

2026

QUALITY CAPSTONE PROJECTS

Improving Patient Care Through Innovation, Quality, and Compassion

NHA | NEBRASKA HOSPITALS

Structured Documentation in High-Risk Care

York General Hospital, York, NE
Bridget Burgess, BSN, RN | Quality and Infection Prevention Coordinator

YORK GENERAL
Our Focus is You.

Background

- 25-bed Critical Access Hospital located in Central Nebraska
- Chart reviews identified an opportunity to improve structured documentation. As we transition to Epic, structured documentation is essential to ensure accurate data migration, support clinical decision-making, and strengthen reporting and regulatory compliance.

Aims

To support a safe transition to Epic, we aim to achieve ≥90% structured documentation across high-risk care areas, beginning with consistent, policy-aligned documentation and communication of critical results in Round 1.

Team

- CNO
- Director of Quality
- Quality and Infection prevention Coordinator
- ED Director
- Med Surg. Director
- OB Director
- Frontline Nursing Staff

Plan

- Audit baseline documentation & Identify gaps.
- Deliver focused education & Policy Review.
- Continue chart audit and compare results.
- Refine workflow and prepare for the next round.

Measure

- Use of structured fields for High-Risk areas
- Reduction in free text
- Audit for policy compliance + staff knowledge

Next Steps

- Sustain gains & address remaining workflow variation.
- Prioritize workflow review, individual structured-field coaching, and follow-up audit.
- Confirm focused support closes the gap.
- Identify and repeat process for Round two. Anticipated to start in October with the start of FY27.

Results

Documentation improved each quarter and is approaching the 90% target

FY2026 OVERALL

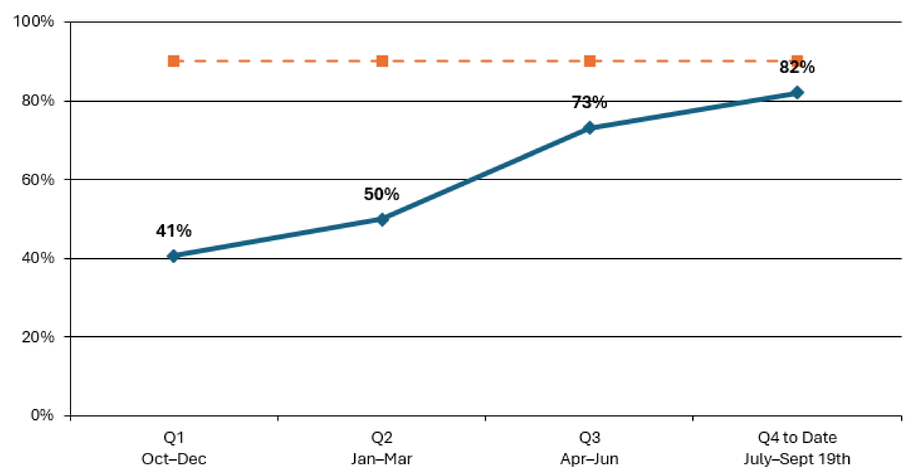
63.3%

documented

695 documented

393 not documented

n = 1098 critical labs



+41 percentage points from Q1 to Q4-to-date

Source: FY2026 Critical Results Surveillance dashboard. Data through Sept. 19, 2026.

YORK GENERAL

Streamlining Employee Tuberculosis Screening

Cozad Community Health System

Background

- 20-bed Critical Access Hospital located in Cozad, Nebraska
- Review of the new hire onboarding process identified inefficiencies in employee TB screening
- New hires were required to return to the hospital multiple times to complete the two-step tuberculin skin test (TST) process
- Multiple visits increased Employee Health workload and administrative burden
- Missed return appointments created barriers to timely screening completion
- Opportunity identified to streamline the process while maintaining compliance with TB screening requirements
- QuantiFERON-TB Gold testing was selected as an evidence-based alternative to replace the two-step TST process
- Goal: Improve efficiency, reduce employee visits, and simplify onboarding while maintaining compliance

Plan

- Streamline the new hire onboarding process by integrating TB screening into a single Employee Health visit.
- Implement QuantiFERON-TB Gold testing as the standard TB screening method for all new hires.

Screening Method	Average Visits Required
Two-Step TST (Baseline)	4
QuantiFERON-TB Gold	1

Results

- Employee Health visits reduced from **4 visits to 1 visit per new hire**
- Maintained **100% TB screening compliance**
- Streamlined new hire onboarding process and reduced Employee Health follow-up and scheduling burden

🧪 TB Gold Testing

✓ One blood draw

✓ One visit

✓ No return appointments

✓ Faster onboarding

✓ Maintained compliance

Aims

Achieve 100% compliance with required TB screening for all new hires by replacing the 2-step TST process with QuantiFERON Gold-TB testing.

Measure

- TB screening completion rate
- Employee Health visits per screening
- Time to complete TB screening

Next Steps

- Continue annual **monitoring of TB screening** compliance.
- Review laboratory turnaround times.
- Conduct periodic audits of screening records.
- Sustain QuantiFERON-TB Gold as the standard TB screening method.
- Share results with other Employee Health programs as a best practice.

Team

- **Renee Lighthall**| Director of Quality

Robert Dyer | Chief Executive Officer

Monica Heineman, PharmD | Pharmacy Director

Laboratory Department

Glycemic Status

Lexington Regional Health Center

LEXINGTON REGIONAL HEALTH CENTER

Background

Diabetes remains a leading cause of preventable complications and healthcare utilization. An analysis of organizational data revealed opportunities to improve the identification and follow-up of patients with elevated HbA1c levels

Month	Patients Tracked	Follow-up Scheduled	Follow-up Completed	A1C Improved
May 2026	10	6	7	1
June 2026	24	21	12	3
July 2026	18	10	6	1
August 2026	13	6	0	0

Team

Kristina Peterson, MLT
Chrystal Dowling, LPN
Brian Doss, MD
Noemi Murillo Corona, RN

Aims

- By December 31, 2027, increase provider awareness and management of diabetics through monthly glycemic status reports, resulting in a 10% improvement in the percentage of patients meeting glycemic control targets (HbA1c <8%) across the organization.

