



Welcome to the 38th Annual Rocky Mountain Interprofessional Research & Evidence-Based-Practice Symposium Poster Gallery

**"Advancing Health Science Together:
Increasing Our Collective Visibility & Impact"**

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Poster Review Instructions

To earn NCPD contact hours for the Online Poster Review, sign in to uchealth.cloud-cme.com. Click On-Demand Courses and select "Rocky Mountain Research & EBP Symposium Poster Presentation".

Select 6 posters to review. Make a note of the poster number for each one-you will need this later. For each poster you will be asked to rate the poster on its impact to your clinical practice and comment on how it will impact your practice.

A list of posters is provided on the next 2 slides.

Rocky Mountain Research & EBP Symposium Poster Presentation

October 8-November 9, 2026

Nursing Outcomes: At the end of the poster presentation, participants will be able to articulate 1 evidence-based practice change, quality improvement initiative, or research principle that was presented.

UCHealth is the Approved Provider providing the contact hours.

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Requirements to receive contact hours:

Completion/submission of electronic evaluation form in CloudCME (Participant must answer all questions to receive contact hour certificate).

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2	If you Build <u>It</u> They Will Come: Impact of Structured Support on Nursing Participation in EBP & QI Dissemination	Betty Miller, MSN, RN, APRN-CNS, ACCNS-AG, CEN, SANE-A
3	Let's Clear the Air(way)!-SLP-Led Tracheostomy Team Reduces Life-Threatening Mucous Plugging Events Through Standardization of Early Tracheostomy & Laryngectomy Care	Chris Harris, M.S., CCC/SLP
4	Bringing cardiac implantable electronic device interrogation to day surgery in a rural hospital	Christopher Black, RN, BSN, Frances D'Arcy RN, MHA
5	Factors Influencing New Graduate Nurse Retention in the Operating Room: A Qualitative Study	Denice S. Loisy MSN, RN, CNOR, Martha Grubaugh PhD RN NE-BC FAONL, Karen Hessler PhD FNP-BC
6	Westwood Inbasket Message Management-AI Triage Tool	Elizabeth Chavarria, BSN, RN Sandra Hulzar-Carillo, MA
7	Initial Behavioral Engagement Patterns in Pediatric Weight Management	Emily Skrocki, DNP, APRN, CPNP-PC
8	Welcome to the Jungle: Jumanji Gaming Modality & the Donna Wright Competency Framework	Gabrielle Mundie, BSN, RN, CNOR
9	Enhancing Health-Related Quality of Life & Patient Activation: An Education & Coaching Centered Health Promotion Program Evaluation	Jessica Champion, DNP, MPH, MSN, RN, CPH Scott Harping, PhD, MPH, RN, APHN-BC, FNAP
10	Virtual Reality: Improving Completion of Cardiac PET/CT Imaging in Claustrophobic Patients	Kaitlyn Amidon, BSN, RN, MBA Brittany Fjellman, MSRS R.T. (R)(N) Jamie Schmitt, RDCS, RVT, MHA Abigail Young, B.S. CNMT
11	Bilingual SmartText with QR-Code vCard to Increase Pediatric Referral Completion Rates: A Quality Improvement Project	Karen L. Gentile, DNP, APRN, CPNP-PC
12	Telehealth Through the Survivor's Lens	Katie Frost, BSN, RN, SANE-A
13	Shaping of Professional Identity in Generation Z Nurses	Kristen Meister-Davis, PhD, RN, NPD-BC
14	Zone Staffing in Nursing "Own Your Zone"	Luke B Johnson, BSN, RN, CMSRN Karrie Cournage, RN; Beth Ziebarth, BSN, RN PCCN
15	Individualized Education, Improved Outcomes	M Patrias, BSN, RN, OCN; M Rossi BSN, RN L Miller BSN, RN, OCN
16	Journal Club a la Carte: Pick-a-Format Evidence Discussions for Busy Nurses	Marc Perrealut, MSN, RN, CCRN Janine Roberts, MSNEd, RN
17	Metro Denver Critical Care Mentorship Program for New Graduate RNs	Margo Schenk, BSN, RN, CCRN

Poster #	Poster Name	Presenter/Author Names
18	Improved Case Management and Therapy Collaboration to Streamline ED Workflow and Decrease Patient Length of Stay	Alyssa Cormack, MSOT, OTR/L, Mark Magdaleno, PT, DPT Matt Montgomery, PT, DPT, MPH Anna Baca PT, DPT, NCS
19	Potential Negative Impacts of AI Use in Forensic Nursing	Megan Thimell, BSN, RN, CEN, TCRN, SANE-A
20	A Quality Improvement Project to Improve Recognition of Clinical Deterioration and Time-Sensitive Cardiac Arrest Interventions Through High-Fidelity Simulation	Shannon Webber, MSN-Ed, RN, CCRN Marcia Litteral MSN, RN, CCRN Lisa Whitcomb, BSN, RN, CCRN Renee Hidy, BSN, RN, PCCN Carrie Dreith, BSB Riley Mulligan MSHCE, BSN, RN-BC
21	Looking at All Angles: A Sustainable Microburst Quality Improvement Model to Enhance Just-in-Time Critical Care Education and Clinical Practice	Shannon Webber, MSN-Ed, RN, CCRN Marcia Litteral MSN, RN, CCRN Lisa Whitcomb, BSN, RN, CCRN Renee Hidy, BSN, RN, PCCN
22	Reducing Emergency Resternotomies Through Interprofessional Simulation-Based Cardiac Surgery Resuscitation Training	Shannon Webber, MSN-Ed, RN, CCRN Marcia Litteral MSN, RN, CCRN
23	Scan, Watch, Recover: Transforming Discharge Education with QR Code Videos	Sonja Welter, BSN, RN, CPAN
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26	Utilization of EPIC's Snapboard to Level-Load the Center for Cancer and Blood Disorders Infusion Center Schedule	Jenny Flynn, BSN, RN, CPHON Kristin Hyatt, MS, RN, CPHON, Cassie Lang, MSN, CNS, ACCNS-AG, CCRN Ginny Lugo MS, RN, NE-BC
27	From Scrubs to Self-Efficacy: The Power of Nurse-Led Bedside Rounds to Boost Confidence & Patient Care	Julie Marshall, DNP, RN, CCM, CNE, PED-BC
28	Newborn Hearing Screening: Evaluating Methods & Timing for Improved Outcomes	Alice Mhango Kaitlyn Bell

Red Cell Ready Implementing a Pre-Anesthesia Testing Anemia Pathway

Angela Burgess, RN, BSN, CAPA
Clinical RN III: Charge Nurse, Pre-Procedure Services

Background

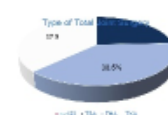
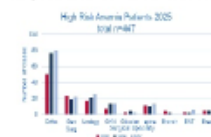
- Research supports the importance of Pre-Anesthesia Testing (PAT) Departments where patients see an advanced care provider (APP), that helps identify and evaluate medical conditions such as anemia. (1,2,4)
- Hemoglobin (Hb) is an iron-rich protein found in red blood cells that transports oxygen from the lungs to body tissues and returns carbon dioxide to the lungs. Low levels indicate anemia. Hb is essential for energy metabolism.
- Iron Deficiency Anemia, identified by Hb <13 for both genders, is the most common type of microcytic anemia worldwide. 30-40% of elective surgical patients are anemic preoperatively. (4)
- Orthopedic surgeries account for 25% of all operating room procedures nationwide. (4)
- The highest risk, elective, orthopedic surgeries performed at Broomfield and Longs Peak Hospitals, are total joint replacements.
- Perioperative anemia is associated with increased mortality, postoperative complications, including stroke, myocardial infarction, acute kidney injury, and surgical site infections. It correlates to higher risk of ICU admission, longer hospital stays, and more complex discharge needs. (2,3,5,6,7)
- While blood transfusions remain the cornerstone treatment for anemia; they do not treat the underlying cause, are costly, and expose the patients to additional health risks such as allergic reactions, fluid overload, infection and thrombosis. (2,6,7)
- Our goal was to optimize these patients for the safest surgical experience as possible, by creating an anemia pathway to identify and treat iron deficiency anemia (Hb <13) prior to total joint surgery.

Project Question

Will the implementation of an anemia pathway in the PAT clinic successfully identify iron deficiency anemia prior to total joint surgeries, thus decreasing 30-day readmission rates?

Method

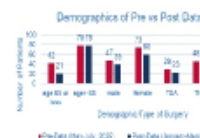
- An electronic health record (EHR) scoring system was used to report and identify high-risk criteria from patient's medical records. Patients flagged for anemia were tracked for three months (May 2025-July 2025). Data collection revealed total joint surgeries, including knees, hips, and shoulders, were the largest patient population with a high-risk criteria of anemia.



- With the help of existing resources and PAT providers, an anemia pathway was created for the Longs Peak Medical Center PAT department, that services patients for the Broomfield and Longs Peak Hospitals and Longs Peak Ambulatory Surgery Center.
- Referrals for the PAT clinic were placed for all total joint replacement patients and APPs in the PAT clinic started using the anemia pathway January 5, 2026.
- Post implementation data was collected for three months (January 2026-March 2026).

Outcomes

- Demographics and type of total joint surgery were tracked in both pre and post anemia pathway implementation data, to ensure samples were similar.



- In the 3 months prior to the anemia pathway: the 30-day readmission rate, for total joint surgeries, was 20% with 8.3% of those readmissions occurring to patients with untreated Hb <13 and 0 patients had anemia diagnosed in the PAT clinic.
- In the 3 months post anemia pathway implementation: the 30-day readmission rate dropped to 11.1%, with 0% being patients with undiagnosed anemia. 3 patients had a diagnosis of iron deficiency anemia, with follow up initiated by the PAT clinic.

Discussion/Implications

- Manual review of the scoring system needed to occur to ensure the high-risk patients, flagging for anemia were captured per surgical specialty.
- Of the 120 total joint patients that had surgery from May-July, 21 or 17.5%, were seen in the PAT clinic and should have had additional anemia testing considered.
- The post data collection revealed that from the 99 patients with total joint surgery, from January-March, 13 or 13.1%, were seen in the PAT clinic and had a Hb <13.
- Per the anemia pathway, lab values of Hb <13 AND microcytosis (MCV<85) warrants additional iron testing. This was done on three patients.
- The 10 other patients did not require the additional anemia testing based on normal MCV, current diagnosis/treatment, and/or Anesthesiologist consultation.
- At the time of this poster creation, 30-day readmission rates for March 24-31 2026, were not collected due to.
- Future state of this project includes discussion of Hb <12 for women as a pathway edit verse EHR notification change request for abnormal lab results, iron infusion process and authorization, and expansion to other surgical specialties.

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Poster #2

If you Build It They Will Come: Impact of Structured Support on Nursing Participation in EBP & QI Dissemination

Betty Miller, MSN, RN, APRN-CNS, ACCNS-AG, CEN, SANE-A



Background

As a Learning Health System, Denver Health aims to deliver high-quality efficient care by systematically integrating local data and evidence into practice. Dissemination is an essential part of the Learning Health System model as it allows others to learn from successes and failures.

As essential members of the healthcare team, nurses often play an active role in care improvement but may not engage in dissemination of their work for many reasons, such as time constraints, lack of mentorship, lack of awareness of opportunities, or simply seeing care improvement as a part of their routine work.

Though there are many internal & external opportunities for nurses to participate in scholarly activities; perceptions of nurse readiness and willingness to participate in dissemination are mixed and participation is variable.

Purpose

The purpose of this initiative was to evaluate the impact of structured support and digital resources on nurse participation in EBP, research, and QI dissemination.

Design

Four themes guided the development of this initiative: resources, accessibility, mentorship, and visibility.

To address common barriers to participation, a variety of resources were developed, including:

- ✓ **Downloadable digital poster template**
 - Guided instructions for each section and links to helpful resources
- ✓ **Appointment booking link**
 - Free 1:1 consultation with Nursing Research
- ✓ **Digital Poster Submission Form**
 - Fully digital submission process
 - Financial commitment from Professional Development to print posters
- ✓ **Professional and inviting flyers**

All resources were presented in-person and shared in digital format with QR codes and active links to increase accessibility across shifts and care sites.

Posters were displayed in the hospital main hallway, alongside the "gratitude wall" and "nurse appreciation posters" during Nurse's Week, highlighting nurses' impact on care improvement as a part of the celebration. Posters were also available for viewing online in a virtual poster fair.

All disciplines were encouraged to interact with posters through voting. Nursing staff had the option to claim Continuing Education Units (CE).

Post-surveys were provided to authors and poster viewers to better understand their experience and the impact of participation.

Results

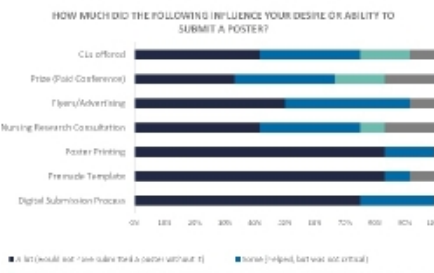
14 posters with 24 authors were submitted by bedside nurses, leaders, educators, and advanced practice nurses from across Denver Health.



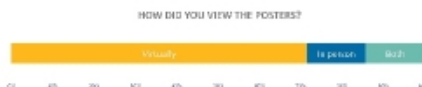
While there were many motivations for sharing their work, authors' primary motivator was the opportunity to improve care.



The resources provided had a significant impact on authors' decision to participate.



77 attendees interacted with the digital CE & voting form, and completed the post-survey. About half opted to claim CEs.



51%

"I learned about a project that could benefit my care area"

74%

"This year's posters make me feel proud of Denver Health's Nursing discipline."

40%

"This year's posters inspired me to share my own work/projects in the future."

23%

"This year's posters have motivated me to get involved in quality, research or shared governance."

"As an employee in [an ambulatory clinic], this virtual option allowed me to review this fabulous set of work by the nurses."

"I was thankful for the opportunity to do the poster and I wouldn't have done it without the template and help."

Implications

Nurses in a wide variety of roles and care environments are actively engaged in shaping and improving care, but may not share their work without practical supports.

There is a potential skill and knowledge gap related to EBP and/or scholarly activities among nursing staff, as evidenced by the high proportion of authors who found 1:1 consultation for poster development and the premade guided template helpful or essential for submission.

- Active mentorship from nurse scientists & mentors is valuable for staff working on improvement projects.

Digital resources allow for both engagement and flexibility.

- As more "digital natives" join the nursing workforce, effectively leveraging technology is a necessity.

- Dissemination of nurses' improvement work through poster fairs is one effective strategy for engaging nurses in the Learning Health System.
- Engaging with peer's improvement work bolsters nurse's pride in their profession, interest in sharing their own work, and desire to participate in quality and professional governance.

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Acknowledgement

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Let's Clear the Air(way)!

