Understanding the Lived Experiences of Sleep Among African American Adults with Type 2 Diabetes in Connecticut: Descriptive Phenomenology

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Introduction

- Type 2 Diabetes (T2D) disproportionately affects African American (AA) adults in the U.S.[1]
- Approximately 60% higher diabetes risk and greater complications among Black/African American adults[2]
- Sleep essential for metabolic health; many adults lack recommended duration[3]
- Greater sleep difficulties reported among Non-Hispanic Black adults[4]
- Sleep disruption shaped by socially patterned factor
  - socioeconomic stress
  - neighborhood conditions
  - racial discrimination
  - shift work and inflexible schedules
  - unequal healthcare access[5]

Purpose: Describe lived sleep experiences of AA adults with T2D in Connecticut

Сергей Белый. (2026). *Elegant AI-powered sleep apnea mask and CPAP machine designed for African American women* [Stock illustration]. Adobe Stock.

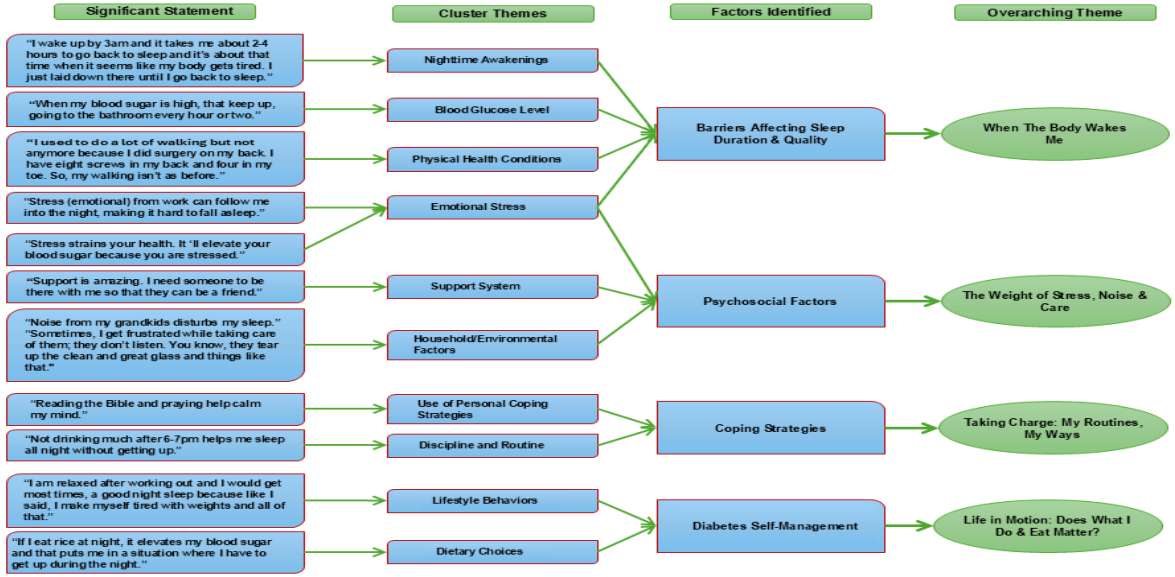
Method/Procedure

- **Research question**: What is the essence of adults Black/AAs sleep experiences living with T2D?
- **Design**: Pilot Study, Descriptive phenomenology
- **Sample**: Purposive sampling
  Three Black/African American women with T2D ≥5 years
  Participants recruited from Hartford community
- **Data Collection**: In-depth interviews using open-ended prompts
  "Describe your experience of sleep"
  Phone interviews based on participant preference
  30–60 minute interviews audio-recorded and transcribed verbatim
- **Data Analysis**: Colaizzi's phenomenological 7-step method (1978)[6]
- **Rigor**: Bracketing maintained throughout interviews (Husserlil,1970)[7]

Preliminary Findings

- Participants: Black/African women
  - ❖ Mean age: 62 years
  - ❖ Average duration of diagnosis: 23 years
- 107 significant statements emerged
- Four themes emerged describing participants' sleep experiences
- **Insight rarely captured in prior studies**: "I make myself tired with weights and I would get a good night sleep" (P1)

Figure 1. Dendrogram Illustrating Significant Statements, Themes, Factors, and Overarching Themes



Conclusions/Implications

- Sleep experiences shaped by physiological, psychological, lifestyle, emotional, social, and spiritual influences
- Key factors included blood glucose fluctuations, daily routines, household roles, diet, and coping strategies
- Support from healthcare professionals important for sleep hygiene and integration of daily activities into routines
- Findings highlight need for culturally sensitive, holistic, multidisciplinary approaches to improve sleep, diabetes self-management, and overall health outcomes

"When someone has a good sleep, it means they are "lazy, that they don't like to be active." (P2)

Galvez, M. (2025, May 2). Sleep inequality in Black women: Barriers to diagnosis and care. Neurology Advisor. https://www.neurologyadvisor.com/features/racial-inequality-of-sleep-black-women/

Limitations

- Small sample (*n*=3) Data saturation was not achieved; results should be interpreted with caution
- Homogenous sample: Black women, Christian
- Varying diabetes diagnosis and education influence sleep experiences

References

Creation Of A Provider Education Tool To Facilitate SMART In Pediatric Asthma

Amanda C. Filippelli[1,2], Brenda McNeil[1], Joy Elwell[1], Melanie Sue Collins[2], Amirul Anuar[2], Jessica Hollenbach[2]

[1]University of Connecticut School of Nursing, Storrs, CT, [2]Connecticut Children's Medical Center, Hartford CT

AIM: To evaluate the impact of a PCP education tool to improve comfort and attitudes and facilitate implementation of SMART for pediatric asthma management.

Introduction

- *Asthma is the most common childhood chronic disease, affecting approximately 6.5% US children.*[1]
- *An evidence to practice gap exists in adhering to international guidelines recommending Single Maintenance and Reliever Therapy (SMART) for children.* [2,3]

Methods

- *Provider Educational Tool for SMART developed.*
- *Tool and Survey was distributed to providers trained in SMART by Easy Breathing© program.*
- *Provider knowledge and comfort with SMART was assessed by survey that was distributed and managed via REDCap.*

Results

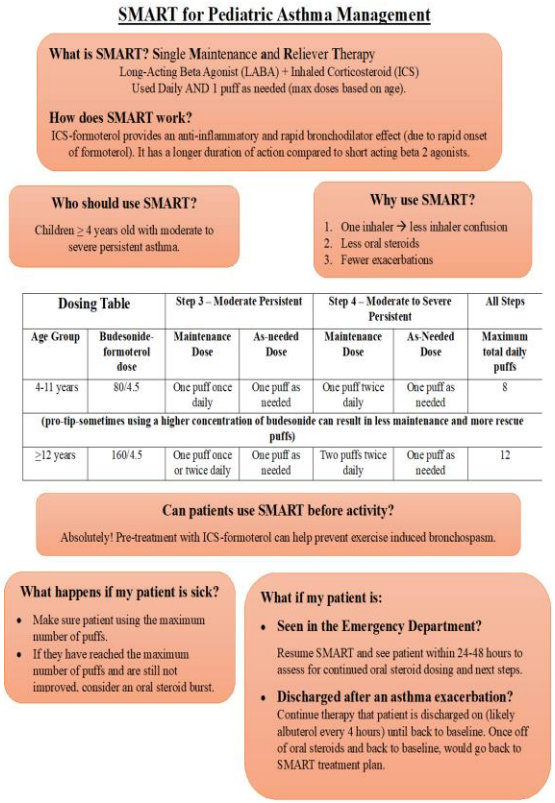
Table 1: Demographics of Study Participants

	Baseline Survey N=14	Post Survey N=10
Provider Type		
MD	9	6
DO	1	1
APRN	3	3
PA	1	0
Practice Type		
Private Practice	2	2
Community Health Center	2	2
Academic Pediatric Practice	10	6
Years in practice, mean (range)	19.5 (3–48)	18.9 (3–38)

Acknowledgements

Thank you to Sigrid Almeida and Vaishali Belamkar for their assistance with data and REDCap support.

Provider Education Tool



SMART for Pediatric Asthma Management

What is SMART? Single Maintenance and Reliever Therapy
Long-Acting Beta Agonist (LABA) + Inhaled Corticosteroid (ICS)
Used Daily AND 1 puff as needed (max doses based on age).

How does SMART work?
ICS-formoterol provides an anti-inflammatory and rapid bronchodilator effect (due to rapid onset of formoterol). It has a longer duration of action compared to short acting beta 2 agonists.

Who should use SMART?
Children ≥ 4 years old with moderate to severe persistent asthma.

Why use SMART?
1. One inhaler → less inhaler confusion
2. Less oral steroids
3. Fewer exacerbations

Dosing Table		Step 3 – Moderate Persistent		Step 4 – Moderate to Severe Persistent		All Steps
Age Group	Budesonide-formoterol dose	Maintenance Dose	As-needed Dose	Maintenance Dose	As-Needed Dose	Maximum total daily puffs
4-11 years	80/4.5	One puff once daily	One puff as needed	One puff twice daily	One puff as needed	8
(pro-tip-sometimes using a higher concentration of budesonide can result in less maintenance and more rescue puffs)						
≥12 years	160/4.5	One puff once or twice daily	One puff as needed	Two puffs twice daily	One puff as needed	12

Can patients use SMART before activity?
Absolutely! Pre-treatment with ICS-formoterol can help prevent exercise induced bronchospasm.

What happens if my patient is sick?
- Make sure patient using the maximum number of puffs.
- If they have reached the maximum number of puffs and are still not improved, consider an oral steroid burst.

What if my patient is:
- **Seen in the Emergency Department?**
  Resume SMART and see patient within 24-48 hours to assess for continued oral steroid dosing and next steps.
- **Discharged after an asthma exacerbation?**
  Continue therapy that patient is discharged on (likely albuterol every 4 hours) until back to baseline. Once off of oral steroids and back to baseline, would go back to SMART treatment plan.

The Easy Breathing© program and educational materials and research as well as this project is approved by the Institutional Review Board at Connecticut Children's.

Table 2: Survey Responses by Question

	Baseline Survey N=14	Post Survey N=10
Do you find SMART to be easy to understand?	Yes – 12 (86%) No – 2 (14%)	Yes – 7 (70%) No – 2 (20%) Did not answer – 1 (10%)
Comfort level using SMART to manage asthma? (scale of 0-10) Mean (range)	8 (3-10)	7.5 (4-10)
How do you think SMART compares to the previous recommendations for persistent asthma SMART is …	Better – 13 (93%) Same – 1 (7%) Worse – 0 (0%) I don't know – 0 (0%)	Better – 7 (70%) Same – 0 (0%) Worse – 2 (20%) I don't know – 1 (10%)

Table 3: Positive attributes of SMART vs. barriers that limit SMART

Why SMART was "Better than previous recommendation"	Barriers that Limit Prescribing of SMART
Ease of use	Cost of medication/Insurance coverage
Better patient compliance	Community awareness of SMART
Minimize confusion	Lack of self-efficacy
Better symptom control	Prescribing one for home and one for school
	Behavior change modification

Significance and Conclusions

- *A one-page summary of SMART was identified as being helpful but did not improve provider attitudes of SMART.*
- *Qualitative feedback from PCPs identified facilitators of SMART including ease of use and improved symptom control as well as barriers including cost/insurance coverage and lack of community awareness.*

Limitations

- *Self selecting group of providers*
- *Survey was not validated*
- *Time to complete survey*
- *Missing data*

References

Be Anxious for Nothing: Religious Coping in an Immigrant Community

Candace De Vieira, MSN, PMHNP - BC

Joy Elwell, DNP; Vanessa Bolling, DNP; Narash Samaroo, Th.D

Introduction

- *Immigrants are at higher risk of experiencing poor mental health.* [1, 2]
- *Stigma, resource inaccessibility impact their ability to receive care.* [2]
- *Sometimes they seek help from religious leaders before professionals.* [3]
- *Mixed results when considering the role of religion in mental health.* [4]
- *Religious coping can be either positive or negative.* [5]
- *Mental health education via religious organizations can increase mental health knowledge and decrease stigma.* [6]

Pargament's Theory of Religious Coping

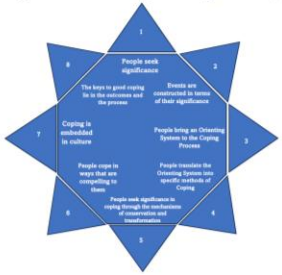


Figure 1. *Assumptions of Pargament's Theory of Religious Coping* [5]

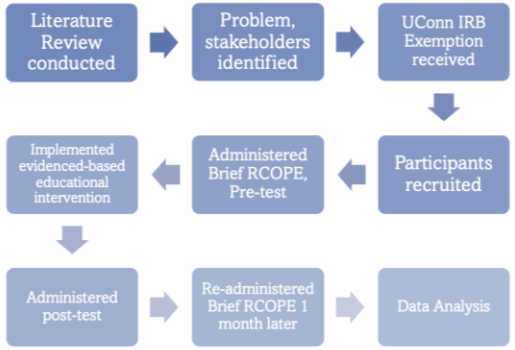
Purpose & Aims

- *The purpose of this project is to educate an immigrant community in New York City on mental health and religious coping.*
- *The goal is to bridge the gap between religion and mental health to improve mental health awareness and religious coping.*
- *PICOT: In an immigrant community, does the use of an educational tool improve mental health awareness and increase religious coping over one month?*

Method

- *Design: One-sample pre-post test study design.*
- *Setting: Christian Community Fellowship (CCF), a 250-member faith-based organization in Queens, NY.*
- *Sample: Convenience sampling of adult congregants who identified as immigrants having experienced a stressful life event.*
- *Tools:*
  - *Project Investigator created educational intervention and pre-test*
  - *Brief RCOPE* [7]
- *Intervention:*
  - *Pre-test assessing knowledge of mental health and religious coping, and Brief RCOPE both administered*
  - *45-minute in-person evidence-based education intervention on mental health, mental illness, the role of religion and religious coping in mental health*
  - *Post-test assessing knowledge of mental health and religious coping, and Brief RCOPE both re-administered*

Procedure



Results

- *Three linear mixed-effects models to examine changes in knowledge scores, Positive RCOPE Scores, Negative RCOPE Scores*
  - *Random intercept: participant ID*
  - *Fixed effects: survey time (pre vs. post), age range, gender*
- *Knowledge scores increased by an average of 4.72 points.*
- *Positive RCOPE scores increased while Negative RCOPE scores decreased from pre to post, holding age and gender constant.*
- *Significant increases in Positive RCOPE scores were observed in the 30-39, 40-49, and 70-79 age brackets relative to the youngest group (20-29).*
- *Gender did not significantly impact knowledge or Positive RCOPE scores.*
- *Males exhibited significantly lower Negative RCOPE scores compared to females.*
- *The regression analysis indicates that the intervention was successful across all three primary outcomes.*

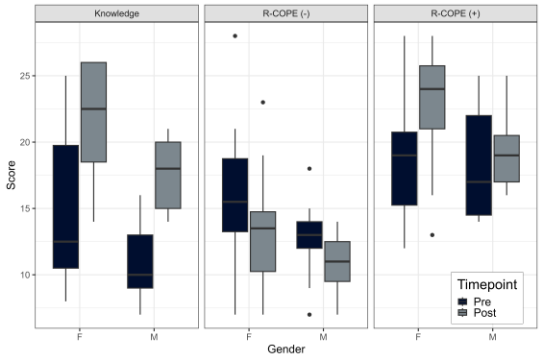
Table X. Regression coefficients from mixed-effects models for each outcome (Knowledge, R-COPE positive, R-COPE negative).

