SOUTHERN ILLINOIS UNIVERSITY
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2026 DNP Poster Presentations Post-Master

Thursday, April 30, 2026

Reducing Avoidable Hospitalizations from Long-Term Care Facilities Through Interdisciplinary Team Education

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PROBLEM INTRODUCTION

Why it Matters

Avoidable transfers increase resident risk and cost; early recognition + structured communication can reduce them.

PROJECT METHODS

Pretest
- n=232
- complete=217

- Asynchronous Education Modules

Posttest
- N=15
- 6.5% response rate

IMPACT ON PRACTICE

Results identified STOP & WATCH as the key knowledge gap, making it the priority for frontline coaching. Next steps include scenario-based microlearning pairing STOP & WATCH with SBAR escalation and tracking process metrics (STOP & WATCH use, SBAR completeness, callback timeliness, ACP documentation) alongside monthly transfer trends.

LITERATURE REVIEW

- Care Paths
- Transfer Tracking
- QI Review

Interact

- Early-change observations
- Frontline cueing

Stop & Watch

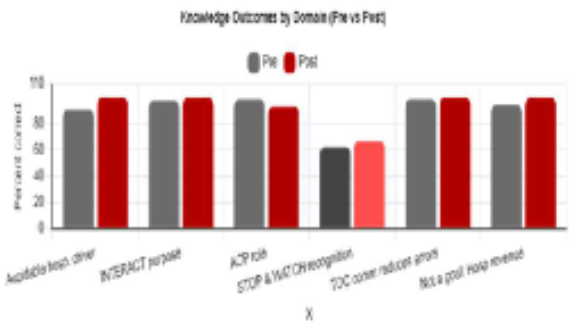
- Structured escalation
- Documentation

SBAR

- Goal-centered decisions
- Avoid unwanted transfers

ACP

EVALUATION



CONCLUSIONS

Take-Home:

STOP & WATCH remains the key target for practice reinforcement

Enhancing Early STI Screening among Adolescents in the Emergency Department: Increasing Utilization of the Adolescent Questionnaire on Sexuality

Licia Dones MSN, PMHNP-BC and Dr. Jane Hunt
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PROBLEM INTRODUCTION

- High STI rates among adolescents require early identification and intervention.
- There is a need for consistent sexual health screening of adolescents in the emergency department. Many adolescents do not receive this care within their primary medical home, making emergency department visits a valuable opportunity to provide routine and preventive healthcare services.
- Prevention of complications and improved outcomes depend on timely screening, education, and treatment.
- The Adolescent Questionnaire on Sexuality (AQS) was developed in the SLCH to identify STIs in adolescents in the ED.

PROJECT METHODS

- Baseline AQS completion rates were collected from the electronic health record for rooms 3–6 in the emergency department.
- Education and workflow reinforcement were provided to nursing staff on the importance of administering the AQS.
- AQS completion rates were monitored after implementation using data from the electronic health record.
- Pre- and post-implementation completion rates were compared to evaluate the effectiveness of the intervention.

IMPACT ON PRACTICE

- Implementation of consistent adolescent health screening by emergency department staff.
- The AQS process can continue to be utilized in the emergency department workflow.
- The predicted long-term impact has improved early identification of sexual health risks and expansion of screening practices throughout additional pediatric care areas.
- Through this project, it was recognized that behavioral health patients needed additional ways to be given sexual and reproductive healthcare resources after the visit, as QR code scanning is not available to these patients who do not have devices.

LITERATURE REVIEW

- The literature supports that structured adolescent screening tools improve early identification of STI risk behaviors and increase screening rates.
- Improving adolescent access to timely screening, education, and treatment while preventing long-term complications should be a priority for healthcare providers caring for this population.

LIMITATIONS

- Workflow demands and device availability presented barriers to this project.
- Some behavioral health patients were unable to safely complete the questionnaire, which resulted in a decline in participation in this project.

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CONCLUSIONS

- We identified a way to provide resources to patients with behavioral health concerns through the request of printing these resources.
- Despite education and reminders, AQS utilization did not increase. Future work should understand key stakeholders perspectives on how to improve AQS utilization, particularly in those presenting with behavioral health complaints.

Improving Screening Mammograms

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PROBLEM INTRODUCTION

Breast cancer is the second leading cause of mortality among women despite effective screening methods. With adherence to mammography guidelines remaining suboptimal.

Barriers such as limited access to care, socioeconomic factors, time constraints, and patient hesitancy contribute to inconsistent screening implementation.

Variability in provider knowledge and implementation of evidence-based guidelines may further impact screening practices.

PROJECT METHODS

- **Design & Setting:** Quality improvement project in an internal medicine clinic using a pre- and post-survey design
- **Participants:** Inclusion—primary care providers actively practicing at the clinic; Exclusion—researcher (to reduce bias), provider on maternity leave, and clinical staff
- **Data Collection:** NSPCP (2025) Part B survey (37 questions) administered anonymously; 12-week tally tracking of patient scheduling preferences and risk assessment completion
- **Intervention & Evaluation:** Provider education on screening guidelines followed by post-survey to assess changes in knowledge, barriers, and screening practices

LITERATURE REVIEW

- Breast cancer screening reduces mortality; guidelines recommend routine mammography starting at age 40
- Risk includes non-modifiable (age, genetics, family history) and modifiable factors (obesity, inactivity, alcohol use)
- Social and system-level barriers limit screening adherence and contribute to disparities
- Provider knowledge gaps and workflow inefficiencies impact guideline adherence, education and improved access may enhance screening rates

EVALUATION

Survey Findings: B1 (Provider Screening Recommendations): +10% improvement

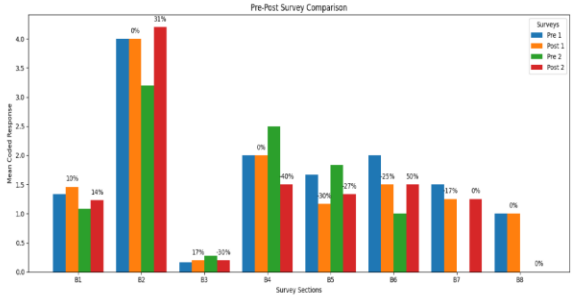
B2 (Screening Type for Average-Risk Women): +31% improvement

B5 (Patient Barriers): decreased by 30% (Survey 1) and 27% (Survey 2)

B6 (Practice Barriers): decreased by 25%

Minimal change in **B3 (Delivery of Care), B4 (Referral Volume), and B8 (Clinical Breast Exams)**

Statistical Analysis: Paired t-test showed a **significant difference ($p < .001$)** between pre- and post-survey responses



IMPACT ON PRACTICE

- Improved provider knowledge and adherence to evidence-based breast cancer screening guidelines
- Increased screening completion rates, contributing to clinic performance improvement (**75.1% to 78.8%**)

LIMITATIONS

- Small sample size (**n = 2**) limits the ability to generalize results
- Self-reported survey data may introduce response and social desirability bias
- Screening completion was not tracked, limiting outcome evaluation
- Short implementation period and data collection challenges may affect accuracy
- Analysis also did not include formal statistical testing to determine the significance of observed changes, limiting ability to determine definitive conclusions about intervention effectiveness

CONCLUSIONS

- Provider education and workflow strategies, including same-day mammography and clinic-scheduled appointments, may enhance screening adherence when consistently implemented.
- Future efforts should focus on improving documentation of screening completion and expanding sample size and duration to better evaluate intervention effectiveness and support stronger statistical analysis.