SLP-Led Tracheostomy Team Reduces Life-Threatening Mucous Plugging Events Through Standardization of Early Tracheostomy & Laryngectomy Care

Chris Harris, M.S., CCC/SLP

Introduction/Background

Mucous Plugging: A Life-Threatening Complication

- Highest risk in first 48–72 hours post tracheostomy & laryngectomy
- Driven by inconsistent suctioning + inadequate humidification

Research Shows

- Standardized, multidisciplinary care reduces complications and multidisciplinary tracheostomy teams are associated with reduced length of stay, fewer adverse outcomes, decreased time to voicing, and improved decannulation rates

At Highlands Ranch Hospital

- Despite having an established multidisciplinary tracheostomy team mucous plugging events still occurred in 33% of patients following head and neck cancer reconstructive surgeries with alternative airway from July 2024–March 2025

Practice Gap

- No consistent workflow across units led to variable care and preventable harm

Methods

Design

- Quality Improvement initiative (pre/post analysis, 18 months)

Team

- SLP-led multidisciplinary team: SLP, RT, Nursing, ENT

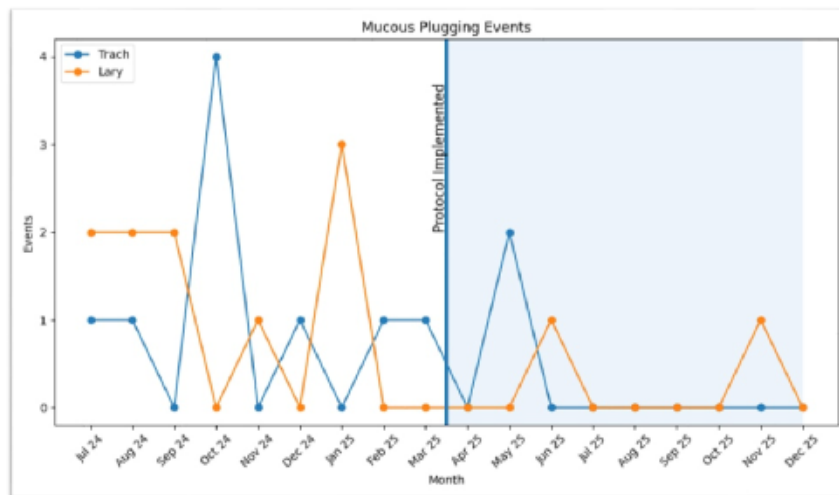
Intervention (First 48 hours s/p trach/lary)

- Scheduled suctioning (Q2) + saline lavage
- Standardized humidification (external AIRVO heated humidification)
- Staff education on mucous plug prevention

Outcomes Measured

- Mucous plugging events
- Rapid response activations
- Escalations in level of care

Results



79% reduction in mucous plugging events following protocol implementation

No mucous plug–related rapid responses occurred in the post-implementation period

No escalations in care following implementation

References

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Conclusion & Future Direction

- Consistent suctioning and humidification are essential to prevent early airway obstruction following head and neck reconstruction surgery with alternative airway
- A standardized, SLP-led, team-based approach improves airway safety and supports rehabilitation readiness
- Evaluate protocol effectiveness across broader alternative airway populations, including non-head and neck cancer patients
- Explore whether reduced suctioning frequency (e.g., Q4 + lavage during the first 48 hours) maintains similar outcomes
- Explore whether Heat Moisture Exchangers (HMEs) vs. external humidification provide comparable results

Acknowledgements

Sincere appreciation is extended to the HRH Tracheostomy Team for their collaboration in making this QI initiative possible.

Team Members Include:

- Dr. Christopher Oliver
- Meagan Grandgenett
- Morgan Aranda
- Tara Smith
- Abigail Barron
- Frank Newsome
- Aisyah Pruitt
- Wendy Marquez
- Erin Heib
- Caleb Minetree

Bringing cardiac implantable electronic device interrogation to day surgery in a rural hospital

Christopher Black RN, BSN | Frances D'Arcy RN, MHA

Process improvement • Day Surgery • UCHealth Yampa Valley Medical Center, Steamboat Springs, CO

Background

Cardiac implantable electronic devices (CIEDs)

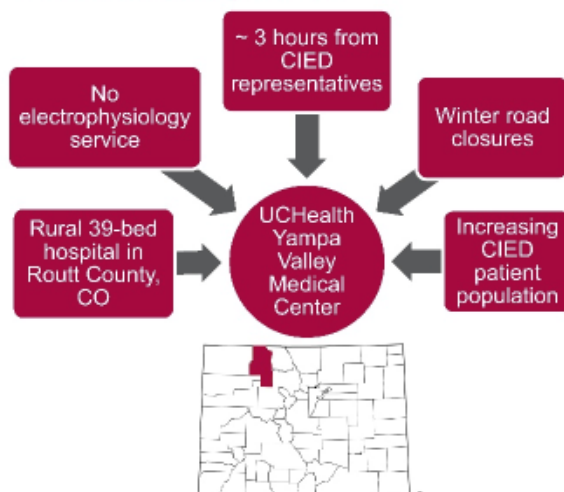
≈ 300,000 to 400,000 new CIEDs are placed annually in the U.S.¹

Pacemakers

Implantable cardioverter-defibrillators (ICDs)

- Devices are routinely checked through "interrogations."
- Dependent on procedure type and patient health, CIEDs might require perioperative interrogation.
- At UCHealth Yampa Valley Medical Center (YVMC), interrogations were historically completed by in-person device representatives.

The rural access problem



Needed change

With limited CIED representative availability and no in-house solutions, the legacy interrogation process resulted in procedures being delayed, cancelled, or transferred.

Goal

- To create a timely, nurse-led CIED interrogation process in Day Surgery.

Measures

- Reduced procedure delays, cancellations, consults, and in-patient holds.

Research and implementation

Spoke with major CIED companies to determine available resources.

Spoke with other UCHealth facilities to learn existing education and workflows.

Obtained three companies' interrogation devices.

Developed competencies and hands-on training.

Rolled out interrogation process in Day Surgery and Emergency Department with in-services.

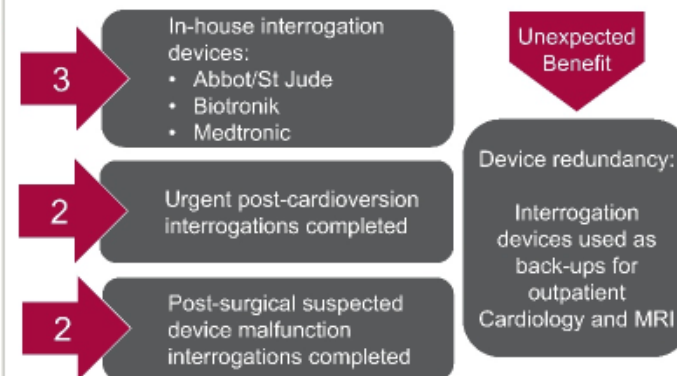
A new point-of-care workflow

The remote representative remains available in real time.



Process outcomes

Since go-live April 1, 2026



Continual process improvement

- Obtain a Boston Scientific CIED interrogator (the Latitude Consult)
- Develop workflows for nurse-led "MRI Mode" reprogramming in conjunction with Radiology
- Extend resource benefits to in-patient nursing



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Factors Influencing New Graduate Nurse Retention in the Operating Room: A Qualitative Study

Denice S. Loisy, MSN RN CNOR (Clinical Nurse Educator, Southern Region), Martha Grubaugh PhD RN NE-BC FAONL (Research Nurse Consultant), and Karen Hessler PhD FNP-BC (Research Nurse Scientist)

Background & Significance

- Growing demand for surgical care
- Challenging recruitment for operating room (OR)
- Retiring nurses and turnover: need to replace
- High cost of turnover
- Understanding the why nurses leave
- Lack of OR exposure in nursing school
- Retention matters as much as recruitment

Objectives

To assess and understand:

- the new graduate OR nurse intention to stay in nursing **and** in the specialty of operating room nursing.
- the new graduate perspective on transition to practice.
- if the transition to practice experience of the new graduate nurse contributed to their decision to stay or not to stay in the specialty area of OR nursing.
- if pre-graduate exposure to the operating room influenced transition to practice in the operating room and likelihood of retention.

Inclusion Criteria

- Currently working in a UCHHealth OR
- New graduate nurse
- 2 years or less experience

Memorial Hospital North

Culture, support, and mentorship for the new graduate nurse is critical for retention



"I was an ACP before, which really, really helped because without that I, right now, I'm already so overwhelmed."

Demographics: (Mean $\pm$ SD)

Sample size	n=9
Age (years)	32.3 $\pm$ 8.5 (Range 22-45)
Months of OR Nursing Experience	8.1 $\pm$ 8.3 (Range 1-27)
Gender	Female 9 (100%)

Participants were:

- Predominantly White/Caucasian (88.9%)
- Worked in the Memorial Hospital North (MHN) OR (44.4%) (nearly ½ of participants)
- Nursing school graduates in 2024 or 2025 (77.8%).
- Non-Hispanic (88.9%)

Method & Data Collection

- Qualitative descriptive study
- Semi-structured, open-ended questions
- Virtual interviews recorded and analyzed
- Thematic analysis of responses
- Validation of themes by each investigator

Results

Two themes & 5 subthemes for each identified:

- **Acculturation**
 - Pre-exposure
 - Programs/Structure
 - Acceptance/belonging
 - Leadership/Preceptor Support
 - Relationship building
- **Complex Environment**
 - Difficult specimen to learn
 - Fast-paced
 - High cognitive load
 - High responsibility/autonomy
 - Task-oriented

Future Impact

- New graduates are the workforce pipeline to the OR
- Time and resources to train
- Retention is a high priority

Scan QR Code for References
& Acknowledgements



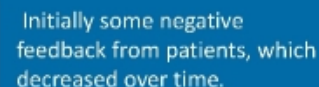
Purpose, Aim, or PICOT

Methods/Intervention

References

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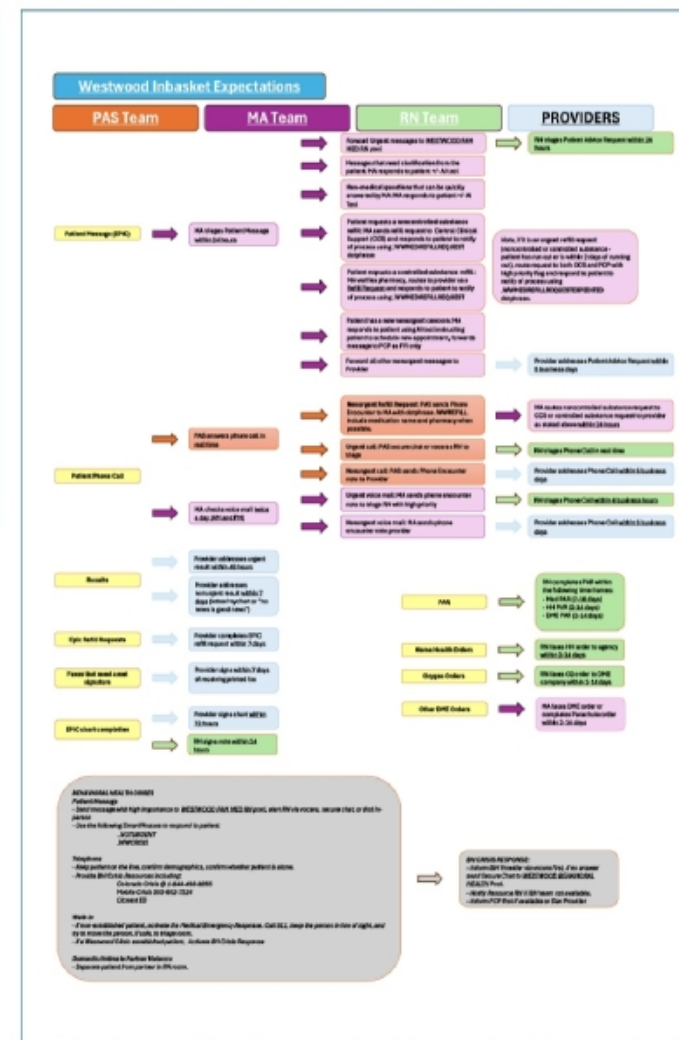
Analysis & Results



Increased satisfaction from MAs. Ex: "I have gotten use to using it and it comes in handy. I think it would be nice to personalize messages but when we have a lot of messages coming in from the weekend on Monday it is nice to have the AI tool."

Implications to Nursing Practice & Impact at Denver Health

- The impact on Denver Health includes improving overall patient care for all patients by answering inbasket messages promptly.
- Decreased amount of time MAs spent answering messaged, increasing job satisfaction.
- Patient response wait time for messages to be answered improved.



Initial Behavioral Engagement Patterns in Pediatric Weight Management

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Background & Objective

Children entering a behaviorally focused pediatric weight-management program completed patient-reported survey questions on physical activity and dietary habits. This evaluation examined baseline behavioral engagement to identify educational needs and establish program priorities.

Objective
Track baseline behaviors and perform a needs assessment to support healthier lifestyle choices.

Methods

- 1 Design**
Retrospective, cross-sectional chart review
- 2 Period**
January 1, 2024 to December 31, 2025
- 3 Sample**
47 patients who completed all four survey questions at initial primary care weight-management visit
- 4 Analysis**
Descriptive statistics: proportion not engaging in recommended behaviors

Behavior domains assessed

- Screen time
- Physical activity
- Fast-food consumption
- Sugary drink intake

Survey instrument: 2-1-Some-Almost None questionnaire



Results: baseline behaviors

Proportion of patients not yet meeting recommended behaviors at program entry:



Needs assessment signal by behavior domain
Higher percentages indicate larger opportunity for targeted education.

Educational priorities

Priority	Domain	Education focus
High	Screen time	Reduce recreational screen time
High	Fast food	Plan meals, reduce frequency
Moderate	Physical activity	Build activity goals
Maintenance	Sugary drinks	Reinforce positive choices

Program evaluation implication

- Baseline patient-reported data can guide education toward behaviors with the largest gap from recommended targets at the first visit.
- Use this needs assessment to refine educational content, counseling emphasis, and follow-up goal-setting.

Conclusions

- 1 Screen time and fast-food intake present the largest baseline gaps and may yield the greatest benefit from focused education.
- 2 Physical activity remains a moderate priority because a considerable portion of patients did not meet target behavior.
- 3 Most patients self-reported success in limiting sugary drinks; education should reinforce and maintain this positive behavior.

Next steps

- Integrate baseline results into visit-based education materials.
- Prioritize counseling prompts for screen-time and fast-food reduction.
- Track behavior change over time to evaluate educational impact.

Abstract, References & Disclosures



This author reports no relevant financial relationships.

WELCOME TO THE JUNGLE

Jumanji Gaming Modality & the Donna Wright Competency Framework

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O.R. Clinical Nurse Educator



Affiliations
Denver Health and Hospital Authority,
Operating Room Department

Background

Regulations require hospitals to validate the competency of clinical staff at hiring and at least every three years. Traditional competency evaluation methods can be tedious for clinicians and evaluators alike. Play-based adult learning can combat burnout, improve retention, promote psychologically safe environments, and improve team dynamics. Competency cycles prepare clinical teams for excellent practice, but can also offer engaging team building and bolster safe, sustainable organizational ecosystems.

Jumanji Content Selection Method

- 1 Competency objectives were selected from quality trends, staff inquiries, leader requests, and practice gap analyses. Low-frequency, high-impact events were prioritized.
- 2 Game material was derived from facility policies, deidentified clinical scenarios, professional organizations' guidelines, and peer reviewed scholarly sources.
- 3 Game content took the form of tests, case studies, emergency drills, return demonstrations, and discussion groups. These formats align with the Donna Wright approach.
- 4 Game mechanics supported evaluation of critical knowledge, skills, and practices. Immediate remediation was tailored for each group based on individual needs assessments.

Results

58 nurses participated in a 2-hour educational board game with supplemental online content. 37 nurses completed evaluations for the gamified method. One nurse educator evaluated all 58 participants, in 28 total facilitation hours. Three primary competencies were assessed with thirteen sub categories. The event supported competency validation for all OR nurses at Denver Health. The facilitator "stacked the deck" to support uniformity of evaluations in the context of gameplay variability.



Analysis

When asked, "Did you find this information useful?" 95% of respondents said "yes." 88% said they would or might change their practice after the event. 65% indicated they would share information with a colleague. Participants disliked event scheduling format. Respondents recommended that future iterations omit online content, citing that the in-person game left them feeling well-prepared. Respondents requested future events to cover advanced Trauma care. Jumanji evaluation metrics exceeded all other measured modalities of competency assessment.

