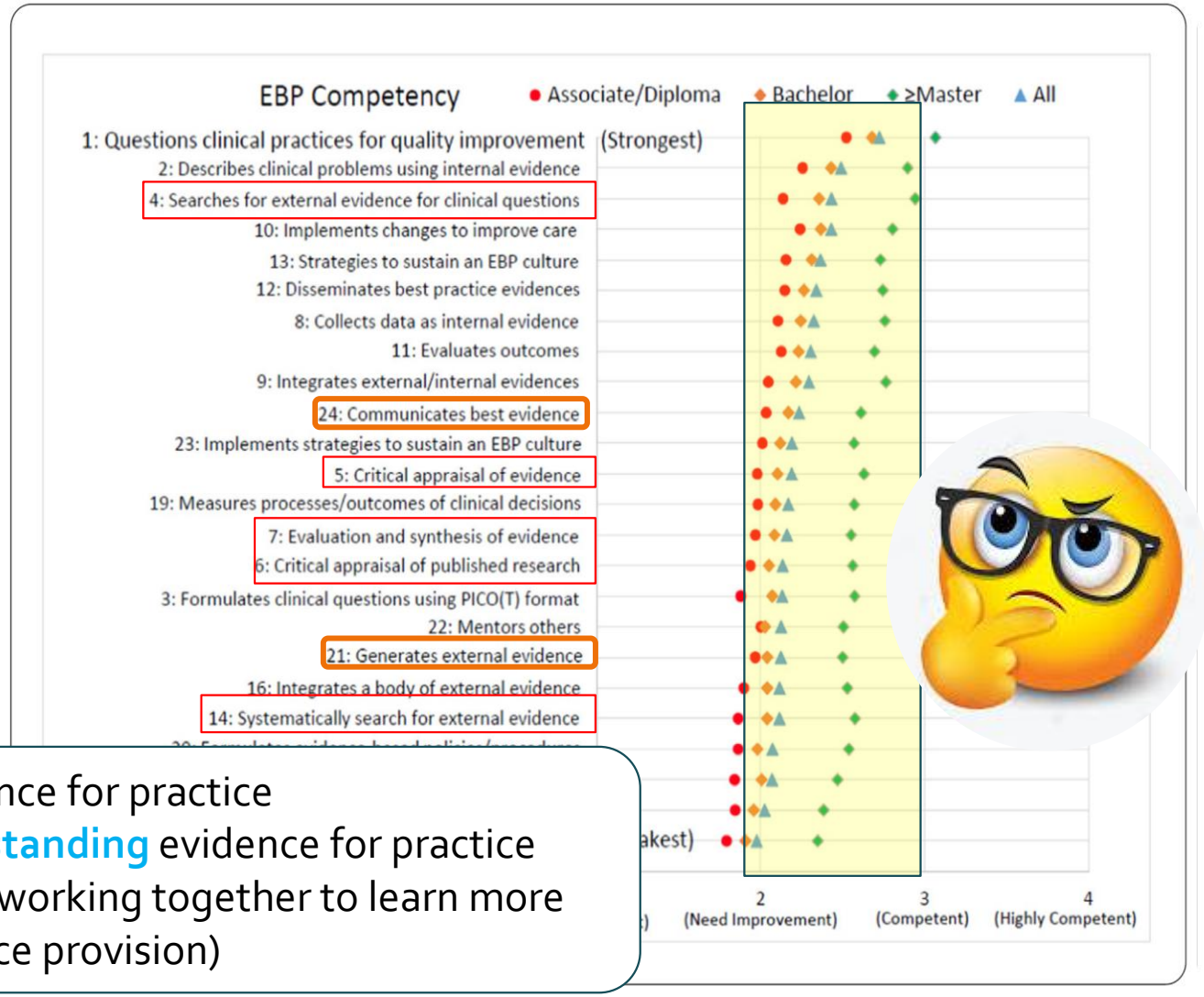
Make other people the smartest in the room by asking good questions

Questions Are the Answer | The Leading Blog: A Leadership Blog
https://www.leadershipnow.com/leadingblog/2018/12/questions_are_the_answer.html

Original Article

The First U.S. Study on Nurses' Evidence-Based Practice Competencies Indicates Major Deficits That Threaten Healthcare Quality, Safety, and Patient Outcomes

- ❑ EBP Knowledge
- ❑ EBP Beliefs
- ❑ Implementation
- ❑ Organizational Culture
- ❑ EBP Mentorship
- ❑ EBP competency (RN/APRN)



- **Increased confidence** in accessing evidence for practice
- Improvements to knowledge and **understanding** evidence for practice
- **Increased morale, sense of team** (from working together to learn more about evidence use or think about practice provision)