Improving Nurse Well-Being Through A Mindfulness-Based Education Strategy

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PROBLEM INTRODUCTION

- Nurses, particularly those working at the bedside, experience significant trauma, stress, and fatigue, placing them at high risk for burnout and compassion fatigue (CF)
- Nurses experiencing CF are also more likely to report an intention to leave their positions.
- In 2021, national nurse turnover reached 27.1%, with each nurse departure costing healthcare organizations an average of $46,100 and requiring up to six months to replace.
- Northwestern Huntley Hospital had a large volume turnover of nursing staff and management during and following COVID.

PROJECT METHODS

- This project evaluated the effectiveness of a mindfulness-based intervention among ICU nurses at a Level II suburban hospital in northern Illinois.
- The intervention took place over 8 weeks and consisted of learning modules and exercises designed to improve resilience and reduce burnout.
- A program including eight modules were assigned via the organizational Teaching and Learning module.
- Each module contained an introduction to the topic, short videos obtained from the American Nurses Association's website (with permission), and post-module activities to promote engagement with the materials.
- Burnout and resilience were measured using the Copenhagen Burnout Inventory–Short Scale and the Connor-Davidson Resilience Scale before and after an eight-week mindfulness program.
- Forty nurses were recruited, with 12 enrolling in the intervention and all 12 completing the post-intervention survey.

IMPACT ON PRACTICE

- Findings from this subject group were mixed, however, several studies have shown that mindfulness interventions may help nurses better manage stress and burnout.
- Decreased burnout has been linked to better patient outcomes and decreased intention to leave for nursing staff.

LIMITATIONS

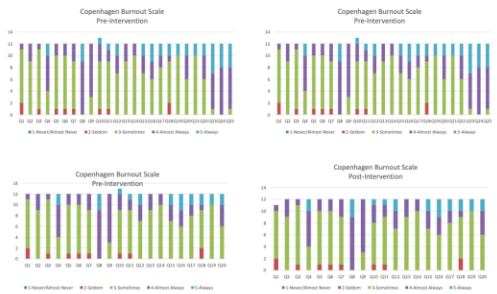
- Limited sample size.
- Stakeholder buy-in.
- Changes in management and staff during the project implementation.

LITERATURE REVIEW

- Burnout continues to contribute to workforce instability, with approximately one-quarter of healthcare professionals reporting consideration of leaving their roles.
- Prioritizing self-care is crucial to well-being, and mindfulness can be a central component of a healthier work-life balance (Banks, 2015).
- In a study of 124 urban firefighters, increased mindfulness was associated with fewer symptoms of PTSD and lower levels of depression, as well as avoidance of PTSD symptom development (Smith, et al, 2011).
- Increased self-care behaviors, support systems with other nurses, and support from family and friends can also serve as resilience builders (Christianson, et al. 2023).

EVALUATION

- Pre-intervention results indicated moderate levels of burnout and minor-to-moderate resilience.
- Following the intervention, both burnout and resilience scores decreased or remained stable.



CONCLUSIONS

- Although the result of this intervention did not show an improvement, several studies have supported that mindfulness interventions may help nurses better manage stress and burnout.
- Future areas of study could expand on mindfulness techniques and incorporate them into daily practice.
- Future projects could include a longer study with a larger sample size
- Future study recommendations include a check-in with the subjects in 6 months to assess if mindfulness education was successful in the short term or over the long term

Temporary dialysis catheters: A QI project to examine evidenced-based practices and reduce rates of malfunction

Lauren McDonnell

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PROBLEM INTRODUCTION

- Acute kidney injury is common in the ICU
- Many will require continuous renal replacement therapy (CRRT)
- The temporary dialysis catheters used for RRT have many complications that delay care and increase nursing burden

Aim: To examine unit-based practices as they relate to evidence- based catheter practices (EBP) and reduce rates of catheter malfunction.

LITERATURE REVIEW

- A literature review revealed several factors affecting catheter function

More complications:

Nontunneled lines[3,4,6,7]

Left IJ insertion [1,3,5,7]

Subclavian insertion[1,3,5,7]

Tip in lower SVC or CAJ [3,4,6,7]

Less Complications:

Tunneled lines [3,4,6,7]

Citrate/heparin lock [5]

Right IJ insertion [1,2,3]

Bilateral femoral insertion [3,4,5,7]

Tip in upper right atrium [3,4,6,7]

[1] Benichou, et al, 2021 [2] Bitunguramye, A., et al 2024 [3]Hu, et al.,2024 [4]Kelly, et al., 2023 [5]Lok, et al, 2019 [6]Mendu, et al., 2017

PROJECT METHODS

Site: Urban, 17 bed medical ICU
Inclusion criteria: Patients admitted to the ICU requiring CRRT
Exclusion Criteria: Patients admitted to the ICU not requiring CRRT.

IRB approval

Data Collection

Descriptive analysis and identification of intervention

Intervention Identified – sodium citrate instillation after line insertion

Intervention implemented

Results/Evaluation

Variable	P-value (line malfunction; downtime)
Tip Location	< .001; <.001
Insertion Site	.166; <.011
Citrate Instillation	<.001; .026

- 3 variables had a statistically significant relationship with line malfunction; 2 with machine downtimes
- A recommendation was made to trial instillation after line insertion.
- Intervention went into effect on Nov 2, 2025.
- Findings demonstrate a modest reduction in catheter-related issues and unplanned machine downtimes in the citrate group (31.41% and 13.09%) when compared to the non-citrate group (38.46% and 21.74%)

IMPACT ON PRACTICE

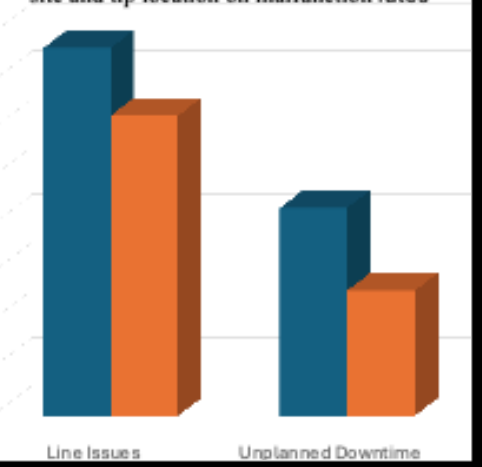
- Alerted unit to deviations from EBP
- Implemented citrate instillation post catheter insertion

LIMITATIONS

- Staff buy-in
- Time burden
- Retrospective data collection
- Compliance with intervention
- Small sample sizes

CONCLUSIONS

- Data collection ongoing to evaluate trends in catheter-related issues and line failure over time.
- Citrate instillation in temporary dialysis catheters may reduce rates of catheter malfunction
- Future directions for the project include reinforcing nursing education and further examining the impact of insertion site and tip location on malfunction rates



A Quality Improvement Project to Decrease the Number of Indwelling Foley Catheter Days in Admitted Patients with Acute Urinary Retention

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PROBLEM INTRODUCTION

The Centers for Disease Control and Prevention (2008) state Catheter associated urinary tract infection (CAUTI) is preventable and is not reimbursed to hospitals.

