CARITAS HEALTH GROUP

Caritas Research

Issue#5 Winter 2006

Research can take many forms. In this issue we highlight the importance of surveys and the information that can be obtained. Newer advances in surgery as well as radiological procedures draw our attention to improved patient care, and new cartilage therapy tested by orthopedic specialists may prove useful for arthritis sufferers.

Dr. Fred MacDonald, Caritas Research Centre

Caritas Patient Safety Survey

In recent reviews of our health care system, both the Canadian Nursing Advisory Committee (CNAC) and the National Steering Committee on Patient Safety (NSCPS) express fundamental concerns about the safety of today's health care environments. There is a lack of evidence on the factors associated with successful implementation of patient safety initiatives. However researchers agree that if any change to patient safety is to be successful it has to be done in a culture that supports and promotes safety. With this in mind, the newly formed Caritas Patient Safety and Quality Assurance Committee decided to do a baseline research survey to determine the organization's safety culture.

The aim of the study was to establish the perceptions of staff and physicians regarding patient safety. The Patient Safety Climate in Healthcare Organizations (PSCHO) questionnaire, one of three organizational safety measurement tools identified by the Canadian Council of Health Services Accreditation, was distributed at all three Caritas sites in early 2005. The primary purpose of this instrument is to measure safety climate by assessing the attitudes and experiences about safety climate as enacted in the organization. The survey itself provides for anonymous response; approximately 6000 surveys were distributed to staff and physicians over a two week period. A total of 778 surveys were returned giving an overall response rate of 13.27 % (778/5865). The highest response rate came from management, as 78.02% (71/91) of managers responded to the survey.

The majority of the mean scores for the 38 items were determined to be 3 out of 5, a neutral response which indicates that respondents as a whole neither agree nor disagree with the statements. However, item number 14 – "My unit recognizes individual safety achievement through rewards and incentives" received a score of 1.78 ± 1.08, which indicates that the respondents as a whole disagree with this statement. Item 10 - "Asking for help is a sign of incompetence" and 13 - "If I make a mistake that has significant consequences and nobody notices, I do not tell anyone" (both of which were reversed) had scores of 4.44 ± 0.94 and 4.40 ± 0.94, respectively. Because these scores were reversed, this indicates that overall the respondents do not feel asking for help is a sign of incompetence and are likely to report mistakes. The overall mean score for all 38 patient safety climate questions was 3.25 ± 1.36. This result indicates a neutral patient safety climate.

Karen Macmillan and Jon Popowich, Co-Chairs, Caritas Patient Safety and Quality Assurance Committee

We hoped for a 30% response rate overall but fell well short of this target. The largely neutral range scores may accurately reflect the perceptions of physicians and staff,

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but with the inadequate sample we cannot know for sure. Nonetheless, we can learn from this initiative. **Comparing our experience with research surveys to a recent article by Fleming (2005), we have developed the following recommendations:**

1. Building capacity – need to spend more time strategizing with management and staff on how to get a robust response rate.

2. Selecting an appropriate survey instrument – we chose an instrument that is listed as one of three by the CCHSA.

3. Obtaining informed leadership support – it is critically important to have visible and informed leadership support and public sharing of the findings for successful safety culture measurement and improvement initiatives.

4. Involving healthcare staff - surveys are snapshots with the aim to engage staff in working together for safety.

5. Obtaining a higher response rate on future surveys - the lessons learned should be considered and incorporated into the next attempt.

6. Data analysis and interpretation - safety culture measures provide only a baseline. Ideally organizations would be compared with organizations with the best safety standards.

7. Feeding back survey results

8. Agreeing on safety interventions via consultation - discuss each category of safety and possible strategies to continue monitoring and improving, with staff.

9. Implementing safety interventions - assessments with concrete actions and ongoing communication.

10. Track safety changes over time.

(Fleming, M. (2005). Patient safety culture measurement and improvement: A how to guide. Healthcare Quarterly, 8, 14-19.)