Conceptual Use → **Symbolic/Instrumental/Persuasive Use**

Melnyk BM, et al. The first U.S. study on nurses' evidence-based practice competencies indicates major deficits that threaten healthcare quality, safety, and patient outcomes. *Worldviews Evid Based Nurs*. 2018;15(1):16-25. doi:10.1111/wvn.12269

Evidence-Based Practice: You must look at the evidence

Pixar - UP

Speed Dating

For research

5 SPEED DATING QUESTIONS for LITERATURE REVIEW

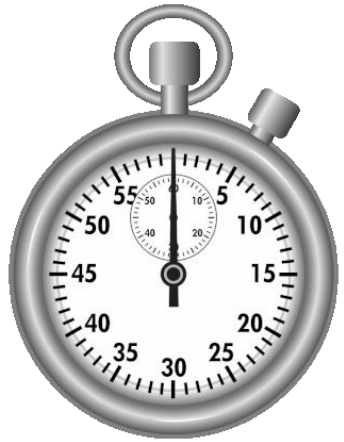
- **What was the issue?**
  - Do I see this in my practice?
- **Who did they study?**
  - Are the participants similar to my patients?
- **What did they do?**
  - Is it realistic or feasible for my setting?
- **What were the results?**
  - How were the outcomes measured?
  - Do the results matter to my patients?
- **Any concerns?**

PICO	Question	Where in Paper
Problem (Purpose)	Is this a problem I see in my practice	Abstract, end of introduction paragraph
Population (sample)	Does the study evaluate patients similar to my population? Who is included? Who is excluded?	Abstract, purpose statement, methods: inclusion/exclusion, results (demographics)
Intervention	What is the intervention – is it realistic or feasible in my setting Study design (observational, randomized)	Abstract, Methods
Comparison	What is the intervention being compared to – is this a reasonable comparison	Abstract, Methods
Outcomes/ Results	What did they look at? What did they find? Do the outcomes matter to my patient	Abstract, Results

CHRISTMAS OFFERINGS

Fast versus slow bandaid removal: a randomised trial

Jeremy S Furyk, Carl J O'Kane, Peter J Aitken, Colin J Banks and David A Kault



CHRISTMAS OFFERINGS

Fast versus slow bandaid removal: a randomised trial

Jeremy S Furyk, Carl J O'Kane, Peter J Aitken, Colin J Banks and David A Kault

ABSTRACT

Objective: To determine whether slow or fast bandaid removal is less painful.

Design, setting and participants: A prospective, randomised, crossover tr… carried out at James Cook University, Townsville. Participants were healthy … from Years 2 and 3 of the James Cook University medical school program.

Interventions: Medium-sized bandaids were applied bilaterally in three star… locations and removed using slow and fast techniques.

Main outcome measures: Pain scores were assessed using an 11-point verb… pain scale.

Results: 65 participants were included in the study. The overall mean pain sc… bandaid removal was 0.92 and for slow bandaid removal was 1.58. This repres… highly significant difference of 0.66 ($P < 0.001$).

Conclusion: In young healthy volunteers, fast bandaid removal caused less p… slow bandaid removal.

Applying dressings to wounds is a common practice throughout the world, both in and out of hospitals. At times, removing such dressings can be more painful than the wound itself.[1] Research on dressing removal has often focused on expensive new products[2] and, although speed of dressing removal has been controlled for in some studies[2] (implying that speed is a factor), we are not aware of any research directed specifically at different speeds of dressing removal. There are Internet sites addressing how to reduce the pain associated with removal of certain brands of dressings, such as Band-Aid (Johnson & Johnson, New Brunswick, NJ, USA) (eg, http://www.wikihow.com/Remove-a-Band-Aid); however, there is no consensus on the issue of speed.

The pain of dressing removal is thought to be related to the mechanical stripping of the stratum corneum from the underlying epidermal and dermal cells.[3] However, the perception of pain is complex — it is a multifactorial experience influenced by culture, previous pain events, beliefs, mood and ability to cope.[4]

Simple dressings are known by many different names, such as sticking plasters. Band-Aid is one of the most popular and best-selling brands of simple dressings worldwide; it is used so frequently both … and health care settings th… been adopted for ge…

The two most com… removal are slow ba… fast bandaid remov… the slow technique … the noxious stimul… exposing the individ… stimulus. With the … exposure to the n… perceived as less pai… stimulation of pain-p…

We aimed to com… methods of bandaid… tively answer the quest… removal, fast or sl…

METHODS

The study was a prospective, randomised, crossover trial comparing FBAR with SBAR in … healthy volunteers. It was conducted … August 2009 at James Cook University, Townsville, Queensland.