Implications & Impact

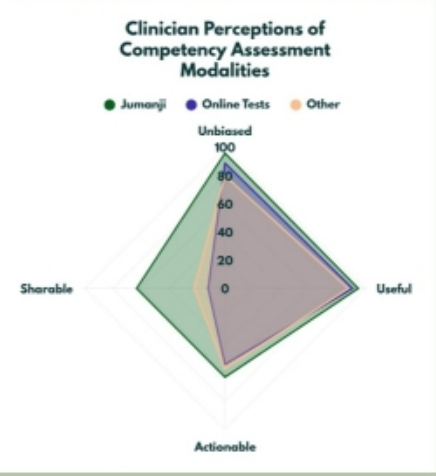
Jumanji-methods delivered engaging, comprehensive content & immediate, tailored remediation. It was perceived as useful, fun, & complied with the Donna Wright model. Future investigations should compare novel gamified modalities and strive to identify statistically significant variables. Surgeons, anesthesiologists, and OR leaders described OR nurses as exceedingly well-prepared when debriefing post-Jumanji emergencies like malignant hyperthermia & hybrid trauma events. Anecdotal improvements to RN self efficacy were noted by nurse leaders and educators after the event.



Initiative

The O.R. Educator sought engaging, comprehensive competency evaluation methods with capability for immediate, tailored remediation. They sought methods that would require minimal in-person staff time, minimal operational costs, align with organizational preference for the Donna Wright competency model, & truly prepare staff to deliver excellent care in future clinical emergency scenarios.

2026 RN Competency Objectives	
Clinicians will demonstrate competency with interprofessional collaborative communication according to Denver Health policy and Operating room best practices.	
a. Closed loop communication	
b. TEAMSTEPS: CUS, two challenge risks, & assertive statements	
c. Critical Issues Communication	
d. Specimen streakouts	
e. "Take-out" devices	
f. Hand-off & SBAR report & documentation	
Clinicians will demonstrate effective navigation of emergency protocols and resources according to Denver Health policy and Operating room best practices.	
g. RACE/PAUSE	
h. Hybrid OR trauma response	
i. O.R. Trauma Emergency C-services	
j. Malignant Hyperthermia Response	
Clinicians will demonstrate safe use of OR equipment according to Denver Health policy and Operating room best practices.	
k. Instrument scanning, and reporting contaminations	
l. Laser & Radiation safety	
m. Safe equipment navigation, set-up, clinical application, troubleshooting, and reporting of errors	



Key Sources & Acknowledgements

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Wright, D. (2005). The ultimate guide to competency assessment in healthcare (3rd ed.). Creative Health Care Management.
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References



Results Cont.

Enhancing Health-Related Quality of Life & Patient Activation: An Education & Coaching Centered Health Promotion Program Evaluation

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University of Colorado Anschutz College of Nursing, Aurora, CO

Background

DNP Essentials I, II, V, VII

- Chronic diseases are the leading cause of morbidity, mortality affecting over 129 million Americans (CDC, 2024)
- Modifiable lifestyle behaviors (e.g., diet, activity, stress) contribute to chronic disease burden, emphasizing the need for preventative interventions (CDC, 2024)
- Lifestyle-based education and coaching improve health-related quality of life (HRQOL) and patient activation, supporting chronic disease prevention and self management (Amiri et al., 2024; Marcos Delgado et al., 2021; Lin et al., 2020)

Purpose

DNP Essentials I-III, VI-VIII

This project evaluates the impact of Whole Health Collaborative's hybrid health promotion program on HRQOL & patient activation using lifestyle education curriculum and coaching strategies.

Methods

DNP Essentials I-IV, VI-VIII

Design: Program evaluation using HRQOL (SF 36) and patient activation (PAM-13) surveys with repeated measures at key milestones T1 (pre), T2 (mid), and T3 (post) guided by RE-AIM framework.

Setting: 3 cohorts in Denver metro area. Participants ≥ 18 yrs (N=30)

- Atlas:** Real estate workplace
- Cross Purpose DEN & NM:** Nonprofit organization supporting career development

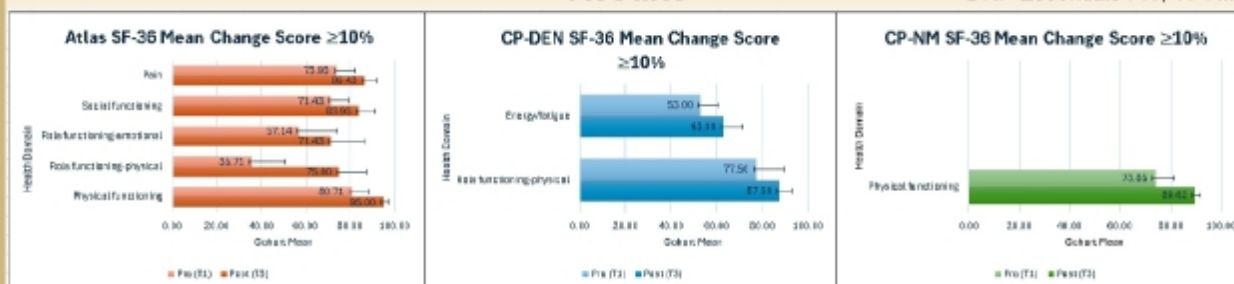
Intervention: 21-week program

- 5 weekly lifestyle education group sessions
- Followed by 13 weeks of individual coaching messaging + 2 virtual visits

Primary outcome: Improve HRQOL and PAM mean change scores of 3 cohorts by 10% in one or more of the SF-36 domains from T1 to T3.

Results

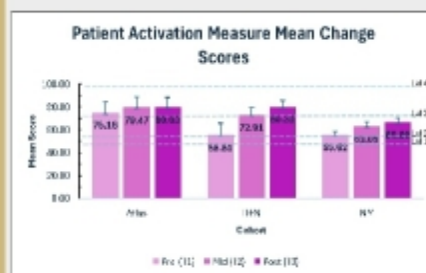
DNP Essentials I-IV, VI-VIII



$\geq 10\%$ mean improvement in 5 of 8 HRQOL domains. Smaller gains ($<10\%$) observed across the 3 remaining domains from T1 to T3 (N=7)

$\geq 10\%$ mean improvement in 2 of 8 HRQOL domains. Smaller gains ($<10\%$) observed across the remaining 6 domains from T1 to T3 (N=10)

$\geq 10\%$ mean improvement in 1 of 8 HRQOL domains. Smaller gains in 5, no change in 1, and a decrease in 1 from T1 to T3 (N=13)



Mean PAM scores increased across all three cohorts from T1 to T3. CP-DEN increased from level 2 to 3 (N=30)

Balance Measure 1: Attrition

- Atlas $\rightarrow$ 10% minimal attrition
- CP-NM $\rightarrow$ moderate 35% attrition
- CP-DEN $\rightarrow$ highest 57% attrition
- Overall, 33% lost by T2 and 3% by T3

Outcome Domain	Effect Type	p-value	Interpretation
General Health	Cohort	0.003	Differences between cohorts
Patient Activation (PAM)	Cohort	0.010	Differences between cohorts
Patient Activation (PAM)	Time	0.034	Improved over time
Patient Activation (PAM)	Model (Overall)	0.016	cohort + time affect PAM
Role Functioning-physical	Cohort x Time	0.036	Change varied by cohort
Physical Functioning	Time	0.051	Trending-improved over time

ANOVA showed statistically significant in two HRQOL domains, while one domain trended toward improvement. Patient activation revealed statistical significance across cohort, time and overall model.

Balance Measure 1: Feedback

Thematic analysis revealed no entirely negative effects attributable to the program. 87% of participants reported exclusively positive experiences, while 13% reported mixed experiences, with negative aspects primarily attributed to low activation.



Discussion

DNP Essentials I-VIII

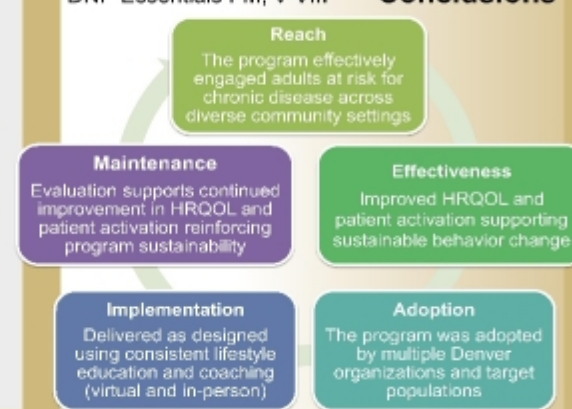
- HRQOL:** Improved across all cohorts, with each meeting the goal of a $\geq 10\%$ increase in at least one domain; magnitude varied by cohort (Atlas: 5; CP-DEN: 2; CP-NM: 1)
- Patient activation:** Improved across all cohorts over time, with CP-DEN and CP-NM achieving a $\geq 10\%$ increase.
- ANOVA:** Results suggest cohort differences were observed in general health. Patient activation differed by time, cohort, and showed a significant overall model. Role functioning-physical showed a significant cohort x time interaction, with physical functioning showing a positive trend.

Limitations

- Limited to 3 cohorts setting & population
- Potential violation of statistical assumptions
- Incomplete survey data led to participant removal, reducing sample size across cohorts
- Timeline (holidays) & delivery differences (virtual vs. in-person) may have limited results

DNP Essentials I-III, V-VIII

Conclusions



Virtual Reality: Improving Completion of Cardiac PET/CT Imaging in Claustrophobic Patients

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uchealth

Background/Relevance & Significance

- Anxiety & Claustrophobia are barriers to successful cardiac PET/CT imaging, particularly when prolonged stillness and confinement are required.

- Anxiety may contribute to premature study termination, motion artifact, and delayed diagnosis.

Confined Space + Study Duration + Psychological Distress = Perfect storm for study failure

- A systematic review and meta-analysis found VR significantly reduced anxiety in patients undergoing cardiac procedures compared with standard care. (Micheluzzi et al., 2024).

- Virtual reality provides immersive distraction and offers a non-pharmacologic strategy to improve tolerance of anxiety-provoking imaging.

Methods/Strategy & Implementation

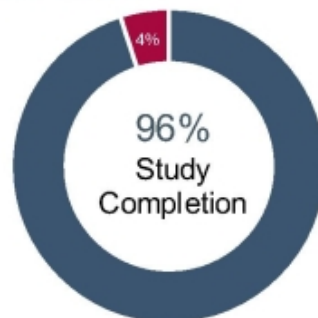
Quality improvement initiative evaluating VR during cardiac PET/CT imaging in patients with self-reported anxiety/claustrophobia or interest in VR.

Participants: N = 137

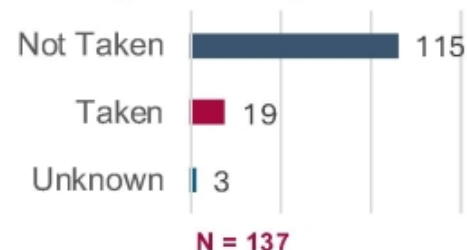
- 1 Patient Arrival
- 2 Pre-Assessment
- 3 Eligibility Screening
- 4 VR Headset Applied
- 5 PET/CT Imaging
- 6 Post-Use Survey

Can virtual reality (VR) support successful completion of cardiac PET/CT without compromising diagnostic image quality?

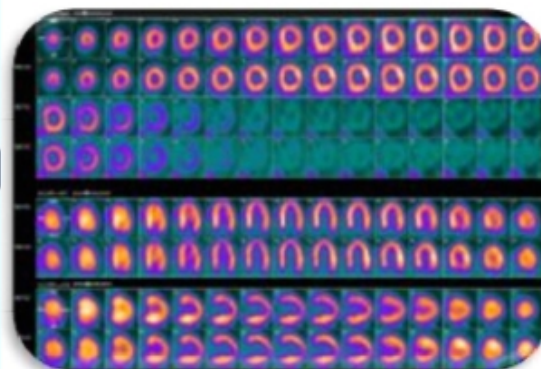
Results/Outcomes



Adjunct Anxiolytic Use



Diagnostic image quality maintained during VR use



Low-cost, patient-centered strategy to supporting completion of clinically valuable cardiac PET/CT imaging.

Implications

Improved Patient Experience

- Provides a non-pharmacologic option to support patients experiencing claustrophobia.

- Preserves Access to Diagnostic Testing**
 - Supporting study completion may reduce barriers to clinically valuable cardiac PET/CT imaging.

- Practice Integration**
 - VR can be incorporated into existing imaging workflows without added staff or scan time.

- Potential for Broader Application**
 - Findings support evaluation of VR in other anxiety-provoking imaging and procedural settings.

Value & Sustainability

Small Investment · Scalable · Preserves Imaging Resources

\$4,387 Initial Cost **~\$2,959** Potential loss per incomplete study

~2 Saved Studies to Offset Investment

- No added staffing
- No added scan times

References & Acknowledgements

Non-Invasive Cardiac Testing Team
Cardiovascular Service Line Leadership
UCHealth Innovations Team
Our patients who participated in the quality improvement initiative
Micheluzzi et al. Effectiveness of virtual reality on pain and anxiety in patients undergoing cardiac procedures. *National Library of Medicine* (2024).
Photo Credit: Author Acquired
The authors have no financial disclosures or conflicts of interest to report.

Bilingual SmartText with QR-Code vCard to Increase Pediatric Referral Completion Rates: A Quality Improvement Project

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Background

- Roughly **20% of children require specialty care**, yet national **referral completion rates range from 51-73%**^{1, 2, 3}
- Incomplete referrals result in delays in care^{3, 4}
- Inconsistent workflows, complex scheduling processes, and language barriers contribute to health equity disparities such as delays in scheduling^{1, 3, 5}
- Clear communication and streamlined scheduling improve completion rates** and support system-level policies that promote language-accessible, technology-enabled AVS tools^{6, 7, 8}

Primary Aim

To **increase specialty referral completion rates** in the top 5 medical specialties (allergy & immunology, dermatology, ophthalmology, orthopedics, otolaryngology) in the CHC from 60% to 70% within 90 days of order entry⁹

Methods

Framework: The Model for Improvement.¹⁰ Leadership collaboration informed the PDSA cycles.

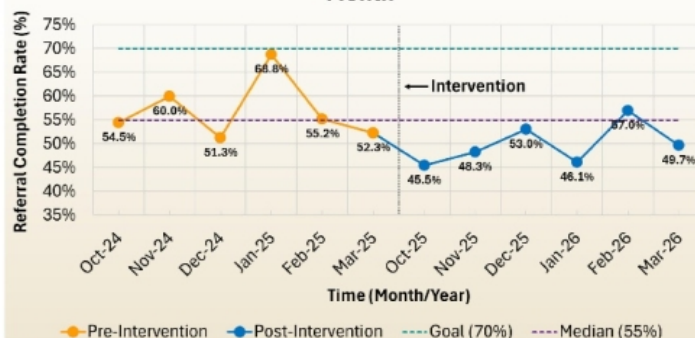
Setting & Population: Pediatric patients in the CHC referred to top five specialty clinics with a preferred written language of English or Spanish.

Intervention: A bilingual SmartText placed in the AVS providing referral instructions and a QR-code vCard with specialty contact information.

Data & analysis: Pre-and post-intervention data was extracted from the electronic health record (EHR) and analyzed using Chi-Square test of Independence and Descriptive Statistics.¹¹

Results

Run Chart of Specialty Referral Completion Rate by Month

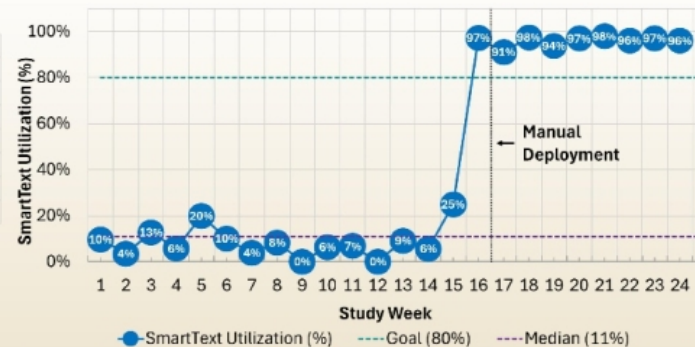


● Pre-Intervention ● Post-Intervention --- Goal (70%) --- Median (55%)

↑ Interpretation

A chi-square test of independence revealed a significant result, ($\chi^2(1) = 17.32$, $p < .001$). Although the difference between groups was statistically significant, the intervention did not achieve the intended improvement in referral completion.

