AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

COLORADO AWHONN SECTION NEWSLETTER
VIRTUAL CONFERENCE EDITION

Volume 8, Issue 3 September 2020

AWHONN
COLORADO
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

VIRTUAL

Section Chair Report

Inside this Issue:

Hello Colorado AWHONN Members,

We hope you enjoy our "virtual" conference enclosed in this newsletter. You will find 7.5 CE in viewable webinars. Six of these come directly from the 2019 National Conference.

- A Multi-Modal Strategy to Improve Comfort and Reduce Opioid Utilization Post Cesarean Section (30 minutes = 0.5 CH)
- Keeping Babies Safe: Sudden Unexpected Infant Death and Sudden Unexplained Postnatal Collapse (57 minutes = 1.0 CH)
- Maternal Mortality: Reframing Women's Healthcare Providers Roles in Reduction (54 minutes =1.0 CH)
- Perioperative Care in the Obstetric Setting (59 minutes = 1.0 CH)
- Promoting a Positive Birth Experience in Women with a History of Trauma (32 minutes = 0.5 CH)
- Tic, Tac, Toe: Fluids, Ephedrine, and Neo: How to Manage Hypotension Following Neuraxial Anesthesia (44 minutes = 0.75 CH)

I do recall my colleagues that attended the Hypotension Following Neuraxial Anesthesia found it one of the most helpful lectures on management of labor epidurals.

The other offerings come from other 2019 webinars that AWHONN hosted. The CE for these webinars are free for both our Full Members and our E-Members.

RN's that are not members of AWHONN can purchase these offerings for $75. That being said an E Membership is only $96. For just a little more you can become a member and receive all the benefits and get the 7.5 CE. https://awhonn.org/Membership/

To access the e learning- https://www.eventbrite.com/e/co-awhonn-virtual-conference-2020-tickets-120240880711

Registration begins 10/1/2020 and ends 12/15/2020 and learning must be completed by 12/31/2021.

We are honored to reveal the 2020 CO AWHONN Nurse of the Year! As well as all of the incredible nominees. I was privileged to review the outstanding nominations and give my thanks to every one of the candidates. You will also be able to view our poster submissions virtually. Thank you to all of our poster presenters.

We have scheduled the 2021 conference live and in-person September 16-17 at the Marriott Fort Collins. I hope to see you there!

Isabelle Campanella MSN,RNC

CO AWHONN Section Chair

Recorded 2019 Convention Sessions

1. A Multi-Modal Strategy to Improve Comfort and Reduce Opioid Utilization Post Cesarean Section

Description: This presentation describes the work of an interdisciplinary work group which came together in order to assess opioid utilization in women post-cesarean section. We will outline how nursing staff were educated on the importance of utilization of non-opioid methods of pain relief in this population and will describe methods used to promote comfort among these women.

Objectives:

a. Describe non-pharmacologic techniques as well as non-opioid medications which can be used to

improve comfort among women post cesarean section.

b. Identify risk factors associated with increased opioid utilization post-cesarean section.

c. Outline methods by which an interdisciplinary work group can assess data and impact post-operative

pain control in women who have undergone cesarean section.

Presenters: Adriane Burgess, PhD, RNC-OB, CCE, CNE and Any Harris, BSN, RNC-MNN

Length: 30 minutes; CH = 0.5

NCC code: INP - Professional Practice (Code 6), MNN – Professional Practice (Code 4), WHNP-BC - Professional Practice (Code 5)

2. Keeping Babies Safe: Sudden Unexpected Infant Death and Sudden Unexplained Postnatal Collapse

Description: Sudden Unexpected Infant Death (SUID) and Sudden Unexplained Postnatal Collapse (SUPC) are two serious concerns when caring for families in the postpartum period. Through a case study, this lecture will assist the bedside nurse in further understanding these phenomena. They will come away with a better understanding of SUID/SUPC as well as assessment skills and prevention strategies to keep babies safe in the hospital and to teach parents how to keep their newborns safe at home.

Objectives:

a. Define Sudden Unexplained Postnatal Collapse (SUPC).

b. Identify at least two risk factors for SUPC.

c. Explain at least three recommendations for the prevention of SUPC.

