Doctor of Nursing Practice
Consortium Program:
Minnesota State Colleges and Universities

Compendium of Clinical Capstone
Project Abstracts

Volume V

Minnesota State Colleges and Universities

Doctor of Nursing Program
2013
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Minnesota State Colleges and Universities
Doctor of Nursing Practice Consortium Program

DNP Scholarly Event:
Presentation of Doctoral Clinical Scholarship Projects

Date: Tuesday, March 26, 2013
Time: 8:00 am – 4:00 pm
Location: Horizon Wimba
http://netclass.mnstate.edu
Room ID: DNPScholarly

Horizon Wimba Setup Instructions
Program Schedule

8:00 am - 8:30 am  Welcome, Introductions, and Remarks

DNP Program Management Council Co-Chair
Sonja J. Meiers, PhD, RN
Professor and Director, Graduate Programs in Nursing
College of Nursing and Health Sciences
Winona State University

DNP Coordinating Council Chair
William J. McBreen, PhD, RN
Dean, College of Nursing and Health Sciences
Winona State University

8:30 am - 9:00 am  Keynote Address: Given Back to Our Profession

Diane Twedell, DNP, RN, CENP
Chief Nursing Officer Mayo Clinic Health Systems - Southeast MN Region
1000 First Drive NW
Austin, Minnesota 55912

9:00 am - 3:30 pm  Poster Presentations

Rhonda Bender  9:00 - 9:30 am
Maureen K. Gerson  9:30 - 10:00 am
Nancy Hall  10:00 - 10:30 am
Therese M. Jacobson  10:30 - 11:00 am
Michelle M. Lisowski  11:00 - 11:30 am
Erin E. Martin  11:30 - 12:00 noon
Lunch  12:00 - 1:00 pm
Laurel Ostrow  1:00 - 1:30 pm
Stacey L. Rosenberg  1:30 - 2:00 pm
Emily Sorensen  2:00 - 2:30 pm
Nancy Van Aman  2:30 - 3:00 pm
Michelle K. H. Wald  3:00 - 3:30 pm

3:30 pm – 4:00 pm  Closing Remarks

Program Management Council Co-Chair
Sue Ellen Bell, PhD, RN, PHCNS, BC
Professor
College of Allied Health & Nursing
Minnesota State University, Mankato
Congratulations
2013 Doctor of Nursing Practice Graduates!

Rhonda Bender
Maureen K. Gerson
Nancy A. Hall
Therese M. Jacobson
Michelle M. Lisowski
Erin E. Martin
Laurel Ostrow
Stacey L. Rosenberg
Emily Sorensen
Nancy Van Aman
Michelle K. H. Wald
Abstracts

Rhonda Bender, MS, RN, CNP
Impact of Adopting Guidelines Supporting Family Presence During Resuscitation (FPDR) on Nurses’ Perception of Risks, Benefits, Self-confidence, and Practice of FPDR in a Rural Midwestern Medical Center

Maureen K. Gerson, MSN, RN
Palliative and End-of-Life Nursing Education for Health Care System Staff

Nancy A. Hall, MS, RN
Implementation of a Facilitated Advance Care Planning Process in an Assisted Living Facility

Therese M. Jacobson, MS, RN, ACNS-BC, CWOCN
Identification, Prevention, and Management of Incontinence-Associated Dermatitis (IAD) in Hospitalized Adults: Translating the Evidence into Practice

Michelle M. Lisowski, MS, RN, APNP
Hepatitis C Patients with Cirrhosis in Primary Care Clinics: Implementing Evidence-Based Guidelines

Erin E. Martin, CRNA, MNA
Patient Education Regarding Analgesic Options for Labor and Delivery

Laurel Ostrow, MAT, MSN, RN, ANP-C
“Intellectually Starved,” A Study of the Effects of Life Review on Elder Depression in Long Term Care

Stacey L. Rosenberg, MS, RN, CNE
An Educational Intervention Addressing Nurses’ Cultural Competence

Emily Sorensen, MSN, RN, FNP-C
Nurse Practitioner Satisfaction with Initiation of Depression Screening on an Inpatient Diabetes Service

Nancy Van Aman, MSN, RN, FNP-BC
High-fidelity Simulation in a Nurse Residency Program: Effective Decision-making to Prevent Failure to Rescue

Michelle K. H. Wald, MSN, RN, CNP
Documentation of Comprehensive Pain Assessment in Outpatient Medical Oncology – Best Practice
Impact of Adopting Guidelines Supporting Family Presence During Resuscitation (FPDR) on Nurses’ Perception of Risks, Benefits, Self-confidence, and Practice of FPDR in a Rural Midwestern Medical Center