Indwelling Foley catheters are the greatest risk factor and the most important modifiable risk factor for CAUTI (Shuman & Cherneworth, 2018).

Acute urinary retention is the inability to adequately void the urinary bladder and requires drainage via intermittent catheterization or an indwelling Foley catheter (Giblin, Kowalik, & Plante, 2020).

Factors that may impact acute urinary retention include constipation/fecal impaction, effects of individual or cumulative effects of medications, immobility, voiding method, post-operative status, and mobility status (Nguyen, et al., 2016).

The project aim was to create and implement a Fight the Foley EMR prompted pre-catheter insertion checklist to identify and treat modifiable risk factors impacting urinary retention while using intermittent catheterization to reduce the need for an indwelling Foley catheter during hospital admission.

Factors of focus include constipation/fecal impaction identification and management, screening for current use of medications affecting urinary retention that could be dose adjusted or discontinued, prescribing an alpha blocker medication, encouraging ambulation, and out of bed to void to improve bladder emptying.

LITERATURE REVIEW

Keywords terms/phrases: acute urinary retention, indwelling Foley catheter, CAUTI, catheter-associated urinary tract infection, preventing acute urinary retention, screening for urinary retention, catheter algorithm, management of acute urinary retention, reducing catheter use, risk factors for urinary retention, constipation and lower urinary tract symptoms, and medications.

Common causes identified included anatomical or mechanical obstruction, postoperative status, side effects of medications, neurological comorbidities, decreased mobility, infection, and iatrogenic causes (Ryan et al., 2020).

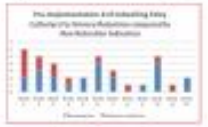
CINAHL, Medline, PubMed, Google Scholar, OVID, Discover Search Engine, AUA, CDC

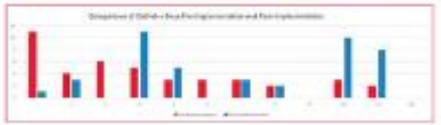
Literature supported the use of a bladder scanner to identify urinary retention. Consensus was lacking on an acceptable post-void residual to define urinary retention and when to intervene with catheterization.

Ann Arbor Criteria defined appropriate and inappropriate indications and use of intermittent catheterization and placement of an indwelling Foley catheter (Meddings et al., 2015).

EVALUATION

- A 12% decrease in the percentage of catheters for urinary retention was recorded. Pre-implementation, 38% of catheters were due to urinary retention, compared with 26% post-implementation.
- No significant change (p-value of 0.95) in the number of days was documented due to 2 outlying complex patients requiring extended catheterization and classified by staff as urinary retention.
- If outlying patients were excluded, a decrease from 42 pre-implementation catheter days to 28 post-implementation catheter days occurred; however, despite this consideration, no significant change would have been recorded (p-value of 0.33).
- Post-implementation use of intermittent catheterization increased and prevented placement of 13 indwelling Foley catheters.





LIMITATIONS

- The new protocol of performing intermittent catheterization up to 4 times before an indwelling catheter was placed was not followed by all nurses; documentation reflected continuation of the previous policy.
- Nursing staff did not place intermittent catheter orders per policy/protocol; this limited the pharmacy urinary retention order from prompting a clinical pharmacist review of medications with potential to cause retention or providing a recommendation of an alpha blocker.
- When the pharmacy urinary retention order was prompted due to an indwelling catheter, the order did not flow to the pharmacist's queue for review due to the rule not being created properly by information systems.
- 5 of the 12 indwelling Foley catheters were placed on the pilot unit. The other catheters were placed on outside units not yet implementing the "Fight the Foley" protocol for urinary retention.
- A patient with an indwelling catheter for 11 days due to immobility was documented by nursing staff with the indication of urinary retention.

PROJECT METHODS

The project was implemented as a pilot on a 21 bed medical-surgical unit at a moderate sized acute care hospital in the Midwest.

Criteria for inclusion--adult patients with an indwelling Foley catheter placed for urinary retention.

Exclusion criteria--patients with a chronic Foley catheter, catheter placed for intake and output, surgical procedures, placement for healing of a perineal or sacral wound, difficult catheterization, catheters placed by urology service, and end of life care.

A urinary retention checklist was created in the EMR to be activated with the placement of an indwelling Foley catheter or the use of intermittent catheterization with an indication of urinary retention.

The checklist addressed screening and treating constipation, ambulation, out of bed to void, treatment of infection, pharmacy consult for medication review, and use of intermittent catheterization.

In-service education was provided to involved healthcare professionals prior to pilot project implementation.

Data was collected 12 weeks pre-implementation and compared to data collected 12 weeks post-implementation.

IMPACT ON PRACTICE

The quality improvement project highlighted the importance of considering factors that may contribute to urinary retention and working to modify/correct them during admission to reduce the need for an indwelling Foley catheter.

Implementation of the "Fight the Foley" Power form checklist into the EMR, use of intermittent catheterization, and clinical pharmacist review of medications decreases the number of indwelling Foley catheters placed during inpatient admission.

CONCLUSIONS

Although the final p-value was not statistically significant, the pilot study demonstrated a decrease in foley catheter days with implementation of the protocol.

An increased use of intermittent catheterizations was noted.

Following the pilot launch, the stakeholder adopted the new protocol hospital wide.

Further development of this quality improvement on a larger scale has the potential to produce statistically significant results.

Comparing the Effectiveness of Telehealth and In-person Depression Management Using PHQ-9 Score Changes

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PROBLEM INTRODUCTION

Major depressive disorder (MDD) is the leading cause of disability amongst adults, and it affects overall health, productivity and quality of life.

The COVID pandemic accelerated the expansion of telehealth, increasing access to mental health.

Despite its growth, questions remain about whether telehealth is as effective as traditional in-person care for depression

PROJECT METHODS

Location: Outpatient private behavioral clinic

Population:300 adults diagnosed with depression.