Presenter: Patricia Klassa, MSN, RN, IBCLC

Length: 57 minutes; CH = 1.0

NCC code: INP – Newborn (Code 5), LRN - Neonatal Complications (Code 3), MNN - Newborn Assessment & Management (Code 3), NIC - Physiology and Pathophysiology (Code 2), NNP - Physiology & Pathophysiology (Code 2)

Recorded 2019 Convention Sessions (cont.)

3. Maternal Mortality: Reframing Women's Healthcare Providers Roles in Reduction

Description: Maternal mortality is rising in the United States, a fact that has been widely publicized in the consumer media. Maternal healthcare providers need to reframe how we view maternal mortality to include the non-obstetric causes of maternal death, which account for more deaths than obstetrical causes.

Objectives:

a. Determine the causes and trends in maternal mortality in the United States

b. Examine the role that women's healthcare providers can play in reducing maternal mortality.

Presenter: Andrew Youmans, MSN, RN, CNM. FAWM

Length: 54 minutes; CH = 1.0

NCC code: INP - Professional Practice (Code 6), MNN – Professional Practice (Code 4), WHNP-BC - Professional

Practice (Code 5)

4. Perioperative Care in the Obstetric Setting

Description: Cesarean section is now the most common surgery performed on women in the United States. Standardized resources will help to provide quality care and safe outcomes to women having cesarean birth and their newborns. This presentation will provide an overview of the new AWHONN evidence-based guideline for the preoperative, intraoperative, and postoperative phases of surgery.

Objectives:

a. Integrate evidenced-based perioperative practice principles when providing care for pregnant women

during the preoperative, intraoperative, and postoperative periods.

b. Identify and utilize patient safety and quality improvement strategies to minimize risk and optimize

perinatal outcomes associated with cesarean birth.

c. Apply a comprehensive patient care model during and after a scheduled or unscheduled cesarean birth.

Presenters: Susan Hale, DNP, RN, C-EFM and Toni Hurley, MSN, RNC

Length: 59 minutes; CH = 1.0

NCC code: INP – Labor & Delivery (Code 2), MNN - Postpartum Assessment & Management (Code 2), WHNP-BC -Normal Physiology and Management (Code 1)

Recorded 2019 Convention Sessions (cont.)

5. Promoting a Positive Birth Experience in Women with a History of Trauma

Description: The impact of past trauma on a woman's pregnancy and birth experience will be explored. An innovative birth planning program that seeks to promote a positive birth experience in this population will be detailed. Strategies for developing, implementing and evaluating a birth planning program for survivors of trauma will be outlined.

Objectives:

a. Explain the risk for a traumatic birth experience in women with a history of trauma such as childhood sexual abuse, intimate partner violence, or previous traumatic birth and its effects on the individual, family, and community.

b. Describe the innovative birth planning program for women with a history of trauma, including the patient interview and birth planning process.

c. Discuss concepts of design, implementation, and evaluation of a birth planning program for women with a history of trauma.

Presenters: Christine E. Conrad, BSN, RNC-OB, C-EFM and Katie Conklin, BSN, RN-CPPS

Length: 32 minutes; CH = 0.5

NCC code: INP - Pregnancy & Obstetric Complications (Code 3), WHNP-BC - Pathophysiology Obstetrics (Code 2B)

6. Tic, Tac, Toe: Fluids, Ephedrine, and Neo: How to Manage Hypotension Following Neuraxial Anesthesia

Description: Hypotension following neuraxial anesthesia is a routine and expected response. However, profound hypotension, greater than 20% change from baseline, can result in fetal distress, or facilitate emergent delivery and therefore should be avoided. Commonly used vasopressors (ephedrine and neosynepherine) can quickly correct the blood pressure, but also have potentially negative effects on the fetus. Rapid infusion of Crystaloid IV fluids, when timely managed, have been shown to decrease the incidence of hypotension, and reduce the need for vasopressors.

Objectives:

a. List the risks and benefits of well timed, rapid infusions of crystalloid IV fluids for neuraxial induced hypotension.

b. Review the pharmakodynamics of commonly used vasopressors for the management of neuraxial anesthesia induced hypotension.

c. Discuss the nurse’s role and responsibilities in the management of neuraxial anesthesia induced hypotension.