Rhonda Bender, MS, RN, CNP

University: Minnesota State University, Mankato

Committee Chair: Sue Ellen Bell, PhD, RN, PHCNS, BC
Committee Members: Sandra Eggenberger, PhD, RN, Lisa Perez, PhD

Purpose: The purpose of this project was to adopt clinical practice guidelines supporting the option of FPDR based on written institutional policy and staff education. The corresponding study sought to answer the clinical question - In a rural Midwestern medical center, how does adoption of a written policy and staff education supporting FPDR based on current evidence impact (a) staff perception of risks and benefits of FPDR measured pre/post-education using the Family Presence Risk-Benefit Scale (FPR-BS), (b) staff report of self-confidence in skills needed for facilitating family centered support during resuscitation measured pre/post-education using the Family Presence Self-confidence Scale (FPS-CS), and (c) the clinical practice of FPDR measured retrospectively by chart review two months pre-intervention, two months during intervention, and two months post-intervention, compared to current practice (no current policy, no staff education, and inconsistent clinical practice of FPDR)?

Synthesis of evidence guiding practice change: FPDR guidelines (a) demonstrated the benefits of FPDR; (b) refuted the perceptions of risk to patients, families, providers, and facilities engaged in FPDR; and (c) encouraged development of written policy and staff education supporting FPDR.

Proposed change in practice: FPDR should be considered in all resuscitation circumstances, offered as an option to appropriate family members, based upon written policy, and supported by staff education.

Strategies of implementation: Strategies to engage multidisciplinary stakeholders included (a) two meetings to examine evidence related to FPDR and conduct needs assessment, (b) ethics committee presentation and discussion, and (c) physician’s luncheon presentation and discussion. A committee of engaged stakeholders wrote the policy submitted for institutional approval. Evidence-based staff education was developed and conducted in collaboration with the primary stakeholder.

Stakeholders: Key stakeholders included the hospital chaplain, chief nursing officer, nurses, social workers, coroner’s assistant, physicians, patients, and service area families.

Method for evaluation: The research design included a pre/post-education survey using the FPR-BS/FPS-CS and a retrospective chart review. The study methodology included implementation of two staff education strategies: (a) an evidence-based inservice presentation, and (b) a clinical lab simulation. The dependent variables included staff perceptions of risk, benefits, and self-confidence related to FPDR compared pre/post-education using non-paired t testing. Pearson r and ANOVA were used to determine correlations between demographic and dependent variables. Clinical practice impact was measured using a six-month chart review that compared the percentages of records with documented family presence pre-intervention, during intervention, and post-intervention using two-month intervals.

Significance of the work: Though causality cannot be determined, a statistically significant increase occurred in nurses’ perception of FPDR benefits and nurses’ self-confidence with FPDR pre to post-educational intervention. The clinical practice of FPDR tripled when pre to post-intervention periods were compared. This study may serve to inform other medical centers seeking to translate FPDR guidelines into clinical practice.
Purpose: In 1997, the Institute of Medicine (IOM) reported that end-of-life (EOL) care needed improvement at all levels (Field & Cassel, 1997). Although effective EOL care is important, nurses are often unprepared to care for and support patients and their families during the EOL (Ferrell, Virani, Grant, Coyne, & Uman, 2000). The purposes of this project were to (a) educate nurses and other health care providers on provision of effective evidence-based palliative and EOL care, (b) implement a system-wide hospice and palliative needs assessment, and (c) facilitate implementation of hospice referral policy/procedures revisions based on identified system needs and Palliative Health Care Guidelines within a small rural Midwestern health care system.

Synthesis of evidence guiding practice change: Overwhelming amounts of literature indicated EOL educational deficits among nurses and other health care professionals throughout the nation. These findings prompted the need for providing additional palliative and EOL education. Clinical practice guidelines, quasi-experimental studies, and descriptive studies provided the majority of the evidence to support the need for palliative and EOL education and the effectiveness of using the End-of-Life Nursing Education Consortium (ELNEC) curriculum.

Proposed change in practice: Within a small rural Midwestern health care system, what was the impact of (a) implementing the ELNEC educational curriculum, (b) completing a system-wide hospice and palliative needs assessment, and (c) revising hospice referral policy/procedures revisions based on identified system needs and Palliative Health Care Guidelines?