Next Steps

- Every visit concludes with a discharge summary outlining follow-up appointments and any scheduled labs

Your Next Steps

Instructions From Your Care Team

Wegovy 2.4 - stop
Continue azelastine
Carafate 1 gm twice a day for reflux

Treat with a slow increase in activity

Stop physical therapy for two weeks

Wegovy restart in two weeks in a lower dose.
Call - before starting in two weeks

Scheduled Future Appointments

Appointment Type	When	With	Where	Contact Information	Status
PT Treatment - Outpatient (LRHC)	09/29/2026 01:15 PM CDT	ROEMMICH DPT, CURTIS	LRHC Rehabilitaion Services		Confirmed
PT Treatment - aquatics (LRHC)	10/02/2026 11:15 AM CDT	SMITH PTA, LEEANN	LRHC Rehabilitaion Services		Confirmed
Established Patient (LRHC)	10/08/2026 02:00 PM CDT	Wells, Roger D PA	Family Medicine Specialists		Confirmed
Card BHI F/U (LRHC)	07/19/2027 12:45 PM CDT	KUMMER, JOSEPH MD	LRHC Specialty Clinic		Confirmed

Standardizing ED Performance Metrics

Franciscan Healthcare, West Point, Nebraska

Background

- 25 bed CAH in West Point, Nebraska
- Services: Acute, Swingbed, Observation, ED, Surgery, Outpatient Services, Home Health, Hospice, Rehabilitation, Business Health and Rural Health Clinics
- Recent changes: ED remodel (2023), acquisition of MercyOne clinic in Oakland (2023), nursing leadership changes in ED

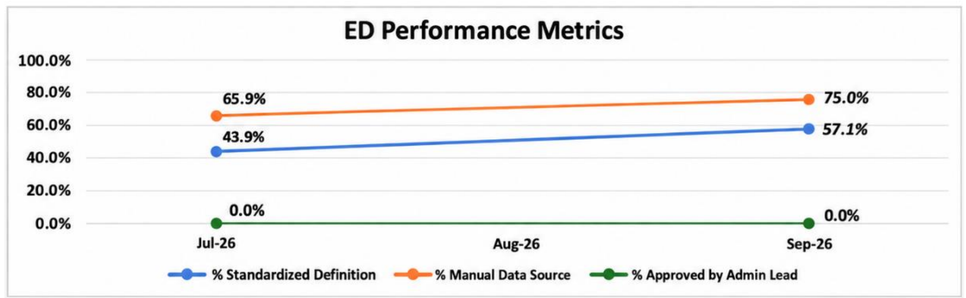
Aims

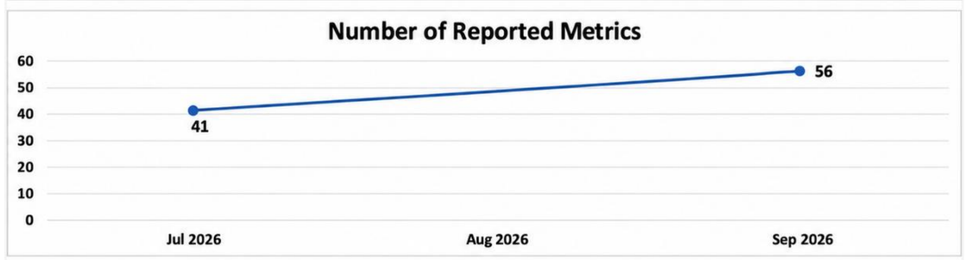
- By July 2027, the Emergency Department will standardize the collection, validation, and reporting of performance metrics by implementing documented metric definitions, standardized data sources, approved reporting processes and consistent validation procedures for 100% of ED performance metrics, resulting in more accurate, reliable, and efficient reporting.

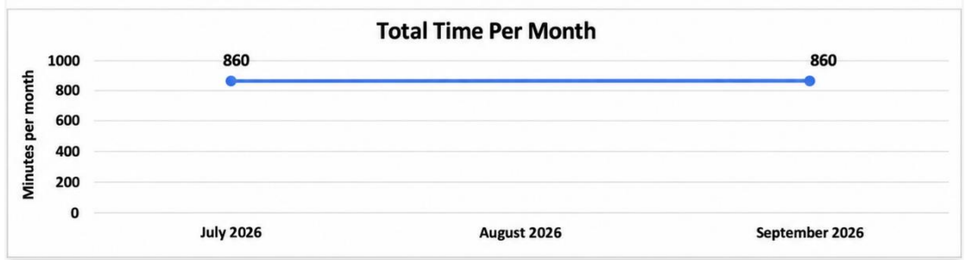
Plan

- Review current ED metrics and validate definition, data source and reporting process.
- For each metric that is manually abstracted, investigate the possibility of building a report to decrease time spend on data abstraction.
- Standardize process for performance measures for the following ED subgroups: Trauma, Chest Pain, Pediatrics, Sepsis and Stroke
- Educate staff on the ED Quality and Statistical metrics. Provide a tool for staff to better understand the metrics being monitored. Educate staff on any changes that directly effect workflows for chart audits.

Results







Measure

- Percent of metrics with standardized definitions
- Percent of metrics with identified and approved reporting processes
- Percent of metrics requiring manual abstraction
- Time required to prepare and report metrics

Team

- The team consists of Dara Schlecht (CNO), Anne Timmerman (Director of Quality), Anna Dennis (Clinical Nurse Manager), Jami Brester (Patient Care Quality Coordinator), Deb Hansen (Receptionist) and Katie Schrad (Quality Coordinator).