The study participants were a conven… sample of healthy volunteers from the … and third years of a 6-year, under… medical school program at James C… versity. Inclusion criteria were age greater than … 18 years and ability to provide informed consent. Exclusion criteria included documented or suspected allergy to adhesive dressings, and chronic pain or anxiety disorder. Written informed consent was obtained from all participants. The participants were not coerced, … were also collecte… operators (CJO and CJB) … -hour training session on dressing … lore commencement of the study … consisted of a single rapid movement, … SBAR consisted of dressing removal … 2-second period. One of us (JSF) obser… dressing removals to ensure consistent … technique.

The primary outcome was pain … which side of the body (left or right) would be tested first. This sequence of bandaid removal was maintained for all three locations in each individual participant. The random sequence was determined by use of standard random number tables. Data on age, sex, the participants' preconceptions about which method … the more painful, ethnicity and amount … assessed by using a 5-point scale, … (equivalent to a paired-sample t test). … results were analysed using independent-sample t tests and simple regression.

A minimum sample size of 60 was needed to demonstrate a difference in mean overall pain scores of 0.5 between SBAR and FBAR, assuming a variance in the data to be analysed of 2, statistical power of 80% (type 2 error of 20%) and an alpha value of 0.05. We thought

CHRISTMAS OFFERINGS

pain scores for dressing removal would be at the lower end of the pain scale and, although the level of clinical significance in this range is not known, we assumed a change of 0.5 to … clinically signifi… ple consisted of young healthy adults; therefore our results may not be applicable to other … age groups such as … tively associated with pain … ur results … types of … further … issues. … ll assist … dopting … oval.

wikiHow to do anything

How to Remove a Band Aid

Author Info | 23 References

Updated: March 29, 2019

Ouch! Removing a band-aid can hurt. Each person experiences pain differently and there is no one-size-fits-all approach. How much hair is in the area, type of band-aid, how long it's been on your skin, and how healed your wound is can all affect how it feels to pull it off. All of these methods can be achieved with common household items and a little bit of patience.

Explore this Article

- Ripping It Off Quickly
- Peeling It Off Slowly
- Peeling It Off Parallel to Your Skin
- Show 3 more...
- Article Summary
- Related Articles

… ons or … consider

… human rather than mechanical operators to conduct both SBAR and FBAR. Although this may have led to human error … and … this … unlikely to become widely available for routine use in the home or hospital. Therefore use of mechanised dressing removers would have limited the conclusions that could be drawn from our study. We would have liked to have recorded video samples of SBAR and FBAR to ensure standardisation of removal speed, but this was not possible owing to insufficient budget.

In a sample of young healthy volunteers, we found FBAR caused less pain than SBAR. A high body hair score and preconception that SBAR would be more painful were also posi-

144-157.
2 Dykes P, Heggie R. The link between the peel force of adhesive dressings and subjective discomfort in volunteer subjects. *J Wound Care* 2003; 12: 260-262.
3 Dykes P, Heggie R, Hill S. Effects of adhesive dressings on the stratum corneum of the skin. *J Wound Care* 2001; 10: 7-10.
4 Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. Acute pain management: scientific evidence (second edition). Melbourne: ANZCA, 2005. http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/cp104.pdf (accessed Aug 2009).
5 World Medical Association Declaration of Helsinki — Ethical Principles for Medical Research Involving Human Subjects. http://www.wma.net/en/30publications/10policies/b3/index.html (accessed Sep 2008).
6 Holdgate A, Asha S, Craig J, Thompson J. Comparison of a verbal numeric rating scale with the visual analogue scale for the measurement of acute pain. *Emerg Med (Fremantle)* 2003; 15: 441-446.

(Received 3 Oct 2009, accepted 19 Oct 2009)

Participa…

We aimed to compare these two common methods of Band-Aid removal (fast vs sl… d to definitively answer th… " which method of removal, fa… slow, causes less pain?"

Methods

Methods

Results

https://www.wikihow.com/Remove-a-Band-Aid

Study Info	Purpose	Sample	Intervention	Outcomes (What/How measured)	Results	Feasibility /use

Evaluation
Synthesis
Critical Appraisal

Why science teachers should not be given playground duty.

AI Assistant

1 request remaining

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Overview

The document reports on a randomized trial comparing the pain levels associated with fast versus slow removal of Band-Aids, concluding that fast removal is less painful.

Copy

What was the main objective of the study?

The main objective of the study was to determine whether slow or fast bandaid removal is less painful. [1]

Copy

Who were the participants in the study?