	Knowledge			R-COPE - Positive			R- COPE - Negative		
Predictors	*Estimates*	*CI*	*p*	*Estimates*	*CI*	*p*	*Estimates*	*CI*	*p*
(Intercept)[1]	17.39	13.22 – 21.56	**<0.001**	16.33	11.56 – 21.10	**<0.001**	14.54	10.50 – 18.58	**<0.001**
Timepoint [Post]	4.72	3.90 – 5.54	**<0.001**	1.78	0.67 – 2.89	**0.002**	-1.56	-2.67 – -0.44	**0.006**
Age Range 30-39	5.01	0.14 – 9.87	**0.044**	5.67	0.10 – 11.24	**0.046**	-2.64	-7.36 – 2.08	0.273
Age Range 40-49	-0.52	-5.23 – 4.18	0.828	5.97	0.58 – 11.35	**0.030**	2.41	-2.16 – 6.97	0.301
Age Range 50-59	-1.63	-6.49 – 3.24	0.512	2.00	-3.57 – 7.57	0.481	2.00	-2.72 – 6.72	0.406
Age Range 60-69	-2.16	-6.66 – 2.35	0.348	4.19	-0.97 – 9.35	0.111	1.43	-2.94 – 5.81	0.520
Age Range 70-79	-0.75	-6.36 – 4.86	0.793	7.50	1.07 – 13.93	**0.022**	-1.50	-6.95 – 3.95	0.589
Gender [M]	-1.78	-4.31 – 0.75	0.168	-1.67	-4.57 – 1.23	0.260	-4.08	-6.54 – -1.63	**0.001**

[1]Reference: Timepoint = Pre, Age Range = 20-29 , Gender = F

Conclusion

- *Results indicate that implementing an educational intervention in a religious organization improved participant's knowledge of mental health*
- *Degree of both negative and positive religious coping also changed 1-month post-intervention.*
- *Age range, more so than gender, had some impact on participant's knowledge of mental health and religious coping.*



Significance

- *Religious centers may act as intermediaries in encouraging conversations about mental health.*
- *This openness may combat stigma, leading to improving awareness.*
- *Religious centers can also be sources for mental health education, nonpharmacological approaches such as religious coping.*
- *Further research may focus on integrating both mental health screenings and non-pharmacological treatment teachings in religious centers.*
- *Impact of factors such as age, gender may need further investigation.*

Acknowledgements

Thank you to my committee, my family, my church, and to Dr. Timothy E. Moore from UConn's SCS for statistical support.

References

SCAN ME

CRNA Education on Best Practice Oxytocin Administration for Parturients Undergoing Elective Cesarean Section: An Evidence-Based Practice Project

Kendall Case, MSN, CRNA, Catherine McQuade, MSN, CRNA, Joy Elwell, DNP, FNP-BC, CNE, FAAN, FAANP, Antoinette Padula, DNP, MSN, CRNA, Melissa Riso, DNP, MSN, CRNA

Introduction

- Cesarean sections (C-sections) account for **32.1% of U.S. births**.
- Oxytocin is the **first-line uterotonic** to prevent postpartum hemorrhage (PPH).
- Significant variability exists in dosing practices.
- CRNAs play a critical role in preventing PPH and minimizing adverse effects.

Aim: Implement educational intervention to improve CRNA knowledge and confidence in evidence-based oxytocin administration during elective C-sections.

Method

- **Design:** Pre- and post-test educational intervention.
- **Participants:** 14 CRNAs at urban academic hospital.
- **Measures:**
  - Knowledge: 9-item multiple-choice survey.
  - Confidence: 1 Likert-scale item (0–5).
- **Analysis:** Paired-samples t-test ($\alpha = 0.05$).

Theoretical Framework

Kurt Lewin's Change Theory consists of 3 stages:

- ***Unfreezing*** – Recognizing need for change
- ***Changing*** – Implementing new practices
- ***Refreezing*** – Reinforcing sustained change

CRNAs were guided from varied oxytocin administration practices toward standardized, evidence-based dosing.

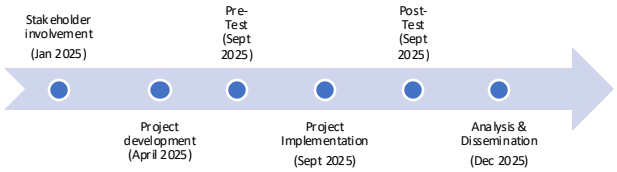
Procedure

CRNAs recruited via departmental email.
Pre-test via Qualtrics pre-education session.
Intervention:
30-minute PowerPoint session on:

- Mechanism and pharmacokinetics of Oxytocin.
- Evidence-based dosing for elective C-sections.
- Review of adverse effects and best practices.

Post-test via Qualtrics post-education session.
Analysis of Data

Timeline



Results

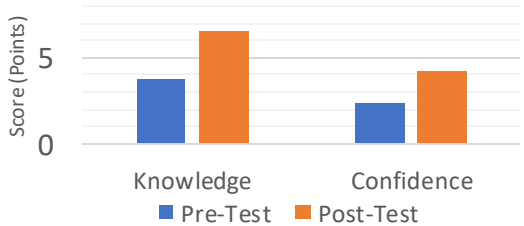
Knowledge:

- Pre M = 3.8 → Post M = 6.5
- $p < 0.001$, **large effect size** ($d = 1.66$)
- **50% average learning gain**

Confidence:

- Pre M = 2.4 → Post M = 4.2
- $p < 0.001$, **large effect size** ($d = 1.70$)

Pre- and Post-Test Scores



Findings

Summary: Education significantly improved CRNA knowledge and confidence in evidence-based oxytocin administration.

Recommendations

- Develop **standardized institutional administration protocol**.
- Integrate **EPIC** decision-support **prompts**.
- Monitor **compliance and outcomes.**
- Expand **structured educational programs** to broader anesthesia staff.

Limitations

- **Small sample size** (N=14) limits generalizability.
- **Single-site** design—results may not reflect broader populations.
- Potential for **response bias** and ambiguous test questions.
- Short-term evaluation only; long-term knowledge retention unmeasured.

Acknowledgements

We would like to thank our advisors, Joy Elwell, Antoinette Padula, and Melissa Riso for their invaluable guidance and encouragement throughout this project.

References

From Novice to Target: Reducing Ambulatory New Graduate Nurse Bullying, A Quality Improvement Project

Christina M. Matousek, MSN, RN, OCN
D'Ana Brooks, DNP, RN, CNL
Joy Elwell, FNP-BC, APRN, CNE, FAAN, FAANP
Tracy Carafeno, MSN, RN, CNML
Ivy M. Alexander, PhD, APRN, ANP-BC, FAANP, FAAN

Background & Significance

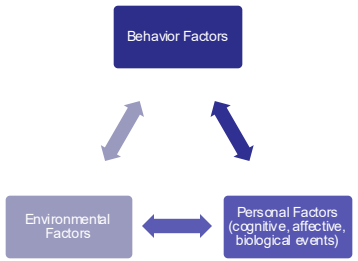
- New graduate registered nurse (RN) bullying has been linked to poor self-esteem, self-efficacy, and professional development[8]
- Can be seen in all aspects of nursing and nursing education[2]
- Includes rude/hostile behavior, berating of individuals, & name calling[2]
- Extensive research confirms the occurrence of bullying but there is a lack of information on why this occurs and how leadership can hold staff accountable[2]
- 78% of nursing students experience bullying[2]
- U.S. >50% of nursing students observed/experience bullying in clinical[2]
- U.S. 60% of nurses leave their first job in the first six months due to bullying[2]
- Two CT hospitals: 90% nurses experienced incivility[7]
- U.S. 34% nurses leave the profession due to bullying – each % of turnover = $340,000 in costs to institution[2]
- Bullying can impact learning and has shown to lead to increased medication errors, falls, and hospital costs[2]

Purpose

- To reduce the bullying of new graduate RNs within the ambulatory hospital setting, improve the knowledge of bullying behaviors, and enhance the communication techniques of individuals who may experience these behaviors.

Theoretical Framework

Albert Bandura's Social Cognitive Theory (SCT)[1]



Best Practice

- Quasi-experimental and randomized controlled trials have found utilizing cognitive rehearsal training (CRT) to reduce bullying and improve perceived comfort level in having critical conversations [4,5,6]
- CRT consists of scenarios on bullying situations, communication techniques, and role playing [4,5,6]

Human Subject Protection

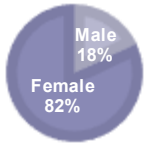
- Approval was obtained by the Nursing Scientific Review Committee at Yale New Haven Hospital

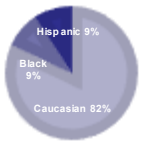
Design

- Quasi-experimental study, quality improvement
- Pretest-posttest survey design
- Independent variable: CRT education
- Dependent variable: Bullying knowledge, perceived comfort level with communication techniques, & bullying incidence

Sample Characteristics

- 11 Bedside nurses in ambulatory oncology
- Median age: 32 years
- Education: 73% BSN





Setting

- Ambulatory Smilow Cancer Hospital at Yale New Haven Hospital; New Haven, CT

Measures

- The Negative Acts Questionnaire (Revised)[3] (NAQ-R)
- 7 item Likert Scale response Bullying Knowledge Questionnaire

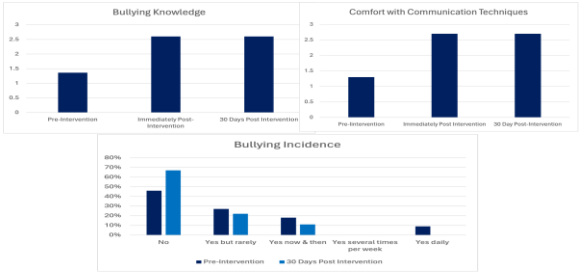
Interventions & Procedures

- One, 90-minute, interactive educational session
- Included information on: Bullying, bullying within nursing, incidence, CRT, 3 case studies reviewed using CRT elements & debriefed following each scenario[6]
- Pre-Survey completed which included Bullying Knowledge Questionnaire & NAR-Q
- Post-Survey included participant satisfaction & Bullying Knowledge Questionnaire
- 1 Month Post-Intervention Survey was distributed to assess NAR-Q data, bullying incidence, and knowledge

Data Analysis

- Descriptive statistics to compare pre-and post-intervention was utilized due to small size

Results



Conclusions

- Improvement in bullying knowledge, incidence, and perceived comfort levels with communication techniques
- Application to hospital setting, anti-bullying education/CRT education provided to all new hires
- Report findings to state legislature to renew anti-bullying bill

References

Enhancing End of Life Education for New Graduates

Christina McElroy, MSN, RN, CHPN, Joy Elwell, DNP, FNP-BC, APRN, CNE,FAAN,FAANP, Rachel Butler, DNP,APRN, FNP-BC, ACHPN & Constance Cozens, MSN, RN

Background Information

- In 2021 1.7 million Americans received hospice care.[13]
- Multiple studies have cited that nurses report a lack of training in providing care for patients at the end-of-life.[7]
- Families of hospice patients gave higher satisfaction scores if the nurses were well skilled in keeping the family informed on the process and plan of care.[2]
- Nearly 50,000 nurses worldwide have End-of-Life Nursing Education Consortium (ELNEC) training. [1]

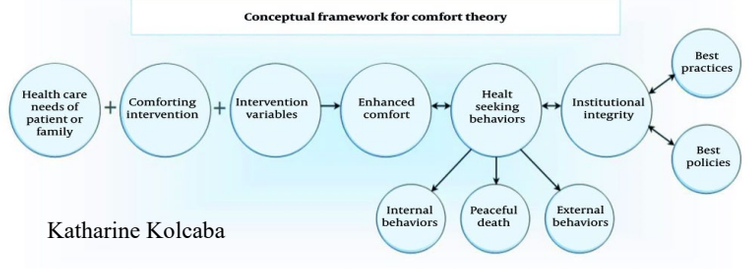
Purpose

- To increase nurses' self-perceived knowledge of caring for patients receiving Comfort Care by educating nurses on how to effectively care for this population.
- To promote the delivery of high-quality comfort care throughout the hospital, new graduate nurses will take the ELNEC course in the new graduate residency.
- *HP 2030- Increase the ability of primary care and behavioral health professionals to provide more high-quality care to patients who need it* [4]

Significance of problem

- There are over 3 million working nurses in the US, less than 40% report having EOL education.[13]
- Discomfort in discussing the dying process is the #1 competency gap reported by nurses, directly impacting patient and family care.[6]
- Suboptimal EOL care results in prolonged suffering for the patient and greater levels of depression and regret for loved ones.[10]

Theoretical Framework



Katharine Kolcaba

Best Practice

- ELNEC was created in 2000 as a national & international education initiative to improve PC education. [1]
- The curriculum is comprised of ACNN recommendations and competencies for education and the IOM's report- Dying in America. [1]
- ELNEC can be taken by anyone that works with chronically ill patients, not just nurses. [1]
- The Core course consists of 6 online modules, including communication, symptom management, and the final hour [1]
- HPNA recommends all nurse have ELNEC training. [1]

Methods

- Single group quasi-experimental pretest-posttest survey
- EOL-Q questionnaire pre and post ELNEC

Sample Characteristics & Setting

- New Graduate nurses under 1 year of practice
- 7 female, 1 male
- 5 Oncology unit, 2 medicine, and 1 ortho/neuro

Setting: A 366- bed, academic, level II trauma center in an urban community

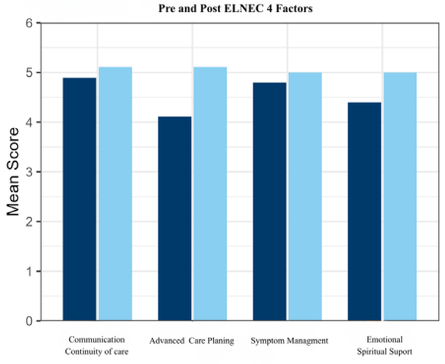
Materials

- ELNEC course ($29 per participant)
- Pre and post electronic knowledge-based survey for nurses

Data Analysis Plan

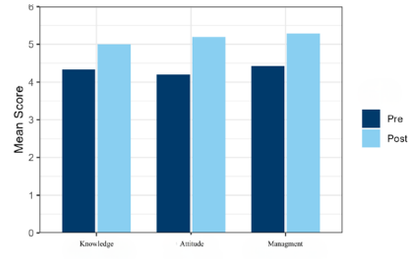
Wilcoxon test to evaluate ELNECs impact on knowledge.