SmartText Utilization Over Time



● SmartText Utilization (%) --- Goal (80%) --- Median (11%)

↑ Interpretation

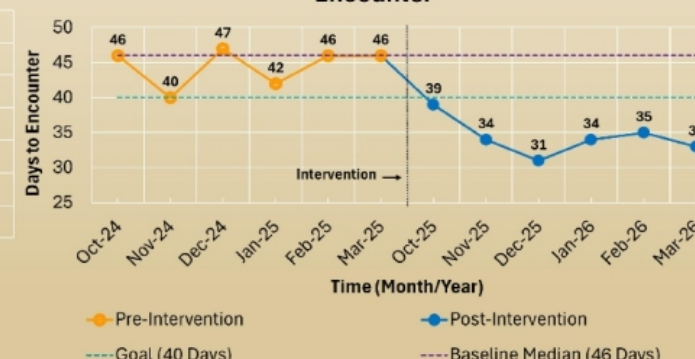
A chi-square test revealed SmartText utilization increased significantly with supplemental manual deployment compared to provider-only use ($\chi^2(1) = 401.37$, $p < .001$).

Run Chart of Days from Referral Order to Appointment Scheduling



● Pre-Intervention ● Post-Intervention --- Goal (7 Days) --- Median (13.5 Days)

Run Chart of Days from Referral Order to Encounter



● Pre-Intervention ● Post-Intervention --- Goal (40 Days) --- Baseline Median (46 Days)

Discussion

- Provider-dependent strategies resulted in inconsistent SmartText utilization.
- Week 16 PDSA cycle focused on manual SmartText deployment (project lead sent the SmartText manually via Epic MyChart message).
- Manual deployment was associated with a reduction in time from referral order to appointment scheduling and encounter.

Limitations

- 50% provider training attendance may have impacted SmartText adoption.

Clinical Significance & Sustainability

- Patient communications should be integrated into automated workflows whenever possible.
- This intervention is **low-cost** and **scalable** within existing EHR infrastructure.
- Sustainability will be supported by embedding automated referral instructions directly into the referral order.
- This supports system-level policies to improve equitable access to care.⁷

Conclusion

Findings align with the literature demonstrating referral completion is a multifactorial, system-level issue.^{3, 5} This QI project currently demonstrates that bilingual, health-literate communication alone is insufficient to improve referral completion but may improve scheduling timelines. These findings highlight the importance of addressing behavioral, cultural, and system-level factors influencing patient follow-through. Sustainable change requires integrating communication into existing clinical workflows and aligning interventions with clinical and sociocultural needs of the patient population.

TELEHEALTH THROUGH THE SURVIVOR'S LENS

Survivor Satisfaction With Telehealth Delivered Forensic Nursing Examinations

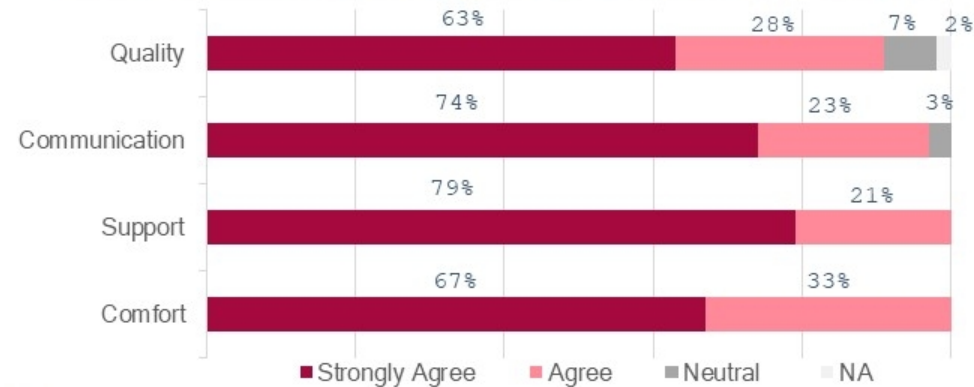
Purpose

- ❖ To evaluate survivor satisfaction with telehealth delivered forensic nursing examinations across four domains: quality, communication, support, and comfort.

Methods

- ❖ HIPAA compliant telehealth platform
- ❖ Post examination survivor satisfaction survey
- ❖ Four survey domains
- ❖ 5-point Likert scale; no respondents selected "Disagree" or "Strongly Disagree"
- ❖ 57 respondents
- ❖ Rural/community-based setting

Survivor Satisfaction Responses Across Four Domains



Data source: Internal forensic examination records and associated survivor satisfaction surveys, n=57

Key Findings

Among 57 respondents, survivors reported high satisfaction across all four domains, with "strongly agree" responses ranging from 63% to 79%.

Significance and Implications

- ❖ Supports survivor centered telehealth care
- ❖ Provides evidence regarding survivor satisfaction
- ❖ May support expanded access to forensic nursing services
- ❖ Continue quality improvement

References

Miyamoto, S., Delwiche, J., Mareboina, M., Hur, Y. S., & Greninger, E. 2025. Acceptability of Forensic Sexual Assault Telehealth Consultation. Telemedicine journal and e-health : the official journal of the American Telemedicine Association, 31(4), 424-430. <https://doi.org/10.1089/tmj.2024.0461>

Shaping of Professional Identity in Generation Z Nurses

Kristen Meister-Davis, PhD, RN, NPD-BC



Background

Generation Z Nursing Population

- Entering the workforce at higher rate, 7x that of other generations (PressGaney, 2025)
- Will soon represent the largest percentage of nurses (Aggarwal et al., 2020)
- Leaving the profession in the first year at higher rate (24%) (PressGaney, 2025)
- Experience higher anxiety, lower confidence, extreme fear of poor outcomes, and less connection to the profession

Gap in Literature

- No current recommendations for support interventions for this generation of nurses
- Identified professional identity as a potential solution to identified challenges

Strong Nursing Professional Identity (PI)

- Improves nursing outcomes (confidence, competence, job satisfaction, professional engagement and commitment) (Hu et al., 2022; Hu et al., 2023; Meng et al., 2023)
- Mitigates effects of high-stress work environments (Dong et al., 2023; Hanum et al., 2022).
- Established and solidified in early practice years (Hunter & Cook, 2018)

Research Question

How do time, place, and social context shape the development of professional identity among Generation Z nurses?

Methodology

Clandinin & Connelly's (2000) Three-Dimensional Narrative Inquiry Space

• Sample

- Purposive and snowball sampling
- 11 participants

Age: 24-28 Years
Gender: 100% Female
Marital Status: 73% Single, 27% Married
Educational Level: 91% Baccalaureate, 9% Associate
Experience: 14-36 months
Length of Nurse Residency Program: 82% 12 months, 9% 6 months, 9% 3 months
Practice Setting: 45% Academic Medical Center, 36% Urban Hospital, 18% Community Hospital

• Data collection

- 45-60 minute interviews
- Narrative transcripts
- Demographic survey

• Analysis

- Transcripts and field notes
- Three-dimensional approach
- Common threads

Findings

Temporality

- Messages and experiences in early childhood
- Initial encounters with nursing
- Validation in the early career years

Sociality

- Public narratives (societal perception & social media)
- COVID-19
- External socioeconomic & political contexts

Place/Situation

- Nursing school
- Workplace

Implications and Recommendations

Organizational & Nursing Leadership

- Represent nursing within the community or host immersion programs
- Support nurse-driven practice change & advocacy
- Develop true zero-tolerance policies
- Provide mental health & self-care resources
- Intentionally connect & recognize
- Encourage career exploration & growth
- Provide additional leadership training

Academic and Clinical Educators

- Be intentional in messaging
- Guide to organizational resources & safety practices

Transition to Practice Programs

- Integrate peer support
- Develop mentorships
- Integrate PI development curriculum

Future Research

- Social media, workplace experiences, & accelerated career progression effects on PI
- Transition to practice interventions effect on PI & nursing outcomes

References



No conflicts of interest to disclose.

Background

Since Lutheran Hospital relocated to a new building, there has been an increase in patient falls and staff concerns about assignment geography.

Zone nursing, a staffing model used in several hospitals, has proven effective in decreasing patient falls, improving satisfaction, and fostering teamwork. By creating focused care zones, nursing teams can respond faster to patient needs, enhance collaboration, ensure staff receive timely breaks through a buddy system, and promote professional growth through mentoring opportunities. Mindful zone staffing assignments encourage teamwork, efficiency, and continuous learning among nursing staff.

The goal of this trial is to find a fall prevention strategy and increase both nurse and patient satisfaction through a high-impact, low-effort intervention that integrates seamlessly into the current workflow.

Key areas of concern include:

- Difficulty locating RNs for bedside shift reports
- Prolonged bedside shift reports
- Limited access to experienced RNs for support
- Challenges with patient care handoffs before breaks
- Missed breaks and fatigue
- Inefficient patient care due to poor geographical assignments
- Increased risk of patient falls related to assignment layout
- Delayed call light responses leading to decreased patient satisfaction

Challenges

Factors contributing to inability of charge nurses to create zone assignments:

- Continuity of care
- Low census
- Staff skills
- Imbalanced zones - higher acuity patients in one zone versus the other
- Dirty rooms
- Two out of six charge nurses were on maternity leave during the trial
- Insufficient time available for the trial (2 months only)

Method

Quality improvement project using pre and post intervention.

Pre and Post surveys administered to nursing staff (n=47). 9 questions with 5 Likert-scale and 4 quantitative questions used to collect data. The survey measured:

- Quantity of nurses and time needed for bedside-shift reports.
- Availability of experienced nurses for clinical questions and handoffs prior to breaks.
- Geographical assignment relating to patient falls and inefficiency in patient care.
- Overall satisfaction with both acuity and zone staffing.

Fall rates and call light response times are included.

Patient assignments are structured using a Zone Staffing Model: charge RNs create assignments based on location, patient acuity, workload balance, and staff skill mix establishing zone teams composed of two RNs/LPNs and one PCT.

A primary RN, buddy RN, and PCT share essential patient information to maintain cohesive teamwork throughout their shift.

Each team focuses on an average of eight rooms, enabling faster response times and reducing hand-off duration during breaks.

Staff document and remain within their designated zones, ensuring proximity to patients and team availability for support.

Bedside shift reports are focused and streamlined, involving a maximum of two RNs, reducing time and improving efficiency.

Shorter travel distances between patients increase staff productivity, satisfaction, and overall patient safety.

Discussion

- Limited flexibility in patient assignments caused frustration among nursing staff.
- Staff were encouraged to communicate when patient acuity changed and request additional

Results

Survey:

- 66% of staff reported only 1 or 2 nurses were required for bedside shift reports versus only 38% prior to the trial.
- The time spent in bedside shift reports remained unchanged at 20-30 minutes.
- 79% of staff answered often or always find an experienced nurse with zone staffing compared to 70% prior to implementation.
- 46% of staff reported handoffs prior to breaks were easy compared to 37% prior to the trial.
- 58% of staff reported that geographical assignment improved efficiency of patient care compared to 23% prior to the trial.
- 58% of staff reported that geographical assignment rarely or never contributed to patient falls compared to 37% prior to the trial.
- 31% of staff reported being satisfied or very satisfied with zone nursing compared to 59% prior to the trial.

Patient Safety:

Preliminary data shows a decline in patient falls within the first two months of implementation.

- North Wing (zone staffing trial): Falls decreased from 1.5 to 1 fall per month (33.3% reduction).
- East Wing (control unit): Falls decreased from 1.25 to 0.5 falls per month (60%..... reduction).

Response Times:

Average call light response time remained unchanged; however, shower response times decreased by 57 seconds due to staff proximity within geographic zones.

Team Cohesion and Communication:

Staff feedback highlights improved access to experienced nurses, better communication, and ease in locating colleagues for assistance or reports.

Efficiency in Workflow:

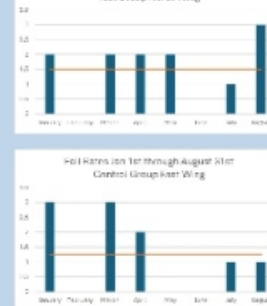
- Bedside shift reports are more focused reducing delays in patient handoffs.
- Break coverage has improved through the consistent use of buddy teams.

Staff Satisfaction:

Nursing satisfaction surveys reflect a decrease in overall satisfaction largely attributed to the rigidity of zone nursing assignments.



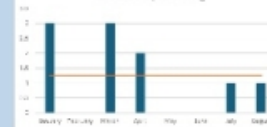
Fall Rates Jan 1st through August 31st
East Group North Wing



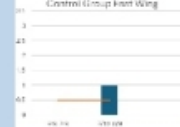
Fall Rates Jan 1st through August 31st
West Group North Wing



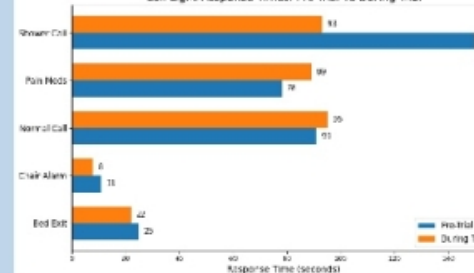
Fall Rates Jan 1st through August 31st
Control Group East Wing



Fall Rates Jan 1st through August 31st
Control Group West Wing



Call Light Response Times: Pre-Trial vs During Trial

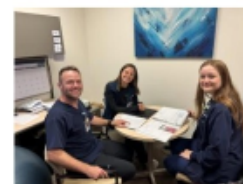


Conclusion

The Zone Staffing "Own Your Zone" model proved to be a high-impact,

Individualized Education, Improved Outcomes

M. Patrias BSN, RN, OCN, M. Rossi BSN, RN, L. Miller BSN, RN, OCN



Background:

- Unit leadership continuously collaborates to improve quality outcomes and patient safety metrics.
- An increase in HAPIs, particularly severe pressure injuries, on a medical oncology unit highlighted the need for a new educational strategy.
- Traditional approaches including unit wide education and friendly competitions did not result in sustained practice change.
- Because frontline staff play a critical role in pressure injury prevention, the leadership team developed and delivered a mandatory 1:1 staff education packet.
- The intervention focused on translating evidence-based prevention strategies into daily bedside practice.