The participants in the study were healthy volunteers from Years 2 and 3 of the James Cook University medical school program. [1] They were a convenience sample, with inclusion criteria being age greater than 18 years and the ability to provide informed consent. [2] Exclusion criteria included documented or suspected allergy to adhesive dressings, and chronic pain or anxiety disorder. [3]

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How many participants were included in the study?

Sixty-five participants were included in the study. [1]

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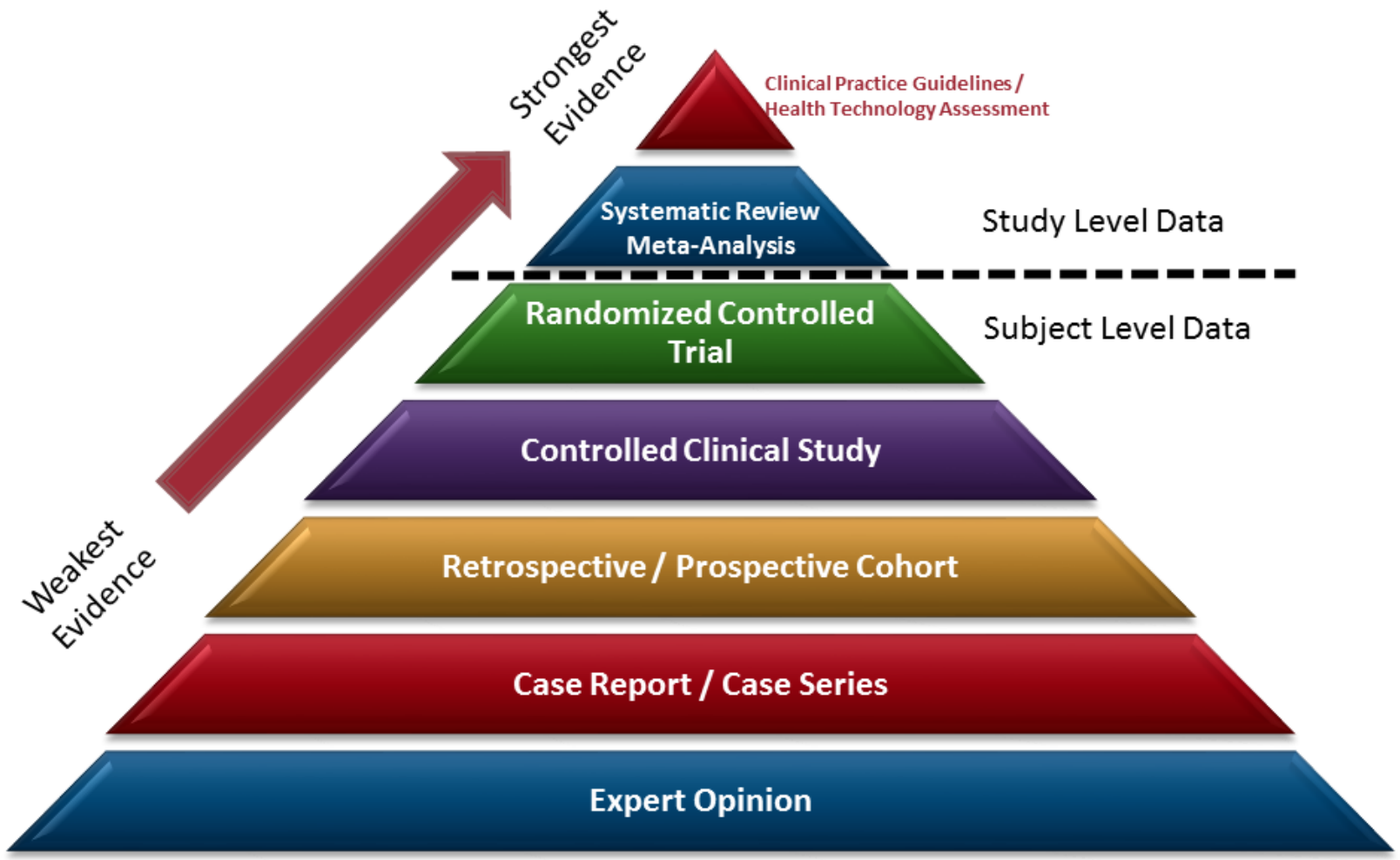
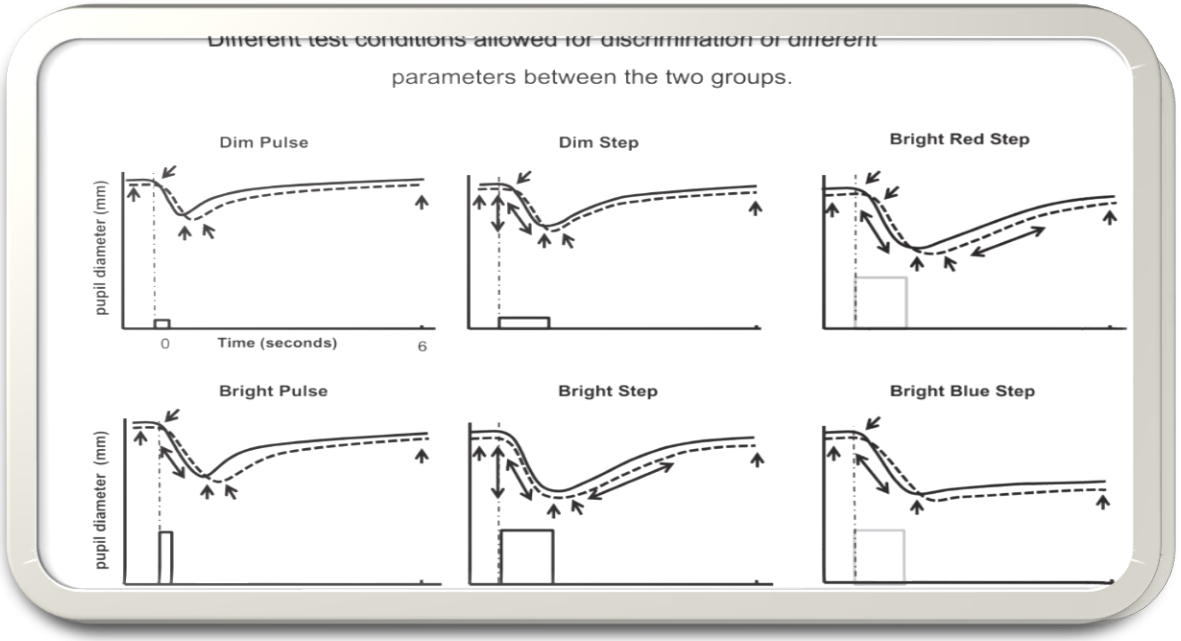
What is the mean age of participants?

