COMFORT IMPROVEMENT PROJECT

A Research Grant Proposal

Presented to the faculty of the School of Nursing
California State University, San Marcos

Submitted in partial satisfaction of the requirements for the degree of

MASTER OF SCIENCE

in

Nursing
Family Nurse Practitioner

by

Bich Nguyen

SPRING SEMESTER
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School of Nursing
College of Education, Health, and Human Services
California State University San Marcos
Abstract

of

COMFORT IMPROVEMENT PROJECT

by

Bich Nguyen

Statement of Problem: Patient comfort is an important outcome in nursing care. Perception of comfort is different from one patient to another. There are many factors that affect patient comfort. The comfort factors identified by Kolcaba consist of four domains: physical, psychospiritual, socialcultural and environmental. These domains are measured by the Shortened General Comfort Questionnaire (SGCQ) which has 28 questions, each answer ranging from 1 (lowest) to 6 (highest). Communication is also important in nursing care because effective communication helps nurses understand what would comfort the patient. The use of a whiteboard in the patient’s room, is proposed as an aid to improve communication between nurses, patients and other members of the professional health care team. The prediction is that the use of the whiteboard may help improve patient comfort as measured by the SGCQ.

Wendy Hansbrough, PhD, RN

Date 5/10/2016
ACKNOWLEDGEMENTS

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INTRODUCTION

Background and Significance

Although a curative treatment or medical procedure is important to treat illness, comfort is an important part of the healing process. Since nurses directly provide daily patient care, comfort is thought to be inextricably interwoven in all aspects of the nursing practice. Comfort is always a main focus of nursing. Comfort has been listed in the North American Nursing Diagnosis Association (NANDA) book referred to as “Impaired comfort” and “Readiness for enhanced comfort” with several interventions suggested. The concept of comfort is mentioned by notable nursing grand theorists; Florence Nightingale (1859, p. 125) wrote: “[Science] is not for the sake of piling up miscellaneous information or curious facts, but for the sake of saving life and increasing health and comfort.” Goodnow (1935) also asserted that "the nurse is judged always by her ability to make her patient comfortable.” Studies have shown a link between patient comfort and satisfaction (Minville et al., 2006; Bopp et al., 2011). Comfort is also used to measure patient satisfaction with their hospitalization, and to predict the success and growth of the hospital as a business (Quintana et al., 2006). A facility is not considered excellent in patient care if most of the patients complain of discomfort during their stays.

Communication is the transfer of information and helps gain understanding between people. Without communication between nurses and patients, nurses cannot understand what the patients want and how to comfort them. Therefore, it can be assumed that effective communication would help improve patient comfort.

Problem

The patient population at the rehabilitation facility are adults who are recovering from a stroke, neurological disease, spinal cord injury and orthopedic conditions. General satisfaction surveys are filled out by all patients before their discharges and the results are reviewed to
identify opportunities for improved care. A common suggestion from patients is that communication between the staff and patients could be improved. In the weekly staff meetings, issues related to communication between healthcare members and patients are often addressed, and the common problems include the misunderstandings about patient’s plan of care, schedules with a physical therapists or the time of the last dose of pain or anxiety medications given. Thus, communication between nurses and patients is identified as a problem and poses an opportunity for improvement. The installation and use of a whiteboard in the patient’s room was proposed to aid for communication improvement at the facility to address this problem.

**Purpose of Research**

This study will explore the use of a whiteboard in the patient’s room as a shared communication tool to provide information about patient preferences for daily activity schedule and patient plan of care. In that, improved communication is suggested as affecting on patient comfort; the purpose of this project is to determine whether or not the use of a whiteboard in the patient’s room would positively affect patient comfort.

**Implications for Nursing Practice**

The roles of Advanced Practice Nurses (APN) are broad. The APNs have a variety of roles and positions including healthcare providers, managers, researchers or educators in acute settings or outpatient clinics. In a study about advanced practice nurses’ scope of practice, Nieminen, Mannervaara, B. & Fagerstrom (2011) have found five clinical competencies that the APNs often possessed. The five clinical competencies include assessment of patients’ caring needs, the caring relationship, multi-professional teamwork, development of competence and nursing care, and leadership in a learning and caring culture. In another study with 15 nurse practitioners (NPs), Carryer et al. (2007) has also identified clinical leadership as one of the core
roles of the NPs. Clinical leadership is an important competency for the APNs because they play a central role to direct projects that help improve the quality of care provided by the facility.

This project is relevant to advanced nursing practice because the APN is leading the change to use the whiteboard in an effort to improve communication between nurses and patients or family members, which may improve patient comfort.

**Research Question**

Does the use of the whiteboard in the patient’s room to provide information about patient needs and plan of care affect patient comfort levels?

**Hypothesis**

Using the whiteboard to provide information related to patient’s needs and plan of care will improve patient reported levels of comfort.

**Variables**

The independent variable in the study is the use of the whiteboard to communicate patient’s preferences. The dependent variable is comfort level measured by the Shortened General Comfort Questionnaire (SGCQ) (Kolcaba, Schirm & Steiner, 2006).

**Conceptual Framework**

According to Kolcaba (1992), comfort is a holistic outcome that consists of many aspects relating to each other; the aspects of comfort can be arrayed on a two dimensional grid. The first dimension of comfort consists of three states: relief, ease, and transcendence. Relief is defined as “the experience of a patient who has had a specific comfort need addressed.” Ease is defined as “a state of calm or contentment.” Transcendence is defined as “the state in which one rises above problems or pain.” The second dimension consists of four contexts which include physical, psycho-spiritual, social-cultural and environmental (Kolcaba, 1992). Physical comfort refers to
bodily sensations and homeostatic mechanisms. Psycho-spiritual comfort refers to the internal awareness of self. Social-cultural comfort refers to interpersonal, family and societal relationships. Environmental comfort refers to the external background of human experience. It is a two dimensional grid, so each cell reflects the synthesis of two dimensions of meaning where they intersect; a change in one aspect can produce a change in others. The taxonomic structure of comfort is useful for assessing comfort needs of patient and family members, and developing interventions to address those needs (Kolcaba, 2010). The two dimensions of comfort make 12 comfort items, and the taxonomic structure of comfort is shown below.