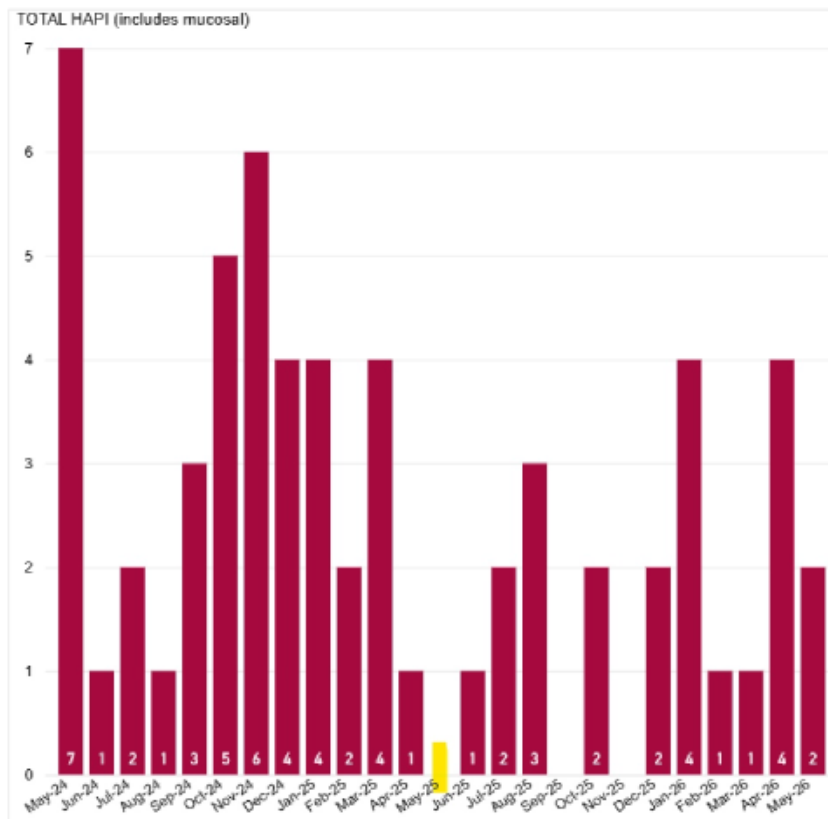
Purpose:

- To evaluate whether mandatory individualized 1:1 HAPI education for bedside staff was more effective than traditional group education.
- To determine the impact of this intervention on the incidence and severity of HAPIs on a medical oncology Unit.
- To examine whether personalized education could enhance staff buy-in, promote sustained proactive change and improve patient outcomes.

Methods:

- Created a comprehensive HAPI education packet informed by unit-specific oncology data, HAPI trends, contributing factors, prevention strategies, staging, and expectations for skin assessments and chain of command escalation.
- Implemented mandatory 1:1 education sessions with all staff members.
- Adapted content to each learner's needs while providing opportunities for discussion, questions and feedback.
- Reinforced unit-specific prevention, policies and identified opportunities to improve bedside care and early escalation.

Results:



Baseline Data (May '24 – May '25)

- 40 Total HAPIs
- 4 Stage 3 HAPIs
- 12 Unstageable HAPIs

Post Intervention Data (May '25 – May '26)

- 22 Total HAPIs
- 1 Stage 3 HAPI
- 4 Unstageable HAPIs

Notable Reductions

- 45% decrease in Total HAPIs
- 75% decrease in Stage 3 HAPIs
- 66.7% decrease in Unstageable HAPIs

Limitations:

- Multiple Interventions in Addition to Individualized Education:** Several HAPI reduction interventions occurred in the 12 months leading up to the education intervention. Therefore, improvement outcomes cannot be attributed solely to the individualized education.
- Conducted on a Single Unit:** This project was implemented on a single inpatient oncology unit. As a result, findings may not be generalizable to other units, patient populations or clinical settings.
- Additional Evaluation is Needed:** Continuous surveillance and outcome monitoring is needed to confirm the sustained effectiveness of the education intervention.
- Time and Resource Intensive:** Providing 1:1 education to every staff member required substantial time and coordination from both unit leadership and bedside staff.

Implications for Practice:

- Individualized education can drive meaningful practice change.
- Individual education creates opportunities for accountability, reinforcement of expectations and meaningful discussion.
- Personalized education supports sustainable quality improvement.
- Unit leadership should consider personalized education strategies to improve quality metrics and improve patient outcomes.

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Poster #16

Intermountain Health - Enterprise Journal Club à la Carte: Pick-a-Format Evidence Discussions for Busy Nurses

Marc Perreault, MSN, RN, CCRN & Janine Roberts, MSNEd, RN

Introduction

- Journal clubs promote awareness of recent research, critical thinking, critical appraisal skills, and a translation of evidence into nursing practice (Lenoard et al., 2022; Valizadeh et al., 2022; Hassan et al., 2024).
- Journal clubs foster collaborative learning and engagement with EBP but historically have been limited by competing priorities and participation barriers (Hassan et al., 2024; Valizadeh et al., 2022).
- System-wide EBP & Research Council shared input on activities to build research and EBP culture. Many members expressed interest in a journal club, yet shared frustrations over barriers
- Traditional journal club barriers: full-article review, time constraints, in-person only formats, workload, limited research experience (Leonard et al., 2022; Valizadeh et al., 2022).

Purpose:

- Identify practical, adaptable journal club frameworks
- Lower barriers to participation
- Build EBP skills and promote evidence translation

Methods

- Presentation developed for system-wide Nursing Research and EBP Council
- Structured formats informed by journal club facilitator resources: Yale New Haven (Davies, 2019) and Oncology Nurses Society (2010)
- Three scalable formats aligned with varying degrees of participant readiness and experience
- Evidence Awareness:** brief introduction to key findings
- Critical Appraisal Lite:** focused analysis of select study components
- Application-Focused:** discussion centered on clinical or operational questions
- Facilitator guidance for topic selection, discussion prompts, and practice implications
- Flexible delivery options: on-unit, virtual, and asynchronous

Anyone can serve up
a journal club: there
are strategies that
may offer a feast of
engagement and
slice through
common barriers.



Scan for references and
resources associated
with this poster



Journal Club Formats

Format	Best For	How It Works
Evidence Awareness	New journal clubs; busy units; novice groups	Share a recent article + short recorded summary; discuss via email or Teams by a set deadline; each member names one practice link
Critical Appraisal Lite	Staff building research confidence; preceptors modeling critical thinking	One focused section (methods, a table); 2-3 guiding questions; pair or small-group discussion, then share-out of strengths and gaps
Application-Focused	Professional governance councils or other teams	Start with a real unit question; evidence supports the discussion; decide if practice change is needed, set priority, EBP question, and team; document

Results

- Creative, realistic approaches for journal club implementation across care settings
- Models addressing participation barriers and progressive EBP competency development
- Council representative enthusiasm for proposed models
- Local implementation planned at 4 hospitals
- Asynchronous council journal club developed from this work
- Number of journal club sessions held since project inception: 12

Discussion

- Flexible journal club frameworks reduce barriers to entry
- Strengthened inquiry culture and evidence-informed clinical decision-making
- Format alignment with learner readiness, time constraints, and clinical context
- Enhanced participation and sustainability across healthcare organizations

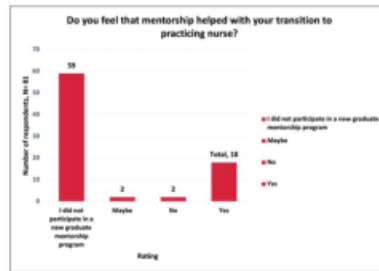
All Disclosure: Generative artificial intelligence (Microsoft's Copilot) was used to assist with drafting, reporting, and editing content for this project and poster. The authors reviewed and verified all generated content and take full responsibility for the accuracy and integrity of this work.

Metro Denver Critical Care Mentorship Program for New Graduate RNs

Margo Schenk, BSN, RN, CCRN, Level III

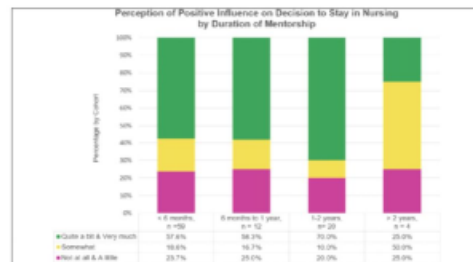
Background

- A 2023 study in Nurse Leader placed focus on how the ongoing nursing shortage leaves newly graduated nurses vulnerable early in their career. Among nurses under the age of 35, 63% report that they intend to leave or are considering leaving the current position, and 66% of nurses reported feeling burned out
- A pre survey conducted prior to implementation of the UCH Mentorship Initiative indicated that most RNs never had a formal mentor, but those that did felt that it was beneficial to their growth as a new nurse



Review of Literature

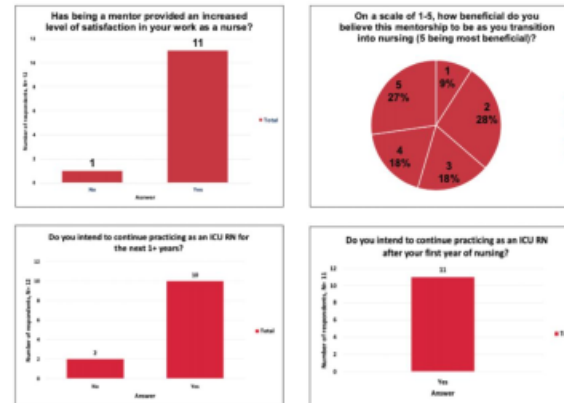
- Key findings in the study showed that nursing mentorship was beneficial for many mentees on their decision to remain in nursing, on their self confidence, problem-solving, professional communication, and transition to practice
- 58.9% of the mentees in this study reported that their mentoring relationship had positively influenced their decision to stay in nursing



Implementation

- New graduate RNs were identified from each participating ICU, and then paired with a mentor from their respective unit
- Mentor/ mentee pairs were matched in Qooper, an online mentorship platform
- Mentor/ mentee pairs were expected to meet in person or via Teams once per month for 30-60 minutes, for a total of 6 months post orientation
- Staff were notified of the initiative in either staff meetings or preceptor meetings, as well as via email
- Overall goal: New graduate RNs (mentee) would show increased confidence in their transition into full time nursing practice, while also indicating their intention to continue in nursing after their first year of practice, while experienced RNs (mentor) would show an increased satisfaction with their current nursing position
 - These outcomes were measured via an online survey sent out to both mentee and mentor
- Feedback and changes to come: Mentors expressed overall satisfaction with the program while mentees expressed a desire for more information regarding the initiative prior to being enrolled and for the program to start immediately after orientation
- Barriers: Due to this being the first cohort of mentorship pairs, some orientees began the mentorship program several months after coming off orientation due to timing of the program start date. This would not be the case for future cohorts

Outcomes



- 63% of mentees expressed a high level of benefit from the mentorship initiative, and 100% expressed intent to continue practicing as an ICU nurse after their first year of nursing
- 91.6% of mentors expressed an increased level of satisfaction in their work and 83% expressed their intent to continue practicing as an ICU nurse for the next 1+ years

Implications

- Changes going forward:
 - New graduate RNs will start to receive information regarding their upcoming mentorship opportunity 1-2 months prior to coming off orientation
 - Mentorship will begin immediately after coming off orientation
 - Mentors will be provided more direction on topics to discuss with their mentee
 - Opportunities to meet as a group will be provided to those that are interested
- The online forum Qooper will remain the main "home" for mentorship pairs
- The utilization of a unit "point person" will remain in effect to aid in the appropriate matching of mentorship pairs

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Improved Case Management and Therapy Collaboration to Streamline Emergency Department (ED) Workflow and Decrease Patient Length of Stay

Alyssa Cormack, MSOT, OTR/L, Mark Magdaleno, PT, DPT, Matt Montgomery, PT, DPT, MPH, Anna Baca PT, DPT, NCS

Background

- The University of Colorado Hospital Emergency Department ranks in the top 25 nationally for ED visit volume.¹ Workflow challenges result in a subset of patients experiencing prolonged lengths of stay (LOS), leading to inefficient resource utilization, increased costs, and decreased patient satisfaction.
- A formal partnership with the Process Improvement (PI) team identified an opportunity to strengthen collaboration between Rehabilitation Therapies, Care Management (CM), and ED stakeholders to address complex discharge barriers and reduce patient LOS.
- Reducing length of stay for patients in the Emergency Department improves patient experience, reduces hospital costs, and can reduce patient mortality.

Methods

- Using the DMAIC (Define, Measure, Analyze, Improve, Control) framework for process improvement, we aimed to improve collaboration between Care Management (CM), Rehabilitation Therapies, and ED teams to facilitate enhanced partnership, efficiency, and optimal care delivery, with the goal of reducing patient length of stay in the ED and Clinical Decision Units (CDU).
- A convenience sample of 38 patients admitted from December 2024 through February 2025 were identified using inclusion criteria jointly determined to be any ED/CDU patient with both Rehab and CM needs and a LOS >36 hours.
- Process mapping was used to identify common themes and root causes of barriers to discharge across the care team.
- Based on these barriers, Rehab, CM, and ED partners collaboratively developed and implemented feasible, sustainable solutions.

Hypotheses

- Increasing interdisciplinary collaboration via PI frameworks can streamline interdisciplinary communication and discharge workflows in the ED
- Implemented changes will result in a reduced ED length of stay among patients with complex barriers to discharge

Results

- Application of the DMAIC framework, incorporating data gathering and analysis, process mapping, and systems thinking, led to strengthened CM and Rehab collaboration. Implementation included:
 - Updated interdisciplinary training and education
 - Launch of an interdisciplinary complex discharge huddle
 - Revised documentation standards to support consistent communication
- Data review indicates a general trend in reduction of:
 - Overall median LOS in the ED
 - Percentage of patients with prolonged LOS (> 36 hours)

Criteria to Call a Complex Discharge Huddle

- Payor source limitations to anticipated higher level of care
- Significant limitations in social support identified
- Uncertain medical and/or functional prognosis
- Patient is refusing recommended discharge plan
- Patient with AMPAC score of > 18 with recommendations for Facility Based Rehab

Updated OT and PT documentation template, including Plan A and Plan B discharge recommendations:
Discharge Recommendation: Facility Based Rehab (can tolerate 3 hours of therapy/day)

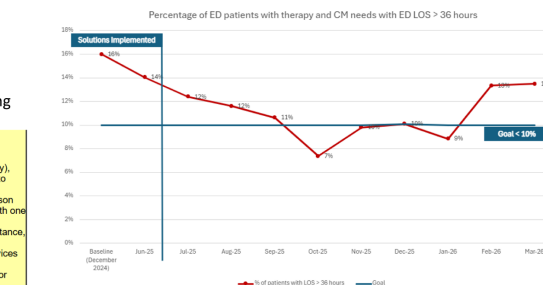
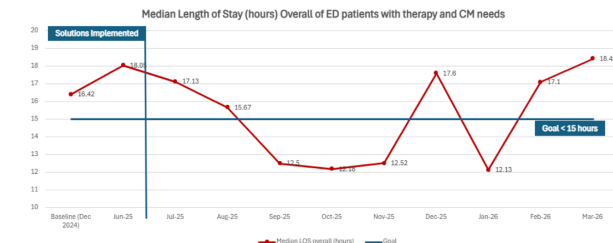
Plan B Discharge Recommendations

If patient is unable to discharge to Facility Based Rehab (can tolerate 3 hours of therapy/day), then based on functional considerations for discharge, the patient will require the following to discharge to prior living situation:

- Level of assist required if patient were to DC home today: bathing with one person moderate assistance, dressing with one person minimal assistance, toileting with one person minimal assistance, meal prep with dependent assist, household management with dependent assist, medication management with set up assistance, and community transportation with one person
- Follow up services if patient discharges home and not to facility: Home OT services, Home PT services
- Length of time anticipated for patient to meet minimal functional requirements for discharge to prior living situation: **2 days**

Key takeaways

- Consistent communication and active stakeholder engagement are paramount to driving meaningful and sustainable systemic change.
- Interdisciplinary collaboration is a cornerstone of effective process improvement. With demonstrated effectiveness, this model could be replicated with other disciplines and scaled across the continuum of care to achieve broader, more efficient implementation.
- Next steps:
 - Ongoing data tracking
 - Monitoring trends in ED LOS and %age of patients with prolonged LOS
 - Ongoing collaboration with interdisciplinary team to adjust implementation plans per Control phase of the DMAIC model



1. Becker's Hospital Review. (2024). Hospitals with the most ED visits in 2024. <https://www.beckershospitalreview.com/rankings-and-ratings/hospitals-with-the-most-ed-visits-in-2024/>

Potential Negative Impacts of AI Use in Forensic Nursing

Megan Thimell, BSN, RN, CEN, TCRN, SANE-A



Background and Current Practice

- Artificial Intelligence (AI) is becoming a more widely used and accepted tool in all aspects of life, including healthcare.
- While it can be extremely beneficial and improve many aspects of the field, questions should be raised on whether or not the risks or detriments outweigh the benefits.
- Currently, AI in forensic nursing can be utilized in the following ways:
 - Triage
 - Data extrapolation and prediction
 - Dictation software
 - Deterioration monitoring
 - Risk assessment/recommendation
 - DNA and ballistics identification
- UCHealth developed a policy in January 2026 determining acceptable use of AI

Baseline Data

- Not a lot of concrete data
- Literature supports that AI has the ability to change perceptions and perpetuate interpersonal violence

Review of Literature

- ANA position statement: "Nurses must ensure that advanced technologies do not compromise the nature of human interactions and relationships central to the nursing profession."
 - Concern for removing the critical thinking aspect of nursing
 - However, is it better at certain things that need pure algorithms and less emotional viewpoint?
- AI is the cause for new terms and types of abuse that patients can experience
 - Deepfakes, image-based sexual abuse (IBSA), nonconsensual intimate imagery (NCII), child sexual abuse material (CSAM)
 - One report noted a 264% increase of AI videos of child abuse in a single year
 - Increase in "AI-lationships" shaping how people interact with others
 - American Psychological Association urging people to be cautious with their interactions with AI; "we must remember it is not a real human."
 - Perpetuating abuse; people have a "safer" outlet for their violence
- AI learns from us, so whatever biases exist are there because we taught them
 - Anchor biases in healthcare field, disparities in race or socioeconomic status and healthcare
- Data privacy and security
 - When AI programs are utilized in healthcare, can HIPAA laws be fully maintained?
- Is it replacing human interaction in healthcare?