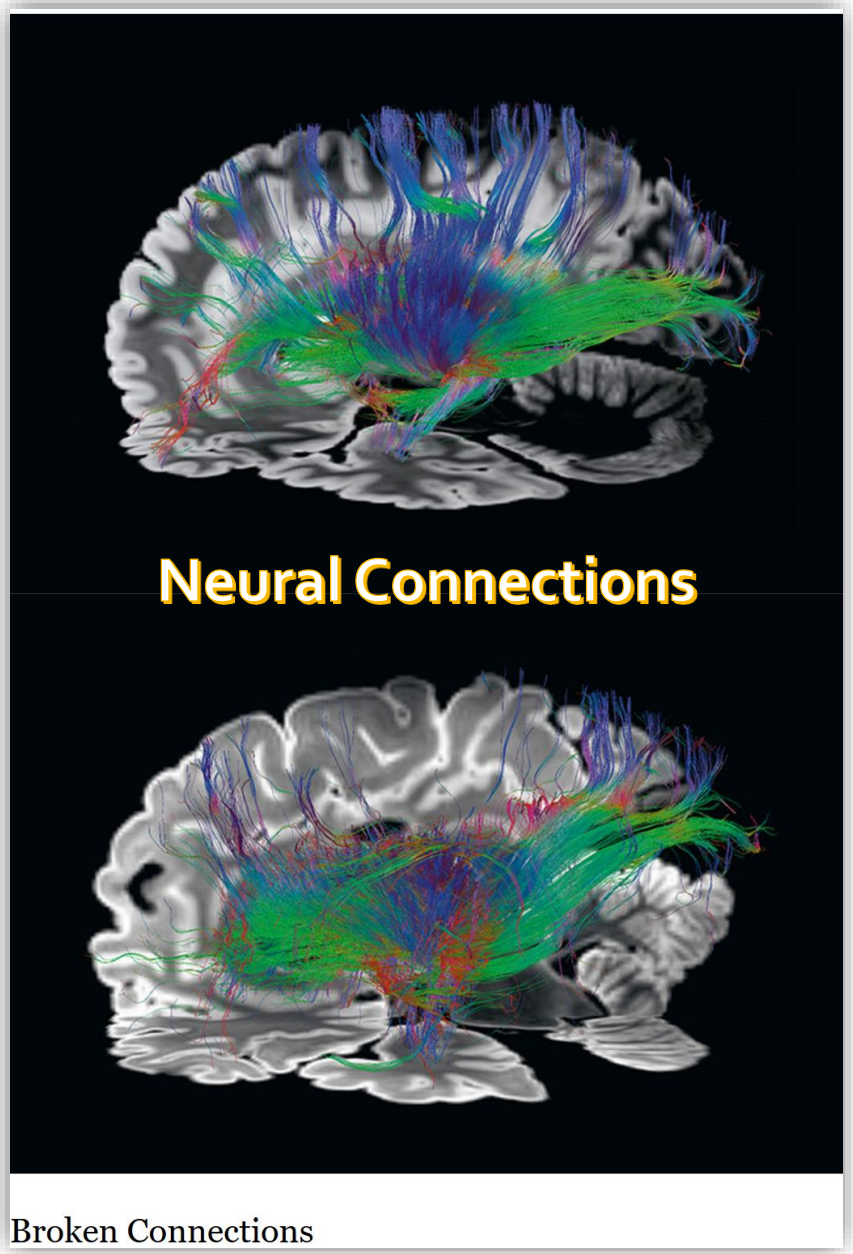
Critical Appraisal of Evidence


Strongest Evidence
Clinical Practice Guidelines / Health Technology Assessment
Systematic Review Meta-Analysis
Study Level Data
Randomized Controlled Trial
Subject Level Data
Controlled Clinical Study
Retrospective / Prospective Cohort
Case Report / Case Series
Expert Opinion
Weakest Evidence



Smartphone Based Pupillometry Using Machine Learning to Detect Concussions

https://www.washington.edu/news/2017/09/06/pupilscreen-aims-to-allow-parents-coaches-medics-to-detect-concussion-brain-injuries-with-a-smartphone/



Broken Connections

https://www.nationalgeographic.com/healing-soldiers/blast-force.html

Behind the Mask

"Sometimes you find yourself saying, I wish ... I would have lost a body part, so people will see—so they'll get it."

National Intrepid Center of Excellence (NICoE)

https://www.nationalgeographic.com/healingsoldiers/index.html

ORIGINALLY PUBLISHED JULY–AUGUST 2023

How Generative AI Can Augment Human Creativity

Use it to promote divergent thinking.

