PROBLEM INTRODUCTION
High incidence of excessive sympathetic outflow activity in many traumatic brain injury (TBI) patients.

• Approximately 8% to 33% of TBIUs acquire paroxysmal sympathetic Hyperactivity (PSH).

The lack of clear definition or terminology of the paroxysmal sympathetic hyperactivity (PSH).

High incidence in severe TBI patients = increased morbidity, mortality, healthcare and societal costs.

• The term Paroxysmal Sympathetic Hyperactivity (PSH) was introduced by a consensus group in 2014 and the Paroxysmal Sympathetic Hyperactivity Assessment Measure (PSH-AM) tool was developed and can be useful in the diagnosis and management of TBI patients.

Lack of integrating evidence-based practice and continuing education in a surgical trauma intensive care unit (STICU).

• Multifactorial: Cost, turnover, perceived need of education, professional accountability, system constraints, and the trauma’s team data with increase in TBI bounce back of patients to the ICU experiencing PSH symptoms.

PURPOSE
This quality improvement project's purpose is to improve the bedside care of TBI injury patients in the STICU by preventing secondary brain injury through early identification and management of PSH. The literature was comprehensively evaluated and provided evidence-based information for the project.

LITERATURE REVIEW

Search strategy and keywords:
Full-text
English
adult population (>18 years of age)
paroxysmal sympathetic hyperactivity (PSH)
autonomic dysregulation
sympathetic storm
Dysautonomia
Traumatic brain injury (TBI), acquired or acute brain injury (ABI).

All articles identified the most common symptoms of PSH as:
- Tachycardia
- Tachypnea
- Hypertension
- Hyperthermia
- Diaphoresis
- Extremity motor posturing.

CINAL, Medline, PubMed

Literature notes that greater than 80% of the paroxysmal episodes in TBI or acquired brain injury patients are related to allostatic responses to noxious and non-noxious stimuli like suctioning, pressure sensations, and noise to name a few.

Studies recognized:
- Symptoms could occur within the first 5 days of admission.
- Symptoms can last up to one year, post injury.
- Symptom management is important throughout all transitional phases in the acute care setting.

PROJECT METHODS

Internal Review Board deemed this a quality improvement (QI) project. Key stakeholders were identified.

Project objectives and outcomes were discussed in detail with key stakeholders prior to project role out to healthcare providers working in the STICU setting.

Probability of increased awareness early identification and management of PSH in TBI patients.

EVALUATION

10 completed surveys and total of 63 participants, 27 out of 63 (42.43)%.

The overall goal was to increase the awareness of symptoms of PSH through educational initiatives, a tool was developed.

Implementation. Post presentation, there were small improvements with early identification and management. Further research and evidence is needed in the utilization of the PSH-AM tool in the acute care setting as well as protocol development for PSH in TBI patients.

IMPACT ON PRACTICE

❖ Immediate impact: Early recognition of the signs and symptoms of PSH in the TBI patient population.

❖ Earlier identification of symptoms allowed for appropriate medication management of this syndrome and likely prevented worsening outcomes.

❖ Nursing care was adjusted to prevent provocation of PSH symptoms and to meet patient and family care needs.

❖ Predicted long-term impact: Utilizing the literature provided in this educational quality improvement project to identify PSH early in TBI patients and provide evidenced based care and medical management in the prevention of secondary brain injury or worsening outcomes.

❖ Ongoing education for staff to adequately assess and care for these patients is vital.

CONCLUSIONS

❖ Data gathered from this quality improvement project indicates that knowledge attainment can be achieved with presenting new evidence on TBI care management and engaging educational seminars in the intensive care setting.

❖ Educational seminars on PSH should be provided to nurses and new healthcare professionals caring for TBI patients.

❖ Key stakeholders and leadership partners should maintain urgency in the early identification and management of PSH in TBI patients.