Interventions and Next Steps

- Interventions
 - Education
 - Presentation to FNE team regarding current use and how this may impact future patient care
 - New acronyms, new ways people are perpetuating abuse with AI
 - SART series available for free for healthcare providers in Colorado
 - Goal to raise awareness and use critical thinking
 - Next Steps
 - Determine what "safe use" of AI encompasses
 - Policies and procedures that are morphing quickly to meet the need
 - Laws and legislature are already in place (Take it Down Law, etc.), but is it sufficient?

References



A Quality Improvement Project to Improve Recognition of Clinical Deterioration and Time-Sensitive Cardiac Arrest Interventions Through High-Fidelity Simulation



Shannon Webber MSN-Ed, RN, CCRN; Marcia Litteral MSN, RN, CCRN; Lisa Whitcomb BSN, RN, CCRN; Renee Hidy BSN, RN, PCCN; Carrie Dreith BSB; Riley Mulligan MSHCE, BSN, RN-BC

Learning Objectives:

- Improve early recognition of clinical deterioration by identifying key physiologic cues and progression toward cardiac arrest in high-risk patient scenarios.
- Demonstrate timely initiation of high-quality chest compressions and defibrillation following recognition of a lethal cardiac rhythm.
- Apply evidence-based resuscitation principles during simulation, including prioritization of rapid interventions to reduce delays in cardiac arrest management.

Background/Relevance & Significance

Needs assessments, clinical event reviews, and Resuscitation Committee data identified persistent gaps in critical care nurses' recognition of patient deterioration and initiation of time-sensitive interventions. System-level data revealed variability in code performance metrics, including delays in intervention, defibrillation fallouts, and codes occurring outside the ICU. Delayed recognition of clinical decline and initiation of critical actions—such as chest compressions, ETCO₂ monitoring, and defibrillation—are associated with poorer patient outcomes. High-fidelity simulation (HFS) provides a safe, controlled environment to strengthen rapid recognition and response during high-risk, low-frequency events. Pre-simulation assessments demonstrated variability in learner confidence, particularly in technical skills and decision-making under pressure.

Purpose

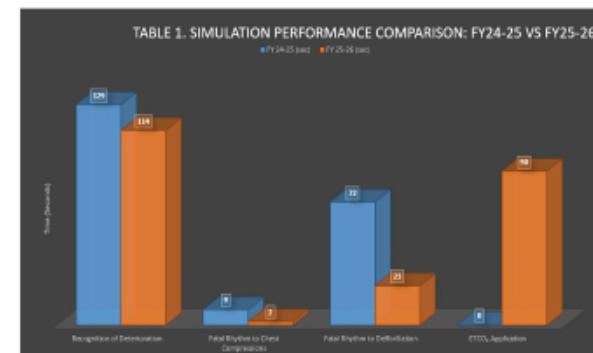
This quality improvement project aimed to enhance nurses' ability to recognize deterioration, initiate chest compressions, apply ETCO₂ monitoring, and deliver timely defibrillation. A secondary aim was to evaluate year-over-year performance trends and changes in learner confidence pre- to post-HFS, aligning outcomes with organizational resuscitation priorities.

Methods/Strategy & Implementation

HFS scenarios were developed using High Acuity Low Occurrence (HALO) principles and aligned with regional priorities, emphasizing early physiologic cues, rhythm recognition, and rapid intervention. Pre- and post-simulation surveys measured confidence across key domains using Likert scales. Performance metrics from FY25–26 were compared to FY24–25, including time to recognition, initiation of compressions, defibrillation, and a newly introduced metric—time to ETCO₂ application. Forty simulation sessions were conducted, incorporating structured debriefing focused on improvement opportunities identified in post-code reviews.

Results/Outcomes

Baseline confidence was highest in knowledge and communication but varied in technical skills. Post-HFS results demonstrated increased "very confident" ratings across all domains, with the greatest gains in technical skills and rapid decision-making. Performance improved compared to the prior year: time to recognition decreased from 2:09 to 1:54 (12%), time to chest compressions from 9 to 2 seconds (78%), and time to defibrillation from 72 to 23 seconds (68%). ETCO₂ application established a baseline metric. Findings align with ongoing system-level opportunities in early intervention and defibrillation timeliness.



Key Outcomes

- Recognition improved 12%
- Chest compressions improved 78%
- Defibrillation improved 68%
- ETCO₂ baseline established at 90 sec.

Limitations

Variability in learner experience, participation constraints, inconsistent ETCO₂ documentation, and reliance on self-reported confidence may limit generalizability.

Implications for Practice

HFS combined with performance metrics supports improved recognition and timely intervention. Integrating simulation with code review data enables targeted, data-driven training. Ongoing simulation is recommended to sustain improvements and reduce variability across care settings.

Looking at All Angles: A Sustainable Microburst Quality Improvement Model to Enhance Just-in-Time Critical Care Education and Clinical Practice

Shannon Webber MSN-Ed, RN, CCRN; Marcia Litteral MSN, RN, CCRN; Lisa Whitcomb BSN, RN, CCRN; Renee Hidy BSN, RN, PCCN



Learning Objectives

- Apply microburst education strategies in clinical practice to support Clinical Judgment and Systems Thinking in critical care.
- Analyze patient care scenarios through interactive microburst activities to strengthen Clinical Judgment and Collaboration.
- Implement an evidence-based practice change to improve outcomes, demonstrating Advocacy/Moral Agency and Facilitation of Learning.

Background/Relevance & Significance:

Critical care environments require clinicians to rapidly apply complex knowledge in dynamic situations. Today's learners prefer efficient, just-in-time information, while others benefit from self-paced engagement. Traditional education methods often fail to meet these varied needs. Microburst education and multimodal strategies improve engagement, retention, and real-time application, making them highly effective in high-acuity settings. This approach complements existing in-person classes while supporting ongoing professional development for current staff.

Purpose:

"Looking at All Angles" was developed to implement a structured, enduring microburst educational activity—delivered through the Microsoft Platform application—designed to provide high-impact, multimodal learning that enhances critical thinking, engagement, and bedside application for critical care staff, including preceptors, new staff, and experienced clinicians seeking continued education.

Methods/Strategy & Implementation:

This recurring initiative is facilitated through Microsoft Platform, allowing flexible participation across shifts and centralized access to content. It incorporates rotating modalities such as case studies, equipment demonstrations, flashcards, and game-based learning (e.g., Jeopardy-style reviews). Sessions are brief (5–15 minutes) and focus on targeted, clinically relevant topics aligned with evidence-based practice and unit priorities.

Microbursts are embedded into workflows and may be completed collaboratively or individually to support self-paced learning. Staff and managers are encouraged to submit topic and activity suggestions, fostering engagement and promoting a sense of ownership and control over their learning. This model reinforces onboarding, supports competency development, and promotes continued professional growth. Activities are facilitated by clinical educators or unit champions. Participants earn 0.25 NCPD contact hours upon completion of an evaluation assessing outcomes, engagement, and intended practice change.

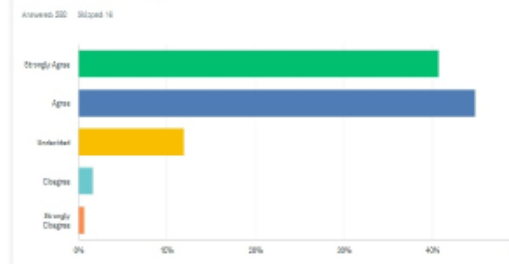
Results/Outcomes:

A total of 308 participants completed evaluations. The primary outcome of strengthening critical thinking in critical care was achieved, with 98.38% reporting agreement or strong agreement that the learning outcome was met. Additionally, 85.61% agreed that interactive teaching strategies enhanced learning. Participant feedback reflected increased confidence, improved knowledge retention, and appreciation for flexible, collaborative learning approaches.

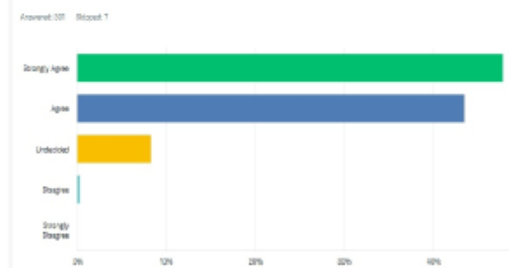
Implications:

This sustainable, scalable model leverages the Platform to support diverse learning needs, including onboarding and continued education. Limitations include variable participation, differing preferences, reliance on technology, and limited hands-on practice. Future efforts will incorporate more tactile learning.

The interactive teaching strategies (i.e. group work, case studies, games, etc.) enhanced my learning.



The speaker(s) were knowledgeable and engaged the participants in the course materials?



Reducing Emergency Resternotomies Through Interprofessional Simulation-Based Cardiac Surgery Resuscitation Training

Shannon Webber MSN-Ed, RN, CCRN; Marcia Litteral MSN, RN, CCRN



Learning Objectives

- **Differentiate** key differences between Advanced Cardiac Life Support (ACLS) and cardiac surgery resuscitation protocols, including prioritization of defibrillation, pacing, and management of reversible causes.
- **Recognize and intervene** on common reversible causes of cardiac arrest in post-cardiac surgery patients (e.g., tamponade, hypovolemia, arrhythmias) using a structured, protocol-driven approach.
- **Demonstrate effective interprofessional team performance** during cardiac surgery resuscitation, including execution of defined roles and participation in emergency resternotomy simulations when indicated.

Background/Relevance:

Post-cardiac surgery patients require resuscitation approaches distinct from standard American Heart Association Advanced Cardiac Life Support (ACLS), which is also offered in similar form by the American Red Cross. Cardiac surgery-specific protocols prioritize early defibrillation, pacing, and rapid identification of reversible causes such as tamponade and hypovolemia. Historically, at a 193-bed Regional Medical Center, critical care float pool nurses and advanced practice practitioners (APPs) were not involved in cardiac surgery care; however, expanded cross-coverage models and staffing changes exposed gaps in protocol adherence, role clarity, and timely intervention.

Purpose:

To improve adherence to cardiac surgery resuscitation protocols and interprofessional team performance through a structured, multimodal educational intervention.

Methods:

A pre-post quality improvement design was conducted in a 12-bed cardiac ICU. Baseline gaps were identified through mock code observation and staff feedback. An existing program was redesigned to improve accessibility using asynchronous prework and multimodal education (didactic, case-based, high-fidelity simulation). Two course levels were implemented: an Initial course (4.75 hours) focused on recognition and management of reversible causes, and an Experienced course (2 hours) emphasizing team performance and emergency resternotomy simulation. Participants included ICU nurses, critical care float pool nurses, cardiac progressive care unit nurses, and APPs. Outcomes were evaluated using simulation performance checklists and post-course evaluations.

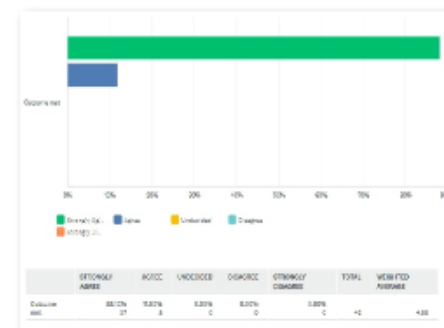
Results:

Forty-two participants completed Initial course evaluations (95.2% RNs). Learning outcomes were high (mean 4.88/5), with 100% agreeing course objectives were met, including 88.1% strongly agreeing. Sixteen participants completed Experienced course evaluations (93.8% agreement regarding achievement of learning outcomes), with strong ratings (mean 4.50/5; 62.5% strongly agree, 31.3% agree). Participants demonstrated improved performance in simulation, including recognition of reversible causes and team role coordination. Qualitative feedback reflected increased familiarity with protocols and earlier escalation of care.

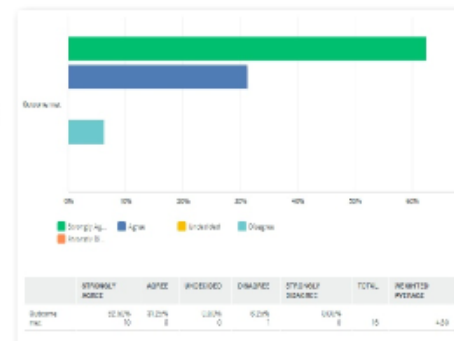
Implications:

This multimodal, interprofessional simulation program improved protocol adherence, team performance, and participant-reported confidence, with demonstrated improvement in recognition of reversible causes during simulation. Tiered simulation-based training may support high-risk cardiac populations. Ongoing simulation and competency validation are recommended to sustain improvements.

Cardiac Surgery Resuscitation Initial Course



Cardiac Surgery Resuscitation Experienced Course



Cardiac Surgery Arrests per AHA Definition

Year	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Total Cardiac Surgeries (n=91)	318	342	343	325	280	310	343	361	324	312
Total number Cardiac Arrests (n=14)	6	13	5	4	16	9	9	5	5	3
ICU who survived to discharge after Cardiac Arrest (%)	0 (0%)	7 (20%)	2 (40%)	5 (80%)	4 (40%)	5 (30%)	2 (22%)	3 (60%)	1 (20%)	1 (33%)
Emergency Resternotomy	1	2	2	3	2	3	2	3	0*	1

*Noted = 40 in database. Data missing = 12/18
 ** patient had chest pain already and upon being in ICU and did not receive all quality bundle interventions and required

Scan, Watch, Recover: Transforming Discharge Education with QR Code Videos: A Nurse-Led Approach to Foley Catheter Instructions

Sonja Welter, BSN, RN, CPAN UCHealth University of Colorado Hospital Aurora, Colorado

Background

- Effective post-anesthesia discharge education is critical to patient recovery and complication prevention, particularly for those discharged with indwelling devices such as Foley catheters.
- Traditional verbal instructions are often insufficient due to patient drowsiness, time constraints, language barriers and varying literacy levels.
- Integrating digital tools, such as QR-code-accessible video modules, may enhance comprehension and retention of discharge instructions

Objective

- Evaluate the impact of multimodal, multilingual discharge education—including QR code video modules, printed text instruction, and hands-on demonstration.
- To improve patient understanding and discharge outcomes for patients discharged with Foley catheters following anesthesia.