Results



"I really enjoyed learning about how to care for a patient at the end of life"

"As a new nurse, the thought of taking care of a dying patient was Terrifying. I feel much more comfortable now"



Implications for Practice

- High quality EOL care provided to patients
- Open conversations about EOL wishes among patients and providers
- Greater comfort in caring for patients at the end-of life

Future directions

- Execute the ELNEC curriculum to all inpatient and emergency room nurses at Norwalk Hospital
- Eliminate the need to move patients at EOL

References & Acknowledgements

This work is dedicated to the memory of my mother, Cynthia O'Brien, whose love and guidance has made me the nurse that I am today.

Scan for references

Longitudinal Associations Between Breast and Nipple Pain and Breastfeeding Outcomes During the First 24 Weeks Postpartum

Confidence C. Francis-Edoziuno and Ruth F. Lucas

Elisabeth DeLuca School of Nursing, University of Connecticut

Background

- Breast and nipple pain contributes to early artificial milk supplementation and breastfeeding cessation
- Longitudinal evidence of the impact of pain related to breastfeeding frequency and exclusivity remains limited

Objective

- To examine the relationship between breast/nipple pain severity and breastfeeding postpartum outcomes from birth to 24 weeks

Method

Design
- Secondary longitudinal analysis
- Primary study: Promoting Self-Management of Breast and Nipple Pain with Technology for Breastfeeding Women (PROMPT) study (R56NR020041, PI: Dr. Ruth Lucas, 2021-2024)

Sample
- Postpartum women followed from birth to 24 weeks
- Inclusion: Breastfeeding and/or pain data ≥5 of 9 timepoints
- N = 195 records

Data Collection
- 9 timepoints: baseline, weeks 1, 2, 3, 6, 9, 12, 18, 24
- Visual Analogue Scale (0–100 mm): Breast/nipple pain
- Ongoing Breastfeeding Assessment: Self-report breastfeeding frequency (24-hr feeds), exclusive breastfeeding (EBF vs non-EBF)

Data Analysis
- Descriptive Statistics (Socio-demographics)
- Mixed-effects models (Breastfeeding frequency, exclusivity, and concurrent/lagged pain predictors)
- Models adjusted for postpartum week and intervention group with subject-level random intercepts
- Significance: α = 0.05

Results

Table 1: ***Demographic Characteristics (N = 195)***

Characteristic	n (%)	Characteristic	n (%)
Education level		**Employment status**	
High school or less	29 (14.9)	Employed	24 (12.3)
Some college/Associate	46 (23.6)	On maternity/sick leave	136 (69.7)
Bachelor's degree	46 (23.6)	Not employed	21 (10.8)
Graduate/professional	74 (37.9)	Other/Unknown	14 (7.2)
Marital/partner status		**Race/ethnicity**	
Never married	51 (26.2)	Non-Hispanic White	104 (53.3)
Married	130 (66.7)	Non-Hispanic Black	27 (13.8)
Domestic partnership	10 (5.1)	Hispanic	52 (26.7)
Divorced/Separated	4 (2.0)	Other	12 (6.2)
Family income		**Breastfeeding experience**	
< $25,000	29 (14.9)	First-time breastfeeding	88 (45.1)
$26,000–$50,000	35 (17.9)	Previous experience	107 (54.9)
$51,000–$75,000	21 (10.8)	**Age in years**, mean (SD)	30.69 (4.92)
$76,000–$100,000	17 (8.7)	**Household size**, mean (SD)	3.82 (1.17)
> $100,000	93 (47.7)	**Infants previously breastfed**, mean (SD)	1.76 (0.93)

Associations between low and moderate/high pain and EBF were strongest at weeks 3-9 **(Figure 1)**

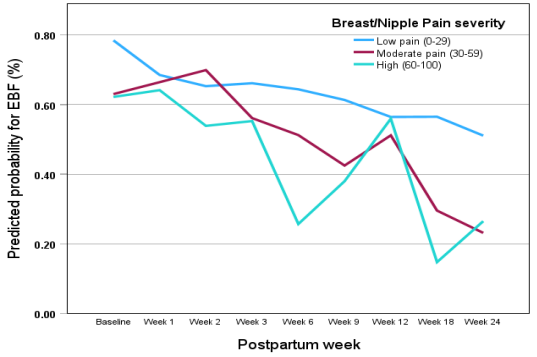


Figure 1: ***Exclusive Breastfeeding by Pain Severity Category Across Time***

- Breastfeeding frequency declined over time and was not significantly associated with breast/nipple pain (p = .447)
- Higher pain significantly reduced odds of EBF (concurrent: OR≈0.99, p=.014; lagged: OR≈0.99, p=.006) **(Table 2)**
- Low pain was associated with ~2× higher odds of EBF (OR≈2.04, p=.024) **(Table 2)**

Table 2: ***Breast/Nipple Pain as a Predictor of Exclusive Breastfeeding***

Predictor	β (SE)	OR	95% CI for OR	p	Model Fit
Concurrent pain model					
Pain severity (continuous)	−0.011 (0.005)	0.989	0.980–0.998	.014	AIC = 7065.379; BIC = 7070.637
Low vs High pain	0.714 (0.315)	2.04	1.10–3.79	.024	AIC = 6974.685; BIC = 6979.932
Moderate vs High pain	0.256 (0.324)	1.29	0.68–2.44	.431	
Lagged (t – 1) pain model					
Pain severity (continuous	−0.012 (0.004)	0.988	0.979–0.996	.004	AIC = 6974.685; BIC = 6979.932
Low vs High pain	0.773 (0.293)	2.17	1.22–3.85	.008	AIC = 6973.035; BIC = 6978.282
Moderate vs High pain	0.533 (0.291)	1.70	0.96–3.02	.067	

Note: All models adjusted for postpartum week and intervention group with subject-level random intercept.

Conclusions & Implications

Breastfeeding frequency and exclusivity represent distinct constructs, and breast/nipple pain primarily influences exclusivity rather than feeding frequency

Breast and nipple pain may function as a behavioral turning point away from exclusive breastfeeding, and early postpartum weeks represent a potential window for intervention

Early identification and management of breastfeeding pain may be critical to sustaining exclusive breastfeeding postpartum

The Healing Power of Movement

Integrating an Evidence Based, Nurse Driven Mobility Assessment Tool as the Established Gold Standard On An Orthopedic | Surgical Unit

Desiree A. Mahon MSN, RN

Denise Bourassa, DNP; Michelle De Layo, DNP, Rachel Meehan, APRN

Introduction

- Early Mobility is an essential component of patient safety, enhanced clinical recovery, and optimized health outcomes.
- The Bedside Mobility Assessment Tool (BMAT 2.0) provides a standardized method to assess and guide patient mobility.
- A lack of consistent BMAT(2.0) use created a gap and variability in mobility practices, adherence and documentation, leading to inconsistent outcomes.
- The CDC recommends that hospitals incorporate early mobility best practices into their clinical practice and inpatient workflow. This can help reduce the risk of functional decline, poor functional outcomes after discharge, and hospital readmissions.

Method

- **Setting:** Orthopedic Surgical Unit of 28 inpatient beds.
- **Participants:** 35 nurses participated in structured BMAT(2.0) education and training.
- **Interventions** included a BMAT (2.0) Saba course, EPIC workflow enhancements, weekly educational tips, visual unit-based resources, mobility support and a BMAT (2.0) pocket guide.
- **Strategies** involved an in-bed mobility initiative, ICU mobility collaboration aptly titled "Awake & Thrive," and the proposal for a dedicated Mobility Technician role.
- **Measures** included nursing confidence and competence (survey results pre and post), documentation compliance, ambulation frequency and distance per shift, patients' lengths of stay, and falls with and without injury.

Implementation Timeline

Clinical Questions

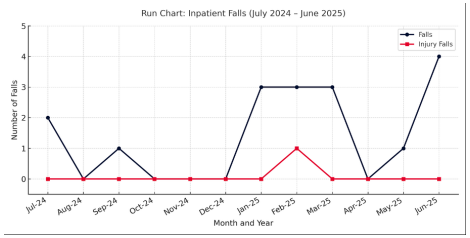
- What impact does the BMAT (2.0) re-implementation from a nursing perspective have on nursing confidence and competence?
- How does EPIC workflow enhancements impact documentation compliance, accuracy and adherence?
- Does consistent use of the BMAT (2.0) support early patient mobility and improved safety outcomes such as ambulation distance, length of stay and falls?
- Is the re-implementation of the BMAT (2.0) from a nursing perspective useful in supporting nursing to autonomously get their patients out of bed earlier?

Procedure

1. The clinical problem of inconsistent use of the BMAT(2.0) due to a lack of confidence and competence was identified.
2. Background evidence and the historical use of the tool was reviewed to establish the need for reimplementation from a nursing perspective.
3. The project methodology was designed with an emphasis on promoting a nurse-driven approach to practice.
4. Leadership support and staff engagement were secured prior to project launch.
5. Orthopedic Registered Nurses completed the BMAT(2.0) comprehensive training program, which was developed using integrated visual and digital learning tools.
6. Interventions were implemented in phases, including dedicated unit- based mobility support and interdisciplinary collaboration.
7. Data collection included pre- and post-intervention surveys, EMR documentation review, and patient outcomes.

Results

- Nursing confidence in mobility assessment increased by 35% following the re-implementation phase.
- Competence in applying the BMAT (2.0) levels improved, supported by enhanced education, training and resources.
- Documentation adherence improved from 62% pre-intervention to 91% post-intervention.
- Patient ambulation increased by 40%, reflecting greater nursing engagement and support in establishing and meeting mobility goals.
- Average patient length of stay decreased by 0.5 days.
- Patient falls decreased by 15%, demonstrating enhanced safety outcomes.



Conclusion

- The BMAT (2.0) re-implementation strengthened nurse-driven mobility practices.
- Nursing demonstrated a higher level of confidence and competence in completing mobility assessments.
- Improved adherence to documentation supported real time monitoring of patients' clinical progress.
- Findings confirm the validity, effectiveness and usefulness of standardized nurse-driven, evidence-based tools in advancing mobility and safety.

Significance

- Nurse-driven mobility assessments foster a culture of safety and accountability.
- Consistent BMAT(2.0) use improves patient outcomes and reduces the risk of harm to both patients and staff.
- The success of this project supports scalability across hospital units, specialties and systems.
- BMAT(2.0) provides an evidence-based framework for sustainable mobility practices that align equitable patient care goals and optimized outcomes.

Acknowledgment

Appreciation is extended to UConn Health Nursing Leadership, and all registered nurses and leadership of UT5 for their dedication and commitment to advancing practices that promote patient mobility and safety.

References

Scan Me

Community-Based Diabetes Self-Management Programs Among Adults in Sub-Saharan Africa: A Scoping Review

Dorothy Wilson[1], Semiloore P. Famisin [2], Richard Marfo [3], Adelaide N. Amponsah [2], Anita F. Oppong [1], Evans F. Kyei [4], Kelley N. Lew [1]

[1]University of Connecticut, Storrs, CT; [2] Kwame Nkrumah University of Science and Technology, Kumasi, Ghana; [3] UMASS Boston, MA; [4] University of Alabama, Tuscaloosa, AL

Introduction

- Diabetes is a growing public health concern in Sub-Saharan Africa (SSA).
- Healthcare system challenges and socioeconomic barriers hinder optimal management.
- Community-based diabetes self-management (DSM) programs have emerged as a promising approach to improve outcomes.
- These programs extend support beyond health facilities and address contextual barriers.
- However, a comprehensive review is lacking to assess their impact and inform future strategies.

Study Purpose

- This scoping review aimed to identify the types of community-based DSM interventions implemented in SSA and summarize reported outcomes.

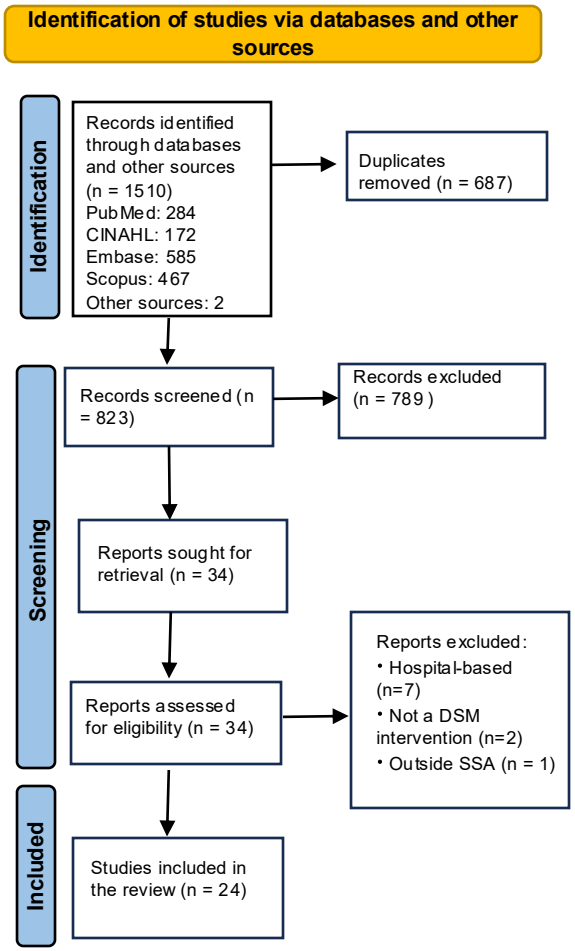
Methods

- Following the PRISMA guidelines, a literature search was conducted in PubMed, Embase, CINAHL, and Scopus.
- Peer-reviewed studies published in English that describe or evaluate community-based self-management interventions among adults with diabetes in SSA were included.
- Articles were screened using Rayyan.
- Data were independently screened and extracted by three reviewers.

Results

- 24 studies were included (n = 17 restricted to type 2 diabetes [T2D]).
- Most studies were conducted in South Africa (n = 9) and Ghana (n = 4).

PRISMA Flow Diagram



Results cont.

- **Intervention designs:** 46% (n = 11) of the studies were randomized controlled trials, with fewer studies using quasi- or pre-experimental designs.
- **Intervention types:** mHealth (n =13), peer-led/ support (n = 6), family-based/support (n = 4), and home-based (n = 1).
- **Improved outcomes:**
  - Behavioral (e.g., dietary intake): 12 studies
  - Physiological (e.g., A1C): 9 studies
  - Psychosocial (e.g., quality of life**):** 7 studies
- **Feasibility and acceptability** were reported as high in 42% of the studies (n = 10).
- **Challenges in mHealth studies:**
  - Poor internet access
  - Data costs
  - Low digital literacy among participants

Conclusions & Implications

- Community-based DSM interventions show promise in improving diabetes outcomes.
- Addressing mHealth implementation challenges may enhance scalability and sustainability.
- Further research is needed to refine intervention models and support integration into communities.