❖ Further research and evidence in the utilization of the PSH-AM tool in the acute care setting as well as protocol development for PSH in TBI patients is needed.
**Introduction of a Spinal Care Pathway Triage Protocol in the Secondary Care Setting**

Tonicia I. Boston, MSN, RN, PM-DNP Candidate
Southern Illinois University Edwardsville

**PROJECT METHODS**

**Setting:** Neuroscience Institute (NSI)-Multidisciplinary Spinal Care Program

**Participants:** NSI Healthcare Providers (HCPs) specializing in Chronic Back Pain Management

**Design:** Evidence-Based Quality Improvement (EBQI) Project

**Review of current literature including evidence-base care pathways**

**IPC equipped SCP Synchronize Care for CBP Adult Patients ≥ 18 years old**

**Interprofessional Collaborative Framework**

**Anonymous Surveys:** Pre-Implementation (June-July 2022) Post-Implementation (August-December 2022)

**EVALUATION**

Key Metric: Pre-Implementation Survey Question Satisfied with the CURRENT triaging process for patients with chronic back pain (CBP) [N=11]

- **Disagree:** 27%
- **Agree:** 9%
- **Neutral:** 64%

**Participants:**
- N=19 NSI HCP’s were invited to participate
- N=11 NSI HCP’s participated in pre-implementation survey
- N=7 NSI HCP’s participated in post-implementation survey

**Post-Implementation Results:**
- 57.14% agreed, and 42.86% highly agreed that the SCP e-tool will be helpful in triaging their CBP patients to the most appropriate care modalities to decrease pain and increase functionality.
- Approximately, 85% agreed or highly agreed that they were willing to adopt a SCP to streamline the delivery of care for CBP patients.

**Limitations:**
- Small sample size
- NSI department underwent restructuring of clinic flow (neurosurgeons changed location)
- Time constraints disallowed personal training sessions on E-Tool utilization

**SEARCH Databases:** Medline, CINAHL Plus, CJNL, EMBASE

**Evidence Based Delivery of Care Method for CBP Patients**

**Burden of Chronic Back Pain**

**Interprofessional Collaboration for CBP Care Management**

**PROBLEM INTRODUCTION**

**Purpose:**
- To integrate a Spinal Care Pathway (SCP), electronic decision support tool (e-tool) into a multidisciplinary spinal care program
- Improve providers’ satisfaction with care delivery and their satisfaction with CBP patient outcomes.
- Decrease variability in care process.

**BACKGROUND:**
- Back pain leading cause of disability worldwide.
- Back pain contributes $365 billion in all-cause medical costs.
- Cohesive multidisciplinary care for clients with chronic back pain (CBP) continues to be challenging.
- Improper CBP care management creates personal, economic, and societal burdens for patients, their families, & healthcare system.
- Care Pathways: Effective at positively impacting patient outcomes

**LITERATURE REVIEW**

**CONCLUSIONS**

**IMPROVED WORKFLOW & STREAMLINING**
- Electronic Clinical Decision Support Tool [E-Tool]
- Point of Care
- Decreased Variability in Care

**SYNCHRONIZED DELIVERY OF CARE**
- Improve CBP Care Management
- Improve Interprofessional Collaboration

**IMPROVED HCP’S SATISFACTION**
- Patient Health outcomes (Pain & Disability)
- Multimodal & Multidisciplinary Collab. Process

The SCP e-tool is a novel, electronic clinical decision support tool that will provide an evidence-based method to improve delivery & quality of care for CBP patients. The results of this EBQI project revealed clinical relevance to support the integration of the SCP e-tool into the NSI’s secondary clinical practice setting.
**New Graduate Nurse Professional Development Planning Meetings – Key to Retention**

Cassandra Adkins, MSN, RNC-OB
Southern Illinois University Edwardsville

**PROBLEM INTRODUCTION**

- Criteria For ANCC Transition to Practice Program (2020)
  - Identification of knowledge, skills or attitudes related to professional role
  - Identification of incremental goals as part of longitudinal plan
- Lack of Formal Process to Identify Longitudinal Plan
  - Leaves new graduate nurses feeling unsupported in journey from novice to expert
- Regular Touchpoints
  - Implemented to increase feeling of support
  - Less likely to leave place of employment (Koneri et al., 2021)