Table 1.

*Taxonomic structure (Kolcaba, 1992).*

<table>
<thead>
<tr>
<th></th>
<th>Relief</th>
<th>Ease</th>
<th>Transcendence</th>
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<tbody>
<tr>
<td>Physical</td>
<td></td>
<td></td>
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<tr>
<td>Psychospiritual</td>
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<tr>
<td>Socialcultural</td>
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<tr>
<td>Environmental</td>
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</table>
Figure 1. Conceptual Framework for Comfort theory (Kolkaba, 2010)
The conceptual framework for comfort theory include health care needs of the patient or family members, comforting interventions over time, intervening variables, enhancing comfort over time, health seeking behaviors and institutional integrity. Health seeking behaviors consists of internal behaviors, peaceful death and external behaviors. Institutional integrity depends on best practices and best policies (Kolcaba, 2010).

In addition, the comfort theory has propositions which serve as a guideline for healthcare members or researchers to apply the comfort theory. The propositions include identification of the patient’s comfort needs, designing interventions to address those needs; the intervening variables are taken into account in designing the interventions and mutually agreeing upon reasonable outcomes; if enhanced comfort is achieved, patients are strengthened to engage in health seeking behaviors or a peaceful death, and institutions with higher "integrity" facilitate higher engagement in HSBs (Kolcaba, 2010).
LITERATURE REVIEW

The research studies used for this project were retrieved from Google Scholar and limited to English and peer-reviewed articles. With a keyword “perception of comfort,” 187 articles were found. To limit the articles, the time frame from 1990 to 2015 was added to the search and only four articles was found. Another keyword, “comfort theory” was searched, and the result was 111 articles. Sorting by relevance, the first article appearing in this search was “A theory of holistic comfort for nursing” by Kolcaba written in 1994. By skimming through the first relevant 20 articles, three other articles about the comfort theory and the instrument to measure comfort were also found. In addition, the keywords “comfort perception, adult, pain and after surgery” were also added to the search; 10 articles were found, but only six articles written in 1990s were selected for the literature review. Another keywords “pain and anxiety,” and a time frame “2000 – 2016” were searched; 35 articles were found from this search, and another seven relevant articles was selected. The keyword “patient comfort” was searched together with each of the keywords such as “comfort food, environment, temperature, noise, communication, whiteboard or satisfaction” and limited with a time frame from 1985 to 2015.” Another nine articles were chosen from the searches. From the articles and references, the names of the nursing theorists and management such as Nightingale, Goodnow and Lewin were identified and by searching with their names as keywords, three relevant articles were added to the list. The last search for “the role of Advanced Practice Nurses,” limited from year 2010 to 2015, located two articles for the literature review. As a result, a total 28 articles were used for this project.

The perceptions of comfort and discomfort are mainly subjective and depend on individual preferences. Pain is described as discomfort whereas pain management engenders comfort. Although pain has a physical origin, pain is also influenced by psychospiritual, sociocultural and environmental factors (Kolcaba, 1992). A qualitative study with a sample of 19
patients and 27 staff members conducted by Tutton & Seers (2003) about comfort in a ward for older people revealed three interesting themes including nature of comfort/discomfort, key determinants influencing the experience of comfort/discomfort and underlying factors that influence the provision of comfort/discomfort. The subthemes of the nature of comfort are enduring daily life, relief pain activities, state and process. In discussing comfort and discomfort, most of the patients in the study talked about “enduring the physical discomfort of unmet needs” such as pain related to physical condition, sitting or immobility. The patients also felt comfortable when they received help during the day. The subthemes of key determinants for comforts include approach, knowing patient, focus and environment. Many patients said that they felt good and comfortable when the staff members paid attention to “little things” such as putting a soft pillow on top of the bed, making an effort to find a mirror, or providing shaves. The attitudes of the staff seemed to be important regarding patient’s experience of comfort. Sometimes patients asked for particular nurses due to their positive attitudes. On the contrary, some patients reported discomfort as they experienced difficulty in getting anything they needed when particular members of staff were on duty. The study also revealed that the underlying factors that influence comfort are power and organization; the patients had a feeling of powerlessness or loss of control over their bodies, and the organization mentioned in this study was the environment, working style and team work.

In another qualitative study with a sample of 16 patients after surgery by Zalon (1997), the findings were also similar. The themes for the study included the immediate reality of pain, security and dealing with pain. Discussing immediate reality of pain, most patients in the study expressed the feeling of pain as the perception of discomfort, and the awareness of pain. For the theme security, the patients were seeking comfort from the nurse’s actions and medications, and
the trust that their pain could be managed. The patients also expressed that the nurse’s roughness would cause discomfort and exacerbate pain. For the theme “dealing with pain,” endurance and control were the subthemes in the study. Some patients thought that endurance of pain is a part of life, and they had a fear of being addicted to any pain medication, so they were reluctant to use them whereas others overused pain medications and expected the nurses to know when pain medications should be given. Some patients perceived a feeling of uncertainty and powerlessness when they were dependent and had severe pain or discomfort.

Discussing comfort, Morse (2000) asserted, “For the nurse, the short-term goal of comforting is to ease and relieve patient discomfort and to assist them in enduring pain.” In a study about pain management in elderly patients after surgery, Sauaia et al. (2005) found that 62 percent of patients experienced severe pain after surgery, and 51 percent of patients reported having a complaint of pain only if it was too much to bear. Pavlin et al. (2002) also revealed in a study of 175 surgery patients that improvements in pain management help improve patient comfort and expedite recovery.