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Barriers and Enablers to Penicillin Allergy Delabeling in Pediatric Primary Care: Findings from a Multisite Qualitative Study

Eileen J. Carter, PhD, RN[a], Elizabeth Monsees, PhD, RN[b,c], Sharon Hwang, MD[d], Tara Schmidt, BS[e], Mary Lou Manning, PhD, RN[f], Cliff O'Callahan, MD, PhD[g], Rana E. El Feghaly MD, MSCI,[b,c] Monika Pogorzelska-Maziarz, PhD[e]

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BACKGROUND

- Penicillin allergy labels are common in children and increase lifelong risk of harm
- Allergy societies recommend the proactive delabeling of low-risk penicillin allergies by history or direct oral challenge.

PURPOSE

- Identify barriers and enablers to penicillin allergy delabeling among pediatric primary care practitioners (PCPs).

METHODS

- Conducted interviews and focus groups with PCPs at 10 primary care practices in the Northeast.
- Grouped barriers and enablers using the COM-B Model of Behavior.

RESULTS

- Twenty-nine PCPs participated in semi-structured interviews and focus groups, **Table**.

Table. Participant Characteristics	Total (N=29)
Primary Care Practitioner, n (%)	
Physician	24 (83%)
Nurse Practitioner	5 (17%)
Years of Clinical Experience, n (%)	
<5	3 (10%)
5-10	8 (28%)
11-15	6 (21%)
16-20	5 (17%)
>20	7 (24%)
Specialty, n (%)	
Family Medicine	12 (41%)
Pediatrics	17 (59%)

Qualitative Findings According to the COM-B Model of Behavior Change

	Barriers	Enablers
Capability	**Lack of skills and training in penicillin allergy delabeling** *"I would be reluctant to [delabel] without more education on the list…of symptoms."* – Interviewee 7, Pediatrician *"I find the trickiest ones to be…the non-urticarial rashes that are happening around day five to seven."* – Speaker 2, Focus Group 3	**Partner with an allergist to develop a clinical pathway** *"If there was structured guidance from an allergist…that would be really helpful."* – Interviewee 10, Pediatrician **Train one practitioner to specialize in delabeling** *"[Train] a PA who's educated enough and just run some, kind of, clinic, where this is all just streamlined."* – Interviewee 12, Pediatrician
Opportunity	**Caregiver unwillingness** *"There are families that are particularly resistant."* – Speaker 2, Focus Group 5 **Resource constraints** *"We have limited space in rooms. And so, tying up a room for an hour and 15 minutes or however long it would take would-would, I think, not be feasible."* – Interviewee 10 **Poor documentation of penicillin allergy histories** *"The documentation of the reaction is very inconsistent, or it says unspecified or unknown and so that's one of the gaps."* – Speaker 4, Focus Group 1	**Engage caregivers in delabeling efforts** *"I think some families would be supportive of it, especially if you have a good relationship with the family."* - Interviewee 9 **Implement innovations to address resource constraints** *"We could…cluster a bunch of patients and just do a whole bunch…at the same time."* – Speaker 3, Focus Group 1 **Improve documentation of penicillin allergy histories** *"I think any kind of documentation…like a picture—that would be so helpful."* – Interviewee 6
Motivation	**Low motivation to delabel** *"We may see the label but not have time to dive into-into it…. so, we'll go ahead and prescribe this instead."* – Speaker 1, Focus Group 5	**Amplify reasons for PCPs to delabel** *"If there was compensation and you could have a complete allergy discussion visit and bill for it, I don't see why we would have difficulties."* - Focus Group 1, Speaker 8

Conclusion and Next Steps

- PCPs are receptive to delabeling low-risk penicillin allergies when provided education, resources, and system-level support.
- Interventions are needed to strengthen PCP skills, engage caregivers, and ensure feasible clinic resources for delabeling.

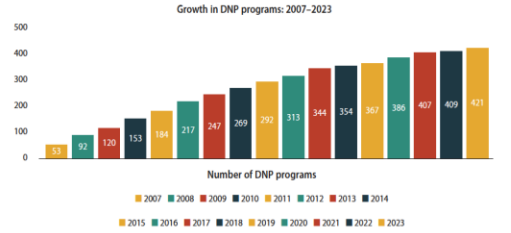
The Jefferson-Nemours Pediatric Award for Clinical Research (PACR) supported all phases of this study.

A Programmatic Innovation: Sustaining DNP Program Growth – Utilizing DNP Graduates as Associate Advisors on Student Committees

Joy Elwell, DNP, APRN, FNP-BC, CNE, FAAN, FAANP, Michelle Cole, DNP, RN, CPN, Catherine Reily, DNP, CRNA

Background

- *Interest in the DNP is significant and growing*
- *Over 439 DNP programs exist in the US, with >500 programs expected by 2027*
- *Growth-associated challenges are consistent with maintaining sufficient support for students*



(AACN, in Anoka and Obrien, 2025)

Purpose

To provide an optimal level of support to each DNP student in a cost-effective, sustainable fashion while also providing scholarly dissemination opportunities to DNP graduates

Drs Emilee Binette and Antoinette Padula (both DNP, 2021 who now serve as Associate Advisors to DNP students at the Uconn | Elisabeth DeLuca School of Nursing (Photo, E. Binette)

Theoretical Framework: Bandura's Social Learning Theory (SLT)

SLT supports this initiative, as it posits that learning occurs in a social context through reciprocal interaction between people and the environment. The core constructs of SLT include modeling/observational learning, outcome expectancies, self-efficacy, and self-regulation.

As experienced learners, DNP students may learn as much from observing peer advisors as they do from formal teaching methods. Including a recent DNP graduate on the committee provides the student with an advisor who has a shared experience.

Several DNP alumnae who serve on DNP Committees as Associate Advisors (Photo, T. Elwell)

Methods

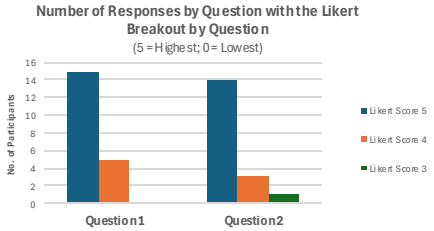
1. *Twenty UConn | Elisabeth DeLuca School of Nursing DNP graduates were invited to serve as associate advisors on DNP student advisory committees*
2. *The participants received gratis UConn Graduate School appointments and adjunct status with the School of Nursing, granting them access to the UConn Library. They were mentored by the DNP Program Director and their student's Major Advisor and did not receive monetary compensation. They are listed as co-authors on the students' publications and poster presentations.*
3. *Over a 3-year period, all 20 DNP graduates were matched with DNP students and served on their committees as associate advisors.*
4. *In the 3rd year, a five-item survey assessing role satisfaction was administered to 20 participants. Participation was voluntary. The survey included two quantitative and three qualitative questions. The response rate was 100%. The survey questions are available in a handout.*

Results

Survey results indicated a high level of satisfaction

Question 1, "How much do you enjoy serving as an associate advisor to a DNP student at UConn?", 15/75% expressed high satisfaction, and 5/25% expressed satisfaction.

Question 2, "How likely are you to serve again in this role again?" 14/70% reported they were very likely to serve again, 5/25% were likely to serve again, and 1/5% was neutral as to whether they would serve again.



Qualitative themes include (questions 3-5), including recommendations for more feedback, additional mentoring, and one respondent reported a desire for monetary compensation.

Conclusions and Significance

The survey results indicate that recent DNP graduates serving as associate advisors report high satisfaction with this role. Their contributions were meaningful, and they expressed an intention to continue serving as an associate advisor to DNP students.

DNP graduates are leaders in Quality Improvement (QI) and Evidence-based practice (EBP) models. They are Implementation Scientists. They provide valuable mentorship to DNP students. These advisors are typically highly motivated and enthusiastic about serving in the role.

Utilizing non-faculty DNP graduates as associate advisors is a feasible option to sustain the three-person advisory committee for DNP students. There are benefits to both the DNP program and the advisors, including expanding valuable resources without additional budgetary impact.

References:

Handouts also available.

Distinct Associations of Adaptive and Maladaptive Perfectionism With Chronic Pain Outcomes

Ingrid Korbani, MSN, AGCNS-BC, PMGT-BC & **Natalie J. Shook**, PhD

Background:

- Chronic pain is shaped by interacting biological, psychological, and social factors.
- Perfectionism may be an important psychological factor in chronic pain.
- Hewitt and Flett's model includes two relevant dimensions:
  - **Self-Oriented Perfectionism: adaptive**
  - **Socially Prescribed Perfectionism: maladaptive**
- Maladaptive perfectionism has been more consistently associated with worse pain outcomes: higher pain severity, greater functional interference, and poorer cognitive-affective responses.
- Adaptive perfectionism has been studied less often, with mixed findings.
- Further research is needed to better understand how these dimensions relate to pain-related outcomes in adults with chronic pain.

Aim:

To examine whether adaptive and maladaptive perfectionism show distinct associations with fear of pain, pain sensitivity, pain catastrophizing, and pain interference in adults with chronic pain.

Method:

Cross-sectional online survey of U.S. adults with chronic pain (N = 149)
Recruited from online support communities - October 2025

Measures:

- **Multidimensional Perfectionism Scale-HF** (α = .769)
- **Pain Catastrophizing Scale** (α = .886) – To measure pain catastrophizing (Exaggerated negative thoughts and feelings about pain)
- **Fear of Pain Questionnaire-9** (α = .789) – To measure fear of pain (Feeling scared of pain and what it might mean)
- **Pain Sensitivity Questionnaire** (α = .950) – To measure Pain sensitivity (How easily a person feels pain and how intense it feels)
- **The interference subscale of the Brief Pain Inventory-SF** (α = .921) – To measure pain interference (The extent to which pain disrupts daily functioning)

Sample Characteristics:

- **Age:** M = 31.9 years (SD = 7.7)
- **Sex**: 55% male; 44% female
- **Race**: 49% White; 34% African American; 17% other
- **Marital Status**: 60% married; 30% single; 10% other
- **Education**: 59% bachelor's; 14% master's; 10% associate; 10% high school
- **Pain Duration**: 43% 6 to 12 months; 32% 3 to 6 months; 25% >1 year
- **Pain Conditions**: back 53%, muscle 40%, headache 39%, joint 35%, neck 28%, abdominal 26%

Results: Multiple Linear Regression with Adaptive and Maladaptive Perfectionism Predicting Pain Outcomes

	Model R^2	ADAPTIVE β (p)	MALADAPTIVE β (p)	Main findings
Fear of pain	.228	.346 (< .001)	.256 (< .001)	Both were significant unique predictors.
Pain sensitivity	.149	.276 (< .001)	.211 (.008)	Both were significant unique predictors
Pain catastrophizing	.137	−.036 (.650)	.377 (< .001)	Only maladaptive perfectionism was a significant unique predictor.
Pain interference	.067	.247 (.003)	.036 (.661)	Only adaptive perfectionism was a significant unique predictor.

Standardized beta coefficients (β) show the unique effect of adaptive and maladaptive perfectionism when entered together.
R^2 reflects the variance jointly explained by both dimensions.

Main Takeaways & Implications:

- Both dimensions showed distinct patterns of association with pain-related outcomes.
- Both maladaptive and adaptive perfectionism were associated with greater fear of pain and pain sensitivity.
- Adaptive perfectionism was uniquely linked to greater pain interference.
- Maladaptive perfectionism was uniquely linked to greater pain catastrophizing.
- These findings suggest that adaptive perfectionism may not always function as a protective factor in chronic pain.
- Assessing both dimensions may help identify different forms of pain-related vulnerability in clinical settings.

References

Supporting Children's Emotion Regulation in a Hospital Setting: Investigating Use of Feel Your Best Self

Jessica B. Koslouski, PhD[1], Lucie Lopez[1], Maria Mathew[3], Mallory Perry-Eaddy, PhD, RN, CCRN[1, 2], Katherine Hinderer, PhD, RN[2] & Sandra M. Chafouleas, PhD[1]

[1] University of Connecticut, [2] Connecticut Children's Medical Center, [3] Trinity College

- Hospitalized children and their siblings face unique emotional stressors, such as disrupted routines and reduced time with caregivers.
- Feel Your Best Self (FYBS) offers simple and engaging instruction in emotion coping strategies for children and their families.
- FYBS has been widely used in schools – this study marks its first formal introduction into a pediatric healthcare setting.

Feel Your Best Self (FYBS) is an award-winning toolkit that brings credibility, accessibility, creativity, and joy as kids and their caregivers explore big feelings together.

UCONN

Connecticut Children's

- A FYBS Table was created in the Family Resource Center of an urban pediatric academic medical center.
- Across 10 observations, two-thirds of visitors to the Family Resource Center interacted with the FYBS Table.
- Over a two-month period, 104 coloring books (73 English, 31 Spanish) were taken from the FYBS Table. FYBS storybooks were also frequently used.

feelyourbestself.org

@feelyourbestself

Impact of Animal-Assisted Therapy on Length of Stay in Depressed Geriatric Patients on a Behavioral Health Unit : A Program Evaluation

Jill Duboff-Jacomini APRN, PMHNP-BC,

Joy Elwell, DNP APRN,FNP-BC,CNE, FAAN,FAANP, Robin Browne, APRN, DNP, Ava Pannullo MD,

Introduction

- Older adults continue to experience longer hospital stays (LOS) on geriatric BHU's
- Animal –Assisted therapy (AAT) has shown promise in improving emotional well- being, and decreasing loneliness
- AAT is a non-pharmacologic intervention that has demonstrated benefits to mood, increased engagement & overall well-being

Purpose

- To assess the feasibility and impact of AAT as a BHU enhancement using de-identified retrospective EHR data. This project aims to determine if AAT is associated with a decreased length of stay

Theoretical Framework:

Kolcaba's Theory of Comfort

- **Comfort theory provides the conceptual grounding with its emphasis on relief,, ease and transcendence**
- AAT supports emotional relief by reducing anxiety, loneliness and distress during hospitalization
- Interactions with therapy dogs foster comfort, connection and reduce isolation

Methods

- EHR data is under review for two naturally occurring cohorts: patients admitted in the three months prior to implementation of AAT and those admitted three months after implementation
- Extracted variables: age, psychiatric diagnosis, admission/discharge dates, LOS, and AAT participation in post implementation patients
- All data fully deidentified for patient privacy
- Descriptive statistics will summarize demographic data and LOS for each cohort
- Comparative analyses will evaluate differences between pre and post groups
- AAT visits are scheduled 3-4 times weekly from 20-30 minutes with a certified therapy dog & handler
- Patients included have a diagnosis of major depression without psychotic symptoms
- Pt were eligible if they met safety criteria, excluded patients were those with allergies , behavioral dysregulation, infection control issues, or medical instability and advanced dementia