Strategies of implementation: By bringing the ELNEC curriculum to this health care system, the intent was to improve nursing knowledge and self-efficacy in providing palliative and EOL care. A system-wide hospice and palliative needs assessment is ongoing and will be used as a basis to recommend system changes. Identified policy/procedure revisions based on Palliative Health Care Guidelines will be used to improve the timeliness of hospice and palliative care admissions.

Stakeholders: All nurses, social workers, physicians, physician assistants, nurse practitioners, administrators, chaplains, patients, families, and any other direct care employees within the healthcare system were considered stakeholders.

Method for evaluation: Variables measured included (a) participating nurses’ self-efficacy and knowledge of EOL scores; (b) the documentation of current system-wide hospice and palliative needs; and (c) hospice and palliative referral rates, average daily census (ADC), average length of service, and percentage of patients with less than seven days on hospice service. Data was collected from (a) ELNEC participants immediately before and after the ELNEC education, (b) documentation generated by the hospice department after system-wide assessments, and (c) ongoing monthly hospice reports as measured pre and post project implementation.

Significance of the work: To evaluate the effectiveness of the ELNEC training, a paired t-test was used. Knowledge and self-efficacy scores of participants’ improvement were statistically significant, and qualitatively, participants highly valued the ELNEC training. Palliative/EOL education of nurses and other health care providers using the ELNEC curriculum is recommended. As health care professionals strive for improved patient and family outcomes in this population, the ELNEC training is an initial step towards countering educational deficits that exist.
Implementation of a Facilitated Advance Care Planning Process in an Assisted Living Facility

Nancy A. Hall, MS, RN

University: Winona State University

Committee Chair: Carole Jenson, DNP, RN, ACNS-BC, CCRN
Committee Members: Sonja Meiers, PhD, RN
Rochelle Scheela, PhD, RN, PMHAPN, CNS

Purpose: Fifty percent of people are incapable of making decisions about treatment when they reach the end of life, leaving others to decide. When uncertainty exists, healthcare professionals default to aggressive treatment, often resulting in less quality of life for patients and the experience of regret and depression for caregivers following the death. The purpose of this project was to implement the Respecting Choices® model of Provider Orders for Life-Sustaining Treatment (POLST)-type advance care planning in an assisted living facility. POLST-type advance care planning results in a document that communicates care preferences as a provider’s order, actionable in local healthcare settings.

Synthesis of Evidence Guiding Practice Change: Studies included in the literature synthesis related to process and outcomes of facilitated advance care planning and/or POLST. Of the thirty-six papers discussed in the literature synthesis, fourteen were included in the analysis of utility. One systematic review and six national guidelines were addressed. Evidence supported the use of facilitated advance care planning and POLST for patients with chronic illness who are possibly within the last year of life.

Proposed Change in Practice: To implement POLST-type advance care planning for residents who may be within the last year of life residing in an assisted living facility.

Clinical question: Among the residents of one Midwestern assisted living facility, what is the effect of POLST-type advance care planning on the number of patients with medical orders addressing life-sustaining treatments, including cardio-pulmonary resuscitation, medical interventions such as intubation and dialysis, antibiotic use, and artificially administered nutrition and/or hydration, and on the patient’s and health care agent’s level of satisfaction with patient and clinician communication about end-of-life care preferences?

Strategies for Implementation: Following identification of project participants, residents and their health care agents were invited to engage in a POLST-type advance care planning session. Informed consent was obtained from residents and health care agents. Advance care planning sessions were facilitated by the investigator (a certified Respecting Choices® facilitator) using a standard discussion guide. A completed POLST form and narrative documentation were sent to the primary care provider for review and signature, then returned to the assisted living facility medical record. The POLST document accompanies the resident to other health care agencies and is recognized as a provider order.

Stakeholders, Method for Evaluation: Stakeholders included assisted living facility staff, providers in health care settings throughout the community, residents of the assisted living facility, and the residents’ providers and health care agents. Evaluation methods included a satisfaction survey administered to residents and their health care agents who engaged in POLST-type advance care planning. Chart review before and after the intervention indicated number of orders addressing life-sustaining treatment.

Significance of the Work: Residents’ end-of-life medical care will be consistent with stated, well-considered preferences. Health care agents will be involved in ensuring residents’ preferences are honored. Health care providers will have clear, reliable documentation to inform care at the end of life.
Identification, Prevention, and Management of Incontinence-Associated Dermatitis (IAD) in Hospitalized Adults: Translating the Evidence into Practice

Therese M. Jacobson, MS, RN, ACNS-BC, CWOCN

University: Minnesota State University Moorhead

Committee Chair: Tracy Wright, PhD, RN, CNE
Committee Members: Barbara Matthees, PhD, RN, CNE
Mari Akre, PhD, RN, NEA-BC

Purpose: Incontinence and incontinence-associated dermatitis (IAD) are common in hospitalized patients. Distinguishing pressure ulcers (PUs) from IAD can be difficult and misclassification of IAD as PUs may negatively impact patient care, customer satisfaction, and the reliability of the institution’s quality data. The purpose of this project was to implement and evaluate the impact of an evidence-based IAD intervention bundle.