Presenter: Cheryl D. Parker, CNP, CRNA

Length: 44 minutes; CH = 0.75

NCC code: INP – Labor & Delivery (Code 2)

AWHONN Webinars for CE Sessions

Use of Insulin for Intrapartum Patients

Description: This webinar includes a brief review of the pathophysiology of hyperglycemia in pregnancy and a discussion of the different insulin regimens for close management of diabetes in labor.

Learning Objectives:

a. Review the benefits of euglycemia during labor, glycemic targets, and therapy goals.

b. Review the types of diabetes and how they can require modifications when using insulin.

c. Review methods for insulin administration.

Presenter:

Molly Killion, RNC-OB, MS, CNS-BC

High-Risk OB Nurse Coordinator

University of California San Francisco

How to Run OB and Neonatal Simulation Scenarios

Length = 60 minutes (1.0 CH)

Conducting Effective Simulation-Based Training

Description: This webinar includes information about content relevancy, intraprofessionalism, budgetary issues, choosing faculty, and debriefing in simulation-based training.

Learning Objectives:

a. List strategies to facilitate debriefing.

b. Review how to keep simulation relevant to attendees.

c. Describe how to involve other disciplines in simulation training.

d. Discuss methods to convey the value of simulation training to the hospital.

e. Determine how many simulation instructors are needed and what kind of training is required to run asimulation training.

Presenter:

Julie Arafeh, MSN, RN

Director of Simulation, Clinical Concepts in Obstetrics

Simulation Consultant, Stanford University OB Sim Program and the Center for Advanced Pediatric and Perinatal Education

Length: 30 minutes (0.5 CH)

Perinatal Sepsis

Description:

This webinar includes background information and risk factors, signs and symptoms, diagnosis, treatment plans, and nursing implications of sepsis.

Learning Objectives:

a. Define intraamniotic infection (chorioamnionitis) and potential risk factors for development of perinatal sepsis.

b. Identify key nursing assessments and protocols for early recognition and management of perinatal sepsis.

c. Identify critical elements for patient education including warning signs.

Presenter:

Carol Burke, MSN, APRN/CNS, RNC-OB, CEFM

Perinatal Nursing Consultant, Retired

Length: 60 minutes (1.0 CH)

Nurse of the Year 2020 Winner!!

Congratulations to the 2020 Colorado AWHONN Nurse of the Year,

Sarah Kueene BA, BS, BSN, RNC-OB!!!

Sara is a bedside Labor and Delivery Nurse and Clinical Educator for Saint Joseph's Hospital and was nominated for her role as an educator, preceptor and bereavement coordinator.

Colorado AWHONN Nurse of the Year Nominees

Congratulations to all of the 2020 Colorado Nurse of the Year Nominees!!

Andrea Elmore MS, RNC-OB, C-EFM

Educator at UC Health

Nominated for her role as an educator and serving as an expert on her unit

Corie Hoskins, RNC-MNN

Mother/Baby Nurse at Lutheran Medical Center

Nominated for her commitment to evidence-based practice and her role in bedside research

Tracy McGuire MSN, RN

OB Nurse at Estes Park Health

Nominated for her phenomenal role as a preceptor

Jennifer Richardson BSN, RN

Labor and Delivery Nurse at Rose Medical Center

Nominated for her patient advocacy and her role in implementation of safety huddles to allow for faster recognition and better awareness of high risk patients.

Colorado AWHONN Poster Presentations

Cyndy Krening

Amy Dempsey

Laura Vorgic

SCL Health

Colorado

TO CATH OR NOT TO CATH? THAT IS THE QUESTION!

Cyndy Krening, MS, RNC-OB, C-EFM, Amy Dempsey, MSN, RNC-OB, C-EFM, Laura Vorgic, MSN, RNC-OB, CNL

Introduction/Background

Safe options for prevention of primary cesarean delivery in appropriate women have been the subject of research, publications, and professional discourse in recent years. Concurrently there has been a focus on the high incidence of catheter acquired urinary tract infections (CAUTI) in hospitals. Reducing unnecessary catheter placement and minimizing duration of indwelling catheters are primary strategies for CAUTI prevention. These important issues converge when promoting vaginal birth in women with epidural anesthesia during labor.