Anticipated Results

- Findings will indicate whether the introduction of AAT is associated with meaningful reductions in LOS, supporting local program improvement
- Enhancement of patient reported experience
- Neutral or mixed results related to potential confounding variables such as placement delays and complex discharge needs

Significance

- AAT may reduce LOS, therapy animals may offer a cost- effective enhancement to geriatric psychiatric care
- AAT may represent an efficient intervention to improve comfort and support recovery

Conclusions

- Findings will be interpreted when available
- Conclusions will state whether findings support or do not support that AAT is associated with reduced length of stay on a geriatric BHU
- Results will be interpreted in relation to Comfort Theory & how AAT may influence relief, ease and transcendence
- Results will inform further program development

References:

Healing Hearts After a Myocardial Infarction: Focusing on Holistic Heart Health with the Implementation of a Depression Screening Protocol

Lauren LeBlanc-Hughes DNP, APRN, AGACNP-BC, Rosemary Swanke DNP, APRN, ACNP-BC, John Glenn Tiu MD, FACC, RPVI, & Jamie Gooch DNP, APRN, ACNP-BC

Introduction

- *Depression affects 1 out of 5 people in their lifetime[3]*
- *Despite depression screening recommendations in multiple national cardiac guidelines, this is not being completed on a routine basis[5,6,7]*
- *Survey completed revealed 49.9% of cardiology providers were unaware of depression being a risk factor for coronary artery disease (CAD), 71% did not ask about depression in over half of their CAD patients, & only about 56% felt comfortable making the diagnosis & treating[8]*
- *Feasibility of a depression screening protocol & referrals for treatment/support has not been well studied in the literature*
- **Gap:** *This gap between literature/guidelines & practice can be linked with the establishment of an advanced practice provider (APP) led depression screening protocol*

Clinical Questions & Aims

- *Will implementing an APP-led depression screening protocol result in an increase in screening, detection, & referrals for further assistance if warranted, prior to discharge, over a 3-month period?*
- *Is an APP-led depression screening protocol feasible & accepted in practice?*
- **AIMS:**
  1. *At least 75% of MI patients who meet inclusion criteria will be screened for depression during admission with the Patient Health Questionnaire (PHQ)*
  2. *100% of patients whose PHQ score ≥ 10 will be offered referral for further evaluation/treatment & additional supports*
  3. *Protocol feasibility & acceptance will be measured via an anonymous APP Likert scale survey post implementation*

Methods

Method	*Quality Improvement (QI) & Feasibility Pilot Study*
Independent Variables	*Age, sex, race, ethnicity, depression history, current use of antidepressants, type of MI, intervention/treatment for MI, PHQ score If applicable based on PHQ score: suicidal ideation, substance abuse, type of referral*
Dependent Variables	*% of patients screened during 3-month period out of total patients who met inclusion criteria, % of patients referred for additional support, APP survey results*
Inclusion Criteria	*Age 18+, English language, Type 1 MI*
Exclusion Criteria	*Vulnerable populations (incarcerated, pregnant, cognitive impairment), primary language not English, Type 2-5 MIs, hemodynamically unstable/intubated*
Setting	*257 Bed - Teaching Hospital*
Timeline	*Admission date of June 1st – August 30th, 2025*
Stakeholders	*Cardiology APPs, cardiology nurse navigators, & multidisciplinary staff*
Materials	*PHQ-2 & PHQ-9 handouts, patient study information sheet, education pamphlet on depression & heart disease, EPIC documentation flowsheet for PHQ score & standardized plan of care note, APP training PowerPoint, sample patient dialogue script, APP Likert survey*

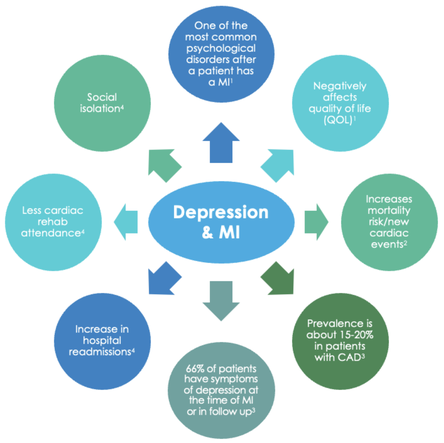


Figure 1: Relationship Between Depression & MI

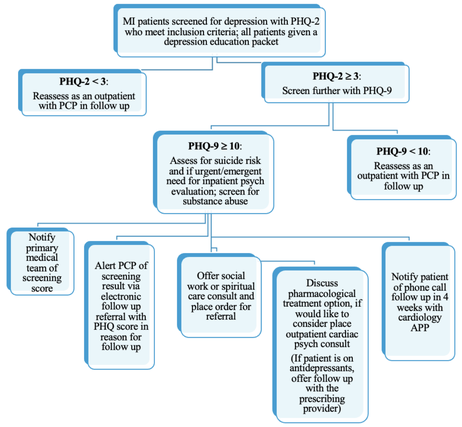


Figure 2: APP Depression Screening Protocol

Procedure

1. *Presentation of QI & feasibility pilot project to stakeholders & IRB review*
2. *Creation of new APP led depression screening protocol based on literature & guidelines[3,5,6,7,9]*
3. *Participants/APP training & orientation to new protocol & implementation*
4. *Implementation initiated: First 2 weeks project coordinator assisted APPs with first 1-2 screenings*
5. *End of implementation, pilot closed: Participating APPs screened via Likert scale survey & patient data compiled*
6. *Patient & APP Data Analysis: Descriptive statistics, data analyzed & reviewed by a statistician*

Results

- *86.1% of eligible patients who met inclusion criteria were screened*
- *3.2% met criteria for referral & received a referral per protocol*
- *95% confidence interval calculated for the 86.1% of screened patients resulting in a range of approximately 74.8%-97.4%*
- *Survey responses among participating APPs rated the QI project with mean scores of 5.5-6 on a Likert scale for majority of questions, score of 1 = strongly disagree & 6 = strongly agree, examining overall pilot experience, satisfaction with educational support, project design, feasibility & sustainability*
- *Reported average time spent on protocol process was 10 minutes or less*

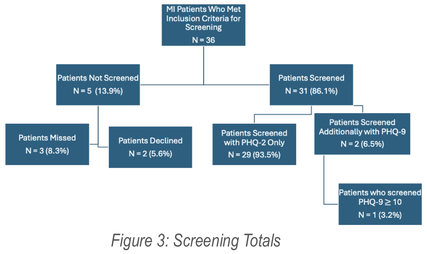


Figure 3: Screening Totals

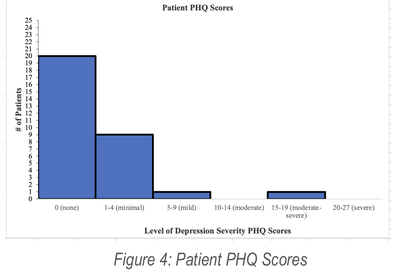


Figure 4: Patient PHQ Scores

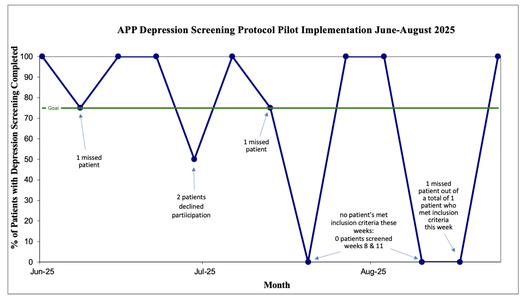


Figure 5: Implementation Run Chart

Figure 6: APP Likert Survey Results

APP Survey Questions	APP 1	APP 2	APP 3	APP 4	Mean Scores	Standard Deviation
My experience with the APP depression screening protocol was overall positive.	6	6	6	6	**6**	**0.00**
My perception of patient responses & reactions was overall positive.	5	6	6	6	**5.75**	**0.50**
I would continue to complete the depression screening protocol if incorporated into routine practice.	5	6	5	6	**5.5**	**0.58**
I felt supported by my peers throughout this depression screening protocol process. Education provided prior to implementation was thorough.	6	6	6	6	**6**	**0.00**
The APP depression screening protocol was well designed & clear.	6	5	6	6	**5.75**	**0.50**
I felt it was a smooth process reading the PHQ questions out loud to patients.	6	6	6	6	**6**	**0.00**
Communication of which patients needed screening completed was clear.	6	6	6	6	**6**	**0.00**
I felt the amount of time spent total completing the screening, education, referral, & documentation was manageable.	5	6	5	6	**5.5**	**0.58**
I experienced some challenges with timing trying to complete the protocol during inpatient admission.	2	1	3	4	**2.5**	**1.29**
I think this protocol actually would be more feasible to complete outpatient at first cardiology follow up.	2	2	4	2	**2.5**	**1.00**
I spent on average minutes on the depression screening protocol process for a single screening.	≤5 minutes	6-10 minutes	≤5 minutes	6-10 minutes	**≤10 minutes**	

6-point Likert Scale: 1 = strongly disagree, 2 = disagree, 3 = somewhat disagree, 4 = somewhat agree, 5 = agree, 6 = strongly agree

Conclusion

- *Evidence based, guideline supported APP led depression screening protocol can effectively bridge the gap between literature/guidelines & current practice*
- *APP led depression screening protocol is highly feasible & accepted in the clinical setting & can successfully identify patients at risk for depression & in need of referral for additional support*
- *This small, single center study demonstrates that the creation of a depression screening protocol is achievable using an APP led protocol & is highly effective in implementing guideline recommendations into practice*

Significance

- *Implications for project replication on a larger scale at other institutions*
- *Though a small percentage of patients needed a referral, can assume the study would have captured more patients in need of referral, had the study been over an extended period*
- *Increased awareness in the gap between guideline recommended depression screening & practice & importance of screening in this vulnerable population*
- *Expanded screening via an APP led protocol brings attention to holistic care*

Acknowledgements

Thank you to my committee, cardiology APP team, nurse navigators, patients, interdisciplinary staff, Dr. Sacco & Dr. Walsh for statistical support.

References

MA Council & Ladder: A Pathway to Growth

Melissa Dibble, RN, MSN, NPD-BC, Mardele Lorenson, RN, MSN, Danielle Dubish, AS, AASMA

Connecticut Children's, Hartford, CT

Introduction

- *High Medical Assistant (MA) turnover and declining engagement*
- *Outdated clinical ladder*
- *Limited meaningful career growth*

MA Turnover impacts:
- *Team stability*
- *Patient experience*
- *Operational costs*

Engagement linked to:
- *Retention*
- *Job satisfaction*
- *Professional growth*

Aim

- *Assess whether updating the Medical Assistant Clinical Ladder and implementing a Medical Assistant Council could enhance engagement, job satisfaction, and retention, ultimately supporting workforce stability*

Method

- *Quality Improvement initiative*
- *All Medical Assistants at Connecticut Children's were eligible to participate*
- *Administered Satisfaction of Employees in Health Care (SEHC) survey in Spring 2025*
- *Redesigned Medical Assistant Clinical Ladder*
- *Launched Medical Assistant Clinical Council (MACC) in July 2025*
- *Repeated Satisfaction of Employees in Health Care (SEHC) survey in Fall 2025*

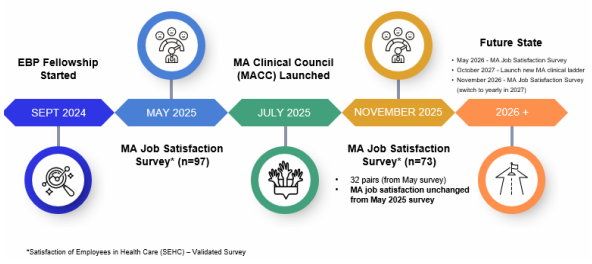


Figure 1, Timeline

Procedure

Literature & Planning
- CINAHL & PubMed search
- MeSH terms: Medical Assistant, engagement, retention, job satisfaction
- External clinical ladder models reviewed
- Literature appraised and synthesized
- IRB non-human subject determination

Stakeholder Engagement
- Stakeholder meetings conducted
- Communication via email, newsletters, meetings intranet, office hours

Data Collection
- REDCap survey distributed via email
- All eligible MAs invited
- Participation voluntary
- Unique identifiers assigned

Data Management
- Data stored in secure shared Dropbox
- Access limited to project team

Results

- *Medical Assistant Clinical Council (MACC)*
  - *Launched July 2025*
  - *Virtual monthly cadence*
  - *~35 Medical Assistants attend monthly*
  - *Focus on voice, practice improvement, patient experience, professional development, and recognition*
- *Medical Assistant Clinical Ladder*
  - *Updated to reflect Magnet standards*
  - *Plan to launch in FY27*
- *Medical Assistant market adjustment completed in March 2026*
- *SEHC showed unchanged MA job satisfaction from May 2025 to November 2025*

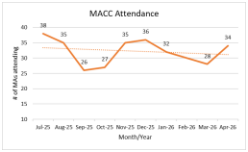


Figure 2, MACC Attendance.
Note: *Higher attendance is likely, but group logins limit accurate counting*

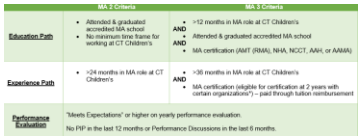


Figure 3, MA Clinical Ladder
Note: *This is only one portion of the full ladder*

Conclusion

Although the November 2025 survey results did not show significant improvement following MACC implementation, early engagement among participating MAs is encouraging. Improvements are anticipated in the May 2026 survey following compensation adjustments, with further gains expected after the updated MA clinical ladder is introduced in FY27. Next steps include sustaining MACC efforts, implementing the clinical ladder, and reassessing job satisfaction in Spring and Fall 2026, alongside continued evaluation of long-term retention trends.

Limitations/Barriers:
- *Incomplete retention data*
- *Challenges in accurately capturing MACC attendance*

Future State:
- *Repeat SEHC surveys in May and November 2026*
- *Implement updated clinical ladder*

Significance

- *Job satisfaction is multifaceted and requires a multi-pronged approach*
- *Improvements in job satisfaction may take time to emerge following implementation of an initiative*
- *Council engagement alone does not rapidly improve job satisfaction*
- *Compensation and clinical advancement also play key roles*
- *Long-term satisfaction and retention trends will continue to be monitored*

Acknowledgements

Thank you, Carrie-Ellen Briere, PhD, RN, Associate Professor, Elaine Marieb College of Nursing, University of Massachusetts Amherst and Nurse Scientist at Connecticut Children's, for your mentoring. This project was part of a Nursing Research Fellowship Project supported by the Institute of Nursing Research and EBP at Connecticut Children's.