Next Steps

- Complete project and implemented new process by July 2027.
- Meet and discuss results for three months after implementation.
- Opportunity to duplicate this project for other departments that

Age Friendly Expansion in Nebraska

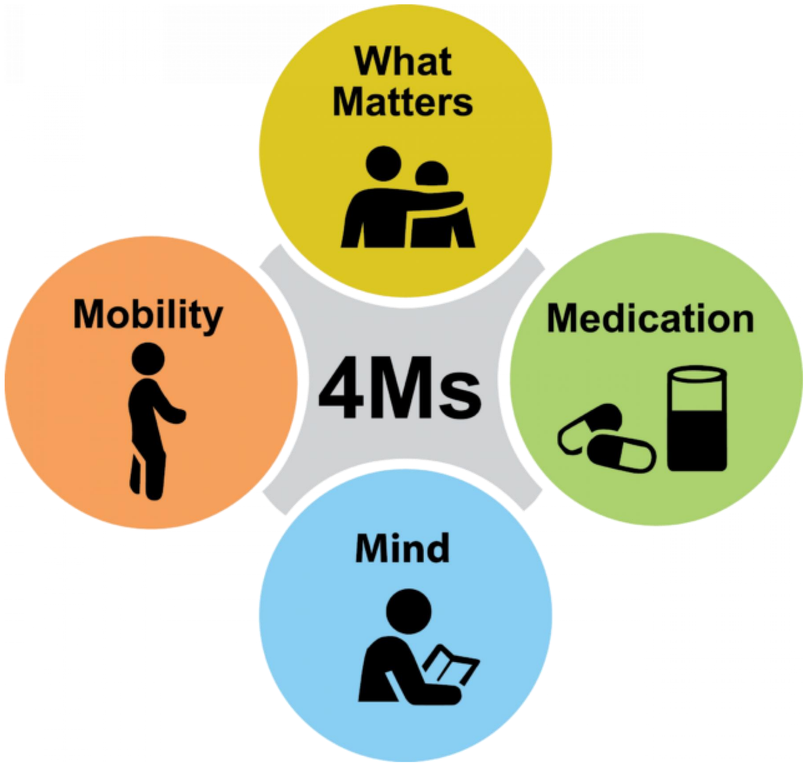
Nebraska Hospital Association

Background

- Nearly 1 in 5 Nebraskans (17.4%) is age 65 or older, and older adults account for a disproportionate share of hospital admissions, ED visits, and readmissions.
- Standard hospital workflows aren't always built around what matters most to older patients — creating gaps in medication safety, cognitive/mental health support, and mobility preservation.
- IHI's 4Ms Framework — What Matters, Medication, Mentation, Mobility — is the national model for age-friendly care.
- CMS's new Age-Friendly Hospital Measure requires public reporting on Care Compare starting 2025 — Level 2 practice gets hospitals ahead of it.

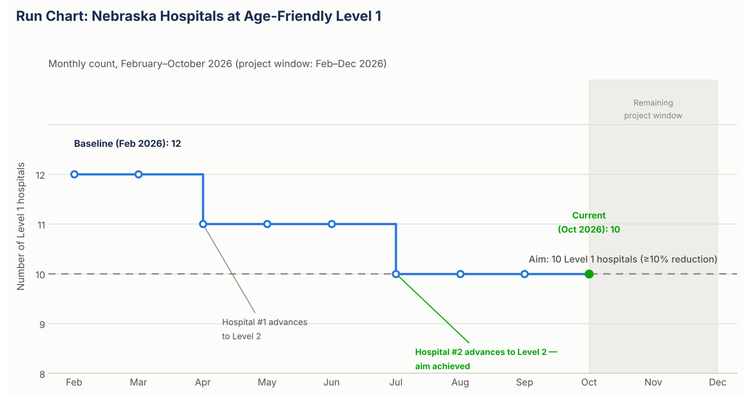
Plan

- Targeted TA — submission kit, tracking template, office hours — for Level 1 hospitals completing 3 months of 4Ms data.
- Goal: at least 1 of 10 remaining Level 1 hospitals (10%) advances to Level 2 this project year.
- Steps: identify readiness → distribute kit/template → host office hours → follow up individually.



Results

- 2 of 12 (16.7%) Level 1 hospitals advanced to Level 2 — exceeding the 10% aim, 4 months early.
- Individualized TA was the deciding factor; hospitals with existing 4Ms workflows advanced fastest.
- Level 1 count: 12 → 10 (Feb–Jul 2026). Aim met in July, 5 months ahead of the Dec 31 deadline.



Next Steps

- Spread: extend the same TA model to the remaining Level 1 hospitals.
- Sustain: monthly check-ins + IHI's rolling 3-month data requirement keep 4Ms documentation routine.
- Long-term: build on Level 2 recognition to initiate Age-Friendly Community status.

Aims

Transition the number of Nebraska Age-Friendly Level 1 hospitals to Age-Friendly Level 2 by at least 10% — from 12 to 10 — as hospitals advance to Level 2 (Committed to Care Excellence) recognition, within 11 months, from February 2026 to December 31, 2026

Measure

- Success = functional progression to Level 2 — 3+ months of documented 4Ms care submitted, not just a plan.
- Metrics: Level 1 hospitals — baseline 12; current 10.
- Measured monthly via IHI's public recognition list + NHA's benchmarking workbook.

Team

Adrienne Crawford, MHA, MS, CCC-SLP
Natalie McMeen, MHA
Amber Lubben
Margaret Woeppel

Improving Care Transitions: Reducing 30-Day Readmissions

Memorial Community Hospital & Health System

Memorial Community Hospital & Health System

Background

- Recognize that 30-day readmissions signal care quality and coordination
- Low CAH volume: every case is a learning opportunity
- No standardized review process; inconsistent rate calculation
- 2025 baseline rate: 7.83%