Synthesis of Evidence Guiding Practice Change: The clinical problem of IAD is multi-factorial requiring implementation of a bundle of nursing interventions. Content in PU prevention practice guidelines reveals the importance of managing incontinence to prevent PUs. Educational programs using photographs may improve nurses’ ability to identify IAD. Nursing documentation can be used to determine the frequency interventions are ordered and implemented.

Proposed Change in Practice/Clinical Question: The clinical question was: For adults with urinary and/or fecal incontinence hospitalized in a large Midwestern academic medical center, how does implementation of an IAD intervention bundle including (a) use of a defined skin care program, (b) education of registered nurses’ (RNs) on IAD assessment, (c) evaluation of absorptive products, and (d) inclusion of IAD interventions within electronic nursing documentation impact (a) prevalence of IAD and content in an IAD procedural guideline, (b) RNs’ knowledge about differentiating IAD from PUs and intertriginous dermatitis, (c) usage of absorptive products, and (d) frequency of documentation of IAD and associated interventions when comparing outcomes pre- and post-implementation of education/product review/documentation changes?

Strategies for Implementation: Implementation involved multiple strategies targeting each component of the intervention bundle. Baseline IAD prevalence and documentation data were collected. Key RNs received education on differentiating IAD from PUs with pre- and post-tests. Enhancements were added to the electronic medical record. Skin care and absorbent products were evaluated and a more absorbent incontinence pad trialed. The IAD procedural guideline was updated. On-line education regarding evidence-based IAD interventions was published for all nursing staff.

Stakeholders and Methods for Evaluation: Stakeholders included staff RNs, patient care assistants, informaticists, quality specialist, clinical nurse specialists, inpatient nursing clinical practice subcommittee, purchasing, nursing supply value analysis team, and linen and central services. Clinical outcomes were evaluated by (a) monitoring incontinence and IAD quarterly prevalence data and (b) comparing pre- and post-test scores of the IAD differentiation education program. Process indicators included: (a) posting of the revised IAD procedural guideline, incontinence product algorithm, and care plans; and (b) installation of the documentation enhancements with chart audits to identify the frequency of incontinence-related nursing interventions. Economic outcome measures included product and linen costs and usage.

Significance of the Work: Following IAD differentiation education, RN IAD knowledge test scores were significantly higher ($p<.0001$). Protectant use increased by 25% after IAD best practice education. The documentation enhancements will facilitate more efficient data retrieval.
Hepatitis C Patients with Cirrhosis in Primary Care Clinics: Implementing Evidence-Based Guidelines

Michelle M. Lisowski, MS, RN, APNP

University: Winona State University

Committee Chair: Mieca Valen, DNP, RN, CNP
Committee Members: Adnan Said, MD, MSPH, Cindy A. Scherb, PhD, RN

Purpose: The number of individuals with cirrhosis continues to increase in the United States, as well as in the Veteran population. Complications from cirrhosis include hepatocellular carcinoma (HCC) and variceal hemorrhage. As the number of patients with cirrhosis increases the number of patients with complications such as HCC and variceal hemorrhage is unquestionably going to increase. The purpose of this scholarly project is to determine if provider knowledge of practice guidelines will increase screening exams in cirrhotic hepatitis C patients, as well as, an increase in the number of correctly diagnosed with cirrhosis. The question proposed is, in a veteran patient population with Hepatitis C and cirrhosis in an urban Midwestern Veteran Affairs Clinic/Hospital, how does implementation of evidence-based cirrhosis screening/surveillance clinical treatment guidelines for hepatocellular carcinoma (HCC) and variceal bleeding impact: (a) imaging rates for HCC; (b) esophagogastroduodenoscopy (EGD) rates for varices; (c) diagnosis (ICD-9 codes) rates of cirrhosis.

Synthesis of evidence guiding practice change: Guidelines for HCC and variceal screening were the basis of the practice change. There is a lack of implementation processes reported in the guidelines. Inclusion criteria for implementation strategies included strategies utilized in Veteran Affairs Health Care Systems. Eight studies focusing on implementation strategies were included in the analysis of utility. Evidence determined the need for a multifaceted approach to guideline implementation in a Veteran facility.