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Nursing-Led Transitions of Care for Adolescents and Young Adults with Recurrent Headaches: A Scoping Review

Madeleine Willett[1], BSN Student, **Dr. Katherine Hinderer**[2], PhD, RN, and **Dr. Sharon Casavant**[1], PhD, RN

[1]University of Connecticut Elisabeth DeLuca School of Nursing and [2]Connecticut Children's Medical Center Nursing Research Institute

Introduction

- *Recurrent headaches, including chronic daily headache and migraine, are common and often disabling among young people (Szperka, 2021).*
- *These conditions profoundly impact daily functioning, quality of life, and psychosocial well-being (Waung, 2020).*
- *Management involves complex physical, behavioral, and lifestyle factors (Hardy, et. al., 2018). .*
- *The transition from pediatric to adult health systems is a critical gap (Trettin, et. al. 2025).*
- *Unstructured transitions can disrupt continuity of care when self-management skills are essential. (Trettin, et. al. 2025).*
- *This study explores nurse-led transition-of-care interventions for adolescents and young adults with recurrent headaches, highlighting key components and gaps in the literature.*

Figure 1 *illustrates the contrast between transition of care—a gradual, development-focused process driven by psychological, developmental, and vocational needs—and transfer of care—a single event moving from pediatric to adult services. For youth with recurent headaches, a supportive transition is essential for continuity of care and effective self-management.*

Methods

Scoping review using Joanna Briggs Institute (JBI) methodology to map evidence on nursing-led transitions of care for adolescents and young adults with recurrent headaches. Guided by Transitions Theory, the purpose of this review is to identify key concepts, intervention components, and gaps in the literature.

Eligibility Criteria (PCC) *Population: Adolescents/young adults (14–26 yrs) with recurrent/chronic headaches.* *Concept: Nurse-led transition interventions (coordinated processes supporting movement from pediatric to adult care).* *Context: Healthcare settings involving transition to specialty headache or neurology care.* *Inclusive of all study designs, grey literature, and policy documents (English only).*	**Search Strategy** *Comprehensive search of PubMed, CINAHL, and PsycINFO.* • *Initial limited search* • *Full database search (Boolean)* • *Reference list screening*
Study Selection *Dual-reviewer screening using Covidence/Rayyan. Abstract & full-text screening with consensus resolution. Reporting via PRISMA flow diagram.*	**Data Charting & Synthesis** *Standardized extraction by two independent reviewers covering study characteristics, population, interventions, and outcomes.* *Summarized via descriptive and qualitative content analysis, presented in tables and evidence maps. (Risk of bias not formally assessed).*

Research Question

*"In young adults and adolescents with recurrent headaches who have recently transitioned to adult care, how does nursing-led transitions of care, compared to standard care, affect **patient satisfaction, pain management, and quality of life?**"*

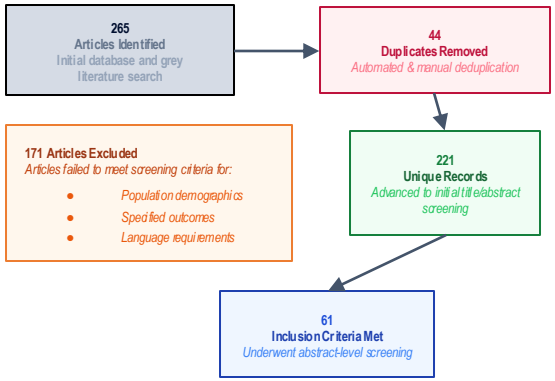
Patient Satisfaction | Pain Management | Quality of Life

Figure 2, *Factors Related to a Response to a Transition Event*

Procedure

The research question was established, and the eligibility criteria were defined using the PCC framework. An initial limited literature review was conducted to refine keywords and index terms, followed by comprehensive database searches in PubMed, CINAHL, and PsycINFO using Boolean operators, as well as grey literature searches (e.g., Google Scholar and Dissertations & Theses). The records were imported into the review management software (Rayyan), and duplicates were removed using both automated and manual methods. Two reviewers independently screened titles, guided by Afaf Meleis's" Transitions Theory, followed by abstract screening using predefined inclusion and exclusion criteria.
Next: Full-text review to be completed.

Results



Significance

Guided by Afaf Meleis's Transitions Theory, this study addresses a critical gap in the transition from pediatric to adult care for adolescents and young adults with recurrent headaches. Current standard care often lacks structured support, contributing to poor satisfaction, inadequate pain management, and reduced quality of life. This research highlights the impact of nursing-led transitions of care in improving these outcomes by supporting role adaptation and continuity of care. The findings also offer a transferable, theory-driven framework for improving transitions across other chronic pain conditions and high-risk populations.

Conclusion

Nurses are well-positioned to lead transition interventions by promoting readiness, supporting self-management, and coordinating care across settings. Yet, evidence on nursing-led transitions for adolescents and young adults with recurrent headaches is limited and scattered. This scoping review will clarify existing knowledge, identify gaps, and inform future nursing practice, program development, and research.

Acknowledgements

Thank you to Dr. Casavant for serving as the advisor for this independent study, to Victoria Helwig at the University of Connecticut Library for her research support, and to Connecticut Children's and Project Headway for their collaboration.

References

Engineering Equity in Patient Monitoring: The Pulse Oximetry Challenge

Students: Angela Dulnuan[1], Sean Dunn[2], Hailey Giordano[2], Akeva Koulla[2], Adeline Richard[2], Madeleine Willett[1]
Faculty Advisors: Mallory A. Perry, PhD, RN[1], Kazunori Hoshino, PhD[2]
1. University of Connecticut Elisabeth DeLuca School of Nursing; 2. University of Connecticut School of Engineering, Department of Biomedical Engineering

Introduction

Pulse oximetry is a noninvasive tool to monitor peripheral oxygen saturation (SpO_2), essential to assess oxygenation and overall health

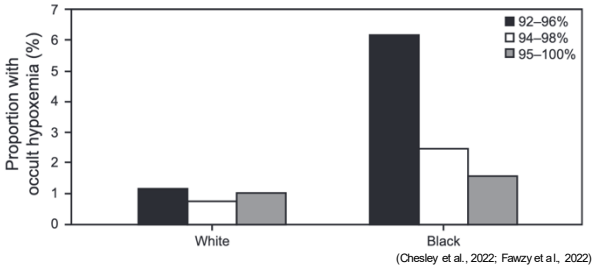
Increased melanin can lead to falsely elevated SpO_2 readings that mask hypoxemia, reducing SpO_2 accuracy in individuals with darker skin tones

Occult hypoxemia is a clinical condition where a patient's arterial blood oxygen levels (SaO_2) are critically low (<88%), but pulse oximeter (SpO_2) readings appear normal (92–96%)

It can delay early recognition and escalation of care, contributing to adverse patient outcomes, including death.

Specifically, **Black patients are 3x more likely to experience occult hypoxemia**, highlighting inherent bias in this healthcare technology

Most commercial pulse oximeters do not have built-in spectrometers to measure or adjust for skin color

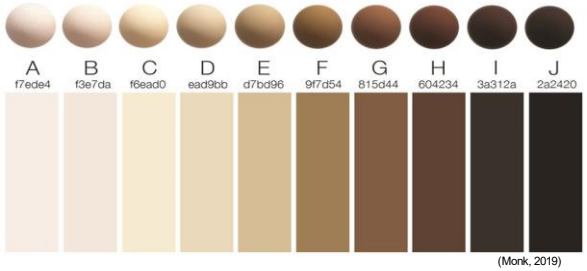


(Chesley et al., 2022; Fawzy et al., 2022)

Study Aims

Develop a spectrometer-integrated pulse oximeter to increase accuracy across all skin tones using the Monk Scale (below)

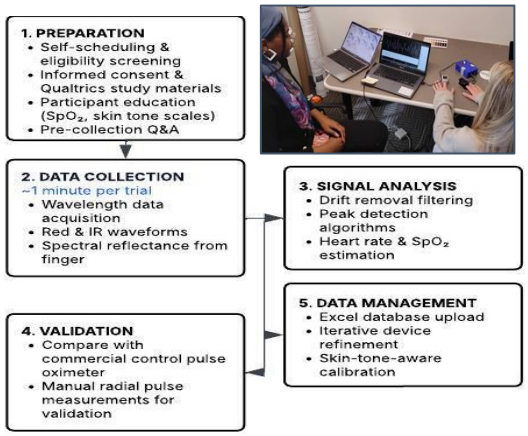
Validate an equitable pulse oximeter device via testing in healthy controls

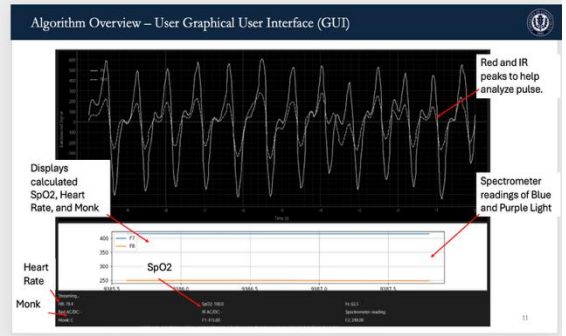


(Monk, 2019)

Methods

Prospective, cross-sectional study to assess signal quality, usability, and output behavior in healthy controls





Results

Table 1. Control Race/Ethnicity Demographics	N = 98
Race, N (%)	
White	39 (39.8%)
Black	22 (22.4%)
Asian	27 (27.6%)
Multiple races*	6 (6.1%)
Native Hawaiian or Pacific Islander	3 (3.1%)
Other	1 (1%)
Hispanic, N (%)	15 (15.5%)

Results

Of 98 healthy controls, there was variation in self-reported skin tone via Monk scale and self-report racial categories (Figure 1)

In a random sample of 51 paired comparisons, there were 14 exact matches. 80.3% fell within ±3 Monk categories (18 darker, 19 lighter) in self-report vs device- reported skin tone

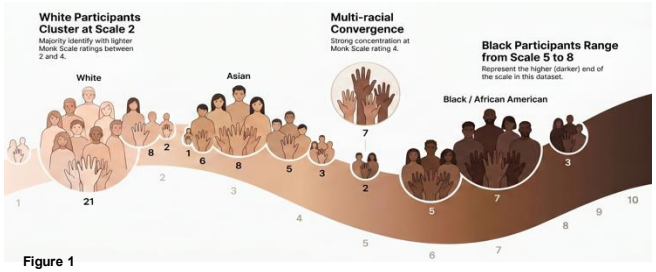


Figure 1

Heart Rate mean absolute error (MAE) exceeded expected threshold (3 bpm) across all Monk values. For SpO_2, MAE remained below expected threshold (<2%) with the exception of Monk A and B (Figure 2)

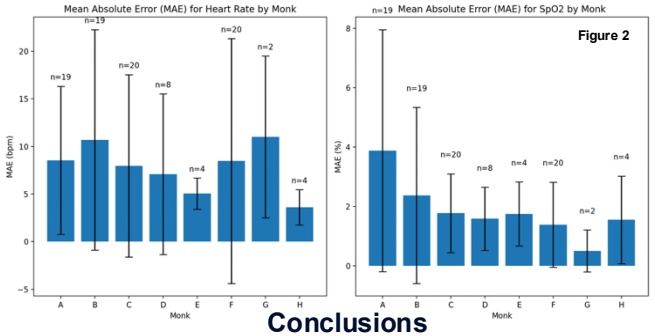


Figure 2

Conclusions

Device-calculated skin tone showed variable agreement with self-report.

SpO_2 accuracy was generally acceptable but less reliable in lighter tones, while heart rate error exceeded thresholds across all groups.

These findings support the need for improved calibration across skin tones

Significance

Results support the limitation of race as a proxy for skin tone, highlighting the importance of directly measuring skin tone using validated scales

Variability in skin tone classification and device performance highlights ongoing limitations in current monitoring technology, reinforcing the need for improved calibration

Exploring Barriers and Facilitators of Cardiometabolic Self-Management in Adults with Serious Mental Illness: A Scoping Review

Melissa Hinds, MSN, RN
Louise Reagan, PhD, APRN, ANP-BC, FAANP, FAAN, University of Connecticut Elisabeth DeLuca

Introduction

- *Adults with serious mental illness (SMI) experience >2× higher cardiometabolic mortality, largely driven by cardiovascular disease and under-addressed modifiable risk factors[1–3]*
- *Cardiometabolic self-management is constrained by multilevel barriers, including cognitive impairment, psychiatric symptoms, stigma, fragmented care, and inequitable access[4]*
- *A scoping review is needed to consolidate current evidence and identify modifiable and non-modifiable factors influencing cardiometabolic self-management in adults with SMI*
- *Purpose: To map individual, social, and systemic barriers and facilitators to cardiometabolic self-management in adults with SMI[5]*

Method

- **Design** *Scoping Review (Arksey and O'Malley; PRISMA-ScR guidelines)*
- **Data Sources:** *Searches conducted in MEDLINE/PubMed, CINAHL, PsycINFO, Scopus, and grey literature*
- **Eligibility Criteria:** *Studies including adults identified as having SMI, e.g., bipolar disorder, major depressive disorder, and schizophrenia, examining barriers and facilitators to cardiometabolic self-management, e.g., diet, physical activity, medication adherence, and metabolic monitoring.*
- **Screening Procedures:** *Titles and abstracts screened, followed by full-text review using inclusion and exclusion criteria*
- **Data Extraction**: *Standardized extraction of study characteristics and multilevel determinants*
- *Final Sample: N=24*
- **Data Analysis**: *Thematic synthesis conducted and findings mapped to individual, interpersonal, and systemic factors affecting cardiometabolic self-management*

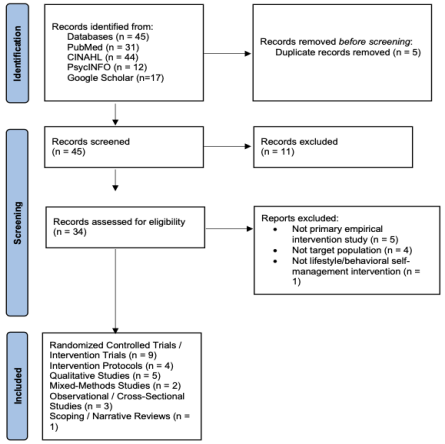


Figure 1 *PRISMA-ScR Diagram*

Results

Barriers addressed in 22 of 24 articles (92%)
Facilitators were addressed in 18 of 24 articles (75%)

Level	Description	Studies Reporting N (%)
Individual	• Cognitive impairment • Psychiatric symptoms • Medication side effects • Low health literacy/knowledge	20 (83)
Inter-personal	• Social isolation/limited support • Stigma and discrimination • Limited encouragement for healthy behaviors	17 (71)
System-level	• Fragmented care • Limited access to care/lifestyle programs • Financial barriers, food insecurity, transportation challenges • Stigma in healthcare settings • Housing instability/social determinants	21(88)

Figure 2: *Barriers to Cardiometabolic Self-Management in Adults with SMI*

Level	Facilitators	Studies Reporting N (%)
Individual	• Motivation/readiness for change • Improved insight and health literacy • Self-monitoring tools (apps, wearables) • Skills training for healthy behaviors	14 (58)
Inter-personal	• Family and peer support • Strong therapeutic relationships • Peer support specialists/ group programs	13 (54)
System-level	• Integrated behavioral and primary care models • Routine cardiometabolic screening in mental health settings • Access to community resources • Technology-supported self-management • Policies that improve access and equity	16 (67)

Figure 3: *Facilitators to Cardiometabolic Self-Management in Adults with SMI*

Implications and Conclusions

- *Self-management in SMI is influenced by multilevel factors*
- *Many barriers are modifiable yet under-addressed*
- *Integrated behavioral, primary, and social care is needed*
- *Integrated care may improve long-term cardiometabolic outcomes*

Significance

- *Addresses a cardiometabolic health equity gap by identifying modifiable barriers and facilitators in a high-risk population*
- *Supports development of evidence-based, targeted interventions*
- *Highlights nurses' role in leading equitable, person-centered, integrated care*

Limitations

- *Heterogeneity in study designs*
- *Inconsistent definitions of self-management and cardiometabolic outcomes*
- *Limited longitudinal and age-specific data, especially in SMI populations, constrained understanding of long-term impacts*

References

Pain Management in Aneurysmal Subarachnoid Hemorrhage Patients: A Program Proposal

Nonhlanhla Ngazimbi MSN, AGACNP-BC

Joy Elwell, DNP, APRN, CNE, FAAN, FAANP, Bliss DaSilva, DNP, AGACNP-BC, APRN, HNB-BC, Maria Rinaldi, APRN, MSN, ACNP

Introduction

- *Aneurysmal subarachnoid hemorrhage (aSAH) is a severely morbid and deadly acute cerebrovascular event characterized by aneurysmal rupture leading to bleeding below the arachnoid layer around the brain.*
- *It is characterized by a hallmark thunderclap headache or "worst headache of life" of which the severe and refractory headache pain plagues patients throughout the prolonged hospitalization.*
- *The literature suggests that pain is difficult to control despite multimodal opioid and non-opioid pharmacological approach.*
- **Pain is multifactorial:** *Meningeal irritation, vasospasm, hydrocephalus, cerebral edema, incisional pain related to external ventricular drain placement and/or craniotomy for aneurysmal clipping.*
- *Uncontrolled pain increases risk of in hospital morbidity and mortality*

Method

The purpose of this project is to evaluate the impact of current pain management strategies and then develop and propose a standardized evidence-based opioid and nonopioid multimodal pain management protocol.