**LITERATURE REVIEW**

- Literature review exploring various types of support for new graduate nurses
- Difficult to find literature focused specifically on professional development planning for new graduate nurses
- Transition to Practice Programs:
  - Additional Opportunities to support new graduate nurses:
    - Supplemental Support: Addition of modules, messaging apps, interactive exercises & immediate peer support increased confidence & self-efficacy
    - Resiliency Education: Potential positive impact on patients & staff satisfaction, retention & turnover costs
    - Peer Support program: Reported most satisfying part of work environment
    - Regular touchpoint program with professional development focus: Increased retention

**PROJECT METHODS**

- Project Aim: Implement regular professional development planning meetings with new graduate nurses to improve new graduate nurses’ intent to stay within the organization and feeling of support.
  - Literature Review: Increase support and retention
  - Stakeholder Identification & Identification of New Graduate Nurses
  - Enrollment of New Graduates in Transition to Practice Program
  - Initiation of monthly professional development planning meetings
  - Data collection & evaluation

**IMPACT ON PRACTICE**

- Increased feeling of support by New Graduate Nurse
- Increase New Graduate Nurse intent to stay / retention

**CONCLUSIONS**

- Transition to Practice Programs are an integral part of the new graduate nurse experience
- Inclusion of professional development planning meetings in the first year of practice has the potential to positively impact the New Graduate Nurse experience
- Potential for increased engagement in future professional development activities, retention, and perception of support

**EVALUATION**

- Casey-Fink New Graduate Nurse Experience Survey
  - Intent to Stay
    - * Positive organization enculturation
    - * Positive peer support
  - * 100% report intent to stay at 1 year
  - * 78% report intent to stay at 3 years
- Intent to participate in future professional development activities
  - * 78% intent to precept
  - * 85% intent to obtain certification
  - * 42% intent to participate in career ladder program

**LIMITATIONS**

- 15 new graduates enrolled – despite frequent attempts, 6 did not participate
- Turnover of educators/professional development coordinators at facility
Enhancing Communication Pathways Between Care Environments to Improve Patient Outcomes
Heather Tucker, MSN, RN-BC, NEA-BC Southern Illinois University Edwardsville

PROBLEM INTRODUCTION
- Transfer of information in healthcare is often completed using electronic communication through the electronic health record (EHR).
- Adverse safety events, such as medication errors, hospital readmissions, and unnecessary emergency department utilization may occur during transitions of care when the transfer of information between healthcare teams does not occur.
- This project aimed to enhance communication through electronic communication methods between acute care and primary practice nurses at the time of patient discharge from the hospital setting.

PURPOSE STATEMENT
- The purpose of this project was to reduce adverse patient outcomes such as hospital readmissions and unnecessary emergency department utilization by developing an electronic communication hand-off tool that promotes information exchange between acute care to primary practice nurses.

LITERATURE REVIEW
- Communication between the acute care and community setting is substantially important to prevent adverse outcomes, promote safety in care transition, and ensure quality outcomes.
- Discharge communication is often automated but limited to review by the primary care physician only, excluding the remaining care team that is involved in the patient’s care delivery.
- Communication relay must occur among all care team members, including nurses. Nurses service as fundamental partners in communication pathways, adding value and enhancing outcomes in critical situations for patients in care transitions.
- Open communication and collaboration will strengthen rapport and care coordination between care environments. Impaired communicated between care entities is directly linked to cause of readmission.
- Communication should be standardized when used between care environments to avoid information omission and prevent adverse events.
- Standardizing communication among nurses at the time of care transition is recommended.
- Communication utilized at the time of discharge should include direct observations from the hospital stay and comprehensive assessment of the patient.