Karen Macmillan and Jon Popowich, Co-Chairs, Caritas Patient Safety and Quality Assurance Committee

Caritas Ethics Survey Results

Gordon Self

In June 2005, the Caritas Ethics Survey was distributed to all staff and physicians to determine how effectively ethics is both personally and professionally practiced at the Edmonton General Continuing Care Centre, and the Grey Nuns and Misericordia hospitals. A total of 746 respondents completed the survey, representing a return rate of approximately 12.4%. Of note, the Caritas Ethics Survey is one of the only known organizational-wide evaluation of ethics conducted at a faith-based health facility in Canada. This is certainly a first for Caritas. The benchmark data will be useful in planning ethics education sessions to better meet the needs of our staff and physicians, and to strengthen our Ethics Consult service. Repeating the survey again in 3-5 years will also track how well the Ethics Service has been accountable in following through with the feedback received, and to identify new opportunities for continuous quality improvement.

Some of the highlight results from the Caritas Ethics Survey include:

Confidentiality – many respondents noted where breaches of patient confidentiality or other inappropriate disclosure of personal information occurred. A campaign is now being planned at Caritas to heighten awareness and clarify corporate expectations in upholding this foundational ethical principle.

Awareness of the Caritas Ethics Service – while some respondents were aware of our Ethics Service and resources, many people were either unaware or unclear as to the role the service plays, or how to access or initiate an ethics consult. Other comments questioned the lack of consistent documentation following a consult. In response to this data, educational sessions were held at all three Caritas sites, entitled, "What's the right Thing to Do? What Can You Expect From The Ethics Service?". A similar article also appeared in the last issue of Insight.

Personal Directives – there is a lingering perception that the role, limits and expectations regarding the use of personal (advanced) directives in clinical decision-making settings remains unclear. Moreover, there were a number of respondents who felt the wishes of the agent named in the patient/resident's personal directive were sometimes ignored or overlooked. A perception exists that physicians are pressured by family members as well. Further exploration in this area is required.

Policy Compliance – a number of respondents indicated a lack of compliance to the policies set by Caritas, and this has resulted in the weakening of the integrity and ethical commitment of the organization. This points to the challenge to be consistent in carrying through with decisions, and to "walk the talk" in terms of ethical principles and standards as articulated in the Health Ethics Guide (the official ethics resource of Caritas, published by the Catholic Health Association of Canada and approved by the Canadian Conference of Catholic Bishops).

Ethics Education – respondents were more likely to have engaged in ethics discussions during education fairs, staff meetings, orientation, and peer to peer consultations. Less attention was given to the once-a-year Caritas-wide ethics venues which tend to attract only a limited number of participants. Based on this feedback, 'Ethics Month' is already being shifted to an 'Ethics Quarterly' format. The survey also points to the opportunity to engage in ethics discussions at department-specific staff meetings, in hopefully, a more meaningful format. These meetings can be arranged with myself or other members of the Ethics Service, at the manager's request.

Summary - Despite some of the opportunities flagged above for improvement, the majority of respondents (94%) felt that healthcare at Caritas was 'important' or 'very important'. It is with this in mind that concerted effort is directed to continually improve the ethics service and to deepen the ethical culture at Caritas. Look for more educational sessions in the future. If you have any comments or suggestions, please call me at 735-2564, or email at gordonself@cha.ab.ca

Finally, special acknowledgments to the Caritas Research Centre for their support in helping learn more about our ethical culture at Caritas.

Gordon Self, Vice President, Mission, Ethics and Spirituality

Parkinson's study to improve healthcare delivery

Dr. Kathy Kovacs-Burns

As Canada's baby boomers age, seniors' healthcare issues are taking on increased significance. In 2001, one Canadian in eight was age 65 years or over. By 2026, one Canadian in five will have reached age 65. And the challenge of an aging population is broader than the delivery of health care. There is also strain on long-term service providers and family caregivers.

Individuals with Parkinson's disease provide a unique window on these challenges. Symptoms of this neurodegenerative disease usually first appear around age 60. Parkinson's affects 1% of the population over age 65 and increases to 2% in the population aged 70 and older. It is estimated that approximately 100,000 Canadians have Parkinson's disease. As a progressively disabling degenerative disease, the social and economic impact of Parkinson's increases over time – for patients, families and the healthcare system.

