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| The purpose of this document is to assist study teams, TGH nursing leadership and the TGH Office of Clinical Research (OCR) in determining the feasibility of bedside nursing support & awareness of research studies. Please complete the following tasks:* Identify all TGH units that will be impacted by the research study.
	+ Identify the top 3 units where majority of research procedures will be performed
* Complete one worksheet for each identified unit.
* Complete the “items” column utilizing the applicable study documents.
* Meet or have a phone conference with the identified nurse managers and educators to review the study specifics.
* Summarize contributions and expectations of both the unit and research teamin the “comments” column.
* Identify which study tasks will be performed by the research staff in the AWARENESS column.
* Identify the amount of additional time for research activities, in increments of 0.25 hours, that will be required from **bedside** nurses for each applicable line item and capture the information in the SUPPORT column.
* Ensure each worksheet is completed in its entirety.
* Print a copy of the worksheet.
* Obtain signatures.
* Utilizing information from the worksheet, complete the TGH Hospital Unit Support of Research Study letter.
* Route worksheet(s) and letter to Janet Davis, jdavis@tgh.org, Senior Vice-President & Chief Nursing Officer, for approval and signature.
* Submit Unit Support & Awareness Worksheet and TGH Hospital Unit Support of Research Study approval letter with the Research Study Proposal Form.
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| **Study Information** |
| Full Study Title: |  |
| Short Study Title:  |  |
| Study Protocol Number: |  |
| Projected Enrollment #s: |  |
| PI Name: |  |
| Study Coordinator:  |  |

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| Meeting Information |
| Meeting Date/Time/Location: |  |
| Research Representatives: |  |
| Unit Nurse Manager: |  |
| Additional Unit Representatives (Name,Title): |  |

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| **List all TGH Hospital Units that will be impacted by the study and/or care of the patient:**  |
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| **Items** | **Nurse Manager Meeting Comments** | **AWARENESS: Study Staff will perform task** **Yes or No** | **SUPPORT: Additional Bedside Nursing Time Required per Patient (increments of 0.25)** |
| Please describe below any nursing support and unit supplies required for the study or indicate none: |
| * Investigational Product (IP) Administration
 |  |  |  |
| * Special procedures
 |  |  |  |
| * Vital signs/Assessments
 |  |  |  |
| * Blood draws
 |  |  |  |
| * Supplies
 |  |  |  |
| * Special monitoring
 |  |  |  |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
 |  |  |  |
| List possible side effects of the IP: |  |  |  |
| Describe the education plan for the effected hospital units: |  |  |  |
| What unit representative will attend the SIV? |  |  |  |
| Will order sets be provided as part of the study? [ ]  YES [ ]  NO* Describe:
 |  |  |  |
| Will a Research Information Sheet be provided as part of the study? [ ]  YES [ ]  NO* If no add a comment
 |  |  |  |

Worksheet Completed by: Study Coordinator:

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PRINT NAME PRINT NAME

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Signature/Date Signature/Date

Unit Nurse Manager:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/Date