Anxiety and pain often relate to each other. The study with 37 participants by Carr, Thomas and Barnet (2005) revealed that anxiety is associated with pain; one third of the patients who had high level of anxiety had experienced significantly more pain than those with less anxiety. The results also showed that the patients who had high level of anxiety before surgery had high level of anxiety and pain after surgery as well. Lerman et al. (2015) also revealed that anxiety was associated with pain. In this longitudinal study, 428 patients treated at two outpatient pain clinics participated at Time 1. Attrition occurred at Time 2, 3 and 4, so only 135 participants completed the study. The results showed that the anxiety predicted pain and pain-related disability as the coefficient β from T1 to T4 was 0.27 (p<0.001). Granot & Ferber (2005) also
found similar results. The sample of the study was 38 patients who had elective abdominal surgery and were free of psychiatric disorders. Patient’s anxiety was assessed before the surgery, and the pain score as well as analgesic consumptions after surgery were determined. The results showed that anxiety significantly predicted postoperative pain in a linear regression pattern with R value of 0.448. The analgesic consumptions increased proportionately with the anxiety and postoperative pain intensity with a linear regression R of 0.721. Therefore, it can be assumed that if patient’s anxiety is managed well, it will also help improve pain management and patient comfort.

Environment and resources were also discussed by the patients and staff members when asked about comfort. Environmental temperature is a comfort factor. Cold temperature will increase muscle tension and restlessness which may aggravate patient discomfort. In a study with 49 patients about warmed blanket by Robinson & Benton (2002), discomfort levels were measured one hour before and one hours after the application of warmed blankets. The results showed a significant change in the mean of discomfort level from before receiving warmed blankets to after receiving warmed blanket (p < 0.0001). In addition, after one hour receiving the warmed blankets, several patients asked for another warmed blanket because the warmth didn’t last long enough. Noise also affects patient comfort. In a study with 295 participants about the noise level in a hospital by Bayo, Garcia & Garcia (1995), 61 percent of interviewees reported being “very annoyed” by the noise level at the hospital, and the staff members also expressed that the noise affected patient comfort.

Many studies have shown that food has a great impact on emotional comfort (Locher, Yoels, Maurer & Ells, 2006; Wurtman & Wurtman, 1989). In a study by Dube, Lubel & Lu (2005) about the effect of food consumption on comfort, 99 percent of 277 participants revealed
that consumption of favorite food would help alleviate the emotional stress and enhance comfort. In addition, the study also showed that high-calorie sweet foods such as ice cream, cookies or chocolate are preferred while the participants are depressed or stressed.

The comfort level can be measured by the General Comfort Questionnaire (GCQ) instrument (Kolcaba, 1992). The GCQ consists of 48 questions which relate to four domains of comfort. The instrument was tested with a sample of 256 participants. The reliabilities of four domains were calculated, and they were 0.7 for physical, 0.78 for psychospiritual, 0.8 for environmental and 0.66 for socialcultural. The Cronbach’s alpha for the GCQ was 0.9. The Shortened General Comfort Questionnaire (SGCQ) was adapted for the study with a sample of 60 participants, in which 35 in the treatment group and 25 in the comparison group (Kolcaba, Schirm & Steiner, 2006). The participants who had received hand massage as an intervention had reported increased comfort level. The Cronbach’s alphas for the study were 0.86, 0.83 and 0.82 at three time points T1, T2 and T3.

Communication helps transfer information between people. Communication is very important in learning about people’s preferences and perceptions of comfort. Without effective communication, it is hard to know about the patient’s goals, the patient’s expectations or what comfort the patients the most. In a healthcare setting, whiteboard can be used as a way of communication and to share information to others. In a study by Wong et al. (2007) about the whiteboard, 71 percent of 120 participants reported that the whiteboard improved communication within the team care members. Since the use of the whiteboard seemed to improve communication between healthcare members, it may also help improve communication between the healthcare members and the patients. In a pilot study about the whiteboards in a
patients’ room, Tan et al. (2013) found that the whiteboard helped significantly improve patient overall satisfaction due to effective communication between the healthcare team and the patients.

**Variables Defined**

The independent variable in the study is the use of the white board to communicate with patients and family members. The dependent variable is patient comfort level measured by the Shortened General Comfort Questionnaire (SGCQ) (Kolcaba, Schirm & Steiner, 2006), and each question ranges from 1 (lowest) to 6 (highest).

Demographic data regarding gender, age and ethnicity will be collected. Gender is defined as self-reported male or female. Age refers to the chronological age of the participant. Ethnicity is defined as American Indian/Native American - Asian - Black/African American - Hawaiian native/ Pacific Islander - White.

**Change management**

There are many factors that drive the need for change. They include internal and external policies, regulations, accreditation, organization and financial issues. Change at any level in an organization occurs to make a difference and to improve the organization. A good decision of change requires careful planning. Therefore, the decision making and planning processes will generally be involved parallel (Dressler, 2002). The decision making process begins with the identification of a problem, then evaluation of the choices by different criteria and taking courses of action. The planning process involves setting goals, developing rules and procedures, then making the decision.

There are many change theories, but Lewin’s theory of change is most suitable for this project. Lewin’s theory includes a force field model of change which has three stages. The three stages are unfreezing stage, moving stage and refreezing stage. In the unfreezing stage, the
problem is recognized. The moving stage is the working stage where the strategies of problem solving are developed and implemented. The refreezing stage occurs after the change is implemented into the work environment. In the force field model analysis, the manager and staff identify the driving forces and the restraining forces. Both manager and staff have to collaborate to make the strategy more effective. As the driving forces increase, the chance of positive change increases. In contrast, if the restraining forces increase, the chance of poor outcomes increases (Lewin, 1947).

According to Dressler (2002), in the change process, the organization and staff will go through three stages which are readiness for change, resistance to change and acceptance of change. Readiness for change is important because it means that the staff and management are willing to make an effort to change. However, resistance to change is always occurred; not all staff are ready to the change due to many reasons including staff experience, seriousness of the change, fear about what may be lost, manager and staff commitment to the organization and planning process. Acceptance of change refers to acceptance of what will be gained, but not what might be lost. The managers and staff should focus on the positive of the change. However, the concerns or loss should not be ignored (Finkelman, 2012).