Given our aging population, how can we make positive changes to meet the needs of individuals affected by Parkinson's? We can't answer that question yet, says Dr. Kathy Kovacs-Burns, Director of Research for the Faculty of Nursing at the University of Alberta. She notes that very little is known about how patients and caregivers experience Parkinson's, certainly not enough on which to base important decisions. "We don't have a good picture of the issues facing Parkinson's patients in northern Alberta. We know very little about how people get information, how they access services, what services they need, and whether there are gaps and barriers in accessing those services. We suspect that there are differences in the experiences of Parkinson's patients who live in rural and urban areas, but we don't know exactly what they are.

"If you want to make informed decisions about what services to fund or enhance, and how to improve the system to accommodate the needs of those affected by Parkinson's, we need this kind of information."

Dr. Kovacs-Burns is leading a study to address this lack of information. Her team is surveying Parkinson's patients and caregivers in northern Alberta (Red Deer north). Both groups were sent detailed questionnaires covering topics such as diagnostic and treatment information, use of support services, costs, perception of services, challenges and needs. The team has received responses from 414 persons with Parkinson's and 329 caregivers. Data analysis began this past summer, and preliminary results have recently become available (see highlights below).

"We've collected a great deal of information," says Dr. Kovacs-Burns. "I'm hopeful our results will be the basis for improved planning. We plan a wide dissemination not only to academic journals, but also to healthcare organizations, physicians and other healthcare workers, and support groups."

This study fits in with the overall theme of Dr. Kovacs-Burns' research – the impact of policy, not only on the delivery of services but also on how this impacts on the health and well-being of vulnerable or marginalized populations. "This research interest evolved from my work experiences with community health organizations and government," she explains. "Many policies reflect of the needs of administrators or funders, as opposed to the people the policies are meant to help. My focus is on how we can involve people in the decision-making process. One of the ways to do this is to gain information about their experiences, which is what we are doing with the Parkinson's project."

Highlights of Results (provided by Dr. Kovacs-Burns)

- Specifically for the Capital Health Region, of the 1,783 people with Parkinson's Disease (2003 Alberta Health data released 2005), 260 responded to the survey. The number of caregivers who responded was 187.
- General demographics of respondents in this survey study were similar to those found in other studies.

The average age of persons with Parkinson's Disease is 71, and the majority were male (62%). The majority of caregivers is female (69%), with about one-third being between the ages of 66 and 75.

- Income levels for both groups were comparable; however, one-quarter of individuals in both groups have less than $30,000 annual income, including those that are retired, working or on assistance.
- About 56% of persons with Parkinson's thought that they were mild to moderately impaired with physical and other changes. Another 26% were significantly impaired and 6% were confined to their bed or wheelchair.
- About 55% of caregivers said that having to look after someone with Parkinson's Disease has made no difference to their health, while 32% said the opposite – the situation has made their health worse. Other personal and social challenges were identified as well.
- Both groups of respondents were somewhat or very satisfied with the level of medical care that the person with Parkinson's received. The neurologist was seen to be critical for diagnosis (58%), treatment and follow-up care (for over 62% of persons with Parkinson's).
- Of other services, Physical Therapy was the most referred to persons with Parkinson's (36%) and found to be the most helpful (31%)
- The likelihood of persons with Parkinson's using various therapies and support services if they were available in their community was split 50/50. The services that persons with Parkinson's would most likely use if they were available, near them or in their communities include exercise groups, toll-free information line, Parkinson's Clinic, free transportation to appointments, homemaker services, speech therapy, and massage therapy. These same services were identified as 'valued' by at least 43% of both groups.
- Various types of Parkinson's information were required or desired by both groups, particularly "symptoms over time", "changes and Parkinson's", treatment, and living well. The neurologist, family doctor, and Parkinson's Society of Alberta offered the most valued information. Caregivers also went to the Internet (30%), and to support groups (24%) for information as needed.
- On average, 8 – 10 hours of Home Care was utilized by about 17% of persons with Parkinson's.
- Those individuals with Parkinson's in long term care or nursing home facilities, said they were generally satisfied with various aspects of care, rehabilitation, daily routines, and knowledge of nursing staff.
- About 83% of people with Parkinson's have drug medical coverage. Additional costs are paid out of pocket by 11% of individuals, up to about $200 per month in some cases. The majority (91%) of persons with Parkinson's said they would pay out-of-pocket for their meds if they had to. Presently 29% of these individuals were paying for their assistive devices. About 81% have had their homes accessible ready.
- The Parkinson's Society of Alberta was well-known to about 74% of respondents from both groups, where different information, support and events were accessed.