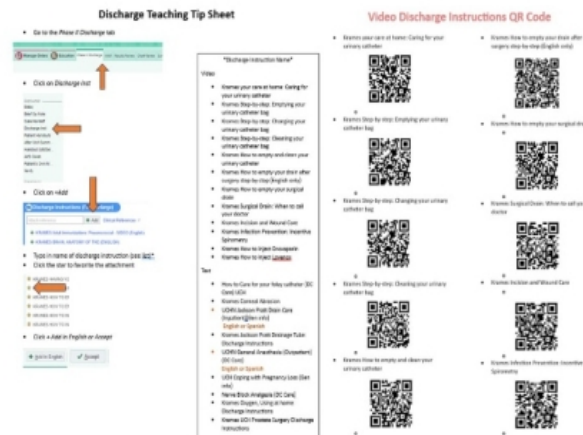
Current Practice

- Phase II nurses provided verbal instructions using the After Visit Summary (AVS) as ordered by the surgeon.
- Patients are provided the written AVS for discharge (English text only)
- Hands on foley catheter teaching is available to nursing staff to show patients and families how to empty, clean and change to leg bag.

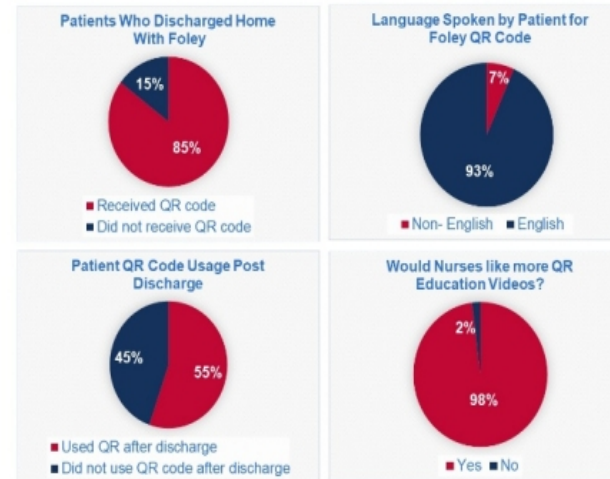
Methods

- Conducted in a post-anesthesia care unit (PACU). Nurses received targeted training on the use and delivery of QR codes linked to short, evidence-based video modules covering Foley catheter care, signs and symptoms of infections and troubleshooting.
- Patients discharged with a Foley catheter received updated AVS to include a printed QR code along with standard written instructions and brief hands on-tactile demonstration.
- To address language diversity materials were made available in English and Spanish, including video content and written instructions when available.
- Nurse engagement, patient satisfaction, and patient comprehension were evaluated through surveys, chart audits, and post-discharge phone calls

Teaching Tools



Results



- A QR-code-based education intervention substantially improved patient understanding of Foley catheters.
- Forty-seven patients rated their knowledge on a 0–5 scale before and after viewing the material. Average scores rose from 2.66 (SD = 1.61) to 3.81 (SD = 0.69), a mean increase of 1.15 points.
- A paired t-test using the observed difference and plausible pre/post correlations produced t-values between 8.6 and 11.6, all with $p < 0.001$.
- This demonstrates a highly statistically significant improvement in patient knowledge.

Conclusion

- Patients who were discharged with a foley catheter and received the QR-based educational video reported that it was helpful and increased their knowledge.
- Over half of the patients discharged home with the QR education videos used the QR code to support their learning at home.
- The QR codes provided meaningful educational support for patients and families during the post-surgical period.

Next Steps

- This project demonstrates the value of multimodal and multilingual post-anesthesia education as well as streamlines and standardize patient education.
- QR codes will expand to include Jackson Pratt (JP) drains and orthopedic discharge teaching—specifically for crutch and walker use.
- Expanding QR-based video education may support safer transitions of care and reduce preventable post-discharge complications across multiple patient populations.

What other discharge education QR codes do nurses want?





BACKGROUND

Childhood cancer survivors (CCS) treated with immunosuppressive chemotherapy are at increased risk for waning or loss of vaccine-induced immunity.

Up to 50% of CCS may exhibit diminished or loss of serologic protection following cancer therapy.

COG LTFU Guidelines recommend:

- Measurement of antibody titers to assess for seroprotection with targeted boosting, or,
- Booster empirically all previously completed vaccine series are recommended 6 months after treatment.

OBJECTIVE

To improve vaccine titer and/or booster rates through multi-level QI efforts from 0% to 60%.

METHODS

Target population for outcome

assessment: patients between 6 -18 months post-treatment of childhood cancer (excluding those who underwent allogeneic HSCT).

Primary process outcome: proportion of patients with Hepatitis B titer measurement and/or booster

Additional measures: other titers assessment, titer results, subjective provider feedback

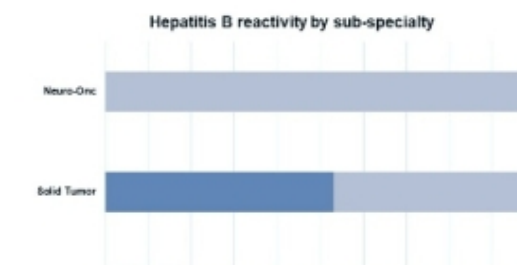
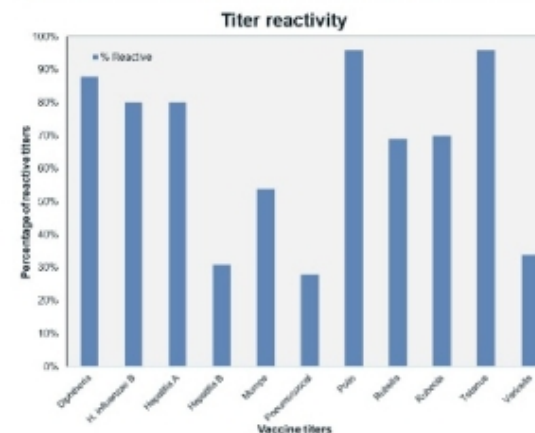
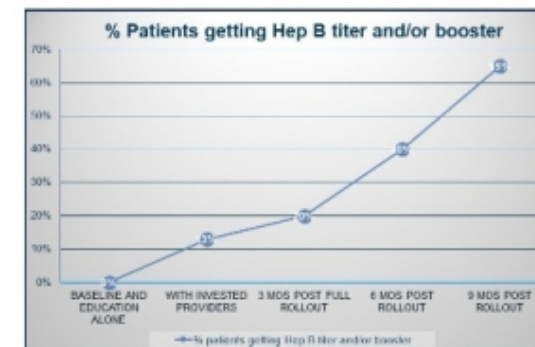
Our Process:

1. Assembled a multi-disciplinary team with interest in the project (physicians, advanced practice providers, pharmacists, nurses)
 - o Identified gaps in care, implementation barriers, workflow challenges

RESULTS

138 patient charts reviewed since November 2025

- 54% liquid tumor, 36% solid tumor and 10% neuro-onc
- 53 of 138 patients had at least a single titer drawn and 98% of those patients required at least a single booster



VA Leads the Way!

38th Annual Rocky Mountain Interdisciplinary Evidence-Based Practice & Research Conference 2026

Maria Wright Juarez, BSN, RN, CCM

Joel Hamilton, PhD, RD

Stephanie Meisinger-Johnson, PharmD, BCACP

Abstract

The PPC Floyd K. Lindstrom Community Based Outpatient Clinic (CBOC) developed and implements Shared Medical Appointments (SMAs). These appointments target Veterans with diabetes mellitus or hypertension and are facilitated by Registered Nurses, and a Pharmacist, a Registered Dietitian. Research shows SMAs result in reduced cost per visit, fewer emergency room visits, lower no-show rates, improved disease management, and reduced overall health care costs.

Purpose

This process improvement project evaluated the effectiveness of each intervention to aid in its adoption across the Veteran Integrated Service Network (VISN).

Methodology

Patient satisfaction was obtained via anonymous Likert scale surveys while averages on hemoglobin A1C, systolic blood pressure, diastolic blood pressure, and Electronic Quality Measurements (EQMs) were obtained via chart reviews. All information was deidentified.

Survey Questions (DM SMA)

- Q1. Overall experience [1-10].
- Q2. Was the information provided easy to understand?
- Q3. Will the information help you manage your diabetes?
- Q4. Do you have a better understanding of what causes diabetes?
- Q5. Were the instructors knowledgeable and approachable?
- Q6a. Do you know who to contact with diabetes questions or concerns? (Yes/No)
- Q6b. If Yes, who?
- Q7. Comments / Feedback (optional).
- Q8. How likely are you to recommend this class to another veteran? (1-5)?

Survey Questions (HTN SMA)

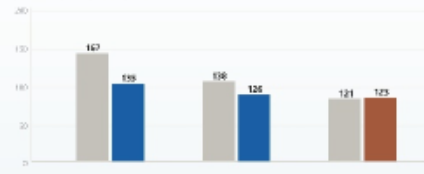
- Q1. Overall experience [1-10].
- Q2. Was the information provided easy to understand?
- Q3. Will the information help you manage your hypertension?
- Q4. Do you have a better understanding of what causes hypertension?
- Q5. Were the instructors knowledgeable and approachable?
- Q6a. Do you know who to contact with diabetes questions or concerns? (Yes/No)
- Q6b. If Yes, who?
- Q7. Comments / Feedback (optional).
- Q8. How likely are you to recommend this class to another veteran? (1-5)?

Results

Figure 1. Outcomes across Veterans with completed before/after blood pressure readings (n = 40).

AVERAGE SYSTOLIC (SBP)	AVERAGE DIASTOLIC (DBP)	PATIENTS IMPROVED (SBP)
134.0 → 130.3	85.5 → 78.2	87.5%
A reduction of 3.7 mmHg, an average	A reduction of 7.3 mmHg, an average	15 of 40 patients lowered their systolic pressure

Figure 2. Veterans with the highest starting blood pressure experienced the largest reductions (n = 40).



Patients who began with an SBP of 150 mmHg or higher saw an average reduction of 32.6 points — nearly three times the improvement seen in the medium-baseline group, and far greater than patients who started closer to a normal range. Based on 40 SMA participants with completed follow-up blood pressure readings (January 8 – December 17, 2025 sessions), 3 participants excluded pending follow-up readings, and 2 rows excluded as incomplete records. Diastolic (DBP) improved in 72.5% of patients, with an average reduction of 7.4 mmHg. Heart rate showed minimal net change (avg ~1.0 bpm) and was more variable across patients than blood pressure.

Figure 3. Outcomes across Veterans with completed before/after A1c laboratory results (n = 62).

AVERAGE A1C CHANGE	PATIENTS IMPROVED	DIABETES RISK REDUCTION
7.99% → 7.00%	85.5%	-2.21
A reduction of 0.99 percent, an average	54 of 62 patients lowered their A1C following the program	Average point reduction for patients starting at A1C ≥8%

Figure 4. Veterans with before/after A1c data (n = 62).

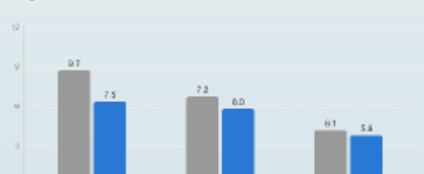
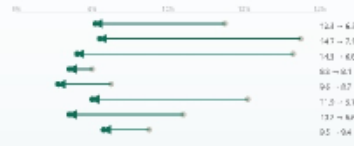


Figure 5. Distribution of A1c change across Veterans (n = 40).



Figure 6. Individual shifts in A1C (high baseline; n = 40).



Patients who began with an A1c of 8% or higher saw an average reduction of 2.21 points — more than seven times the improvement observed among patients already close to target. The longer the arrow, the greater the improvement — and the longest arrows belong to the patients who needed it most. Based on 64 total SMA participants enrolled January 8 – December 10, 2025. Two patients are excluded pending follow-up laboratory results. Patients receiving additional 1:1 support (Clinical Pharmacy Practitioner or Registered Dietitian Nutritionist) showed an average reduction of 1.19 points, compared with 0.87 points for SMA participation alone.

Veteran Feedback

At the conclusion of each appointment Veterans were asked for comments, feedback, and suggestions. This information has been used to further enhance the program. Below are some notable responses, how the program has been adjusted to better meet Veteran needs, and general remarks.

“Great class, low stress but informative.”

SMA facilitators strive to create a low stress, judgement-free, and welcoming environment. This encourages Veterans to ask questions and stay engaged.

“Thank you for the genuine caring expressed and willingness to answer questions.”

“They were so professional, very knowledgeable of the subject matter. I took it as their concern to my well being is so personal and that mattered a lot to me.”

We firmly stand by the statement Veterans get the best care at the VA. Many of our staff are Veterans and the genuine care they mentioned is something we hope every Veteran experiences.

“Could’ve spent more time on the diet.”

Veterans show genuine interest in learning how diet can impact the management of their condition(s). Additional time and interactive activities been added, which has been well received.

Provider Panel Scores

Diabetes SMA – A1C 10+ Missing		
Month/Year	Provider Score (%)	National Average (%)
Sept/2024	10.33	10.08
Nov/2025	8.50	15.55
Hypertension SMA – BP Control Score		
Month/Year	Provider Score (%)	National Average (%)
May/2024	72.97	65.92
Nov/2026	84.92	77.03

Cost Avoidance

Research shows that net savings per patient at 12 months in a diabetes group visit study, driven by fewer hospitalizations (6.1%, 19.4%) was \$1,855.00. Additionally, it is estimated that \$2.5B in net savings is saved via team-based hypertension care modeling interventions across ten years. Cost avoidance is another benefit that can arise from group interventions, such as a SMA.

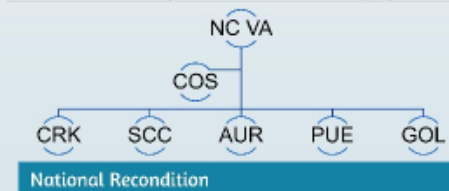
Conclusion

This success resulted in branches forming at other CBOCs within the VISN, some of which have adopted new focus areas (i.e., women's health in Veterans). This project has been highlighted by chairs of the Veterans Affairs Nutrition and Food Service department as a best practice. Additional promotion will help encourage Veteran and non-Veteran institutions to adopt this model and spur additional process improvements of SMAs in various healthcare settings.

Clinic Expansion

A 2012 systematic review conducted by the Durham, NC VA and additional supporting research inspired the structure of the SMAs at the Lindstrom CBOC. Pioneering this module led to satisfactory results. This best-practice was shared on national calls and locally, inspiring the adoption at other CBOCs within the Eastern Colorado Healthcare System.

Month/Year SMA Established	Location
May/2024 BP SMA	Lindstrom CBOC (COS)
Sept/2024 DM SMA	Lindstrom CBOC (COS)
Nov/2024 BP SMA	Castle Rock CBOC (CRK)
April/2025 DM SMA	Castle Rock CBOC (CRK)
Jan/2025 BP & DM SMA	Spacio Center CBOC (SCC)
Mar/2025 BP & DM SMA	Aurora CBOC (AUR)
Apr/2025 BP & DM SMA	Pueblo CBOC (PUE)
BP & DM SMA, Pending	Golden CBOC (GOL)



“I just wanted to inform you that the article you sent to the Express Digest on Shared Medical Appointments will be featured on Wednesday's NFS National Call. NFAB leaders' thought it was a great story and want to spread the word more widely!”

-NFS National Call Co-Chair

This shows that our intention, which is to increase the adoption of SMAs across the healthcare system is coming to fruition.

Utilization of EPIC's Snapboard to Level-Load the Center for Cancer and Blood Disorders Infusion Center Schedule

Jenny Flynn, BSN, RN, CPHON, Kristin Hyatt, MS, RN, CPHON, Cassie Lang, MSN, CNS, ACCNS-AG, CCRN and Ginny Lugo, MS, RN, NE-BC



Children's Hospital Colorado

BACKGROUND

The Center for Cancer and Blood Disorders wanted to optimize its infusion center schedule.

