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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](mailto: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