**Summary**

The extensive review of literature showed that comfort depends on the patient’s perceptions of comfort, their condition and their ability to endure discomfort. Kolcaba specifies four domains of comfort, which include physical, psychospiritual, socialcultural, and environmental comfort. Paying attention to the patient’s needs and providing a quiet environment as well as good resources help improve patient comfort. Based on the population at the facility who are recovering from their recent surgeries, most patient discomfort are pain and
anxiety which are the state of physical and psychospiritual discomfort. Therefore, pain management and anxiety management are important comfort factors. Effective communication is also an important factor in healthcare because it not only promotes understanding between nurses and patients, but also helps the patients achieve comfort and overall satisfaction.
METHODOLOGY

Introduction

Comfort is a fundamental aspect of nursing care. Comfort perception depends on individual needs and point of view. There are many factors that contribute to patient comfort, and those factors were influenced by the four contexts including physical, psycho-spiritual, social-cultural and environmental (Kolcaba, 1992). Although communication is not a part of the four contexts, communication plays an important role in transferring information from one another. Without effective communication, it is hard to learn about what comfort the patients.

A proposal to use the whiteboard in the patient’s room was approved by the director of nursing at the facility where the study will take place with a belief that it will help improve communication between the nurses and the patients and increases patient comfort levels.

Research Question

Does the use of the whiteboard in the patient’s room to provide information about patient’s need and plan of care affect patient comfort levels?

Hypothesis

Using the whiteboard to provide information related to patient’s needs and plan of care will improve patient reported levels of comfort.

Identification of Setting

The project will be conducted at a short term rehabilitation facility, and the participants will include those who are recovering from a stroke, brain injury, neurological disease, spinal cord injury, or orthopedic condition.
Research Design

This project is a quasi-experimental study of unmatched groups. The initial group will complete the SGCQ. Following that, the use of the whiteboards will be initiated. After staff demonstrate regular use of the whiteboards, the SGCQ will be repeated by a second group of patients who are on the unit at that time.

Demographic data of gender, age, diagnosis and ethnicity will be collected for both group one and group two. Group two will also be asked two dichotomous questions about the nurse’s use of the whiteboard and whether or not it was helpful to improve communication.

Population and Sample

The sample for the project is a convenient sample of residents at a rehabilitation facility. The inclusion criteria are the patients who are alert, oriented and able to read and write English. The patients at the facility have generally short length of stay, which are about two to three weeks. Due to the patient’s situation, the length of the study and the implementation of the whiteboards, two different groups of patients are needed for the study. The participants from group one will report comfort as measured by the SGCQ before the installation and use of the white boards. The second group will also be surveyed in the same manner after the white board have been used by the nursing staff on a consistent basis as determined by the researcher. The sample size was calculated by using the G-power 3.1.4 program. With a power of 0.80, an effect size of 0.50, a significant level (alpha) of 0.05, and one tail test, a minimum sample size is determined as 102, of which 51 is the sample size group one and 51 is the sample size group two. An additional 20 percent of missing data or failing to complete the survey is added to the minimum sample size; therefore the desired sample size will be 122, of which 61 belongs to group one, and 61 belongs to group two.
Figure 2. Power analysis prior to data collection.
Measurement Methods

The independent variable in the study is the use of the white board to communicate patient’s preferences. The dependent variable of comfort will be measured using the Shortened General Comfort Questionnaire (SGCQ) developed by Kolcaba, Schirm & Steiner (2006). The SGCQ consists of 28 questions which relate to the four domains of comfort described by Kolcaba (1992) to be physical, psychospiritual, socialcultural and environmental. The instrument had good concurrent validity with a visual comfort level and demonstrated reliability with a Cronbach’s alpha of 0.88 (Kolcaba, Schirm & Steiner, 2006).

Intervention, whiteboard design & Training procedure

The intervention will be the use of whiteboards in the patient’s room by the nurses to communicate with the patients and family members. In the planning stage, the researcher has conducted a short oral survey with the patients about what information that the patients like to have on the whiteboard. Since comfort depends on individual preferences, the information on each whiteboard may not be the same. The template of a whiteboard is shown below.

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse:</td>
</tr>
<tr>
<td>CNA:</td>
</tr>
<tr>
<td>Today goal:</td>
</tr>
<tr>
<td>Plan of care or Meds:</td>
</tr>
</tbody>
</table>

*Figure 3. Template of the whiteboard*

For “today goal,” patients can set any goal for themselves. Some examples of “today goal” include pain management, anxiety management, or can walk 100 feet with a physical
therapist. Depending on the patient’s “today goal,” the “plan of care” is designed. For instance, if “today goal is pain management or anxiety management, the “plan of care” will be the time of pain medication or anxiety medication given, or if “today goal” relates to a session with the physical therapist, the time of the session will be recorded.

After getting the approvals from the IRB and the facility, the participants for group 1 will be selected and the surveys (see Appendix A & Appendix C) will be given to group 1. After data of 61 participants are collected, all nurses are called to attend two hours mandatory in-service about the implementation of the whiteboard. The researcher will explain to the manager and staff what should be written on the whiteboard: the patient’s plan of care, schedule with physical therapist and the time when pain medication or anxiety medication are due. At the end of the in-service meeting, a post test with the questions regarding how to use the whiteboard and how often nurses should use the whiteboard will be given to all nurses. The results will be checked in the meeting. The researcher and the director of nursing will make sure that all nurses understand how to use the whiteboard before the end of the in-service meeting. The researcher and the manager will audit the use of the whiteboard at least once per shift for two weeks to check for consistency. The obstacles identified in this project include inconsistent use of the whiteboard, or not having the erasable pens or markers available for using. After two weeks of implementation and audit, if all nurses use the whiteboard consistently, the researcher will select potential participants for group 2. When 61 surveys are collected, the data analysis will begin.
Table 2.