Proposed change in practice: A multifaceted evidence-based approach to guideline implementation for primary care providers.

Strategies of implementation: Education for primary care providers was completed utilizing academic detailing, educational seminars, opinion leaders and provider educational handouts. Educational seminars were completed at mandatory all provider meetings. The educational seminars discussed background information and statistics related to screening exams, in regards to current veteran population. Educational handouts were distributed at the all provider meetings. One week after the educational seminar an additional article on cirrhosis was emailed to the providers.

Stakeholders: Providers, management, and clinical application coordinators

Method for evaluation: This initiative uses a pre and post intervention design in which pre-intervention data and post-intervention data was collected for patients with hepatitis C and cirrhosis utilizing a chart audit. Focus of data collection was on screening exams for HCC (imaging) and varices (EGD).

Significance of the work: Primary focus of screening by primary care providers was not considered statistically significant, however the time frame between data collection was limited and should be further explored. Screening rates between specialty providers and primary care providers depicted higher screening rates overall in patients cared for by specialty providers; however, the only statistically significant category was in the post guideline HCC screening group. The use of the guideline implementation strategies in areas without readily available access to specialty care (i.e. GI) should be explored.
Patient Education Regarding Analgesic Options for Labor and Delivery

Erin E. Martin, CRNA, MNA

University: Winona State University

Committee Chair: Carole E. Jenson, DNP, RN, ACNS-BC, CCRN

Committee Members: Diane McNally Forsyth, PhD, RN  
Katherine W. Arendt, MD

Purpose: To participate in decision making throughout the childbirth experience, women must be provided with evidence based information regarding pain relief options for labor and delivery prenatally. Numerous factors have resulted in misinformation regarding this topic, which leads to increased anxiety, decreased satisfaction and an inability to participate in the informed consent process. The purpose of this project was twofold: (1) evaluate the institution’s current system of prenatal education regarding analgesic options for labor and delivery through a formal needs assessment, and (2) combine evidence generated from the needs assessment with that from the literature to inform recommendations for changes to the current system.

Synthesis of Evidence Guiding Practice Change: Inclusion criteria: studies that reflected themes of anesthesia/analgesia, patient education, anxiety, satisfaction, informed consent, expectant mothers’ preferences, and needs assessment development. Review completed of 439 articles; filtering resulted in full review of 79 articles (47 included, 32 excluded). Evidence supports the use of needs assessments to evaluate educational interventions, and the use of innovatively presented evidence based information to decrease anxiety and increase satisfaction and decision making ability of expectant mothers.

Clinical Question/Proposed Change in Practice: How do the results of an educational needs assessment of women who have utilized labor and delivery services at a large teaching institution in a Midwestern community within the last two months contribute to recommendations for the enhancement of prenatal education regarding this topic? Survey results will provide guidance for patient-centered enhancements to the current system of prenatal education.

Strategies for Implementation: Educational needs assessment developed based on literature recommendations and with the assistance of the institution’s Survey Research Center. Initial and ongoing meetings held with Clinical Assistant and supervisory staff to review survey distribution process. Patients were approached for participation at their six-week postpartum clinic visits by Clinical Assistants. Surveys returned before clinic departure enhanced return rate.

Stakeholders: Obstetric patients, anesthesia providers, obstetric providers, nursing staff, patient education specialists, clinical assistants, administration from the departments of nursing and anesthesia.

Method for Evaluation: Needs assessment survey developed; administered to 117 women who had utilized obstetric services at the institution. Results compared with evidence from the literature.

Significance of the Work: Ninety-four percent of patients felt they received the right amount of information; 93% felt well informed and able to make an informed choice. Patients who received information prenatally perceived a higher level of being informed (p<.037) than those who received information only in the inpatient setting. The survey revealed a statistically significant reduction in anxiety related to the pain of labor (p<.001) and the thought of having an epidural following receipt of information about epidurals (p=.001). Additional educational offerings should include: pamphlet (provided prenatally and while inpatient), video slide presentation and web-based module including patient stories and explanation of anesthesia team, and a referral system for individual visits with experts on medicated and un-medicated pain relief options.
“Intellectually Starved,” A Study of the Effects of Life Review on Elder Depression in Long Term Care

Laurel Ostrow, MAT, MSN, RN, ANP-C

University: Minnesota State University, Mankato

Committee Chair: Sue Ellen Bell, PhD, RN, PHCNS, BC
Committee Members: Suzanne Narayan, PhD, RN
Hans De-Ruiter, PhD, RN

Purpose: Depression and dementia often coexist among the elderly. These conditions diminish the physical, mental and spiritual quality of life for elders and their families. Recent Medicare standards stress mental health programs and tie reimbursement to performance in this area, especially in long term care settings. The purpose of this project was to implement an evidence-based life review interviewing activity and to answer the following clinical question. In people over 80 living in a suburban long term care setting, experiencing cognitive impairment and possible depression (PHQ9 scores 0-13; BIMS scores 4-14), how does participation in a life review one-on-one interview program impact resident depression scores, as measured by the Geriatric Depression Scale Short Form (GDS-SF) before and after participation?