PROJECT METHODS
- The project site lacked a communication pathway between the acute care and primary practice nurses to utilize when patients transition from the hospital into the community.
- Team/key stakeholders included a Doctoral nursing student, acute care and primary practice nurses, acute care and primary practice RN Supervisors, Director of Quality, EPIC IT Support Team, and participant patients.
- Literature review was conducted identifying twenty references to support the project focus.
- An electronic communication tool was developed for acute care nurses to supply primary practice nurses information related to mutual patients being discharged from the hospital setting.
- The project site was a 24-bed critical access hospital in Central Illinois with implementation involving a medical/surgical unit and five ambulatory care locations.
- A project team, with EPIC support, developed an electronic patient communication tool.
- Education was completed with acute care and primary practice nurses prior to project implementation.
- Pre and post-survey analysis was completed by acute care and primary practice nurses. Post-survey feedback indicated care regarding mutual patients is purposeful to prevent negative outcomes.

EVALUATION
- Acute care and primary practice nurses participated in pre and post-surveys.
- Surveys included evaluation of current communication methods and perceptions of communication among the two care environments.
- Pre-survey results represented an absence of communication between environments.
- Post-survey results represented positive perception of the electronic communication tool.
- Patient outcomes were tracked during project implementation. The electronic communication tool had a utilization rate of 86%. Hospital readmission was 2.3% and emergency department utilization was 2.3% for the data analysis group.

IMPACT ON PRACTICE
- A standard, electronic communication tool was provided within the EHR in order to support communication between care environments at the time of hospital discharge.
- Communication shared between acute care and primary practice nurses enhanced the care of the patient by eliminating otherwise absent communication regarding the patient’s hospital admission.
- Feedback received directly from project team via post-survey included but not limited to:
  - “I think the discharge notes from the acute care nurses are very helpful.”
  - “I suggest we continue this current process.”
  - “Internal communication assists me in providing patient care after discharges. It gives me the information needed to determine how soon follow up is needed and any care that pt may need at home.”

CONCLUSIONS
- Standardized hand-off of patient information from the acute care setting to post-acute providers will reduce information omission and prevent hospital readmission.
- Hand-off communication among the healthcare team can prevent or reduce adverse events and improve patient outcomes during hospitalization, and at discharge when transitioning back to the community.
- Acute care and primary practice nurses found value in enhanced communication through the electronic health record (EHR).
Increasing Knowledge and Awareness of Individuals Who Identify as Transgender in Primary Care
Cindy Wallace MSN, FNP-BC, AAHIVS

PROBLEM INTRODUCTION
• 1.6 million people in the United States identify as transgender (CDC, 2022)
• Lower rates of healthcare seeking behaviors among individuals who identify as transgender due to the stigma conveyed when accessing the healthcare system
• There is a lack of LGBTQ specific knowledge by medical providers

PURPOSE
• To increase awareness and provide education of the primary care needs in the transgender population.

CONCEPTUAL FRAMEWORK
Unfreeze → Change → Refreeze

LITERATURE REVIEW
Four Main Themes
- Knowledge Gaps
- Transphobia
- Barriers to Care
- Patient Experiences

PROJECT METHODS
Pre-test → Education → Post-test

EVALUATION
• Mean scores for pre-test and post-test were calculated using Microsoft Excel
• Differences among means were analyzed for clinical significance

PROJECT METHODS
Pre-test → Education → Post-test

IMPACT ON PRACTICE
- Increased awareness and education in the care of this special population and
- Created a space for providers to learn and ask questions in a non-judgmental atmosphere with open dialogue
- Provided a sample guideline for healthcare practitioners to deliver high quality gender affirming care

LIMITATIONS
- Small Sample Size
- Project Leader's Site
- Increased Transgender Patients
- Time/Schedule Constraints
- Zoom Participants non-adherent to coding instructions

FUTURE RESEARCH NEEDS
- Patient Perspective
- Other Primary Care Clinics
- Faculty/Student Perspective

REFERENCES
www.cdc.gov/hiv/clinicians/transforming-healthcare-provider-affirmative-care.html Patient-Centered Care | For Healthcare Providers | Transforming Health Care | Clinical HIV CDC