(Telehealth n=150 , In-person n=150) 50 participants dropped out (16.7%). Final participants n= 250.

Intervention includes cognitive behavioral therapy (CBT), and medication management

Inclusion criteria: Adults 18 years and older with a diagnosis of MDD, at least two PHQ-9 assessment and follow up via in-person or telehealth exclusively

Exclusion criteria: Patients younger than 18 years old, patients who did not complete their PHQ-9 questionnaire, and patients switching between telehealth and in-person visits

Data Collection: Chart review of clinical notes, PHQ-9 questionnaire scores reviewed at 4 weeks, 8 weeks and 12 weeks. Survey was completed at 12 weeks. Results were compiled and documented

IMPACT ON PRACTICE

- Integrate telehealth into routine outpatient depression care
- Development of engagement strategies to address the participants who did not follow up with their appointment
- Flexible treatment options to improve access to care and engagement
- Implementation of enhanced reminder systems to reduce missed visits and appointment

LITERATURE REVIEW

- Major depressive disorder (MDD) is a common yet underdiagnosed and undertreated mental health condition in the United States.
- It affects approximately 17.3 million adults (7.1%) and carries significant personal and economic burden, costing an estimated $210 billion annually.
- Although MDD is treatable, untreated depression can lead to impaired functioning, strained relationships, and increased comorbidities.
- Patients receive care across multiple healthcare settings, and the U.S. Preventive Services Task Force recommends routine depression screening in adults to support early identification and treatment.
- With comparable outcomes and strong feasibility, telehealth represents an effective, sustainable, and evidence-based alternative to traditional in-person care.
- Telehealth offers a flexible, accessible alternative to in-person mental health care without compromising clinical outcomes.

RESULTS

- Over the 12-week period, both telehealth and in-person care significantly reduced depressive symptoms, with no statistically significant difference in treatment effectiveness observed.
- Based on the review of surveys completed by participants, telehealth demonstrated comparable clinical outcomes while offering increased flexibility and accessibility.
- These findings suggest that depression symptom improvement is driven primarily by evidence-based treatment practice rather than physical care setting.

LIMITATIONS

- Non-randomized design may introduce selection bias.
- Depended on self- reported PHQ-9 results and survey data which may be subject to response bias.
- Conducted in an outpatient behavioral health settings which may limit comparison with other populations

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CONCLUSIONS

Telehealth and in-person depression management showed statistically and clinically significant improvements in depressive symptoms among adults.

Telehealth offers a flexible, accessible alternative to in-person mental health care without compromising clinical outcomes

Findings support the continued use and expansion of telehealth services in outpatient depression management

Nurse-Driven Telemetry Discontinuation Protocol on Medical-Surgical Telemetry Floor

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PROBLEM INTRODUCTION

- Healthcare stakeholders should explore ways to maximize quality with minimal resources.
- Nursing administration standards (ANA, 2016), especially standard 16 - Resource Utilization, require managers to oversee financial resources to ensure quality, safe, and cost-effective care. They also manage resource changes due to operational needs or issues.
- Clinicians are keeping patients on continuous telemetry without discontinuation orders until discharge, despite earlier clinical stability.
- This process did not follow the AHA criteria, which state that unnecessary telemetry rarely benefits patients.

Ramifications of inappropriate utilization of telemetry monitoring in non-ICU:

- Increasing healthcare costs for patients, floors, hospitals, and the government.
- Triggering costly diagnostic tests and treatments due to false alarms.
- Causing overcrowding in the emergency department (ED) or units as patients wait for telemetry beds.
- Raising the risk of alarm fatigue and diverting nursing staff from other patients to address false alarms, as noted by both Chong-Yik et al. (2018) and Pendharkar et al. (2020).

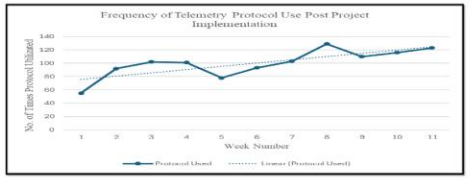
LITERATURE REVIEW

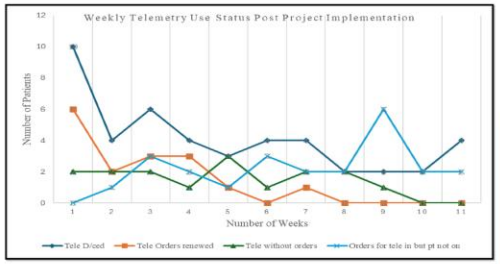
- This protocol aligns with the **Choosing Wisely** campaign, which cites the Society of Hospital Medicine's recommendation: "Don't order continuous telemetry monitoring outside of the ICU without a protocol" (Sandau et al., 2017, last updated 2021).
- The U.S. healthcare system faces financial pressures. The OECD (2017) reported the USA spent $3.5 trillion on healthcare, about $10,739 per person- more than any other country- but ranked near the bottom in health indicators among 36 OECD nations.
- Efforts ought to be made to contain exorbitant expenditures in the healthcare system by using resources conscientiously, without waste or compromising the quality of care (Lyford & Lash, 2020; Zadvinskis et al., 2018; Chong-Yik et al., 2018).
- In-hospital continuous telemetry is identified as a significant source of resource waste, as noted by Yeow et al. (2018), Baibars et al. (2018), and Chakravarthy (2020) as noted by Yeow et al. (2018), Baibars et al. (2018), and Chakravarthy (2020).
- Yeow et al. (2018) found that about 43% of non-ICU-monitored inpatients did not meet AHA Practice Standards for telemetry.
- In Duff et al. (2020), control group patients averaged 86.29 hours on telemetry per month, compared to 70.86 hours with a nurse-discontinuation protocol.
- Chong-Yik et al. (2018) reported $213,986 yearly savings from waste reduction at a 175-bed telemetry hospital.
- Pendharkar et al. (2020) report saving about $244,000 in intervention costs over 11 months by reducing wasteful telemetry.
- Probus & Smith (2020) and Verma et al. (2021) showed harmful effects on patients from delayed ED throughput, including increased mortality.

PROJECT METHODS

- A strong interdisciplinary team—including the Chief Nursing Officers, Chief of Cardiology, an Assistant Chief Nursing Officer, a nurse director, a nurse manager, aa family nurse practitioner, and a house supervisor—collaborated to create this protocol.
- Both the SIUE IRB and the Ascension Health System IRB classified this QI project as exempt.
- The project was launched on a 28-bed adult medical-surgical telemetry unit in a 675-bed urban hospital within a regional healthcare system.
- Only core staff RNs participated in the project, whereas travel RNs, LPNs, and stroke patients were excluded.
- PowerPoint handouts educated nurses on protocol use. A 5-point Likert scale assessed charge nurses' and registered nurses' understanding and satisfaction before and after implementation.
- The concepts of Complexity and Diffusion of Innovation were integrated.
- The project went through the pre-implementation, implementation, and post-implementation phases.