Synthesis of evidence guiding practice change: Included studies examined the impact of life review therapy on elders who experience cognitive impairment, depression and institutionalization. Qualitative and quantitative evidence indicated that life review improved mood in both cognitively impaired elders and their families. A clinical guideline supported this innovation also.

Proposed change to practice: The life review intervention is evidence-based and the method of one-on-one interviews is effective with cognitively impaired elders, according to nursing literature. Autobiographical activities in this population may be adapted for a variety of clinical and community settings. Staff or volunteers may be facilitators. This clinical practice change meets the need for mental stimulation among institutionalized elders.

Strategies of implementation: Interviews were conducted using a pre-designed autobiographical journal from Life Bio. The Assistant Director of Activities did an initial assessment, selecting residents by existing BIMS and PHQ9 scores, and contacted interested residents for participation. A GDS-SF screening was performed before and after completion of the journal.

Stakeholders: Administrators of the clinical site, nurses, activities/wellness staff, residents of the long term care and board and care facilities, and family members were all stakeholders.

Method for evaluation: GDS-SF scores for people participating in the life review interviews were obtained. Field notes concerning the expressions, both non-verbal and verbal of participating residents were kept. Family responses were also noted.

Significance of the work: Impact measures were not statistically significant, though a small lowering of GDS-SF depression scores was noted with some residents. Implications for future projects are that qualitative and quantitative analyses are equally suited for the determination of the benefits of life review with cognitively impaired and depressed elders. This work has also led to the conclusion that severely impaired residents must be considered individually in terms of qualitative benefits, as some residents with severe impairment derived much enjoyment from the activity, as judged by their qualitative report and the positive reports of their families.
An Educational Intervention Addressing Nurses’ Cultural Competence

Stacey L. Rosenberg, MS, RN, CNE

University: Winona State University

Committee Chair: Cindy A. Scherb, PhD, RN
Committee Members: Diane Twedell, DNP, RN, CENP
Mieca Valen, DNP, RN, FNP-BC

Purpose: Joint Commission identified the need for ongoing education for staff which is specific to the population served. The purpose of this project was to implement a cultural competence educational intervention focused on the Hispanic culture and to answer the following clinical question. For nursing staff working in a rural urgent care (UC) and emergency department (ED), does the adoption of a cultural competence educational program focused on Hispanic culture impact the nurses’ level of cultural competence (immediately following the intervention completion and 4 weeks post-education program completion) compared to the nurses’ level of cultural competence, prior to the implementation of the cultural competence educational program?

Synthesis of Evidence Guiding Practice Change: Twenty-one articles and two standards were included in the review of literature. Six articles were included in the analysis of utility. The literature supported several methods of delivery including online and classroom training with the length of education ranging from one hour to a semester long. The Cultural Competence Assessment (CCA) tool was utilized, measuring cultural awareness and sensitivity (CAS) and cultural competence behavior (CCB).

Proposed Change in Practice/Clinical Question: The intervention consisted of two educational sessions, both an hour in length. Session one involved the viewing of a digital versatile disc (DVD) (streamed online or in the classroom). Session two consisted of a facilitated discussion using a discussion guide. A pre-test, post-test, and four week post-test were completed.

Strategies for Implementation: The problem related to lack of cultural competency training was identified by the leaders within the organization as nurses were lacking cultural competence training beyond a 20 minute video upon hire. The expert review team was identified to design and assist with the implementation of the educational intervention. The literature and the facility supported the use of the online and classroom learning program. Participation was required and nurses obtained continuing education units (CEUs). Data were collected, analyzed, and disseminated to the facility.

Stakeholders, Method for Evaluation: Facility employees including nursing staff, administration, nurse educator, chief nursing officer (CNO), and an interpreter. A one-group pre-/post-test design was used (N = 27). Baseline level of cultural competence was obtained prior to the educational intervention. Effect and retention of the intervention were analyzed based on changes in level of cultural competence obtained immediately post-intervention and four weeks post-intervention.