Conclusion

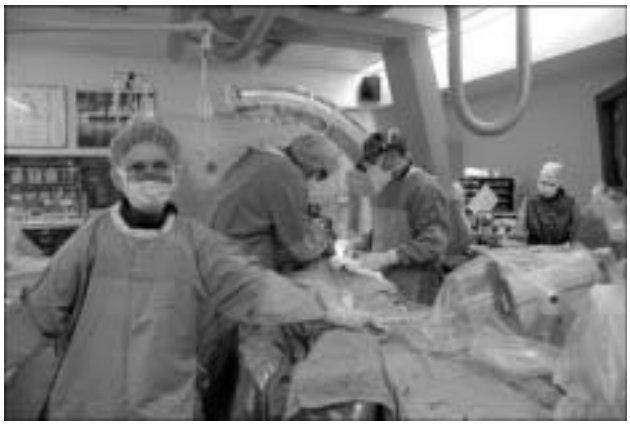
Recommendations have been made based on the study results. In addition, further analysis of the data will be conducted for each of the six health regions, caregivers, rural and urban comparisons, and other correlations.

Endovascular surgery well-established at Grey Nuns Community Hospital

Endovascular surgery

A new, less-invasive procedure for treating some of the major problems that can develop in blood vessels is now available in Edmonton. It's called endovascular surgery – vascular surgery that is carried out from within a blood vessel. Vascular surgeon Dr. Robert Turnbull learned the procedure while on a fellowship in Vancouver in 1996 and brought the skills and knowledge back to the Grey Nuns Community Hospital, the only site in Northern Alberta for endovascular surgery.

"It's an exciting time to be a vascular surgeon because this technology has so much potential," says Dr. Turnbull. "Endovascular surgery only began about 10 years ago and we've been doing it here for six years. It is part of the trend toward minimally invasive surgery. Endovascular surgery offers significant benefits compared to traditional open surgery – a shorter hospital stay, faster recovery, less pain and less risk of complications."

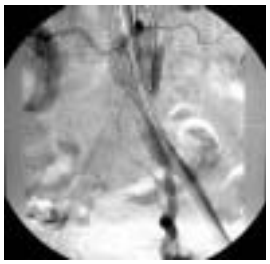


Left to right, Birdie, Xray Tech; Dr. Guspie, Radiologist; Dr. Turnbull, Surgeon; Lorraine, OR Nurse in the Angiography Suite.

There's now a team of vascular surgeons and associated healthcare professionals – including angiographers, interventional radiologists and technicians – practising endovascular surgery in Edmonton. "It's not just the surgeon who makes this happen," notes Dr. Turnbull. "You need a lot of other people who know what they're doing. It's definitely a team effort."

One of the major uses for endovascular surgery is to treat problems with the aorta, the main artery leading away from the heart, and this is a specialty area in Edmonton. The particular conditions treated are aneurysms, traumatic tears and aortic dissection.

During most endovascular procedures, a long plastic tube called a catheter is placed into the femoral artery at the top of the leg. Using X-ray imaging, the surgeon advances the catheter to the problem area of the aorta. A hollow tube made of Dacron (called the graft) is attached to a spring mechanism called a stent. The combined stent-graft (in a collapsed position) is advanced up the catheter. Once it is at the correct location, the stent-graft is expanded so that it presses against the inner walls of the artery. The graft reinforces the weakened section of the aorta.



"The engineering behind this is truly amazing. It is an ingenious system," says Dr. Turnbull.