EVALUATION





Registered nurses appreciated and recognized the value of the new protocol, as evidenced by impressive results from pre- and post-implementation questionnaires.

The pre-implementation survey, using a 5-point Likert scale, showed all ten core floor RNs had no prior knowledge of this protocol.	After the educational session and practical application of the protocol, the post-implementation survey showed a 100% increase in understanding and appreciation.

IMPACT ON PRACTICE

The protocol was implemented solely in the medical-surgical telemetry unit, addressing ongoing telemetry misuses that contradict AHA guidelines.

This project successfully translated evidence into practice, improving patient care by reducing unnecessary patient monitoring, eliminating nurse responses to non-actionable alarms, and freeing time for direct patient care.

These improvements reflect meaningful gains in workflow efficiency and patient safety within the unit.

CONCLUSIONS

The literature review supported a nurse-driven telemetry discontinuation protocol on a medical-surgical telemetry floor.

The nurse-driven intervention can be safely and effectively implemented, eliminating inappropriate telemetry use, reducing waste, alarm fatigue, and costs. This enhances the quality of care and patient safety

LIMITATIONS

- Turnover of core staff, including participating core staff, project stakeholders, and leadership
- Most site nurses were temporary staff, like travel RNs, float pool nurses, and some licensed practical nurses, whom we excluded.
- Lack of department heads meeting the school's academic qualification requirements to oversee
- This QI project was conducted on a single medical-surgical telemetry floor at one hospital, limiting its generalizability.
- The limited timeframe restricted data collection, preventing assessment of long-term outcomes or broad applicability.

ACKWONLDGEMENTS

I want to thank Dr. April Schmidt and Dr. Bernadette Sobczak for their invaluable support and guidance throughout this project. I also appreciate the dedicated staff at Ascension – St. John Medical Center for their outstanding collaboration, which made this project possible.

CLEARING THE DEBRIS OF IMPLICIT BIAS WITH SUBSTANCE USE DISORDER (SUD) PATIENTS IN THE PERINATAL SETTING

Gina Lillian Barrett MSN, RN, RN-C DNP Candidate
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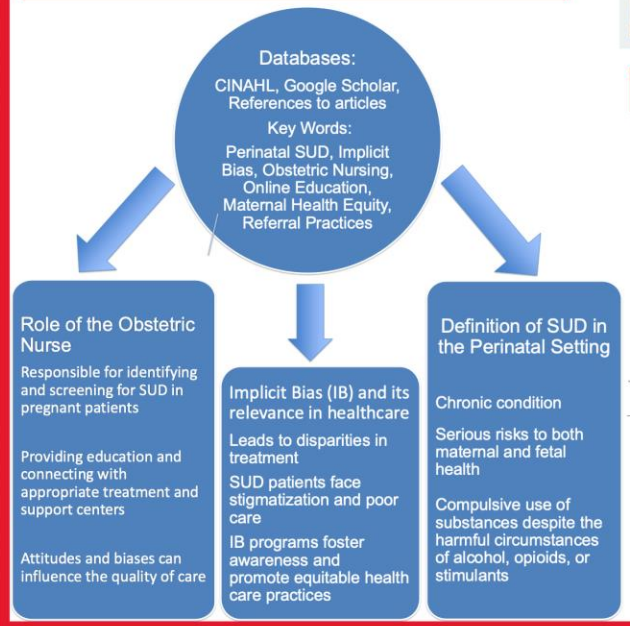
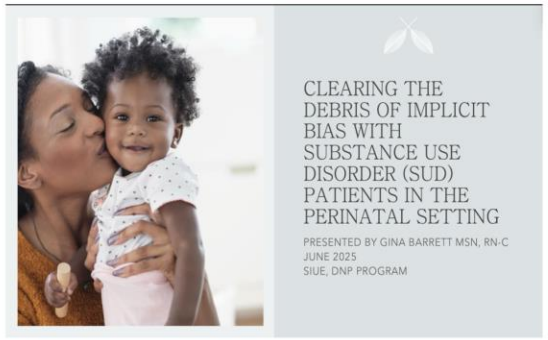
Problem Introduction and Background

- Substance use in pregnancy is increasing in the U.S. and is linked to stigma and disparities. Implicit bias may negatively influence communication, trust, and outcomes in obstetric care.
- Nurses may unknowingly demonstrate implicit bias when caring for perinatal patients with substance-related disorders, contributing to:
  - ✓ inequitable care
  - ✓ decreased patient satisfaction
  - ✓ stigma
  - ✓ limited access to care
  - ✓ social or legal consequences that discourage treatment engagement.

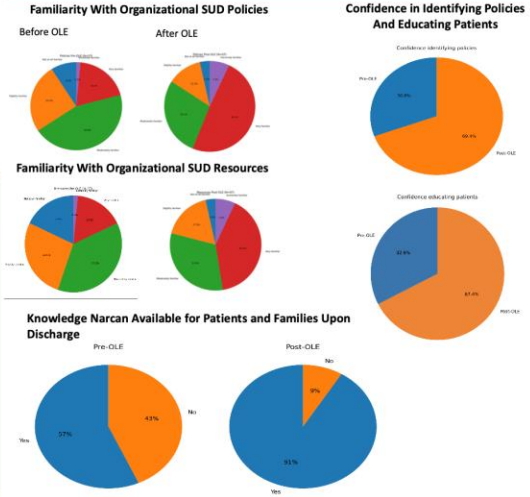
LITERATURE REVIEW



PROJECT METHODS



EVALUATION



IMPACT ON PRACTICE

This quality improvement project showed meaningful clinical improvements in obstetric nurses' knowledge, confidence, and attitudes when caring for perinatal patients with substance use disorder (SUD). After completing the online learning education (OLE), participants reported increased confidence in understanding organizational policies, educating patients about maternal and newborn risks, and communicating non-biasedly. Their responses shifted from lower confidence levels before the intervention to mostly very confident or extremely confident afterward.

Awareness of implicit bias and confidence in listening with compassion also grew. Notably, awareness that Narcan is available to patients and families at discharge rose significantly, highlighting an important patient-safety outcome with the potential to save lives.

Overall, these findings support the OLE as an effective strategy for improving equitable, compassionate, and patient-centered care for perinatal patients with SUD.

CONCLUSIONS

Annual staff development course on SUD

Ongoing reinforcement of treatment plans

Annual Implicit Bias training for all members of the healthcare team

Acknowledgements

I am sincerely grateful to my SIUE faculty advisors, **Dr. Laura Hopper, DNP**, and **Dr. Bernadette Sobczak, DNP**, for their guidance and belief in my ability to bring this project to fruition. With heartfelt gratitude, I thank my on-site stakeholder, **Dr. Olga Marrero, DNP**, for her constant encouragement and support throughout my DNP journey. I also extend my appreciation to **Dr. Damaris Peralta, DNP**, and **Christina Villegas, BSN, RN, AN3**, for their guidance, flexibility, and willingness to help whenever needed. Finally, I thank my friends, family, and colleagues, whose encouragement and belief in me made this achievement possible.