Significance of the Work: A statistically significant increase was found in the level of CAS and CCB between the pre-intervention survey score and post-intervention survey score. A statistically significant change was not found from the immediate CAS and CCB post-test scores to the four week post-test score, indicating the retention of knowledge.
Nurse Practitioner Satisfaction with Initiation of Depression Screening on an Inpatient Diabetes Service

Emily Sorensen, MSN, RN, FNP-C

University: Minnesota State University, Mankato

Committee Chair: Sue Ellen Bell, PhD, RN, PHCNS, BC
Committee Members: Donna Brauer, PhD, RN
Sandra Eggenberger, PhD, RN

Purpose: The purpose of the capstone project was to determine the use, feasibility, satisfaction, and process of instituting depression screening by nurse practitioners on an inpatient diabetes consulting service. This was done through the initiation of depression screening with the PHQ-2 depression questionnaire.

Synthesis of Evidence Guiding Practice Change: Literature supports the correlation between diabetes, including type two diabetes, and depression. There is high-level evidence to support the clinical finding of an increased prevalence of depression among patients who have diabetes. The findings in the literature strongly supported the screening of depression in patients with diagnosed diabetes.

Proposed Change in Practice/Clinical Question: In nurse practitioners on a diabetes consulting service in a large upper-midwestern hospital who are following adult inpatients who have diabetes mellitus type two, how does using the PHQ-2 depression screening tool with initial consult visits impact satisfaction of the nurse practitioners in their ability to appropriately screen patients with type two diabetes for depression (measured by an after-only questionnaire), and impact follow-up for patients after discharged from the hospital as measured over 60 days compared to the current standard of care (no standard depression screening)?

Strategies for Implementation: Implementation began with education of the nurse practitioners and physician assistants on the diabetes consulting service regarding depression in patients with diabetes and how to administer the PHQ-2 depression questionnaire, including exclusion criteria. The providers utilized the depression screening on patients upon initial consult visit. Scores of three or greater were reported to the primary hospital service that was managing the patient’s entire hospital stay.

Stakeholders, Method for Evaluation: Stakeholders in the project included the patients of the diabetes consulting service, the nurse practitioners and physician assistants on the service, the clinical institution, and other diabetes services around the nation.

After the implementation, an anonymous survey was performed of the diabetes consulting service providers to determine provider satisfaction and use of the PHQ-2 tool. A chart review was performed of patients who had been seen by the diabetes consulting service, including records of outpatient follow-up of patients who receive their primary care at the facility.

Significance of the Work: A total of 21% of the patients seen by a nurse practitioner or physician assistant were screened for depression. Of the patients screened, 33% had PHQ-2 score of three or more. Depression screening was deemed a positive practice change by 60% of the providers on the diabetes consulting service. Depression screening with PHQ-2 tool will continue at the discretion of the providers but not become a standard of practice. Other diabetes services at other large hospitals or other hospital services at the clinical institution may wish to incorporate depression screening into their visits.
High-fidelity Simulation in a Nurse Residency Program: Effective Decision-making to Prevent Failure to Rescue

Nancy Van Aman, MSN, RN, FNP-BC

University: Winona State University

Committee Chair: Diane Forsyth, PhD, RN
Committee Members: Carole Jenson, DNP, RN, ACNS-BC, CCRN
Karen Balakas, PhD, RN, CNE

Purpose: Effective clinical decision-making by nurses is essential when caring for patients experiencing deterioration from post-operative complications which risk mortality, termed failure to rescue (FTR). Increasing numbers of new graduate registered nurses (RNs) are employed in acute care settings. Their lack of experience in the decision-making required to care for patients at risk for FTR is a concern. The purpose of this project was to evaluate if education on patient deterioration through high-fidelity Human Patient Simulation (HPS) would increase new graduate RNs decision-making in FTR situations.

Synthesis of Evidence Guiding Practice Change: Analysis and synthesis of fifty-one articles using the Johns Hopkins Nursing Evidenced-Based Practice model showed compelling evidence for the use of HPS in teaching clinical decision-making with new graduate RNs caring for patients experiencing deterioration. Evaluation of evidence at the acute care setting demonstrated this was needed specialty content in the Nurse Residency program.

Proposed Change in Practice/Clinical Question: The use of evidenced-based HPS scenarios developed using guidelines from the National Guideline Clearinghouse to increase clinical decision-making skills in new graduate RNs.