*Timeline of the project.*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Time frame</th>
<th>Date</th>
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<tbody>
<tr>
<td>Planning &amp; IRB approval</td>
<td>2 months</td>
<td>05/20/16 – 07/20/16</td>
</tr>
<tr>
<td>Group 1-test</td>
<td>2 weeks</td>
<td>07/20/16 – 08/03/16</td>
</tr>
<tr>
<td>In-service</td>
<td>2 times (2 hours) (different shifts)</td>
<td>08/04/16 – 08/06/16</td>
</tr>
<tr>
<td>Implementation</td>
<td>2 weeks</td>
<td>08/07/16 – 08/21/16</td>
</tr>
<tr>
<td>Audit</td>
<td>12 times (different shifts)</td>
<td>08/07/16 – 08/21/16</td>
</tr>
<tr>
<td>Group 2-test</td>
<td>2 weeks</td>
<td>08/22/16 – 09/05/16</td>
</tr>
<tr>
<td>Data analysis</td>
<td>1 ½ month</td>
<td>09/05/16 – 10/10/16</td>
</tr>
<tr>
<td>Dissemination to the staff</td>
<td>1 hour</td>
<td>10/13/16</td>
</tr>
<tr>
<td>Odyssey conference</td>
<td>1 hour</td>
<td>10/2017</td>
</tr>
</tbody>
</table>

**Data Collection Process**

The approval from the IRB and the Director of Nursing will be obtained prior to beginning data collection. The researcher will ask a charge nurse working on the floor at the time about the potential patients who meet the inclusion criteria and can participate the study. The potential participants will be approached, and the researcher will explain the study and requests the patient’s participation. Information regarding the project, any risks or benefits and how to obtain the results will be provided verbally and in writing, and informed consents (see Appendix
F) will be obtained. Demographic surveys and the Shortened General Comfort Questionnaire (see Appendix A & Appendix C) will be given to the patients in group one. After reaching 61 surveys for group one (group 1-tests), the researcher will stop collecting the data and will implement the use of a whiteboard in the patient’s room. Due to the new implementation, the researcher will inform the nurses and the staff at the facility about the use of the whiteboard in a mandatory in-service meeting and audits their daily use of the whiteboard after the implementation. When the whiteboard is used routinely by the nurses for about two weeks, the researcher will ask the charge nurse for potential participants for group two and request for participation. All the information pertaining to the project and informed consents (see Appendix F) will be obtained in writing. Demographic surveys and the Shortened General Comfort Questionnaire (see Appendix B & Appendix C) will be given to the participants for group two. When the researcher has collected 61 surveys for group two, the data collection will be complete. All the data (group 1 tests & group 2-tests) will be stored for security in a locked box at the facility, and only the researcher can access them. The demographic surveys and comfort scores will then be input into the computer with the use of the statistic SPSS software. The computer is locked with a password for confidentiality.

**Scoring**

The results of the positive questions are scored as they are, but the results of negative questions are score by reversing the coding. For instance, if the question states “I am very tired,” that is not comfort. If the answer is “strongly agree (6),” it will be scored (1); if the answer is (5), it will be scored (2) and so on. The comfort level is the sum of all questions, and high comfort score indicates more comfort.
Data Analysis

All data from 122 patients will be analyzed by using IBM SPSS Statistics 20 software (2011). Descriptive statistics will be used to analyze the demographic data regarding gender, ethnicity and age from group one and two and determine whether or not the two groups are equivalent.

<table>
<thead>
<tr>
<th>Age of two groups.</th>
<th>Median age</th>
<th>Mean age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Levene’s test will be used to test homogeneity of demographic data among two independent groups. If the p-value is greater than 0.05 (p > 0.05), it indicates that there is no significant difference between group one and group two or there is homogeneity of demographic data. If the p-value is less than 0.05 (p < 0.05), it indicates that a significant difference between two groups exists.

The mean and standard deviation of comfort scores in group one and group two will be determined. The independent samples t-test will be used to analyze the differences between the group mean comfort levels. If the p-value is greater than 0.05, it indicates that there is no difference in comfort level between group one and group two. If the p-value is less than 0.05, it means that the difference in comfort level between group one and group two exists and it suggests that the whiteboard had an impact on the patient comfort.
Table 4.

*Data Analysis.*

<table>
<thead>
<tr>
<th></th>
<th>Comfort Mean</th>
<th>Std. deviation</th>
<th>Test statistic</th>
<th>( p )-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Cronbach’s alpha for the SGCQ with all participants in group one and group two will be calculated to determine the internal reliability of the instrument.

**Bias and Limitations**

To prevent any bias from the participants, the researcher will explain clearly to the participants that their participations and answers will not affect their plans of care at the facility.

The major limitation of the study is the level of consistent uses of the whiteboard daily by the nurses. Although the researcher or the director of nursing will train all nurses to use the whiteboard and give them a sufficient time to implement it, the nurses may use the whiteboard inconsistently, especially those who work part-time or per-diem at the facility. To minimize the limitation, the researcher or the director of nursing will often audit the nurses’ use of the whiteboard at least once per shift during the time of implementation and data collection for group two. To assist the nurses and prevent any excuse of inconsistency, the researcher makes sure that a supply of erasable pens or markers is available for using at all time.

**Ethical considerations**

The IRB approval will be obtained before the beginning of data collection. The participants will receive verbally and in writing all information regarding the project, risks and benefits of participating, and the right to withdraw from the study anytime. The researcher will
also explain to the participants that their information and answers will not be shared with other people and will be kept in a locked box in the director of nursing’s room, and only the researcher can access it. The computer used to analyze the data will also be locked with a username and password for confidentiality.

Summary

Comfort is an important aspect in nursing. Comfort is defined by Kolcaba (1992) as the immediate experience of being strengthened by having the needs for relief, ease, and transcendence met in four contexts which include physical, psycho-spiritual, social-cultural and environmental. The literature review has revealed that people has different perceptions of comfort. In order to help patients increase comfort level, nurses need to know what factors would affect their patient comfort. Effective communication with the patients will help nurses learn about their patient’s preferences and perception of comfort, so they can provide better quality of nursing care. The whiteboards in patient’s room is an aid to communicate with the patients and family members about the patient’s plan of care, daily goal, a schedule with a physical therapist or the time of pain medications given. With the use of the whiteboards at a regular basis, the communication between nurses and patients will improve, and that may also help increase patient comfort.
GRANT ELEMENTS