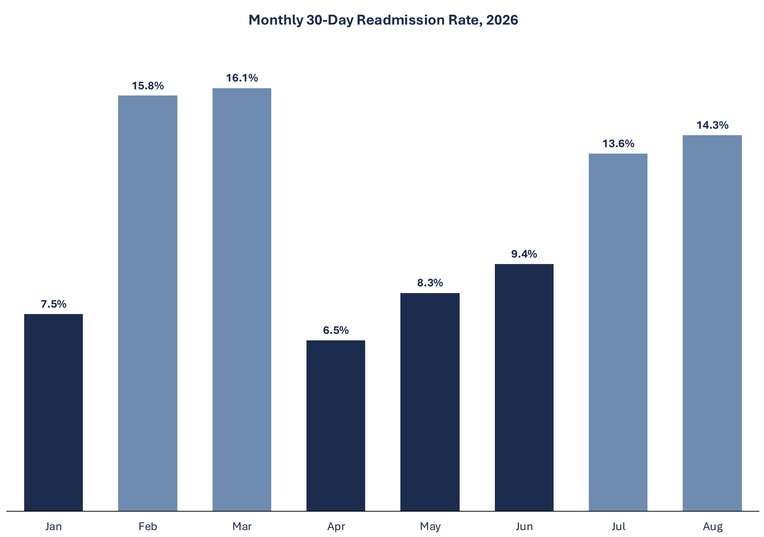
Aims

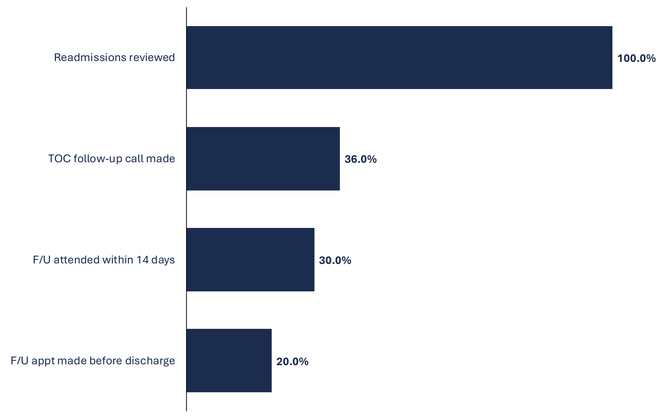
By December 2026, review 100% of 30-day inpatient readmissions using a standardized process and implement at least two interventions to improve care transitions.

Plan

- Standardized review tool, adapted to live review (PDSA 1)
- One validated Epic report as source of truth (PDSA 2)
- Monthly Readmissions Committee, shared Teams log (PDSA 3)
- Follow-up scheduled before discharge + TOC calls (PDSA 4)

Data





Measure

- Outcome: 30-day readmission rate (11.1% YTD)
- % readmissions reviewed monthly (100%)
- % follow-up scheduled before discharge (20%, n=10-11)
- % attending follow-up in 14 days (30%, n=10-11)
- % receiving post-discharge call (36%, n=10-11)
- Balancing: ED revisit rate

Results

- 100% of readmissions reviewed monthly
- 2026 YTD event rate: 11.1% (30 / 271 admissions, CAH)
- 2025 baseline: 7.83% — unverified calculation, inconsistent review; 2026 is our first validated measurement
- 2026 Q1 12.3%, Q2 8.1%, Q3 thru Aug 14.0%
- 18 of 30 reviews drove action: 8 interventions, 10 workflow fixes
- TOC gaps: 20% appt before DC, 30% attended, 36% called (n=10-11; directional)

Next Steps

Close the non-MCH PCP handoff gap and document follow-up scheduling

at discharge. Tighten documentation of findings, actions, and owners.

Extend the model to frequent ED utilizers.

Team

Jennifer Beisheim, BSN, RN
Holly Baker, RN Case Manager
Nicole O'Hearn, Social Worker
Paige Knauss, RN Population Health Coordinator
Jess Riley, Nurse Manager
Amy Zimmer, CNE

Implementing Age-Friendly Care: A Phased Approach to the 4Ms Framework

Franciscan Healthcare, West Point, Nebraska

Background

- Older adults are at increased risk for falls, delirium, medication-related complications, functional decline, and loss of independence during hospitalization. Age-Friendly Health Systems provide a framework for delivering evidence-based, person-centered care that focuses on the individual goals and needs of older adults.
- At Franciscan Healthcare, an opportunity was identified to strengthen consistent Age-Friendly practices for patients age 65 and older that are admitted to the hospital.



Plan

- Identify patients age 65 and older who are admitted to the hospital.
- **Stage 1 – What Matters and Mobility**
- **What Matters:** Nurses will ask and document what matters most to the patient, including goals, preferences, and priorities.
- **Mobility:** Nurses will complete the STEADI fall-risk assessment and if patient screens "at risk" a PT Screen order will be placed. PT will complete a Timed Up and Go (TUG) assessment to further evaluate mobility needs.
- **Stage 2- Medication and Mentation**
- **Medication:** Pharmacy will screen for use of age-friendly medication during every hospital stay.
- **Mentation:** Nurses will complete a delirium screen every 12 hours.

Aims

- To implement the Age-Friendly Health Systems 4Ms Framework on the Medical –Surgical Unit at Franciscan Healthcare through a phased approach, achieving 80% completion and documentation of the 4Ms elements for hospitalized patients 65 years and older by May 1, 2027.

Results

- Stage 1 Implemented Sept 8, 2026
- Stage 2 planned to implement end of Nov 2026
- Data collection in process

Measure

- Percentage of eligible patients (65+) with 4Ms framework completed and documented

Next Steps

- Monitor What Matters and Mobility compliance
- Roll out Stage 2- Medication and Mentation
- Montior implementation of 4Ms
- Share data and feedback with staff
- Sustain and expand the 4Ms throughout ambulatory and outpatient services

Team

Jami Brester MSN
Anne Dennis MSN
Bill Hagemann BSN
Jeff Kirchman PT, DPT, CSCS
Sara Bichlmeier, PharmD, RP

Improving Adherence to Trauma Standards Through Trauma Checklists and Timeouts

Avera St. Anthony's Hospital

Avera St. Anthony's Hospital

Background

- 5-room Emergency Department in a 25-bed Critical Access Hospital, designated as a basic-level trauma center
- Chart audits identified delayed IV antibiotic administration for patients with open fractures
- Trauma care processes vary between activations, with no standardized checklist and inconsistent use of trauma

Baseline: January 2025- September 2026

Total Trauma Patients	89
Open Fractures	6
Received IV Abx Within 1 Hour	1

Aim

Increase compliance with IV antibiotic administration within 1 hour for patients with open fractures from 17% to 100% within 12 months of checklist implementation

Measures

Process Measure

- Trauma patients with completed trauma checklists (%)

Outcome Measure

- Open fracture patients receiving IV antibiotics within 1 hour (%)

Plan and Project Status

- Checklist developed with input from frontline stakeholders, formal Medical Staff approval pending
- Interactive training sessions being developed, focused on team collaboration and communication
- Implement standardized trauma timeouts during EMS handoff and prior to patient departure for imaging

PATIENT NAME / ID STICKER	TIME OF INJURY (DRIVES: TXA WINDOW, OPEN-FRACTURE ANTIBIOTIC TIMING, DOCUMENTATION / TRAUMA PI) TRAUMA TEAM ACTIVATION TIME: _____	TRAUMA TIME OUTS ☐ ON ARRIVAL Time: _____ ☐ BEFORE LEAVING ED FOR IMAGING Time: _____