Transitioning to a New EHR System in a Small Primary Care Practice

Kelly R Hall FNPC
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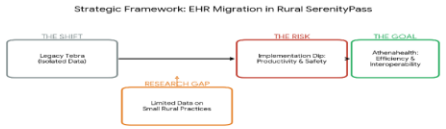
PROBLEM INTRODUCTION

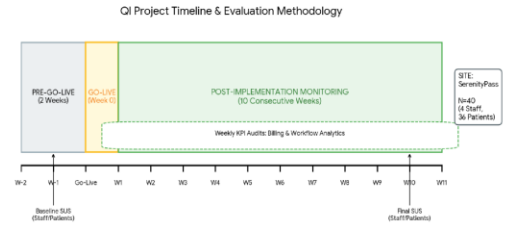
- **The Shift:** Small rural practice migration from legacy Tebra to interoperable Athenahealth.
- **The Research Gap:** Limited data exists for small, community-based practices compared to large health systems.
- **The Risk:** Transitions often trigger short-term drops in productivity and safety.
- **The Goal:** Evaluate the impact of a structured transition on usability and efficiency at SerenityPass.



LITERATURE REVIEW

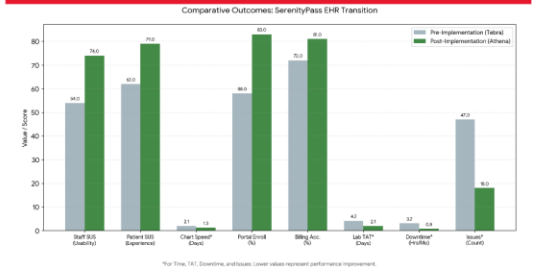
- **Barriers:** Small practices lag due to cost, training demands, and usability issues.
- **Disruption:** Transitions require workflow redesign and "super users" to mitigate data migration issues
- **Selection:** EMR choice must prioritize workflow fit, interoperability, and practice scalability.
- **Implementation:** Success demands staff engagement, phased training, and vendor support.
- **Human Factors:** Success depends on addressing cognitive load and alert fatigue through focused UX training.

PROJECT METHODS



Staff completed Athenahealth's standardized pre-implementation training per their go-live timeline (proven with other practices), followed by defined go-live and post-implementation monitoring of usability scores, charting efficiency, and revenue cycle performance.

EVALUATION



Athenahealth-led training followed defined go-live (Week 13), with 19-week evaluation using SUS surveys (staff 54→74, patients 62→79), Athena analytics tracking chart time (-38%), billing (+9%), portal adoption (+25%), lab TAT (-50%), and downtime (-75%).

IMPACT ON PRACTICE

CONCLUSIONS

This QI project successfully migrated **SerenityPass** from legacy Tebra to **Athenahealth**, bridging a critical research gap for small, community-based practices. Results indicate that a structured, 10-week post-implementation monitoring phase is essential to mitigate the expected "productivity dip" and ensure long-term system stability.

Key Study Outcomes:

- **Usability Transformation:** Staff SUS rose from **54 to 74** (below average to clearly usable), while patient usability reached a high of **79**.
- **Operational Gains:** Achieved **38% faster charting** and **50% faster lab TAT**, demonstrating significant efficiency gains.
- **System Maturity:** Super-user issues dropped from **47 to 18** by week 19, supported by a **75% reduction** in monthly downtime.
- **Revenue Cycle Note:** Billing accuracy reached **81%**; while improved, it remains a primary area for sustained training.

Final Significance: A data-driven, structured transition enables small rural practices to achieve large-system levels of interoperability and patient engagement.

Enhance Recovery after Surgery for Major Gynecologic Surgery in a Rural Hospital: An Education Intervention

Kyle Hardiman, MSNA, CRNA, NSPM-C
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

- Enhanced recovery after surgery (ERAS) is a patient-centered, evidence-based approach that employs multidisciplinary interventions to improve postoperative recovery and reduce complications associated with surgery, pain, and anesthesia (AANA 2022)
- Enhanced recovery after surgery (ERAS) implementation is underway in hospitals worldwide for patients undergoing major gynecologic surgeries and many other types of major surgeries.
- At my rural hospital in Illinois, ERAS education and protocol development have not been completed for ERAS in major gynecological surgery (Hysterectomies)

PROJECT METHODS

- Gave a 45 minute, 40 slide PowerPoint presentation to all staff who would be potentially carrying out future Gyn ERAS protocols/interventions.
- Administered a pre-presentation knowledge test to identify baseline knowledge of the test subjects (N=24)
- Administered a 10-question pre- and post-presentation attitudes and beliefs survey using a forced-choice Likert-scale test (1-4)
- Asked question: What is the most likely barrier for you that could prevent your ability to implement ERAS principles?

IMPACT ON PRACTICE

- Biannual ERAS training and education
- Attitudes about ERAS and willingness to participate in and lead ERAS interventions improved
- Create a protocol and order set for gynecologic cases at my facility.

CONCLUSIONS

- A single educational intervention changed staff's attitudes, beliefs, confidence, and willingness to participate in and carry out ERAS interventions for major GYN surgeries. I recommend biannual ERAS training and education in order to maintain existing practice changes and to orient new staff to ERAS interventions in major gynecologic surgeries.

LITERATURE REVIEW

Goals of ERAS

Decrease length of stay
Decrease pain
Decrease post-operative nausea and vomiting (PONV)
Decrease opioid consumption
Increase bowel function
Increase patient satisfaction
Early ambulation
Early post-operative oral intake
Decrease development of an ileus
Increase wound healing (especially with bowel anastomosis)

ERAS Interventions

Preoperative physical therapy (physically decompensated patients)
Carbohydrate drink within 4 hours of surgery
Regional anesthesia techniques
Gabapentoids (gabapentin, pregabalin)
NSAIDS
Acetaminophen
Intravenous lidocaine
Low dose ketamine
Antiemetic (dexamethasone, Zofran)
Maintain euvolemia during surgery
Early postoperative oral intake
Early postoperative ambulation

EVALUATION

Maximum score possible: 40
Minimum score possible: 10

Pre-test range: 15-40

Post-test range: 18-40

62% of the subjects responded with 4 or greater improvement in comparison score.

75% of the subjects showed a 4 or greater improvement, who were able to have a 4 or greater improvement (individuals that scored a 36 or below on pre-test.

1 test subject had a negative change on the post-test.

3 subjects that were able to improve their score **(did not score 40 on pre-test)** did not improve their score on the post-test.