There are three potential grants for the project. The first grant is from Rehabilitation Nursing Foundation (RNF) which is established by the Association of Rehabilitation Nurses (Association of Rehabilitation Nurses, 2015). The RNF has three different grants which support research and Evidence Based Practice (EBP) projects that have an impact on rehabilitation nursing research. The second grant is Zeta Evidence Based Practice project grant which is funded with an amount up to $2,500 by STTI Zeta chapter (University of Minnesota, 2016). The third grant is Evidence Based Practice Implementation grant which is funded up to $20,000 by STTI/American Nurses Credentialing Center (Sigma Theta Tau International Honor Society of Nursing, 2016). From these grants and organizations, the RNF grants would be most likely applied because the project proposal meets the description and requirement of the RNF grants. The RNF will not only support EBP projects that promote clinical practice in rehabilitation nursing, but also encourage novice nurses who conduct the nursing research. The three RNF grants include “New Investigator Research Award” which grants up to $10,000 for novice researcher, “New EBP Project grant” which grants an amount of $2,500 to promote the translation of research into practice, and the joint STT/RNF grant which gives $4,500 to a recipient that conducts a research topic related to rehabilitation nursing. The application to any of the RNF grants is general and the same for three RNF grants; the RNF will choose which grant is most applicable to the project and recipient. The RNF grant may not cover the entire project budget, but the facility will cover the rest of it.
**Budget**

Table 5.

*Budget of the project.*

<table>
<thead>
<tr>
<th>Personnel</th>
<th>25 nurses, 2 hours in service</th>
<th>$30/hr x 2 hr x 25 = $1,500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplies</td>
<td>Whiteboards ($50) + installation ($5) + erasable pens/markers ($100): 55 whiteboards, 250 pens</td>
<td>($50/whiteboard + $5) x 55</td>
</tr>
<tr>
<td></td>
<td>whiteboard + $100 = $3,125</td>
<td></td>
</tr>
<tr>
<td>Other expenses: Statistic program – SPSS ($800), 1 computer ($650) + copy expenses ($50)</td>
<td>$800 + $650 + $50 = $1,500</td>
<td></td>
</tr>
<tr>
<td>Total cost</td>
<td></td>
<td>$6,125</td>
</tr>
</tbody>
</table>

**Budget Justification**

**Personnel.** The researcher is an APN whose work duties will include this project. Twenty five nurses will spend two hours for in-service at a cost of $30 per hour each. The total cost for twenty five nurses will be $1,500.

**Supply and expenses.** The cost of one whiteboard is approximate $50 each. The cost of installation is $5 each whiteboard and there are 55 beds at the facility, so the cost for the whiteboard and installation at the facility is approximate $3,025. 250 erasable pens or markers are needed for the project, and the cost for 250 pens is approximate $100. For data collection and analysis, one laptop computer, a statistic SPSS program and copy expenses are needed. The cost for a laptop is approximate $650, for a statistic program is $800, and for copy expenses are
approximate $50. The estimated cost is $1,500. The total supply cost and expenses will be $4,625.

**Dissemination**

The results of this project will be submitted for presentation to the Southern California, Sigma Theta Tau International Odyssey Research and Innovations conference. This conference will be held in the fall of 2017. The results will also be presented to the administrative team and health care delivery staff at the rehabilitation facility where the research will be conducted.
REFERENCES


APPENDIX A

Demographic survey for group 1

Thank you VERY MUCH for helping me in my Comfort Improvement Project.

Age:

Gender: Male Female

Ethnicity:  _____ American Indian/Native American
            _____ Asian
           _____ Black/African American
           _____ Hawaiian native/ Pacific Islander
           _____ White

Diagnosis:
APPENDIX B

Test 2 - Demographic survey for group 2

Thank you VERY MUCH for helping me in my Comfort Improvement Project.

Demographic information.

Age:

Gender: Male Female

Ethnicity: ______ American Indian/Native American
          ______ Asian
          ______ Black/African American
          ______ Hawaiian native/ Pacific Islander
          ______ White

Diagnosis:

Did your nurses use the white board to communicate with you?

☐ Yes

☐ No

Did the use of the white board help you understand your plan of care?

☐ Yes

☐ No
APPENDIX C

SHORTENED GENERAL COMFORT QUESTIONNAIRE

Below are statements that may describe your comfort right now. Six numbers are provided for each question; please circle the number you think most closely matches your feeling. This is about your comfort at the moment you are answering the questions.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>There are those I can depend on when I need help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>2.</td>
<td>I don’t want to exercise</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>3.</td>
<td>My condition gets me down</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>4.</td>
<td>I feel confident</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>I feel my life is worthwhile right now</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6.</td>
<td>I am inspired by knowing that I am loved</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7.</td>
<td>The sounds keep me from resting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>8.</td>
<td>No one understands me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>9.</td>
<td>My pain is difficult to endure</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>10.</td>
<td>I am unhappy when I am alone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>11.</td>
<td>I do not like it here</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>12.</td>
<td>I am constipated right now</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>13.</td>
<td>I do not feel healthy right now</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14.</td>
<td>My room makes me feel scared</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15.</td>
<td>I am afraid of what is next</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>16.</td>
<td>I am very tired</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
17. I am content  
18. This chair (bed) makes me hurt  
19. The views are soothing  
20. My personal belongings are not here  
21. I feel out of place here  
22. My friends remember me with their cards and phone calls  
23. I need to be better informed about my health  
24. I don’t have many choices  
25. This room smells bad  
26. I feel peaceful  
27. I am depressed  
28. I have found meaning in my life
APPENDIX D

POST TEST

1. What do you write on the whiteboard?
   a. Date and names of CNA and nurse
   b. Patient’s goal of the day
   c. Plan of care
   d. All the items above

2. What do you write in the “Plan of care”?
   a. Time of medication given if the goal is pain management or anxiety management?
   b. Time scheduled with a PT/OT
   c. Any appointment with a doctor, dentist, social worker/case manager…etc
   d. All the items above

3. How often do you need to use the whiteboard?
   a. Once a day
   b. At least once per shift
Permission to use the SGCQ

Bich Nguyen <nguye209@cougars.csusm.edu> 9/4/15  

to Kathy

Dear Professor Kolcaba,

I would like to ask you for a permission to use the shortened general comfort questionnaire for my comfort improvement project. You would be referenced and fully credited in the paper. Thank you for your kind consideration.