1) PRIMARY SURVEY - xABCDE	2) SECONDARY SURVEY	3) REASSESS
X - EXSANGUINATING HEMORRHAGE ☐ Direct pressure / pack / tourniquet Time applied _____ ☐ Pelvic binder if suspected unstable pelvic fracture ☐ Life-threatening hemorrhage (<3 hr) ☐ Type & Screen / Crossmatch ☐ Blood products initiated ☐ TXA 2 g IV/IO over 10 min	☐ AMPLE Allergies Medications PMH/Pregnancy Last meal Events ☐ Head/Face/Neck/Spine/Back ☐ Chest ☐ Abdomen ☐ Pelvis/Perineum ☐ FAST/eFAST if indicated ☐ Imaging only when indicated and it will not delay necessary transfer ☐ Address Pain ☐ Address Tetanus Status ☐ Extremities: ☐ Distal Pulses ☐ Motor ☐ Sensation ☐ Wounds/Deformities	☐ Repeat xABCDE after intervention or clinical change ☐ Trend: GCS _____ Temp _____ Perfusion _____ ☐ Repeat neurovascular exam when applicable (Splinting, Reduction, Tourniquet Adjustment, Open Fx Management) ☐ **Document response to interventions**
A - AIRWAY + C-SPINE ☐ Airway patent? Suction ready? ☐ Definitive airway if threatened ☐ ETCO2 Monitoring ☐ C-Spine Immobilization In place On Arrival? Y / N Time _____		
B - BREATHING ☐ Expose • inspect • palpate • auscultate ☐ O2/ventilate as indicated ☐ Treat immediately life-threatening chest injury ☐ CXR/eFAST when indicated		
C - CIRCULATION / HEMORRHAGE ☐ 2 large-bore IVs / IO ☐ Control Hemorrhage ☐ Administer Blood Products – Minimize Crystalloids ☐ Blood warmer / rapid infuser used ☐ Calcium after 1st unit ☐ Repeat calcium q4 units ☐ Obtain labs: CBC • PT/INR/PTT • fibrinogen • lactate • iCa	**OPEN FRACTURE BUNDLE** ANY WOUND NEAR A FRACTURE = OPEN FRACTURE UNTIL PROVEN OTHERWISE ☐ OPEN FRACTURE SUSPECTED OR PRESENT **Goal: Antibiotics Within 1 Hour Of Injury** (Or 1 Hour of Arrival If Injury Time Unknown) **Injury Time: _____ Antibiotic Administration Time: _____** ☐ Photograph wound (if able) ☐ Sterile dressing applied ☐ Limb immobilized / splinted ☐ Distal pulse, motor, sensation documented ☐ Ortho/Podiatry consultation completed Time: _____ ☐ DO NOT probe wound ☐ DO NOT aggressively irrigate ☐ Reduce gross deformity if indicated ☐ Repeat neurovascular exam documented after reduction ☐ Transfer initiated if definitive care unavailable	**30-SECOND DEPARTURE CHECK** ☐ Airway secure ☐ ETCO2 present if intubated ☐ Hemorrhage controlled ☐ Patient warm ☐ IV/IO secure ☐ Blood products/medications addressed ☐ Antibiotic Administered (if applicable) ☐ Splints secure ☐ PMS documented ☐ Imaging sent/pushed ☐ Receiving facility updated on significant changes ☐ Verbal Report Given to Transport Team
D - DISABILITY ☐ GCS_____ ☐ Pupils ____ ☐ Glucose ____ ☐ Avoid hypoxia and hypotension		**TRANSFER TIMELINE** Arrival Time: _____ Accepting Facility: _____ Departure Time: _____ Reasons for Transfer Delay:
E - EXPOSURE / ENVIRONMENT ☐ Fully expose patient ☐ Remove wet clothing ☐ Active warming started ☐ Prevent hypothermia		
DAMAGE CONTROL CONSIDERATIONS ☐ **Escalating transfusion requirements** ☐ **Consider OR for hemorrhage control** ☐ **Do not delay transfer for nonessential testing** ☐ **Initiate Transfer Early**	**Time Transfer Decision Made:** _____	*This form is not a part of the patient's record.* *Return completed form to Trauma Nurse Coordinator.*

Evaluation

- Monitor trauma checklist completion
- Monitor compliance with IV antibiotic administration within 1 hour for open fractures
- Use PDSA cycles to evaluate and refine the process.
- Identify additional opportunities for trauma process improvement



Project Team

Jamie Gokie, RN, Trauma Coordinator
Chelsea Stracke, RN, Quality Manager
Beau Fry, DO, ED Medical Director
Anthony Akainda, MD, Trauma Medical Director



Reigniting a Just & Psychologically Safe Culture for Event Reporting

Saunders Medical Center | Wahoo, Nebraska

Capstone Quality Improvement Project

A CULTURE OF SAFETY STARTS WITH ALL OF US

BACKGROUND

- 16-bed Critical Access Hospital in a rural community, including Rural Health Clinic and Long-Term Care
- 2023 survey showed 46% of employees agreed that SMC management is proactive about patient safety
- Became part of our Strategic Plan
- Focus on proactive safety behaviors, transparent communication, and learning from our errors

AIMS

Improve our culture of safety by strengthening leaders' focus on patient safety before adverse events occur.

The aim of this project is to improve survey score on the statement "SMC management is proactive about patient safety" by 10% in 3 years.

Increase survey score in the next safety survey

Increase the number of near misses reported per year

PLAN

Educate on TeamSTEPPS® tools and Just Culture

↓

Create an environment of psychological safety

↓

Utilize "TeamSTEPPS® Tool of the Quarter"

↓

Leaders foster psychological safety through rounding, asking open questions, and following up visibly on concerns

↓

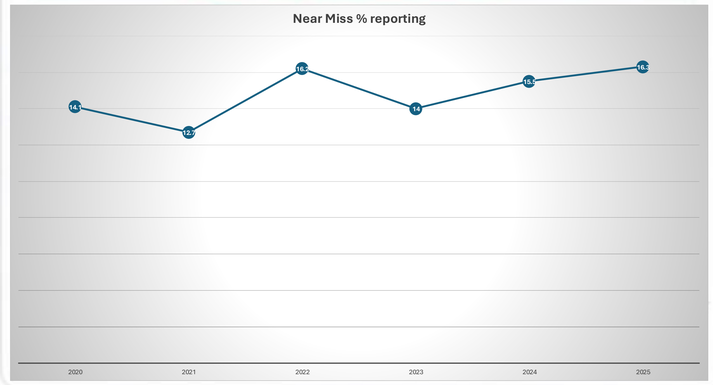
Encourage reporting of near misses and "great catches"

RESULTS

Increase in near misses / great catch reports over past 2 years

Improved engagement and communication across departments

2026 survey, 84% feel management is proactive about patient safety.