As of August 2005, the endovascular team had performed endovascular procedures on 125 patients. They currently perform about 50-60 cases per year. Based on tens of thousands of cases worldwide, outcomes are excellent – morbidity and mortality are orders of magnitude better than open surgery. Recovery time is about a week, compared to 6 to 8 weeks with open surgery. And while the initial cost of endovascular surgery is high – from $10,000 to $15,000 – there are substantial overall savings. Endovascular patients don't spend the day after surgery in the ICU (as open surgery patients do) and they don't spend as much time in the hospital (an average of 3.6 days compared to 7 days with open surgery).

Endovascular surgery is suitable only for certain patients. Some patients do not qualify because of anatomical criteria. For example, the branching of their blood vessels means there isn't enough room to put in the stent-graft, or their pelvic arteries are too twisty to insert a catheter.

Another potential limitation is the long-term durability of the grafts, which is unknown because the procedure has been widely used only since 1995. Because the graft is covering the problem – be it an aneurysm or a tear – if the graft shifts position or fails in some way, the problem would still be there. That is why younger, healthy patients may opt for open surgery over endovascular surgery. "Patients who are in good condition can tolerate invasive surgery," explains Dr. Turnbull. "They pay up front in terms of a longer recovery, but they know the problem has been fixed. With endovascular surgery, there is the possibility that they could require a further intervention down the road.

"On the other hand, there are many patients for whom open surgery is very risky. For many of them, endovascular surgery is the best choice."

To gather data on the long-term performance of the stent-grafts, endovascular surgery patients are followed closely with CT scans at three, six and twelve months after surgery, and then every year after that.

Endovascular surgery just got a boost with the purchase of a high-end portable X-ray machine at the Grey Nuns Community Hospital. This will allow the endovascular surgery team to perform procedures in the operating room, as opposed to the angiography suite. "Ideally you want to do endovascular surgery in a specialized surgery/X-ray suite," says Dr. Turnbull. "That is our next goal."

Research group tests new arthritis therapy

Orthopaedic surgeon Dr. John Cinats sees the devastating effects of arthritis every day. He cites the case of a young man – a patient of his – who had developed severe arthritis in his knee. "The treatment option for his end-stage arthritis is knee replacement, but this patient doesn't qualify because he is only in his 20s," explains Dr. Cinats. "He will have to wait until he is 50 for that surgery. It's very disheartening to have to tell a patient that kind of news.

"The problem is that right now we don't have effective treatments to stop the progression of early arthritis or reverse the degeneration in end-stage arthritis. It is the overriding goal of our research."

Dr. Cinats works with a team of researchers at the University of Alberta including orthopaedic surgeon Dr. Nadr Jomha, cell biologist Dr. Keith Bagnall, radiologist Dr. Robert Lambert and physical therapist Dr. Lauren Beaupre, as well as orthopaedic engineers James Raso and Edmond Lou from the Glenrose Hospital. They study osteoarthritis, the 'wear-and-tear' kind of arthritis that results from damage to articular cartilage, the essential shock absorber of the joints. Unlike many other kinds of tissue, cartilage does not regenerate. The researchers hope to change that.

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"Because we've amassed a wide range of expertise in our team, we can approach the problem of cartilage growth at a number of different levels," says Dr. Cinats. "One of our interests is a kind of cartilage therapy that uses pulsed electromagnetic fields (PEMF)."

PEMF therapy applies a very specific, electrical signal to the skin overlying the joint. The idea behind the therapy is that electrical signals stimulate chondrocytes. These are the cells in the cartilage that produce the matrix – the highly specialized tissue that can withstand enormous compressive forces – and orchestrate the metabolic processes that repair damaged cartilage.

For the past three years the team has focused on developing a laboratory model to study chondrocytes. They began by harvesting healthy cartilage during knee and hip replacement surgeries, bringing the tissue to Dr. Bagnall's lab for cell culture. The team has found a way to preserve the cell line in order to ensure an unlimited supply of chondrocytes. They have also developed a more realistic way of growing chondrocytes, one that mimics the 3-D environment of a human joint. This work has allowed them to undertake cellular-level studies to understand how chondrocytes grow, and how electromagnetic fields can facilitate their movement. (Dr. Cinats' son David, who is in his third year in science at the U of A, has worked in Dr. Bagnall's lab for the past two summers.)