Figure 1. Numeric Pain Scale

Theoretical Framework: Katherine Kolcaba's Theory of Comfort

- *The end goal of nursing is comfort*
- *Comfort is described as the act of soothing distress or sorrow*
- *Comfort exists in 3 forms: relief, ease, and transcendence*
- *Ensuring needs are met in four contexts: physical, psychospiritual, environmental, and sociocultural*

Figure 2. *Katherine Kolcaba's Theory of Comfort Steps to Implementation*

Procedure

1. *Retrospective medical records review over the last five years on patients at the Hartford Hospital Neuroscience Intensive Care Unit.*
2. *Inclusion criteria: awake and alert with Glasgow Coma Scale >13, Hunt Hess Score 2 and 3, aSAH on CT imaging*
3. *Evaluate pain scores as reported on numeric pain scale from admission to discharge on each patient. Evaluate what medications were administered.*
4. *Other metrics: age, sex, ethnic background, weight, and length of stay. No names or birthdays to maintain anonymity.*
5. *Run statistical analysis utilizing the Kruskal Wallis test to evaluate impact of medication regimen on pain scores.*

Results

Data collection is currently underway. Results will be processed as the data continues to roll in.

Program Proposal

- *A standardized evidence-based pain management protocol that includes a detailed and tiered algorithm.*
- *Optimizes adjunct medications with goal of opioid minimization*
  - *Corticosteroids, acetaminophen, anticonvulsants, magnesium, opioids, and Methocarbamol*
- *Warnings and recommendations present for elderly and abnormal laboratory values*

Tier 1	**Adults**	**Elderly >75yrs**
Initial orders for all non-intubated aneurysmal SAH patients reporting pain score >2 on numeric pain scale.	*Acetaminophen 975mg by mouth every six hours* *Magnesium oxide 400mg PO/FT twice daily (BID)* *Oxycodone 5mg every four hours (Q4H) PRN pain 4-6* *Oxycodone 10mg PO/FT Q4H PRN severe to excruciating pain 7-10* *Fentanyl 25mcg intravenously (IV) every two hours PRN pain 4-6 if no PO* *Fentanyl 50mcg IV Q2H PRN pain 7-10 if no PO* *If craniotomy with incisional pain or EVD placement, Gabapentin 300mg PO/FT three times daily (TID) (caution in acute kidney injury [AKI] or chronic kidney disease [CKD]) creatinine clearance (CrCl) <30 ml/min adjust to 100mg PO/FT TID*	*Acetaminophen 975mg PO/FT Q8H* *Magnesium oxide 400mg PO/FT BID* *Oxycodone 5mg PO/FT Q6h PRN pain 4-6* *Fentanyl 12.5mcg IV Q2H PRN pain 4-6* *Fentanyl 25mcg IV Q2H PRN pain 7-10* *If craniotomy with incisional pain or EVD placement, Gabapentin 100mg PO/FT TID*

Figure 3: *Exemplar of aSAH Pain Protocol Tier 1 of 3.*

Acknowledgements

Thank you to my committee, my major advisor Dr. Elwell, , Maria Rinaldi, my associate advisor, Dr. DaSilva who helped bring this project to life. You all have been such amazing support for this DNP journey, and I am so indebted to you. Also, thank you so much to Dr. Anna Cantin who helped build the protocol and Dr. Jaffa who originally created it. A special thank you to Jenn Freund for her support over the years, my entire C9i family, and my mom, Dr. Ngazimbi who supports me entirely.

References:

Scan the OR Code

Handouts also available

Beyond the Bedside: Nursing Student Capstone Experiences Bridging Correctional & Inpatient Care

Amisha Parekh de Campos, PhD, MPH, RN, CHPN, Lauren Boule, MSN, RN, NPD-BC, Amanda Moreau, MSN, RN, CHSE, Kara Parker, MSN, RN, PCCN

Introduction

- Students need a range of high-quality clinical experiences, specifically diverse populations that represent the social determinants of health
- Programs are searching for unique environments.
- Correctional healthcare settings remain an underutilized learning environment, despite offering experiences with diverse, marginalized, and medically complex populations.

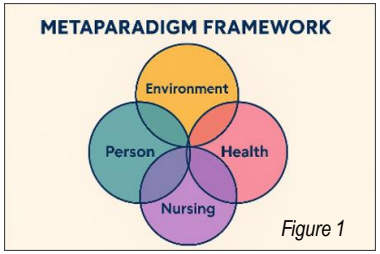
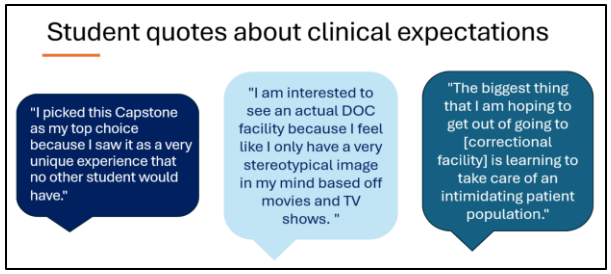
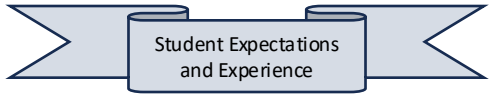


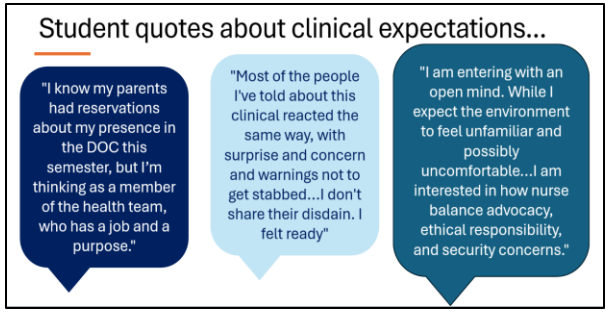
Figure 1

Methods

- Theoretical Framework used: Nursing Metaparadigm – core concepts of person, environment, health, and nursing (Figure 1)
  - Collectively guide clinical decision-making and inform holistic nursing practice.
- Application based Capstone - Personal essay describing:
  - Why do you want to be placed at the DOC?
  - What are your interests and goals for this placement?
  - Why should you be selected? What will you bring to the experience?
- Limit 4 students in group & placement based on the student's top picks.

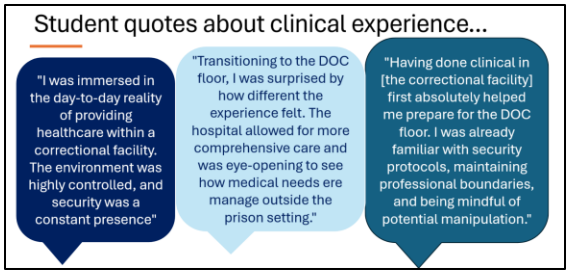


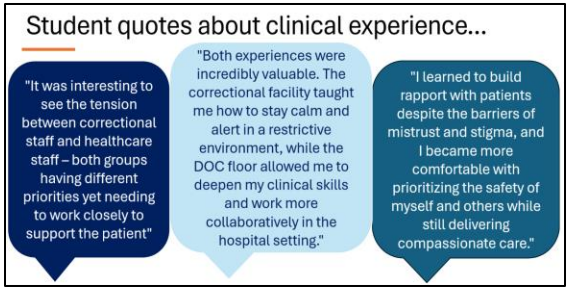




Significance

- Students need a broad range of high-quality clinical experiences
- Diverse populations representing the social determinants of health
- Programs are searching for unique environments





Conclusion

Exposure to correctional healthcare provides a unique opportunity to care for diverse, underserved, and medically complex populations, enhancing students' understanding of the nursing role across varied backgrounds. This experience strengthens critical thinking and the application of evidence-based practice, from recognizing early manifestations of illness to managing complex health conditions.

References

Acknowledgements

Thank you to the graduating Seniors who participated in this Capstone Experience, Clinical Faculty for your supervision and support and taking part clinical partnerships.

Implementation of a Pilot Mentorship Program for Novice Full-Time Clinical Instructors: An Evidence-Based Project

Sherri Hopkins MSN, RN ~ Michelle Cole DNP, MSN, RN, CPN ~ Joy Elwell DNP, APRN, FNP-BC, CNE, FAAN, FAANP ~ Jean Coffey PhD, APRN, CPNP, FAAN

Background

Mentorship is essential for a successful transition from the RN to educator role (NLN, 2022). Low confidence and role strain are linked to factors that contribute to early attrition among nurse educators (Wu & Ho, 2023). Lack of formal onboarding and orientation for nursing faculty is connected to decreased self-efficacy among novice nursing clinical instructors (Hansbrough et al., 2023)

Problem

Rapid growth within the School of Nursing was supported by the hiring of 20 clinical instructors, creating an increased demand for mentoring resources.

Aim

Evaluate the effectiveness of a peer-led group mentorship program grounded in the National League for Nursing Core Competencies and Bandura's Theory of Self-efficacy.

Methods

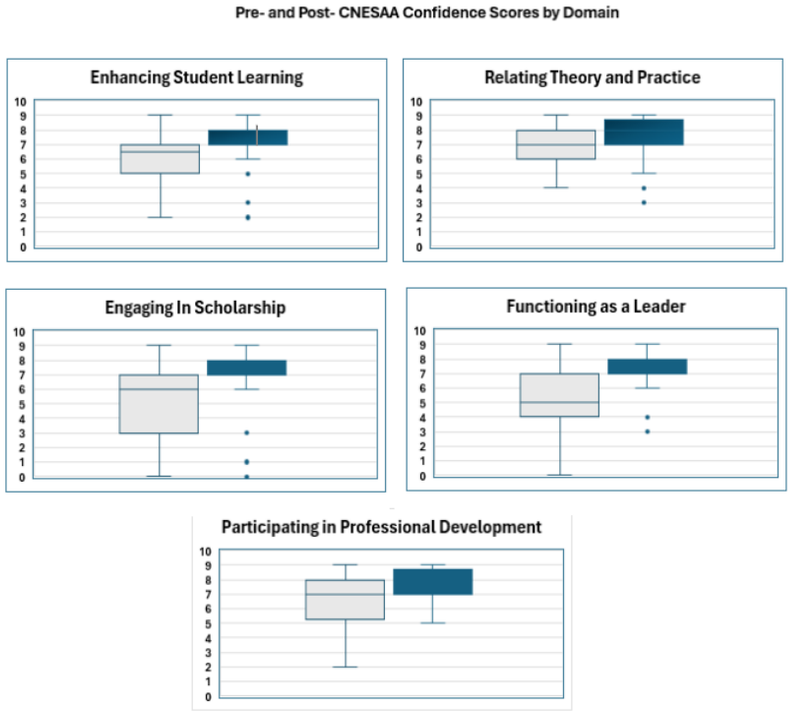
Setting: Elisabeth Deluca School of Nursing
Population: Clinical Instructors with less than 5 years of full-time teaching experience (n=15)
Intervention: Four 45-minute peer-led group mentorship sessions

- Meeting 1: Enhancing Student Learning
- Meeting 2: Applying Theory and Practice
- Meeting 3: Engaging in Scholarship
- Meeting 4: Acting as a Leader & Professional Development

Assessment:
Clinical Nurse Educator Skill Acquisition Assessment (CNESAA)
Pre- and post-confidence scores
Three open-ended questions

Results

Pre- and post-CNESAA survey (n=12)
Open-ended responses (n=11) Benefits of collaboration (n=3); different perspectives (n=3), Peer support (n=5), and access to resources (n=2).



CNESAA Pre- and Post-Mentorship Confidence Ratings Across Five Domains. Ratings range from 0-9; higher scores indicate higher perceived confidence.

Figure 1: Mean confidence scores increased across all domains

Discussion

The post-intervention CNESSA means were higher, indicating growth in all areas. Instructors had a minimum of 3 years of teaching experience, which may have contributed to the high confidence observed before the intervention. Requests for continued mentorship with suggestions to expand open dialogue suggest there is a continued need for further mentorship

Conclusion

The program provided necessary mentorship to Clinical Instructors in an efficient, cost-effective manner, supporting nursing excellence

Significance for Practice

Future direction may include providing the NLN Clinical Nurse Educator Certification preparation
Strategy for faculty retention
Improved sense of community
Opportunities for scholarly group projects
Improved teaching effectiveness → enhanced student learning

Providing group mentorship and aligning sessions with the NLN standards of excellence promote high-quality instruction while simultaneously providing peer support and opportunities for collaboration.