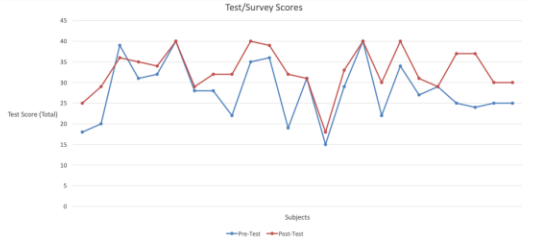
25% of subjects improved 8 or more points on comparison score

17% of subjects improved 10 or more points.

Open-ended answers on barriers:

Too new, no policies; knowledge gaps; time limitation; surgeon support; cost; colleague support; protocols; buy-in, training; surgeon hesitation; surgeon; training; patient participation and compliance; physician preferences and old habits; physician involvement.

Outcomes/Data



Implementation of Stay Interviews

Ronald Kister, MSN, RN, DNP Student
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

Emphasis on Nurse Turnover
- COVID-19 Pandemic & Stressors
- Retirements
- Global Shortage, 7.6 million by 2030

Impact of Turnover
- Patient Flow & Outcomes
- Nursing Workload
- Workplace Satisfaction

PROJECT METHODS

Plan
- Literature Review
- IRB Approvals

Do
- Key Stakeholder Collaboration
- Supervisor and Administrator Training

Study
- Facility Workgroup
- Supervisor and Employee Evaluations

Act
- Data Analysis
- Stay Interview Expansion

Power Apps

IMPACT ON PRACTICE

- Improved Communication
- Identified Opportunities for Improvement
- Pilot Launch of Stay Interviews
- Data Analysis for Action Planning
- Perceptions of Leadership Support

LITERATURE REVIEW

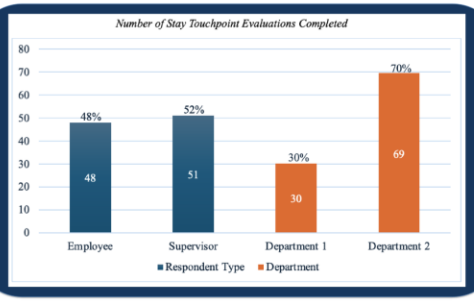
Factors Influencing Nurse Turnover
- Engagement in Hospital Affairs and Development Opportunities
- Perceptions of Leadership Support
- Work Environment

Impact on Organization/Patient Outcomes
- Fiscal Impact
- Burnout and Mental Health
- Adverse Events

Role of Nurse Leader
- Employee Recognition
- Workplace Culture and Environment
- Supervisor-Employee Relationship
- Maintenance of Competency

Utilization of Stay Interviews (Touchpoints)
- Individualized, Proactive Approach
- Opportunities for Improvement

EVALUATION



Data Analysis Using Intellectus Statistics™ Software
- Employees and Supervisors
  - Experienced satisfaction (M = 4.26)
  - Perceived goals were met (M = 2.70)
  - Mostly did not influence decision to stay in position (M = 2.26)
- Significant, Positive Correlations
  - Stay Touchpoint satisfaction and goals being met (r = .45, p < .001)
  - Stay Touchpoint satisfaction and perceived intent of employees to stay in their position (r = .23, p = .047)
- Supervisors more likely to perceive positive outcomes and support
- Differences in perceptions between departments
- Prominent Theme – Communication/Listening to ideas and concerns
- Supervisor satisfaction with using Microsoft Power Apps™ (M = 4.44)

CONCLUSIONS

- Improved perceptions of leadership approachability/accessibility
- Focused supervisor interactions with employees
- Importance of reviewing perceptions between departments
- Incorporating action plans to support change and outcomes
- Leadership collaboration and escalation of concerns is key

Limitations & Opportunities

- Convenience sample of departments which met program requirements
- Recall bias due to several departments having implemented 1:1 meetings
- Results may not be generalizable to other departments
- Opportunities to refine evaluation survey tool and collect unit level data

Implementation of Nurse Mentorship Program

Toni Pohlman RN, MSN, DNP Student
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

Novice nurses are at increased risk for stress, low confidence and dissatisfaction during transition to practice

Inadequate support during this period contributes to burnout and turnover

Experienced nurses play a critical role in guiding and supporting novice nurses

At the time of implementation, the organization lacked a formal nurse mentor program

The purpose of this project was to address the need for a structured mentorship program to improve confidence and job satisfaction among novice nurses

PROJECT METHODS

- This project was implemented in an acute care hospital.
- New nurses were enrolled as mentees, and mentors were senior nursing staff who volunteered.
- Mentors completed a self-assessment. Mentees completed pre-program surveys measuring confidence and job satisfaction.
- Program participation and expectations were given to participants, and mentor-mentee dyads were created.
- The mentor was conducted over three-month implementation period.
- Mentees completed the same confidence and job satisfaction post implementation, and all participants completed a satisfaction survey.
- Survey results were compared and analyzed.

IMPACT ON PRACTICE

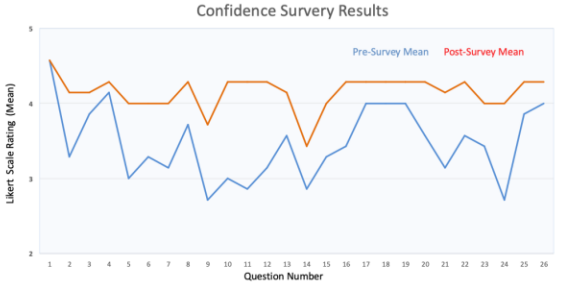
LITERATURE REVIEW

Transition to Practice and Turnover	Impact of Mentorship Programs	Effective Program Design	Barriers to Implementation
High stress loads of novice nurses	Improved confidence and communication skills	Clear goals and expectations	Time constraints and workload demands
Significant first-year turn over rates	Improved patient outcomes and retention	Dyad model (one-on-one) and intentional pairing	Resistance to participation and limited financial incentives
Average cost of nurse turnover exceeds $56,000	Enhances clinical decision-making	Visible leadership and ongoing evaluation	Resource constraints of smaller organizations

EVALUATION

Evaluation Design	Pre- and post-surveys measured job satisfaction and confidence
	Post program satisfaction survey for all participants
	Quantitative Likert-scale comparison (pre vs post)
	Qualitative comments reviewed for themes
Job Satisfaction	High baseline scores
	15 of 26 items improved or remained unchanged
	Overall satisfaction remained high
Confidence	Pre-scores >50% of items scored a 3.5 or less
	25 of 26 items improved post-intervention
	Post score items ranged 3.43-4.57
Program Satisfaction	High satisfaction reported
	Mentors recognized value despite limited in-person time

CONCLUSIONS



- The mentor program improved novice nurse confidence across all measured competencies.
- Job satisfaction remained high suggesting mentorship supported a positive transition to practice.
- Participants reported high satisfaction with the program, indicating perceived value.
- Structured mentor programs support novice nurse transition to practice.