Bich Nguyen

Kathy Kolcaba <kathykolcaba@yahoo.com> 9/6/15  

to me

You have my permission to use this instrument. Good luck w your project. Dr. K
Appendix F

Informed Consent – Comfort Improvement Project

Invitation to participate

Bich Nguyen, a graduate student in the school of nursing at California State University San Marcos, is conducting a study about comfort improvement. The objective of this project is to help improve patient comfort with the use of the whiteboard in the patient room. You are invited to participate in the study because you are a resident at this facility and are able to read and write English.

Requirements of Participation

You will be asked to answer the questions regarding general demographic, and 28 questions in the Shortened General Comfort Questionnaire (SGCQ). It takes approximately 20 minutes to complete the surveys.

Risks and Safeguards

There are no cost for participating in the study, but you may have some potential risks and inconveniences which include loss of personal time to participate in the surveys, potential stress of past experiences.

This survey is anonymous. If you choose to participate, no one will be able to identify you. Nothing you say on the questionnaire will in any way influence your present or stay at the facility. You have the right to not answer any question that makes you uncomfortable. If you choose to participate, you will be asked to not discuss your answers with other residents. Your completed questionnaire will be kept in a locked box in the DON’s office, and only the
researcher has the key to this box. The results will be input in the computer and the computer is locked with a password for confidentiality.

**Benefits & Incentives for Participation**

There is no incentive for participating in the study. The information collected may not benefit you directly, but it is believed that the study has a potential to positively effect on the quality of nursing care at the facility in the future.

**Voluntary Participation**

Your participation in this study is voluntary. You may withdraw from the study at any time for any reason without any consequences.

**Contact Information and Signatures**

If you have any questions or concerns about completing the questionnaire or about being in this study, you may contact Bich Nguyen at (858) 837-1340 or at nguye209@cougars.csusm.edu.

This study has been approved by the California State University San Marcos Institutional Review Board. Questions about your rights as a research participant should be directed to the Institutional Review Board at irb@csusm.edu or (760) 750-4029. You will be given a copy of this form to keep for your records.

☐ I am at least 18 years old and I agree to participate in this research study.

_________________________________________ Date: _________________________
Participant’s signature

_________________________________________
Participant’s name (PRINT)

_________________________________________  ____________________________
Researcher’s signature  Researcher’s name (PRINT)
Call for Research Proposals: Care Transitions

The Rehabilitation Nursing Foundation (RNF) of the Association of Rehabilitation Nurses (ARN) is soliciting proposals for one-time funding for research studies that focus on the coordination or transition of care and services from one provider to another, one health care facility to another, or from a health care facility to home in a rehabilitation patient population.

The purpose of this call is to address current problems of inadequate care coordination and transitions of care, which are in large part, due to shorter lengths of stay in acute care facilities and higher use of post-acute care (PAC) facilities (e.g., inpatient rehabilitation facilities, skilled nursing facilities, long-term care hospitals, and home health agencies).

Major problems identified with inadequate care transition and coordination include, but are not limited to

- health care errors;
- unmet patient and caregiver needs;
- poor satisfaction with care;
- high rates of preventable readmissions;
- increased health care costs;
- lack of effective transition communication between providers, patients, and caregivers; and
- ineffective patient care education for the patient and caregiver at transition.

The ARN white paper, *The Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions* (Camicia et al, 2014), serves as a catalyst in the development of researchable questions that address care transition and coordination of services in the rehabilitation patient population.


This call for proposals is dedicated to investigations that have the potential of generating data that will lead to further extramural funding and that contribute to the larger body of rehabilitation and health care knowledge. This call does not include quality improvement, program evaluation, and other performance improvement projects.

- Maximum funding available is $30,000
- Number of awards to be funded will depend on the quality of proposals submitted and the amount of funding requested
- Time period for the grant is January 1, 2017 – December 31, 2019
- Preference will be given to applicants who are members of ARN
- Proposals will be reviewed by members of the Research Fund Committee and a peer review panel
- Funded applicants will be expected to disseminate findings by submitting a manuscript for publication in the ARN journal, Rehabilitation Nursing, and an abstract for presentation at the annual ARN Educational Conference
- Proposal must adhere to the attached “Guidelines for Proposals”

Questions

Nurse researchers who have specific questions or concerns not addressed in this packet should contact the RNF office.

Rehabilitation Nursing Foundation
8735 W. Higgins Rd. Suite 300
Chicago, IL 60631
800/229-7530 or 847/375-4710
E-mail: sfoutsakos@connect2amc.com
Introduction

Rehabilitation Nursing Foundation (RNF)
The Rehabilitation Nursing Foundation (RNF) was formed by the Association of Rehabilitation Nurses (ARN) for the purpose of advancing rehabilitation nursing through education and research. The grant program was established in 1988 to encourage nurses to conduct research.

Mission Statement
The Rehabilitation Nursing Foundation is dedicated to advancing rehabilitation nursing practice by promoting, supporting, conducting and disseminating research to improve the quality of healthcare to individuals with disability or chronic illness.

Rehabilitation Nursing
Rehabilitation nursing is a specialty practice area within the scope of professional nursing practice. Rehabilitation is the diagnosis and treatment of human responses of individuals and groups to actual or potential health problems stemming from altered functional ability and altered life-style.

The goal of rehabilitation nursing is to assist the individual with disability and chronic illness in the restoration and maintenance of maximal health. The rehabilitation nurse should be skilled at treating alterations in functional ability and life-style resulting from physical disability and chronic illness.

Rehabilitation nurses provide comfort and therapy, promote health-conducive adjustments, support adaptive capabilities, and promote achievable independence. This practice takes place in many settings and roles.

Guidelines for Proposals

Focus Areas
This special call for research proposals addresses the coordination or transition of care and services from one provider to another, one health care facility to another, or from a health care facility to home in a rehabilitation patient population. The ARN white paper, *Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions* (Camicia et al, 2014), should serve as a catalyst in the development of researchable questions that address care transition and coordination of services in the rehabilitation patient population.

Eligible Applicants
The principal investigator (PI) for the research grant must have a research doctorate or be enrolled in a research doctoral program, be a registered nurse who is active in rehabilitation or who demonstrates interest in and significant contributions to rehabilitation nursing. Preferences will be given to members of the Association of Rehabilitation Nurses (ARN).