→ by TOJIN T. EAPEN, DANIEL J. FINKENSTADT, JOSH FOLK, and LOKESH VENKATASWAMY

Deliberate Innovation

How to Use Generative AI as Your Questionstorming Thought Partner

Editorial

The Integration of Artificial Intelligence Into Critical Care Nursing

Guest Editorial

Integrating Artificial Intelligence Into Critical Care Nursing: Next Steps

Carl Goforth, PhD, RN, CCRN
Jenny Alderden, PhD, APRN, CCRN, CCSN

AACN Advanced Critical Care
Volume 34, Number 4, pp. 280-286

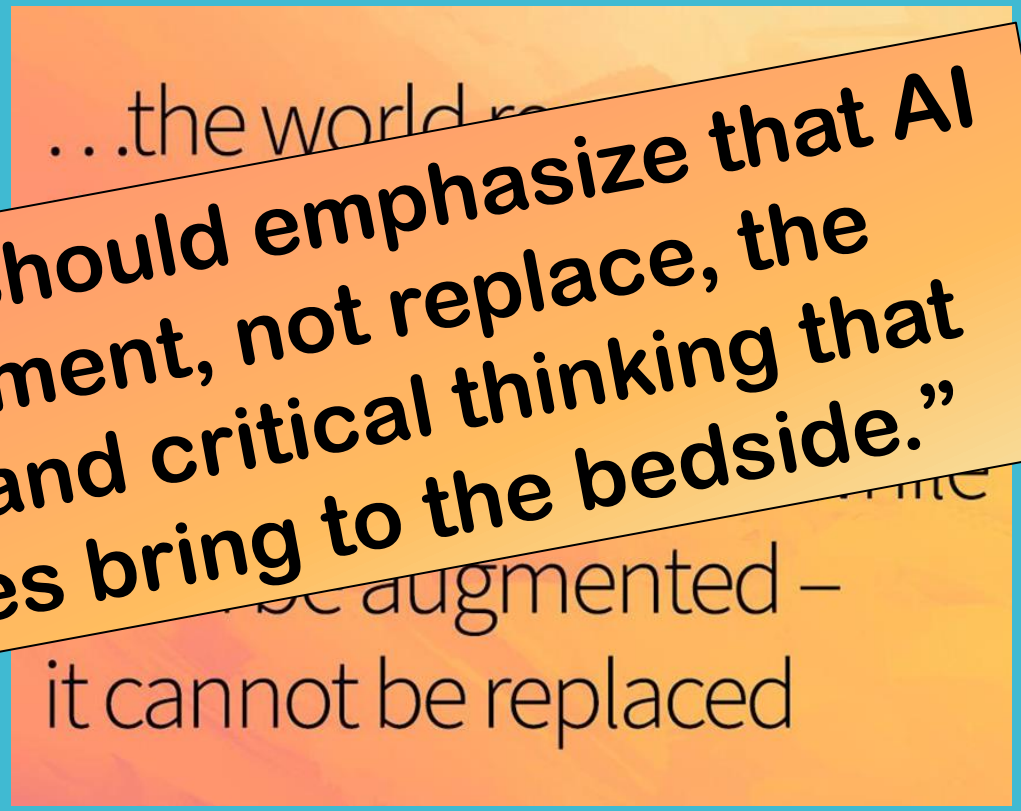
Technology Today

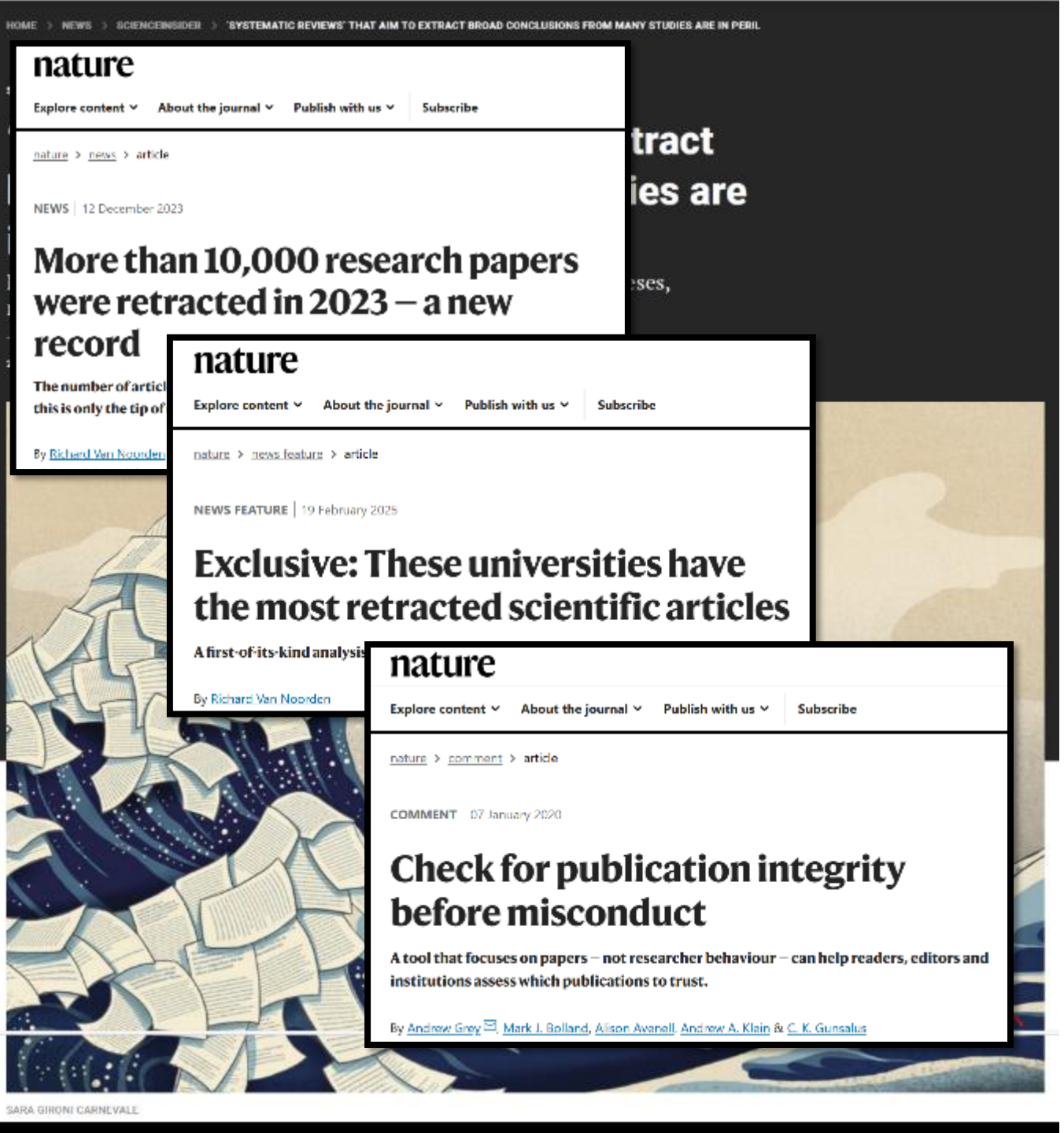
Linda Harrington, PhD, DNP, RN-BC, CPHQ, CENP, FHIMSS, FAMIA
Department Editor