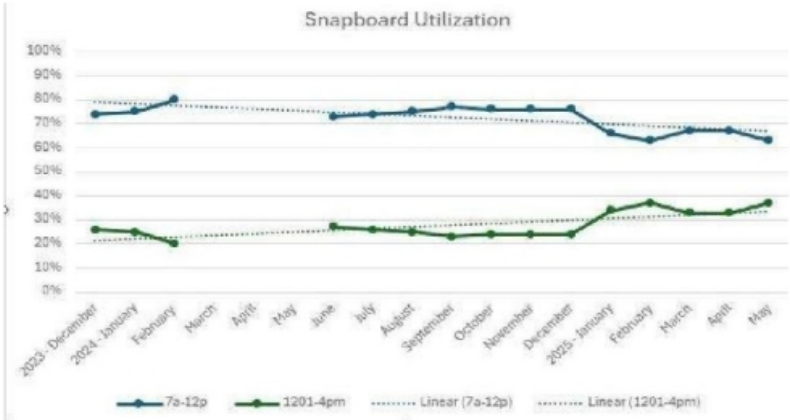
- Chart audits from December 2023-February 2024 revealed that on average 76% of patients were scheduled between 7:00 a.m. and 12:00 p.m.
- Further data collection showed the template was only 24% utilized.
- Patients scheduled before 12:00 p.m. had an average waiting room time of 15 minutes and an average time from arrival to first medication of 43 minutes.
- Our intervention period was from March 2024 – May 2024, with post data collection starting June 2024 – June 2025.
- By utilizing EPIC's Snapboard tool, we will be able to level load (balance) the schedule: increase utilization of template by 10% 12 months post, decrease average waiting room time by 10%, time from arrival to first medication given by 10% and number of patients scheduled before noon by 10%

METHODS

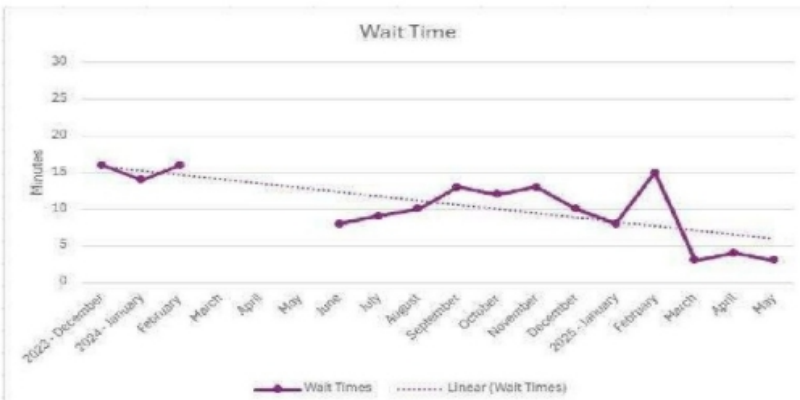
Utilizing a pre-post design we assessed the impact of implementing Snapboard scheduling.

- Implementation began in May 2024 and post data was collected monthly for 12 months post.
- We focused on data-driven process improvement such as bottlenecks in morning schedules, delays in first medication given and percentage of template utilized in the afternoon.
- By identifying root causes of delays, utilization of EPIC reports and implementation of a decision tree, we optimized patient placement based on length of infusion and priority, monitored and adjusted scheduling algorithms based on real time feedback.
- Patient volume, staffing, renovations, exam room schedule, and pharmacy staffing were reviewed as audits each day to note if these factors increased times.

RESULTS



- Utilization of the Snapboard template in the morning decreased and afternoon use increased by 5% (afternoon pre 24%; post 29%)
- This adjustment and shift to more patients being scheduled in the afternoon allowed for us to impact our wait times as fewer patients were arriving at the same time, allowing for quicker rooming
- Wait times decreased from 15 mins. to 9 mins. post intervention on average



CONCLUSIONS

- After implementing the new system, average patient wait times decreased by 30%.
- However, the time to first medication administration remained unchanged at 54 minutes.
- The number of patients scheduled before noon dropped by 10%, although 66% of appointments were still concentrated in the morning hours.
- Appointment distribution saw a modest improvement of 3%.
- Efforts to encourage schedulers to utilize afternoon slots led to overbooking at the 1300 hour. This highlighted the need for session limits—restricting the number of appointments per hour—as a strategy to better balance the schedule.

IMPLICATIONS

- Utilization of EPIC Snapboard Tool can help level load the schedule and increase utilization. This can impact the flow of patients in a busy outpatient infusion center.
- Further quality improvement projects can be done to focus on ways to improve scheduling throughout the day by utilizing session limits (limiting the number of patients scheduled per hour).

DISCLOSURES

No financial disclosures

FROM SCRUBS TO SELF-EFFICACY:

The Power of Nurse-Led Bedside Rounds to Boost Confidence & Patient Care

Julie Marshall, DNP, RN, CCM, CNE, PED-BC
Children's Hospital Colorado | Regis University



REGIS UNIVERSITY
LORETTO HEIGHTS SCHOOL OF NURSING

Children's Hospital Colorado

BACKGROUND & PURPOSE

This Doctor of Nursing Practice (DNP) project implemented Nurse-Led Bedside Rounds (NLBR) on a pediatric inpatient unit to address the absence of a standardized bedside rounding process. The lack of structured rounds contributed to frustration among nurses and families due to inconsistent communication and limited participation in care discussions. Nurse-Led Bedside Rounds are an evidence-based practice that enhances patient and family engagement, improves communication and interdisciplinary collaboration, and strengthens nursing self-efficacy. Increased self-efficacy has been associated with reduced burnout, improved nurse retention, and better patient outcomes. Guided by Powell-Cope's Theory of Negotiating Partnership, the project promoted family-centered care by recognizing caregivers as essential partners in their child's healthcare journey. A comprehensive review of 36 studies informed the initiative, supported the selection of a validated pediatric inpatient nursing self-efficacy instrument, and established the evidence base for implementation. Kotter's Change Model provided the framework for project implementation, adoption, and long-term sustainability.

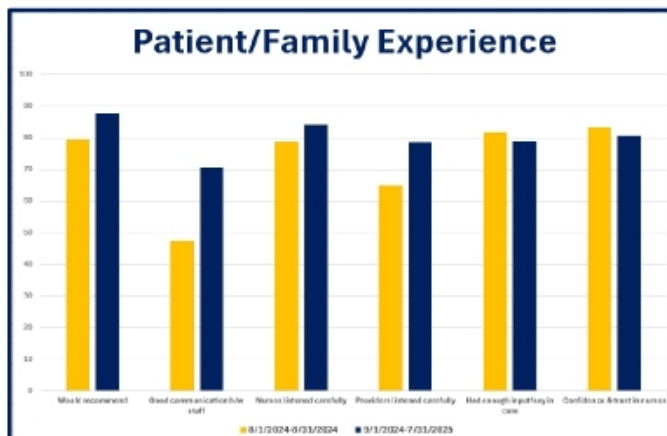
METHODS

Following stakeholder approval, a structured NLBR process was developed and implemented on a pediatric inpatient unit.

Intervention Components

Standardized nurse-led rounding tool
Education, simulation, and role-play training
Verification of preferred family contact information
Daily interdisciplinary bedside rounds
Nurse presentation of patient assessment
Family participation and shared decision-making
Interpreter services arranged as needed
EMR workflow integration

RESULTS



CLABSI	Falls with Injury	Length of Stay	PIV Infiltration or Extravasation
0	30% ↓	2 Hours ↓	14% ↓
Maintained Zero CLABSI Rate (27% ↓ CVC days)	7.05 → 4.90 (per 1000 patient days)	Average LOS reduced by 2 hours	18.28 → 15.68 (per 1000 patient days)

Nursing Outcomes	Pre-intervention (N = 81) Median (IQR)	Post: 3 months (N = 62) Median (IQR) n (%)	Post: 12 months (N = 40) Median (IQR) n (%)	p-value
Altruism	4.46 (0.69)	4.62 (0.67)	4.61 (0.42)	0.15
Communication	4.36 (0.90)	4.64 (0.54)	4.64 (0.54)	0.05
Management	4.40 (1.00)	4.77 (1.00)	4.73 (0.75)	0.02
Proficiency	4.41 (0.91)	4.58 (0.83)	4.62 (0.56)	0.03
Rate of Rounding Participation (post only)	--	45 (72%)	28 (70%)	--
Number of Rounds (post only)	--	10 (43.2)	20 (49.2)	--

TOOLS

Nurse-Led Bedside Rounds:
Standardized Rounding Tool 2.0

Nurse

1. Introductions and invite patient and family into the conversation.
"If LAB UNAVAILABLE AT ROUNDS, CALL STARRED PHONE NUMBER"
2. Short summary of stay (one liner):
 - a. Focused & abnormal assessment; VS trends; PEWS/SNAP changes;
 - b. UOP & 24hr 0701-0700: total Intake & Output;
 - c. PRNs (last 24hrs);
 - d. 24-hour event summary;
 - e. RN recommendations/concerns/order clean up;
 - f. Additional information;

Provider/Learner:

1. Presentation as appropriate
2. Assessment/Plan
3. Goals for discharge (reminder to put DC Criteria on EWB)

Family

- Plan and ask family top concerns/questions.

ALL:

- Any additional questions or concerns that have not been addressed?



CONCLUSIONS

Nursing Self-Efficacy: Significant Improvement

Overall self-efficacy improved significantly through survey using a validated tool for Pediatric Nursing Self-efficacy. Improvements demonstrated across all measured domains. Standard deviation narrowed, indicating increasing consistency.

Patient & Family Experience: Improvement

Communication between team members
Respect and listening behaviors
Family engagement
Likelihood to recommend the hospital

Quality Outcomes: Decreased Harm

Reduced Length of Stay
Maintained zero CLABSI despite increased line days
Reduced PIV infiltration and extravasation rates
Reduced falls with injury rate

IMPLICATIONS

This project demonstrates that nurse-led bedside rounds strengthen nurse confidence, foster interdisciplinary collaboration, and enhance patient- and family-centered care.

NLBR represents an evidence-based, sustainable strategy to improve both professional nursing practice and pediatric patient outcomes.

DISCLOSURES

I have no financial disclosures to share.

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Newborn Hearing Screening: Evaluating Methods and Timing for Improved Outcomes

Alice Mhango & Kaitlyn Bell | Regis University, Loretto Heights School of Nursing

38th Annual Rocky Mountain Interprofessional Research & Evidence-Based Practice Symposium

"Advancing Health Science Together: Increasing Our Collective Visibility & Impact"

BACKGROUND & SIGNIFICANCE

- Newborn hearing screening supports early identification of hearing loss, which can affect speech, language, and cognitive development.
- Denver Health's current protocol uses automated auditory brainstem response (AABR) for newborn hearing screening.
- Screening timing may affect accuracy: early testing can increase false-positive results and repeat testing, while later testing may affect the timing of diagnosis and care.
- This project evaluates both screening method (AABR vs. OAE) and timing (≤ 24 hours vs. > 24 hours).

PURPOSE & PICO QUESTIONS

Purpose: Determine how screening method and timing affect detection, pass rates, false-positive referrals, and repeat testing.

PICO #1 • METHOD

P: Term and late-preterm newborns

I: Universal AABR screening

C: OAE-based screening

O: Detection of congenital hearing loss and false-positive screening

PICO #2 • TIMING

P: Healthy newborns in the well-baby nursery

I: Screening at or before 24 hours

C: Screening after 24 hours

O: Hearing-loss identification, pass rates, false-positive referrals, and repeat screening

LITERATURE REVIEW & SEARCH STRATEGY

DATABASES

- PubMed: 13,098 $\rightarrow$ 3,642
- Google Scholar: 9,920 $\rightarrow$ 3,030
- EBSCO (CINAHL/Medline): 9 $\rightarrow$ 3
- Cochrane Library: 7,002 $\rightarrow$ 28

KEYWORDS & FILTERS

- "newborn hearing screening," "AABR," "OAE"
- "early screening," "24 hours," "after 24 hours"
- "false positive," "pass rate," "hearing loss detection," "repeat screening"
- Last 5 years • English • Peer-reviewed

FINAL EVIDENCE SET

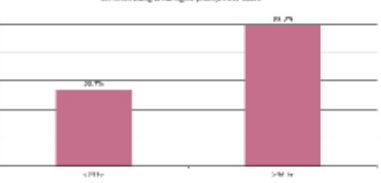
12 articles

Systematic reviews, cohort studies, observational studies, controlled comparative research, and qualitative evidence were critically appraised and synthesized by screening method, timing, accuracy, false positives, pass rates, and follow-up outcomes.

RESULTS: SCREENING TIMING

Later screening was associated with higher pass rates and fewer false-positive referrals.

Schwarz et al. (2023) • 735 newborns



Additional evidence: Vonk et al. (2026) analyzed > 1.6 million newborns and found the lowest false-positive rates on days 5–13, with earlier screening associated with higher referral rates. Mackey et al. (2022) found screening after 3 days reduced referral rates.

RESULTS: EARLY-SCREENING CONDITIONS

Schwarz et al. (2023) • 735 newborns

FALSE POSITIVES

7.61% $\rightarrow$ 1.63%

After ear cleaning

INITIAL FAILURES

3.9%

Of newborns screened

NURSING TAKEAWAY

Ear assessment/cleaning before early screening may reduce false positives, repeat testing, and parent stress.

Key implication: if screening must occur early, address modifiable conditions before testing and ensure repeat screening before discharge.

RESULTS: AABR VS. OAE

Evidence showed a trade-off between diagnostic accuracy and time/resource efficiency.

AABR

- Greater diagnostic accuracy in reviewed studies
- Lower false-positive/failure rates than OAE in comparative evidence
- Detects neural and cochlear pathway problems
- Requires more time and resources

OAE

- More time- and cost-efficient
- Measures cochlear response to sound
- Higher referral/failure rates in several comparisons
- May be useful within multi-stage screening protocols



Multi-step evidence: Hetzopoulos et al. (2024) reported that most programs use combined OAE + AABR approaches, with screening coverage $> 90\%$. Parangrit et al. (2025) also found newer/multi-step protocols improved detection and reduced false-positive results.

EBP FRAMEWORK: IOWA MODEL

- Problem-focused trigger: variability in screening accuracy and false-positive rates.
- Evidence synthesis: compare AABR vs. OAE and screening timing.
- Practice change: consider a later screening process and/or multi-step OAE + AABR protocol.
- Implementation: engage nurses, providers, audiology, leadership, and parents.
- Evaluation: monitor pass rates, referrals, false positives, detection, and follow-up.

CRITICAL APPRAISAL

STRENGTHS

- Includes high-level evidence, including a systematic review
- Large sample sizes in several studies
- Consistent outcomes: pass rates, false positives, referrals
- Mix of study designs

LIMITATIONS

- Many studies were observational
- Some studies had small samples
- Different settings and screening protocols
- Limited research directly combining timing + screening method

IMPLICATIONS FOR NURSING PRACTICE

- Support evidence-based screening timing and workflow.
- Assess the ear and address vernix/fluid when early screening is necessary.
- Educate parents about screening results, repeat testing, and the importance of follow-up.
- Coordinate care with audiology, providers, and other interdisciplinary team members.
- Use EHR documentation, tracking systems, and follow-up alerts to reduce loss to follow-up.

EVIDENCE-BASED RECOMMENDATION

When clinically appropriate, newborn hearing screening should be performed after 24 hours of life, ideally closer to discharge.

- Later screening is supported by evidence showing improved pass rates and fewer false-positive referrals.
- If screening must occur early, perform an ear assessment/cleaning and ensure repeat screening before discharge.
- Denver Health may continue universal AABR while considering a feasible multi-step OAE + AABR approach.
- Pilot and evaluate workflow, false positives, detection rates, referrals, and follow-up before broad implementation.

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