Saunders MEDICAL CENTER

Be Well.

Quality Team

Tracy Gatewood,
Denise Sabatka RN CPHQ, and
Jessica Trutna RN CIC



MEASURES

MEASURE	BASELINE	CURRENT
Near Miss Reports	14.0%	16.3%
Great Catch Reports	N/A	Increased
Survey Score	**46%**	**84%**

NEXT STEPS

- Review results of the 2026 safety survey
- Leaders model behaviors, coach staff, and monitor progress through feedback and surveys
- Standardize practices, share lessons learned, and refine strategies using data for continuous improvement
- Continue to support a just culture and a safe space to speak up and report

EVERY VOICE MATTERS. EVERY REPORT COUNTS. EVERY PATIENT BENEFITS.

TEAM STEPPS® Leadership | Communication | Situation Monitoring | Mutual Support

Reducing Multiple IV Attempts Through Ultrasound-Guided IV Educati

Callaway District Hospital

Background

Peripheral IV access is frequently required across the ED, Outpatient, Inpatient, and Observation departments. Patients with difficult IV access may require multiple insertion attempts, increasing discomfort and potentially delaying care. CDH policy recommends ultrasound-guided IV access after two unsuccessful peripheral IV attempts; however, prior to this project, only two nurses had received ultrasound-guided IV training with only one nurse utilizing this technique consistently.

BASELINE DATA

12.8%

of IV episodes required more than 2 attempts



15 of 117

IV INSERTION EPISODES

Data collected from April 1, 2026- August 15th, 2026

Aims

- By October 1, 2026, expand ultrasound-guided peripheral IV education and competency among RNs at CDH while establishing a sustainable competency-validation process, with the long-term goal of reducing multiple IV insertion attempts.

Plan

- Standardize ultrasound-guided IV education.
- Complete online education and in-person training.
- Provide hands-on guided practice.
- Progress to supervised patient attempts.
- Validate competency after ≥5 supervised attempts with ≥75% success.
- Continue monitoring IV attempts and ultrasound utilization with Data Collection across ER, Inpatient, Outpatient, and Observation encounters.



Measure

- **Outcome:** Percentage of IV episodes requiring >2 attempts.
- **Process:** RN education completion, supervised competency progression, ultrasound utilization, and number of RNs achieving competency.
- **Competency:** ≥75% success rate for USGPIV insertion over at least 5 supervised patient attempts.

Results

- **9 RNs** expressed interest in training.
- **6 RNs** completed online and in-person education.
- **3 RNs** progressed to supervised patient attempts.
- Competency development remains ongoing. Current data include **117 IV episodes**, with **15 (12.8%) requiring >2 attempts**. Current data do not yet demonstrate sustained improvement.

Next Steps

- Continue supervised practice and staff education; reinforce adherence to the standardized IV-access process; complete training for remaining interested nurses; continue data collection; conduct additional PDSA cycles; evaluate competency requirements within the critical-access setting; and incorporate ultrasound-guided IV education into ongoing nursing education as the process develops.

Team

Kacee Gillis, RN – Nurse Educator/Project Lead;
Kristin Bailey – CNO/DON;
Kellsy Beshaler – Quality Director;
Brett Eggleston – CEO;
Cassie Penn – COO

Completion of Patient Profile

Columbus Community Hospital, Columbus, NE

Background

Patient profile audits and leadership review identified inconsistent completion and documentation practices across multiple departments, resulting in incomplete patient profiles, conflicting information within the EMR, and potential impacts on patient safety, data accuracy, coding, and reporting. Contributing factors included unclear documentation expectations, workflow variation, time constraints, and limited staff education. This project was initiated to standardize patient profile documentation, improve completion and accuracy rates, and establish sustainable auditing, education, and coaching processes to ensure reliable patient information across the continuum of care.

Element	Baseline
OB History	49%
Alcohol Use	39%
Recreational Drug Use	30%
Allergies	43%
Tobacco History	62%

Legend:

- ≥90%
- 50–89%
- <50%

Plan

- Map current workflow and identify barriers
- Standardize patient profile expectations
- Create Patient Profile Data Dictionary
- Utilize monthly audit process
- Educate staff on documentation requirements
- Provide leadership coaching and feedback
- Partner with IT for workflow optimization
- Monitor results and sustain through ongoing audits

INSERT IMAGES OF TEAM, DATA DISPLAY ON THE UNIT, ETC.

Results

Baseline compliance ranged from 25%–79% across required Patient Profile elements.
Standardized audit tool and monitoring process implemented
Patient Profile Champion role established in the ED.
Workflow redesign and staff education completed
Improvements observed from Q1 to Q2 2026:
OB History: 49% → 62%
Alcohol Use: 39% → 68%
Recreational Drug Use: 30% → 61%
Allergies: 43% → 69%
Tobacco History: 62% → 77% Ongoing audits and coaching continue to drive improvement toward complete and accurate patient profiles.

Next Steps

- Sustain monthly audits and feedback.
- Implement Data Dictionary organization across departments.
- Continue staff education and leader coaching.
- Optimize workflows and EMR functionality.
- Spread successful practices organization-wide.
- Monitor progress toward 100% Patient Profile completion and ≥90% documentation accuracy.