References

A Nurse Practitioner-led QI Project to Combat Antimicrobial Resistance

Sunitha Abraham, MS, FNP-BC, University of Connecticut School of Nursing

Joy Elwell, DNP, FNP-BC, APRN, CNE, FAAN, FAANP Valerie Kiefer, DNP. APRN, ANP-BC, Jennifer Agatep, MS, AGACNP-BC, CEN, Eileen *Reid, FNP-BC*

Introduction

- Antimicrobial resistance (AMR) stands as an invisible yet rapidly advancing pandemic that poses a dire threat to global health, security, and development.
- The misuse of antibiotics has led to the emergence of multidrug-resistant pathogens, posing a significant challenge to treatment and increasing the risk of fatal outcomes (World Bank Group, 2024).
- Antibiotics can disrupt the delicate balance of the gut microbiome, paving the way for various chronic health issues (Fishbein et al., 2023). In emergency departments (EDs), urinary tract infections (UTIs) account for the majority of antibiotic prescriptions.
- Each year, AMR contributes to over 35,000 deaths in the United States alone, with the CDC estimating that addressing the threats posed by AMR could incur more than $4.6 billion in healthcare costs annually (CDC, 2024a; CDC, 2024b). In response, the World Health Organization (WHO) is committed to reducing human deaths related to AMR by 10% by the year 2030 (WHO, 2024b).
- The theoretical proposition under examination is whether the retrospective application of an evidence-based guideline—advocating for the discontinuation of empirical antibiotics in patients with negative urine cultures—can increase the number of antibiotic-free days while ensuring patient safety.

Method

A multicenter retrospective observational study of patients discharged from the ED on empiric antibiotics for suspected UTI and later had a negative urine culture. The primary objectives were to develop an evidence-based guideline and validate it through a retrospective chart review to establish the safety of discontinuing antibiotics.

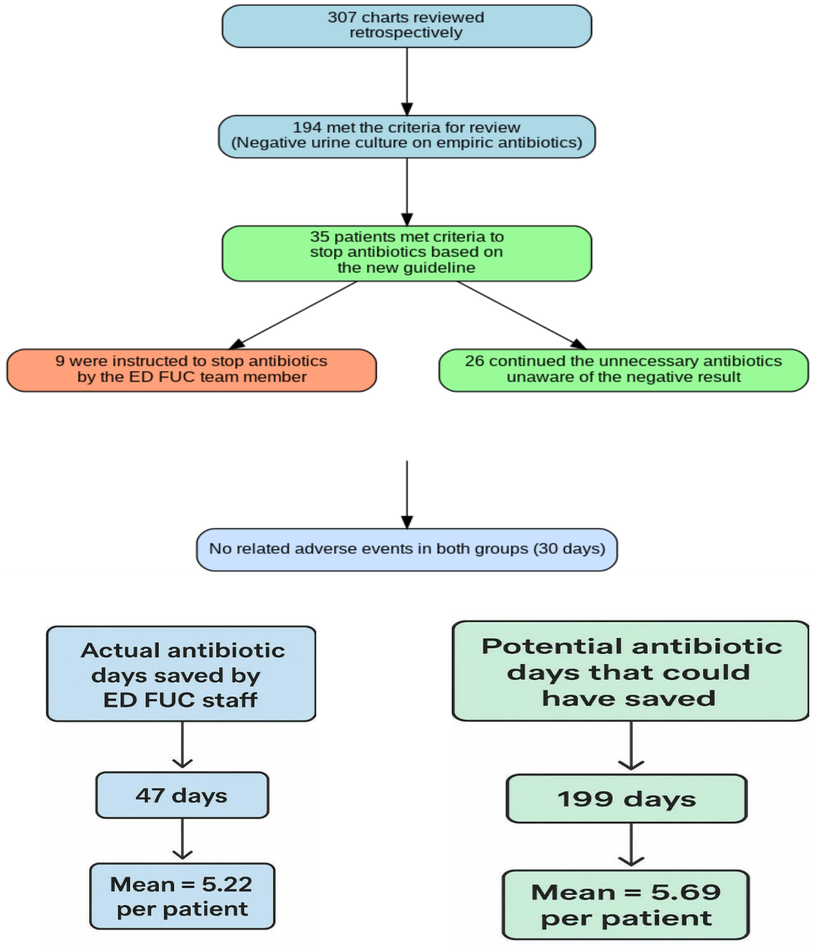
Data were collected from the EHRs of patients from five EDs and the VUC of a NY metropolitan hospital system. Over a 12-month period, 307 charts were reviewed, and new evidence-based guideline was applied. Only 35 patients were deemed eligible to stop antibiotics safely.

Procedure

1. Development of the new evidence-based guideline in collaboration with ID, ASP, ED chief, departmental leaders, and the quality safety officer
2. Development of a RedCap audit tool in collaboration with the statistician
3. Validation of the guideline by retrospective chart review to establish safety.

The evidence-based guideline

Results



Conclusion

74% of patients were unaware of their negative test results and inappropriately continued their antibiotics. This not only poses a risk to their long-term health but also threatens our environment (Ye et al., 2024; Tang et al., 2023). There is potential to save an average of 5.69 antibiotic days per patient.

Ensuring that patients are promptly informed of their negative urine culture results and screened for safe discontinuation of the treatment, we can effectively halt unnecessary antibiotic prescriptions. This could prevent potential long-term complications and aid in combatting AMR.

Significance

Antimicrobial Resistance (AMR) is a quietly advancing pandemic that threatens to thrust us back into the dark ages of medicine, where simple infections could once again become life-threatening (WHO, 2024). The rampant overuse of antibiotics is a primary driver of this crisis. The Infectious Diseases Society of America (IDSA) strongly advises against routine screening and treatment of Asymptomatic Bacteriuria (ASB) except for the high-risk populations (Colgan et al., 2020).

However, this situation is largely preventable. Nurse Practitioners (NPs) are uniquely positioned to champion transformative change within our clinical environments. This Quality Improvement (QI) initiative aims to address a critical gap in our current practices, enabling us to take proactive steps in combating this urgent public health issue.

References

Relationship Between Nurses' Knowledge and Self-Efficacy in Pain Management

Wilfred Elliam, Stephen Walsh, Wanli Xu

Introduction

- Nurses' self-efficacy (SE) and knowledge about pain management are recognized as key determinants of high-quality, evidence-based care[1]
- Previous studies have reported unsatisfactory pain management knowledge score (36.7 ± 6.9%)[2] and SE (46.17 ± 16.69)[1,3] among nurses and examined constructs independently[4,5]
- Unclear which demographic and professional factors predict these competencies or how knowledge, education level, and experience interact to influence SE in clinical practice

Purpose

- To explore what demographic variables (education level, role, length of credential/licensure) are associated with pain management knowledge and pain management SE
- To investigate the possibility of an association between pain management knowledge and SE after controlling for demographic variables

Theoretical Model

Bandura's Self – Efficacy Theory (SET)

Method

Design: Cross-sectional survey study

Procedure:

- Email addresses of RNs and APRNs were obtained from the CT Board of Nursing
- 10,000 APRNs and RNs were randomly selected
- Email invitations, including link to the Qualtrics survey, were sent between October 2024 and August 2025
- Participants had the option to enter a raffle through a separate, unlinked form

Data Analysis

- Multiple Linear Regression done in SPSS to investigate possibility of association between pain management knowledge and SE after controlling for demographic variables
- Pearson's correlation analysis to examine the association between pain management self-efficacy and knowledge scores

Results

Demographic Data

	Mean (SD)
Age	45.7(13.1)
Years Licensed/Credential	10.8(6.4)
	N (%)
Sex: Female	210 (90.5%)
Race	
White	24 (10.3%)
Black	180 (77.6%)
Asian	6 (2.6%)
Ethnicity:	
Hispanic	12 (5.2%)
Professional Role	
RN	168 (72.8%)
APRN	63 (27.2%)
Education	
Diploma	7(3.0%)
Associate	15(6.4%)
College	106(45.5%)
Master	81(34.8%)
PhD/DNP	24(10.3%)

Association Between Pain Management Knowledge and Self-Efficacy Scores

	r	p
Pain Management Knowledge/ Self-Efficacy Scores	0.015	0.82

Association Between Pain Management Knowledge and SE after Controlling for Demographic Variables

	β	p
Pain Management Knowledge	0.007	0.92
Education Level	-0.025	0.75
Professional Role	0.025	0.76
Years of Licensure/Credential	-0.003	0.97

Participant Characteristics & Outcome Measures

	Pain Management Knowledge			Pain Management Self-Efficacy		
	Mean (SD)	f	p	Mean (SD)	f	p
Education		1.6	0.17		0.6	0.66
Associate	80.0 (1.0)			85.7 (9.7)		
Diploma	79.9 (10.8)			85.8 (9.7)		
Bachelor	80.6 (9.7)			87.4 (11.7)		
Masters	80.2 (9.7)			85.1 (13.8)		
PhD/DNP	83.5(9.0)			88.1 (12.4)		
Professional Role		1.9	0.17		0.6	0.40
RN	79.9 (9.9)			85.5 (12.4)		
APRN	82.9 (8.5)			85.9 (12.7)		
Years Licensed		2.1	0.10		0.4	0.79
< 5	79.6 (8.6)			85.7 (12.5)		
5 - 9	81.9 (9.7)			85.8 (11.1)		
9 - 15	80.9 (13.4)			87.4 (15.0)		
≥15	81.9 (8.9)			85.2 (12.3)		

Implications

- Future studies should focus on environmental factors such as workplace support and mentorship on pain management
- Health facilities should provide continuing pain management competency training to nurses
- Nursing education should include skills training in pain management

Conclusion

- Findings suggest professional role, educational attainment, and years of licensure/accreditation do not substantially influence nurses' pain knowledge and SE in pain management.
- Caution should be taken when interpreting the findings due to low Chronbach's α

Simulated Mock Codes in The Acute Care Setting

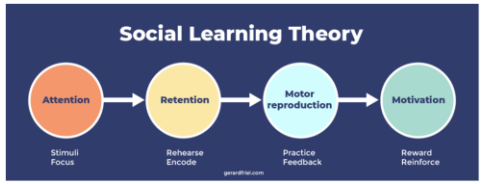
Yara Mendez, MSN, RN, CCRN, DNP Candidate. University of Connecticut

Jessica Palozie, DNP, APRN, ACNP-BC, CNE, Major Advisor, Rosemary Swanke, DNP, APRN, ACNP-BC, ACNS-BC, Associate Advisor, James Behme, Mentor

Introduction

- *Cardiac arrest requires rapid, coordinated response, yet high-stress environments can lead to delays and performance gaps.*
- *Mock codes provide safe, effective method to improve ACLS/BLS skills, teamwork, and clinical decision-making.*
- *The Covid-19 pandemic caused a significant decline in in-person simulation training, limiting practice opportunities.*
- *Post pandemic gaps identified hesitancy in response, delayed rhythm recognition, delayed defibrillation, delayed ETCO2 application, and poor role clarity.*
- *Inpatient cardiac arrest mortality remains high (up to 80%), emphasizing the need for improved preparedness.*
- *Evidence and RQI recommendations support simulation with deliberate practice and structured debriefing to improve outcomes.*

Theoretical Framework



(*What is Social Learning Theory, Why Use It in E-Learning, and How? Dember, 2023).*

Method

- **Design & Participants**: *Interprofessional staff (RN, APRN, MD/DO, RT, PharmD) at UConn Health. Participation was voluntary (N=30).*
- **Setting**: *Academic Hospital. In situ simulations on two inpatient units using high-fidelity mannequin.*
- **Intervention**: *Structured mock codes (prebrief, simulation, debrief) conducted Oct 2025. ACLS/BLS scenarios with ROSC were achieved.*
- **Evaluation Tool**: *SET-M (19-item, Likert scale) assessing prebriefing, learning, confidence, and debriefing. Shows strong reliability.*
- **Analysis & Ethics**: *descriptive and inferential stats (t-test, ANOVA, p<.05) using SPSS. IRB approved. Anonymous data collection.*

Clinical Timeline

Procedure

- **Implementation Period**: *Simulated mock codes were conducted September-October 2025. Occurred across inpatient units with manager collaboration and scheduling coordination.*
- **Interprofessional Simulation Setup**: *High-fidelity mannequin and monitor were used to simulate real-time patient conditions. Simulation coordinator and technician managed scenarios, vitals, and rhythms.*
- **Mock Code Execution**: *Two in-situ mock codes completed October 14 and 28, 2025. Key stakeholders (nursing, leadership, emergency response teams, fire department) notified prior to events.*
- **Participation Preparation**: *Staff recruited via hospital-wide communication. Voluntary participation with consent obtained. Structured prebriefing included role assignment and equipment orientation.*
- **Performance Metrics Evaluated**: *Time to emergency activation, team response, CPR initiation, rhythm recognition, defibrillation, and ETCO2 application. Monitored ACLS/BLS skills performance with ROSC outcomes.*
- **Debriefing & Evaluation**: *Structured 10-minute debriefings facilitated reflection, feedback, and learning. Participants completed demographic forms and SET-M to evaluated simulation effectiveness.*

Results

- **Sample (N=30)**: *70% female. 30% male. Majority aged 25-44 (70%). Two mock code sessions with 15 participants each.*
- **Interprofessional Representation**: *RN (50%), APRN (6.7%), MD/DO (13.3%), RT (13.3%), CNA (10%), PharmD (3.3%), ASA (3.3%).*
- **Experience & Education**: *Wide range of clinical experience (<1 year to >15 years). Majority of RNs held BSN degrees. APRNs held MSN degrees. Physicians/pharmacist held doctoral degrees. CNAs held HS diplomas. RTs were mixed with ASN and BSN degrees.*
- **Mock Code Participation**: *53.3% participated in mock codes and 46.7% have not participated in mock codes (most notably the MDs/DOs).*
- **SET-M Outcomes**: *No significant difference between prebrief vs learning and confidence. Significant improvement in debrief scores (p=.046).*
- **Role-Based Findings**: *RNs/APRNs reported highest benefit from debriefing (p=.062). Suggesting strong alignment with real clinical roles.*

Conclusion

- *High census, patient acuity, staffing constraints, and limited unit resources impacted simulation implementation.*
- *Structured prebriefing, simulation, and debriefing model enhanced ACLS/BLS competency and psychological safety.*
- *Simulation improved clinical judgment, critical thinking, and confidence in emergent response.*
- *Associated with improved patient outcomes.*
- *Debriefing provided critical reflection, feedback, and skill reinforcement.*
- *Sustainability supported through protected time, strategic scheduling, and interdisciplinary collaboration.*

Significance

Debriefing demonstrated the greatest impact, with significantly higher scores compared to prebriefing (p=.042), highlighting the value of structured reflective discussion.

Nursing professionals derived the greatest benefit from debriefing (p=.062), likely due to their central role in real-time patient care.

- *Nurses were first responders in 86.7% of events, reinforcing their critical role in early recognition and intervention during cardiac arrest (Kuzma et al., 2020).*
- *Simulation supports patient safety by allowing skill development and error reduction in a risk-free environment (Janse van Vuuren et al., 2018).*

Acknowledgements

- *Thank you Dr. Palozie, Dr. Swanke, Jim Behme, and Dr. Mahon for all your guidance and support. It is truly appreciated.*

References

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