Success in the lab has paved the way for a clinical trial, which is currently being piloted. The study group is made up of patients who are getting treatment for osteoarthritis caused by bow legs. Standard treatment is to wear a brace that eases the stress on the inside part of the knee. In the study, a PEMF generator – a device the size of a cell phone – will be attached to the brace. One group will have a functioning generator; the other will have a placebo generator. The team hopes to enroll a total of 160 people.

Each group will be closely monitored. A new protocol for MRI screening of changes in cartilage in the knee has been developed by Dr. Lambert's group. To date, MRI has been used to assess cartilage tears, but not subtle changes. "This protocol gives us an objective tool to measure results," notes Dr. Cinats. "It will complement the more subjective information we get from patients."

The team is also collaborating with University of Calgary nanotechnology researcher Dr. Daniel Kwok. He is investigating the potential for using PEMF to guide tiny 'nanocarriers' to the appropriate position in a joint after injection. These nanocarriers could be used to carry drugs or even chondrocytes directly into the cartilage.

The team is seeking more funding to expand the research. Dr. Cinats hopes the pilot stage of the clinical trial will provide results of interest to funding agencies.

"We're very fortunate to have such a highly qualified group of people to work on this project," he says. "It's not just the principal researchers who make this a success. We have technicians, students and fellows in the lab, and nurses in the hospital who contribute greatly. Multidisciplinary research like this only works when everyone is committed to working together."

Did you know that?

- 48,475 hospitalizations for total hip and knee replacements performed in Canada in 2002-2003, of which 48,419 were performed on Canadian residents. Compared to 1994/95 numbers, the number of total knee replacements in 2002/03 increased by 77%. The number of total hip replacements increased by 33% compared to 1994/95.
- Women were more likely to have a total hip replacement procedure compared to men in 2002-2003. Among total hip replacement recipients, 59% were female and 41% were male.
- Women also had a higher rate of knee replacement compared to men. Among total knee replacement recipients, 61% were female and 39% were male.
- The mean age of a patient who underwent a total hip replacement in Canada was 68 years in 2002-2003.
- There has been a decrease in average length of stay for these procedures since 1994/95. For total hip replacements, the average length of stay decreased by 29.4% from 13.6 days in 1994/95 to 9.6 days in 2002/03.
- For total knee replacements, the average length of stay decreased by 39.3% from 12.2 in 1994/95 to 7.4 days in 2002/03.
- Degenerative osteoarthritis was the most common diagnosis grouping indicated for both primary total hip replacements (81%) and primary total knee replacements (92%).
- For total hip replacements, the second most commonly reported diagnosis grouping was osteonecrosis (5%) followed by inflammatory arthritis (4%).
- For total knee replacements, the second most commonly reported grouping was inflammatory arthritis (5%), followed by post-traumatic osteoarthritis (2%).

Reference: Canadian Institute for Health Information. Canadian Joint Replacement Registry (CJRR) 2005 Report

Caritas Research Day 2006

The 2nd Annual Caritas Research Day was held on January 26, 2006 at the Grey Nuns Community Hospital. The Caritas Research Steering Committee extends a special thank you to the following guest speakers and researchers for contributing to this event:

Dr. Lorne Tyrrell, Professor and CIHR/GSK Chair in Virology, Department of Medical Microbiology and Immunology, University of Alberta

Dr. Jana Rieger, Clinical and Research Fellow, COMPRU and Assistant Professor, Speech Pathology and Audiology, University of Alberta

Dr. Liana Urichuk, Research Associate, Child and Adolescent Services Association.

Dr. Shoo Lee, Scientific Director, Integrated Centre for Care Advancement through Research (iCARE), University of Alberta and Capital Health formerly Centre for Health Outcomes Research

Dr. Lola Baydala, Physician, Child Health, MCH and Associate Professor, Pediatrics, University of Alberta; **Dr. Hedy Bach**, Research Associate, MCH Pediatric Research Group and Lecturer, University of Alberta

Leanne Loranger, Senior Physical Therapist, Misericordia

Dr. Carole Estabrooks, Professor & Canada Research Chair in Knowledge Translation, Faculty of Nursing, University of Alberta

Janice Chobanuk, End of Life Palliative Care Clinical Educator, Edmonton General

Dr. Anne Neufeld, Professor, Faculty of Nursing, University of Alberta

Dr. Clifford B. Sample, General and Minimal Access Surgeon, Department of Surgery, University of Alberta and Grey Nuns Community Hospital.