Aims

Increase Patient Profile completion, accuracy, and consistency across participating departments to 90% compliance by July 2026, supporting safe patient care, reliable documentation, and improved data integrity

Measure

- Patient Profile Completion Rate (% compliant profiles)
- Documentation Accuracy Rate (% profiles without discrepancies)
- Monthly Audit Compliance
- Staff Education Completion
- Patient Profile Champion Utilization
- Staff Workflow Impact/Time Burden

Team

Nursing Leadership Team

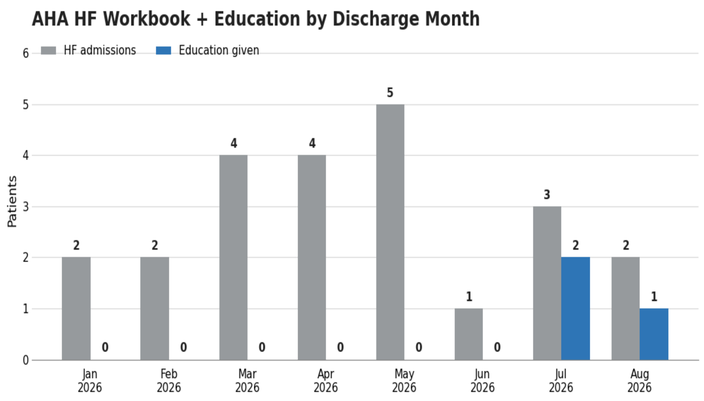
Sue Deyke, RN, Lisa Perrin, RN, Nicole Blaser, RN, Gunner Belz, RN, Kim Eisenmann, RN, Kayla Gehring, RN Alecia Neidig, RN and Jon Brunott, CRNA

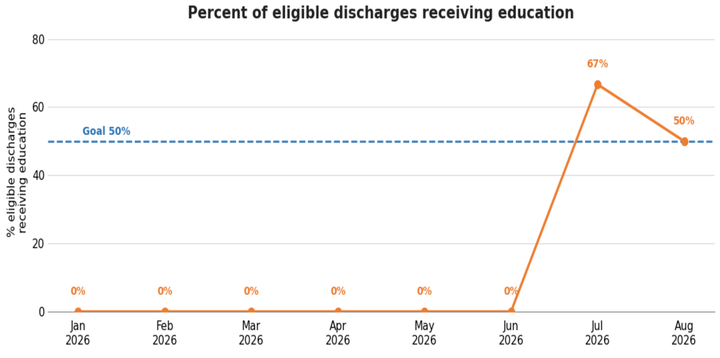
Improving Heart Failure Outcomes with Discharge Education

Fillmore County Hospital Geneva, NE

Background

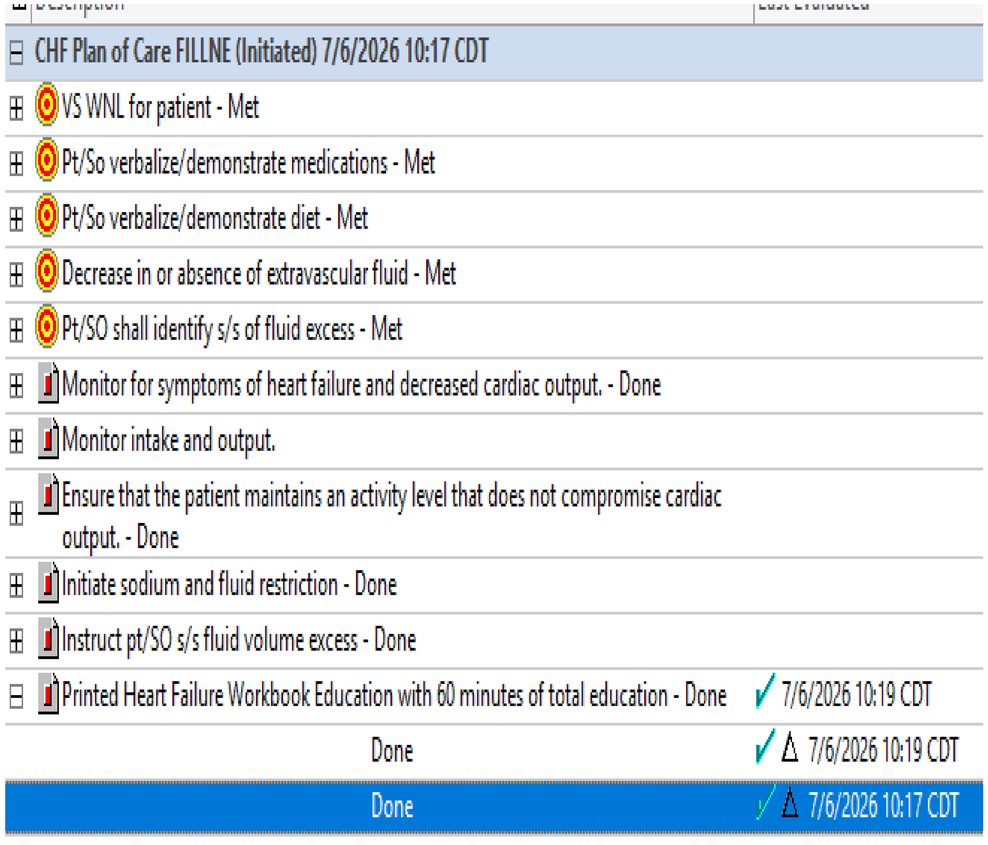
- 20-bed med/surg CAH
- Chart audits revealed a lack in discharge education which led to readmissions
- We saw the opportunity to increase patient outcomes with improved compliance.





Plan

- Educated staff to utilize the discharge workbook for all patients discharged with a heart failure diagnosis.
- Educated staff to document when education was completed for tracking.
-



Results

- Heart failure care plan initiated on admission
- AHA Heart Failure workbook given to patient on admission
- Nurses starting discharge education on admission

INSERT IMAGES OF UTILIZATION RATIO AND CAUTI RATE

Next Steps

- Continue monthly chart audits on heart failure patients
- Continue to track trends and provide education to staff as needed

Aims

Increase the utilization of the AHA Heart Failure workbook on admission by 90% for patients with a diagnosis of heart failure by December 1, 2026.

Measure

- Percentage of patients who receive the workbook on admission and receive 60 minutes of education.
- Percentage of patients who have documented education review prior to discharge.