Clear the Crib: A Quality Improvement Initiative to Promote Safe Sleep Practices

Kenzi Schuh, MSN, RNC-OB, C-EFM
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

- Preventable cause of infant mortality
- Unsafe sleep environments observed in the hospital
- Inconsistent staff modeling and caregiver education
- Standardized, unit-wide approach was needed

PROJECT METHODS

- Simulation-based reinforcement
- Random crib audits
- Visual reminders throughout the unit
- Staff education sessions

LITERATURE REVIEW

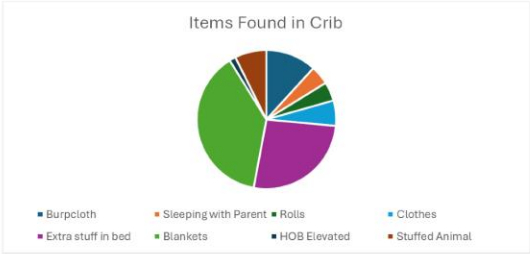
The impact of hospital safe sleep education extends to caregiver actions once the patient is home.

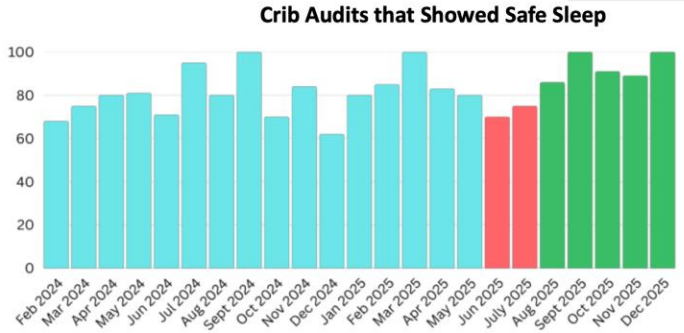
Better education, visual cues, and straightforward rules can encourage safer sleep habits at home.

Use of simulation can improve provider knowledge and perceived responsibility.

Use of audit and feedback methods can encourage maintenance of practice change as part of quality improvement efforts.

EVALUATION





Baseline safe sleep compliance of 81% prior to Clear the Crib

Following interventions compliance of 92%

IMPACT ON PRACTICE

Immediate Impact
- Standardized safe sleep modeling
- Improved crib compliance
- Increased staff engagement

Long-Term Impact
- Cultural shift toward safe sleep accountability
- More consistent caregiver education
- Sustainable reinforcement through ongoing audits

CONCLUSIONS

The Clear the Crib initiative improved staff adherence to safe sleep practices.

The project reinforced consistent safe sleep modeling behaviors.

Standardized education and accountability strategies supported sustainable improvements in neonatal safety in the hospital setting.

ACP in the Primary Care Setting

DaJauna Young, APRN
Southern Illinois University Edwardsville

PROBLEM INTRODUCTION

- Advance Care Planning (ACP) is a vital process that helps patients communicate their future medical care preferences, ensuring these wishes are respected even if they cannot express them later.
- ACP supports patient autonomy, reduces unnecessary treatments, and enhances care quality. However, ACP is underutilized in primary care due to time constraints, provider discomfort with end-of-life discussions, lack of training in culturally sensitive communication, and insufficient EMR support.
- These challenges are more pronounced in communities of color, were historical mistrust and cultural differences further hinder ACP conversations. In the project's setting—a small urban clinic in Chicago serving mostly African American and Hispanic patients—ACP discussions were rare, risking misalignment between patient values and medical decisions.

PROJECT METHODS

Guided by CARES Framework – 3-month project in a primary & urgent care clinic, Chicago's South Side.

- Participants: 4 providers (MD/NP/PA) & 6 clinical/support staff involved.

Clinic-wide Education:

- Training on ACP CPT billing codes 99497 (first 30 minutes) & 99498 (additional 30 minutes).
- EMR documentation best practices.
- Cultural competence strategies for end-of-life discussions.

Workflow Optimization:

- Incorporated EMR prompts & templates with ACP CPT codes 99497 & 99498 embedded in documentation workflow for easy billing.
- Support staff flagged patients ≥65 years or with chronic conditions during pre-visit chart reviews.

Culturally Relevant Materials:

- Brochures & conversation guides tailored to minority patient population.

Proactive Provider Engagement:

- Providers initiated ACP conversations without waiting for patient request.

Ongoing Monitoring & Refinement:

- Weekly EMR audits.
- Staff feedback sessions to identify bottlenecks & adjust workflow.

IMPACT ON PRACTICE

- ACP now standard for all eligible patients, supported by EMR alerts/templates.
- Patient understanding improved via pamphlets & verbal discussions.
- Long-term benefits: better care alignment, increased revenue, fewer unnecessary hospitalizations, stronger patient-provider trust.
- Sustained adoption: annual staff training, onboarding integration, quarterly EMR audits, multimedia/patient portal education, and community partnerships.
- Billing Accuracy Protocols: Training staff in correct coding and billing for ACP reimbursements
- Cultural competence: improved understanding of cultural values and barriers

CONCLUSIONS

This quality improvement project demonstrated that ACP engagement can be dramatically enhanced through a combination of targeted education, workflow improvements, and culturally sensitive patient communication. While limited by scope and duration, the project produced measurable gains in provider confidence, patient engagement, and operational efficiency. Sustained use of these methods should reinforce patient-centered care and be adaptable to other similar clinical environments.

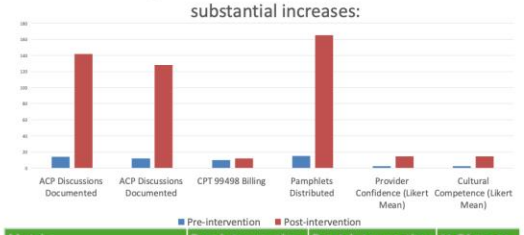
LITERATURE REVIEW

Key Highlights

- Advance Care Planning (ACP) benefits improves patient satisfaction, goal-concordant care, and reduces family burdens.
- Early initiation of ACP discussions by providers leads to documented healthcare preferences.
- Challenges in ACP comprehension across diverse patient populations.
- Importance of structured provider training, EMR tool integration, and culturally tailored patient education to increase ACP engagement.
- Role of workflow optimization and active staff engagement combined with EMR integration to enhance ACP documentation rates.

EVALUATION

Pre and post-intervention comparisons revealed substantial increases:



Metric	Pre-intervention	Post-intervention	% Change
Discussions Documented	14	142	914%
Discussions Documented	12	128	967%
CPT 99498 Billing	10	12	20%
Pamphlets Distributed	15	165	1000%
Provider Confidence (Likert Mean)	2.1	14.5	12.4
Cultural Competence (Likert Mean)	2.3	14.4	12.1