Dr. Shrawan Kumar, Professor, Department of Physical Therapy, Faculty of Rehabilitation Medicine and Professor, Neuroscience, University of Alberta

Jeremy E. Shragge, Chairman, Graduate Students' Association of Canada & MSc Candidate: Nutrition and Metabolism International Institute for Qualitative Methodology, University of Alberta

Dr. G. Richard Spooner, Professor & Chair, Department of Family Medicine, University of Alberta and Physician, Grey Nuns Family Medicine Centre

Dr. Rebecca Davis Mathias, St. Joseph's College, University of Alberta and **Gordon Self**, Vice-President, Mission, Ethics and Spirituality, Caritas Health Group

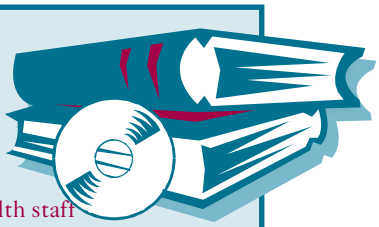
Dr. Lorne Tyrrell

Thank you to the researchers who also provided and/or presented posters.

Please contact the Caritas Research Centre if you were unable to attend and would like a copy of the research abstracts or slides. The event was video-taped. DVDs will soon be available for viewing through Library Services at MCH and GNCH.

Thank you to the staff of Audio Visual Services, GEM Catering and Environmental Services for their invaluable support and assistance.

Exciting news from Library Services! More Healthcare information at your fingertips!



The following *new* electronic resources have been added to the *e*-Library:

A-Z *e*-Publications – a searchable database of all *e*Resources available to Caritas & Capital Health staff
Clinical Evidence – a searchable database of evidence-based responses to over 200 clinical questions; under the Nursing Books @ OVID link
***e*CPS –** Canadian drug information
images.MD – over 48,000 medical images with accompanying description
Nursing Books @ OVID – eight new full-text nursing textbooks
Capital Health/Caritas Journals – over 200 new journals supporting medicine, nursing and allied health

Contact Library Staff for more information or to schedule an *e*Library instruction session – Grey Nuns 735-7300; Misericordia 735-2708.

Research Corner

Violet Pui

M. Violet Pui, MSc, OT(C), OTR, occupational therapist at the Grey Nuns Community Hospital, published an article based on her masters degree research study in the October 2005 issue of Canadian Journal of Occupational Therapy, Volume 72 Number 4.

The title of the article is Continuing professional education and the Internet: views of Alberta occupational therapists.

Background

Occupational therapists have identified barriers to accessing continuing professional education (CPE) in the traditional face-to-face formats. One alternative to traditional, centrally located, face-to-face CPE is course delivery through the Internet.

Purpose

This study examined Alberta occupational therapists' perceptions of Internet-based continuing professional education.

Method

A questionnaire was mailed to 800 randomly sampled Alberta occupational therapists (response rate = 35.5%; n = 281).

Results

Respondents pursued CPE to increase skills, knowledge and maintain clinical competency. They reported that a face-to-face CPE course was more useful than distance courses. Although almost 90% of respondents had access to computers with an Internet connection at home or at work, and nearly 65% thought that their computer knowledge was sufficient, only 2.9% had previously taken Internet-based CPE.

Practice Implications

In order for the Internet to be accepted as a common, useful and alternative delivery tool for CPE in occupational therapy, the perceived barriers such as the lack of personal time, cost, and limited interaction with other learners and instructors will need to be addressed.

Check out the new Caritas website. This new website includes a Research section designed to assist researchers. **http://www.caritas.ab.ca**

Connie Bryson contributed the following articles in this newsletter; *Parkinson's study to improve healthcare delivery, Endovascular surgery well-established at GNCH* and *Research group tests new arthrits therapy.* Connie is an Edmonton-based freelance writer specializing in science, technology and business topics. She is the winner of the 1999 ASTech Excellence in Science and Technology Journalism Prize.

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