Team

Tiffany Switzer BSN, RN
Megan Johnson MSN, RN
Rita Bixby MSN, RN
Jill Hammer BSN, RN
Pam Murphy BSN, RN
Lisa Hopken BSN RN, CNO
Ashley Havel BSN, RN
McKayla Armstead BSN, RN

ED Obstetric Emergency Readiness in a Non-Delivering Critical Access Hospital: Developing a Frontline Staff-Driven Training Program

Gordon Memorial Hospital, Gordon, NE

Gordon MEMORIAL HOSPITAL DISTRICT

Background

- 25-bed Critical Access Hospital; 3 ED days; no ICU.
- Labor & Delivery services ended in 2007.
- Outpatient general surgery available on limited days each month; no unscheduled access to anesthesia services or a surgical team.
- Emergency department services only; no ability to perform emergency C-section.
- Hospital births have declined to 1 or less per year; most deliveries are precipitous births or involve limited/no prenatal care.
- This project was selected because obstetric events are low-incidence but high-risk in a rural setting with limited access to OB services.

Plan

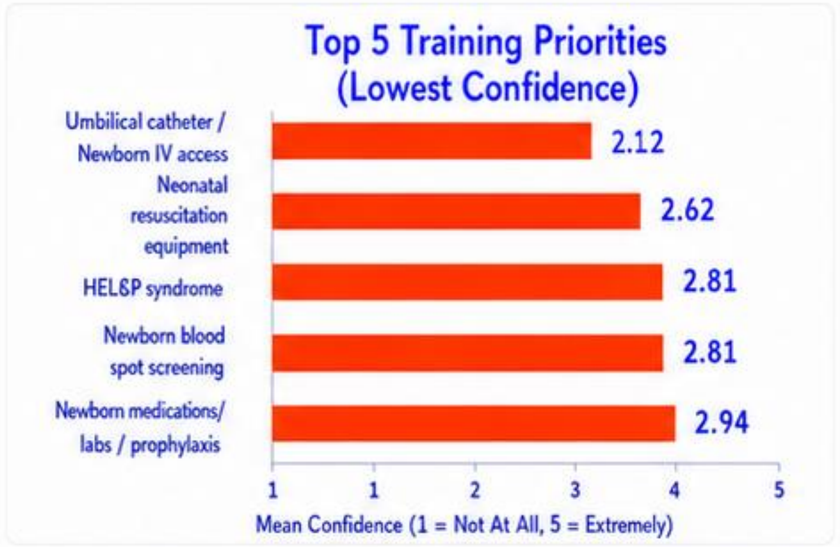
- Use the AIM Obstetric Emergency Readiness Resource Kit to guide project design, protocol review, and education selection.
- Develop a frontline nursing staff survey to assess confidence level regarding OB readiness to guide and determine effectiveness.
- Form an interdisciplinary OB Readiness QI team.
- Prioritize low-frequency/high-risk gaps identified in the survey.
- 6-month education plan:
  1. Foundations: maternal/newborn vital signs, abnormal findings, role clarity.
  2. Neonatal resuscitation setup: warmer, airway, CPAP/flowmeters.
  3. Maternal hypertensive emergencies: preeclampsia, HELLP, eclampsia, magnesium sulfate.
  4. Postpartum hemorrhage and emergency transfer workflow.
  5. Newborn post-delivery care: APGAR, glucose/temp, meds, labs, blood spot screening.
  6. Integrated interdisciplinary simulation and policy drill
  7. Repeat the confidence survey after education to measure improvement.

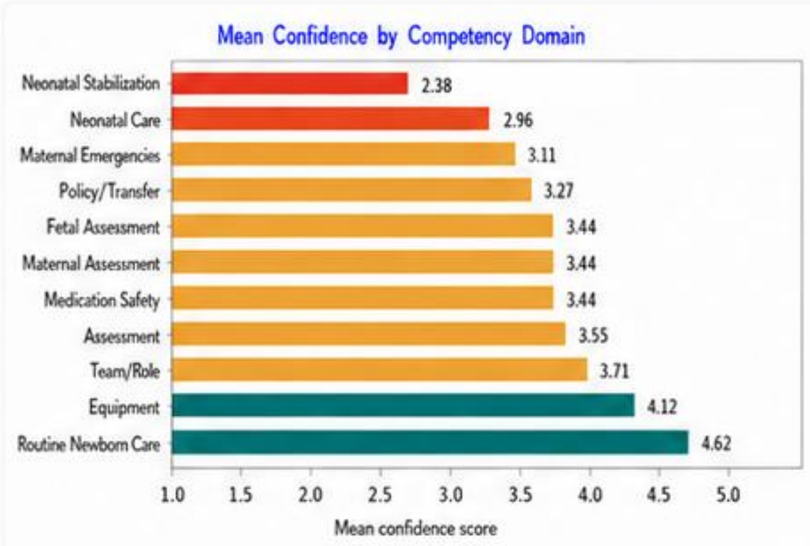
Ongoing: quarterly scenario drills and annual certifications/refresher (NRP, STABLE, ENPC as feasible).

Results

KEY FINDINGS

- Overall mean confidence: 3.38 / 5.
- Strongest areas: Newborn care (mean 4.62), locate infant warmer (4.19), locate fetal monitoring equipment (4.05).
- Lowest-confidence domain: Neonatal stabilization (mean 2.38).
- RN confidence generally exceeded LPN and Paramedic confidence on all-staff foundational items.





> *Baseline assessment confirmed strong routine newborn care skills but significant gaps in low-frequency, high-risk obstetric and neonatal emergencies, supporting a simulation-focused rural OB readiness program.*

Aims

- Assess baseline Emergency Department staff confidence related to labor, delivery, newborn stabilization, and obstetric emergencies.
- Identify top training priorities for all staff and licensed clinicians.
- Develop a frontline staff-driven obstetric readiness education plan.
- Improve nursing skills, role clarity, and confidence in managing obstetric emergencies.

Measure

1. Post Education Survey Mean Confidence Level ≥ 4.2 on Priority Areas.
2. Low-confidence response rate < 10% Not At All/Slightly
3. Scenario Drill and Training Participation ≥ 90% Nursing frontline staff.

OB Readiness QI Team

- Kathryn Kruger, RN, BSN — Chief Nursing Officer
- Alexandra White, DO — Provider Champion
- Amanda Kehn, RN, MSN — Chief Quality Officer
- Lindsey Nelson, RN, BSN — Quality Improvement RN