ChatGPT Is Trending: Trust but Verify

Linda Harrington, PhD, DNP, RN-BC, CPHQ, CENP, FHIMSS, FAMIA

“Hospital policies should emphasize that AI is designed to augment, not replace, the clinical judgment and critical thinking that critical care nurses bring to the bedside.”





"We re ntific
work ific
kn

- **Get your evidence from legitimate sources (e.g., professional organizations, PubMed, CINHAL)**
- Extraordinary claims require extraordinary evidence
- Correlation is not causation
- Randomization matters
- RCTs are not the only valid evidence – but be wary of "expert opinion"
- Peer review matters
- Number of similar studies matters
- Chat GPT is not a reference

Your homework for today

- **Be a part of the forest**
- **Squint with your ears**
- **Listen like you were wrong**
- **Find a book at an old bookstore (especially if it has a cat)**
- **Make the world's best peanut butter & jelly sandwich**
- **Remember the mask**
- **Watch Elf but beware of sharks**

Journal of Evaluation in Clinical Practice
International Journal of Public Health Policy and Health Services Research

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Maternal kisses are not effective in alleviating minor childhood injuries (boo-boos): a randomized, controlled and blinded study

The Study of Maternal and Child Kissing (SMACK) Working Group

3 million tweets!

SOCIAL SELECTION *Popular topics on social media*

Spoof kissing paper sparks debate

A satirical study showing that a mother's kisses didn't help injured children to feel better left several clues that it was fake. The funder was Proctor and Johnson, a made-up medical company, and one of the references was entitled, "So what the hell is going on here?". The paper, describing a fictional randomized controlled trial (RCT) of mothers kissing their toddlers, was designed to illustrate the limitations of evidence-based medicine, which uses data from such clinical trials to direct the practice of medicine. Many people who shared the article on Twitter played along with it. Angela Smith, a urologist at the University of North Carolina School of Medicine at Chapel Hill, tweeted: "Maternal kisses apparently ineffective at alleviating boo-boos in RCT-our household now switching to 'blowing on it'." But some commenters said that the article, which the editor of the *Journal of Evaluation in Clinical Practice* knowingly published in his journal, could be misleading and needs to be clearly labelled as satirical. *J. Eval. Clin. Pract.* http://dx.doi.org/10.1111/jep.12508 (2015)

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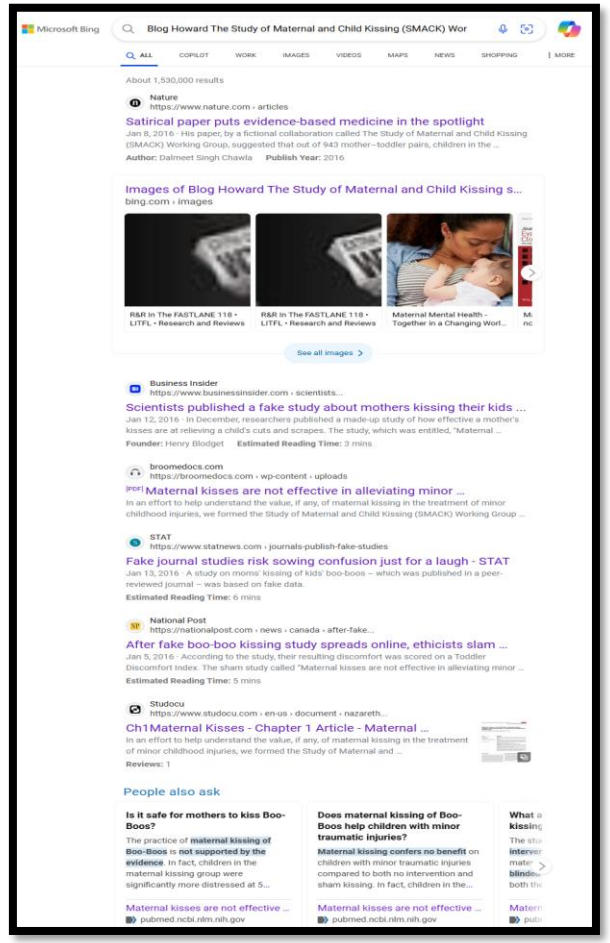

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