Strategies for Implementation: HPS Scenarios were developed with effective decision-making as a learning objective, and decision-making was emphasized in the HPS scenario pre-briefing and debriefing. Nurse Residents were exposed twice to the same HPS scenario, offering a baseline measure of their decision making, with follow-up repeat HPS in one month. Three HPS scenarios were developed and the participants were randomly assigned to a particular scenario, then matched for that same scenario in the follow-up repeat HPS.

Stakeholders: New graduate RNs, Professional Practice Department, Risk Management Department, Rapid Response Team, Physicians and other providers, Regulatory Agencies, Patients.

Method for Evaluation: Quasi-experimental two group post test design compared scores between the 1st and 2nd HPS scenario using the Lasater Clinical Judgment Rubric (LCJR). Participant decision-making was evaluated by videotape review of the HPS scenarios. The LCJR has four developmental levels including: Beginning, Developing, Accomplished, & Exemplary. The rubric also measures four phases of decision-making: Noticing, Interpreting, Responding, & Reflecting.

Significance of the Work: All participants had initial scores in the Developing level as expected of new graduate RNs and demonstrated statistically significant growth within that level. Statistically significant growth in all phases of decision-making was demonstrated with the Noticing phase showing the highest significance. The use of HPS as a teaching strategy may facilitate in moving new graduate RNs from the Developing Level to the Accomplished Level of decision-making, which could result in improved outcomes for patients at risk for FTR.
Documentation of Comprehensive Pain Assessment in Outpatient Medical Oncology – Best Practice

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Committee Chair: Julie Ponto, PhD, RN, ACNS-BC, OCNS
Committee Members: Marlea Judd, DNP, RN, CRNA
Sonja Meiers, PhD, RN

Purpose: Pain is a common and often undertreated symptom experienced by patients with cancer. Unrelieved pain can impact quality of life for the patient and their family. A retrospective chart review conducted in the clinical setting revealed an overall documentation rate of 18% for comprehensive pain assessment. The purpose of this project was to improve documentation of comprehensive pain assessment in the electronic medical record as part of a practice quality improvement initiative.

Synthesis of Evidence Guiding Practice Change: Regulatory agencies require screening and treatment of pain at the time of every outpatient visit. Clinical practice guidelines for management of cancer-related pain and quality indicators for cancer-related supportive care are available. All guidelines mandate the performance and documentation of a comprehensive pain assessment for those patients reporting pain as the basis for therapeutic decision-making. Involvement of nursing in assessment, monitoring, and evaluation of pain, as well as in the provision of patient education can result in increased adherence to clinical guidelines and improvement in patient reported pain scores.

Proposed Change in Practice/Clinical Question: In adult oncology patients in an outpatient Medical Oncology clinic in a large Midwestern academic medical center, does the use of a registered nurse (RN) during the outpatient care visit for those patients with sarcoma or head/neck cancer presenting with a pain score of ≥4, compared to current practice without involvement of an RN, result in improved documentation of a comprehensive pain assessment as reflected in the EMR?

Strategies for Implementation: A baseline retrospective chart audit was conducted in April 2012, which revealed an overall documentation rate of 18% for comprehensive pain assessment. The audit results were presented at a staff wide meeting, during which time a review of the cancer-related pain literature was provided. A survey of providers was conducted to assess barriers to performance and/or documentation of pain assessment. A three-week pilot study was developed that involved patients with sarcoma or head/neck cancer reporting a pain score of ≥4. These patients were referred to an RN for comprehensive pain assessment, the results of which were reported to the provider and documented in the EMR.

Stakeholders: Medical Oncology physician and administrative leadership, nursing leadership and staff, clinical assistant supervisor and staff, medical secretary supervisor and staff.

Method for Evaluation: A post-implementation chart audit was conducted that included all sarcoma and head/neck cancer patient visits during the three-week period.

Significance of the Work: RN involvement during the outpatient visit of patients with sarcoma or head/neck cancer reporting a pain score of ≥4 improved the rate of documentation regarding comprehensive pain assessment to 63%. Such documentation is mandated by regulatory agencies and clinical practice guidelines as a fundamental component of quality in pain management.
Clinical Sites of DNP Students

Friendship Village of Bloomington, Bloomington, MN
Gold Pine Home, Bemidji, MN
Havenwood Care Center, Bemidji, MN
Mayo Clinic Health System, Austin, MN
Mayo Clinic, Rochester, MN
Missouri Baptist Medical Center, St. Louis, MO
Sanford Health, Bemidji, MN
William S. Middleton Memorial Veterans Hospital, Madison, WI
Winona Health, Winona, MN

Thank you to other clinical sites which supported the DNP Program
and were not mentioned above.
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