Responsibilities of Principal Investigator

1. Completion of the project within 2 years of initial funding;

2. Submission of a progress report to the RNF Research Fund Committee every 6 months until the research is completed;

3. Submission of a publishable manuscript presenting the findings to the ARN journal, *Rehabilitation Nursing*, within 2 years of completed research;

4. Presentation of a paper or poster pertaining to the research at an Association of Rehabilitation Nurses educational conference within 1 year of completed research;

5. Acknowledgment in any publication, paper, or poster that the research was supported by the Rehabilitation Nursing Foundation of the Association of Rehabilitation Nurses.

Required Information
Prepare the proposal according to the *Publication Manual of the American Psychological Association* (6th Ed.). The proposal narrative is limited to 10 typed, double-spaced pages using 12-point, Times New Roman font, and 8 1/2" x 11" paper with 1 inch margins. Sections not included in the 10-page proposal are references, project budget, appendices, and RNF required forms.

The following RNF forms/materials are required and must be completed upon submission:

1. Research Checklist – the form verifies inclusion of all required materials

2. Summary Data Form – the form includes title of the study and contact information of PI and co-investigators.
3. Administrative Approval Form – the form indicates that the principal investigator (PI) has his or her employer’s approval to conduct the proposed study.

4. Abstract Form – using the form, the abstract must be typed, double-spaced, limited to 350 words, and should address the purpose and significance of the research, the research methodology, and the plan for analysis.

5. IRB Approval Letter – the IRB or Protection of Human Subjects Committee approval letter may be pending at the time of submission, but written approval must be received by ARN before any funds will be awarded.

Proposal Headings
The proposal must include and address the following National Institutes of Health (NIH) headings:

1. Significance
   This section includes the description of the problem, its significance to rehabilitation nursing, a concise and critical review of current literature including an explicit description of how the proposal will build on the ARN white paper, *Essential Role of the Rehabilitation Nurse in Facilitating Care Transitions* (Camicia et al., 2014).

2. Investigators
   Clearly specify the investigator who will be responsible for the conduct of the study (i.e., the PI) and his/her contributions. Describe the functions of all personnel involved with the project (e.g., co-investigators, consultants, or other key personnel). Include a NIH BioSketch (Appendix D) of the PI, all co-investigators, and consultants. Please see NIH BioSketch form and instructions or go to this link for the form and instructions: [http://grants.nih.gov/grants/funding/phs398/phs398_8.html](http://grants.nih.gov/grants/funding/phs398/phs398_8.html)

3. Innovation
   This section provides a description of the study’s potential for challenging or shifting the current research or clinical practice paradigms through the use of such venues as novel theoretical concepts, approaches or methodologies, instrumentation, or interventions.

4. Approach
   This section describes the overall strategy, methodology, and analyses appropriate to accomplishing the study aims or purpose. At a minimum, include a discussion of the design, sample, protection of human subjects, data collection, procedures, instrumentation, analysis, and potential limitations.

5. Environment
   This section describes the scientific environment in which the study will be conducted and ways in which the surroundings contribute to success of the study. Include institutional support, equipment and other physical resources available to the investigator. Additionally, obtain written approval of the appropriate administrator of the institution or agency in which the PI is employed. (Administrative Approval Form)

6. Timeline
   A precise timeline illustrating project tasks and objectives to be completed in less than 2 years is required.

Additional Sections (separate from proposal)

References
References address the bibliographic information of sources cited in the proposal.

Project Budget
A budget for the entire project must be submitted. If RNF funds are to be used for only a portion of the budget, identify the specific items for which you seek support. Identify remaining items to be funded from other sources and in-kind contributions. Clearly describe those sources of funding or support in addition to the amount you are seeking from each entity. Salaries are acceptable costs.

This section must specify the direct costs associated with the research. Travel expenses to the ARN Annual Educational conference for presentations should be included in the budget. Indirect costs and travel expenses for other meeting presentations will not be funded by RNF. The purchase of a computer will not be funded unless significant justification is provided in the proposal. Include notation of contributed funds, personnel, or indirect allowances. The budget must represent sufficient funds to complete the project.
Because funds are not distributed in one sum, the principal investigator should propose a strategy for the receipt and distribution of funds during the length of the project. The strategy should facilitate the conduct of the study and may be done on a semiannual basis, by expense voucher, by task or objective, or by another means. The funding year shall begin January 1, 2017.

**Appendices**

Include all of the following in the Appendices:

- Appendix A: Measurement Instruments
- Appendix B: Institutional Review Board Approval
- Appendix C: Participant Consent Forms
- Appendix D: NIH Biosketches and Other Supporting Documents

**Submission Requirements**

1. Submit the entire packet electronically as a single PDF file.

2. Complete all proposal materials. Incomplete proposals will not be considered.

3. Email proposals to:
   Rehabilitation Nursing Foundation
   info@rehabnurse.org

4. **Deadline - Proposals must be emailed by March 1, 2016 (Noon Central Time).**

   Proposals received after this time will not be considered. An email confirmation will be sent within 48 hours of receiving your proposal. There are no exceptions to the deadline based on failure to receive application materials.

**Evaluation Procedures**

Proposals will be reviewed by members of the Research Fund Committee and a peer review panel. Proposals will be rated according to the NIH criteria for proposal review. For more information see: http://grants.nih.gov/grants/peer_review_process.htm. The Research Fund Committee members will make funding recommendations to the RNF Board of Trustees. The RNF Board of Trustees has the final authority on funding decisions.

All applicants will be notified of the disposition of their proposals after action by the RNF Board of Trustees. Principal investigators will receive a summary critique of their proposal from the review committee.

**Notification of Award**

Grant recipient(s) will be notified in July 2016.

Funds will be awarded to the institution, agency, or investigator at the discretion of the RNF Board of Trustees and will be based on the recommendations of the Research Fund Committee. The strategy for funding proposed by the principal investigator will be considered in the decision. Proof of review and approval the Human Subjects Review Board or Institutional Review Board (IRB) from the PI’s institution must be received by ARN before any funds are awarded.