Urinary retention is a known side effect of labor epidural anesthesia. Maintaining an empty bladder is essential to provide opportunity for a fetus to descend toward a vaginal birth. Ideally this is accomplished with minimal risk of CAUTI. There are few data available related to bladder management of laboring women with an epidural. Common treatment for urinary retention in labor patients is to place an indwelling catheter, or to intermittently catheterize. The risk for infection related to bladder emptying must be balanced with the need to prevent a full bladder which may impede fetal descent, increase the length of labor, thereby increasing risk for cesarean delivery.

Objective

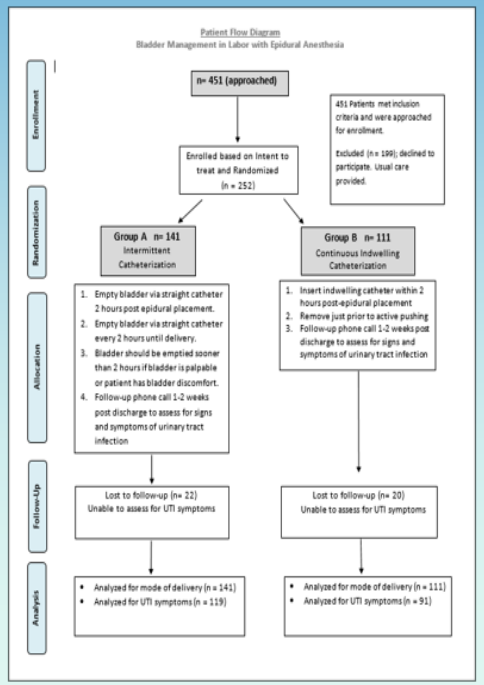
To compare intermittent with continuous catheterization during labor with epidural anesthesia on route of delivery and incidence of urinary tract infection (UTI) symptoms perceived by postpartum women.

Design

This randomized, controlled trial was held at three Denver metro institutions. 252 women who had term, singleton pregnancies in labor with epidural anesthesia participated in the study. Participants were randomly assigned to either indwelling or intermittent catheterization. The primary outcome was route of delivery; secondary outcome was perceived symptoms of UTI after hospital discharge.

Methods

Patients who met inclusion criteria were enrolled in the study and randomized to either indwelling or intermittent catheter groups following epidural placement and prior to catheterization. Following discharge, patients were contacted about UTI symptoms.



Data

Recruitment for the study and follow-up phone calls after delivery were conducted between August 2018 and February 2019. A total of 451 first-time mothers were approached to participate in the study and of those, 252 women were consented. Of those women consented for this study, a total of 111 participants were randomly assigned to the continuous catheterization group, with the other 141 participants randomly assigned to the intermittent catheterization group.

Characteristics of Study Participants

Characteristic	Total Sample	Continuous Catheterization Group (N=111) n	Continuous Catheterization Group (N=111) Mean	Continuous Catheterization Group (N=111) Standard Deviation	Intermittent Catheterization Group (N=141) n	Intermittent Catheterization Group (N=141) Mean	Intermittent Catheterization Group (N=141) Standard Deviation	p-Value
Maternal Age	252	111	29.3	5.6	141	29.7	4.9	0.488
Body Mass Index	251	111	30.5	5.3	140	31.0	5.4	0.452
Gestational Age	251	111	39.6	1.1	140	40.0	0.9	0.003*
Newborn Weight (grams)	250	111	3301.4	441.5	139	3339.1	418.9	0.491
Second Stage (minutes)	217	98	113.8	85.7	119	125.9	88.4	0.311

*Statistically Significant

Mode of Delivery and UTI Symptoms

	Total Sample	Continuous Catheterization Group (N=111) n	Intermittent Catheterization Group (N=141) n	p-Value
Cesarean Birth	50	18	32	0.394
Vaginal Birth	202	93	109	
UTI Symptoms	7	3	4	0.929
No UTI Symptoms	202	90	112	

Conclusion

There was no statistically significant difference in mode of delivery or symptoms of UTI in women receiving either intermittent catheterization or continuous indwelling catheter after labor epidural. Given that there were no significant differences, bladder management after epidural in labor should be at the discretion of the patient and healthcare team.

Colorado AWHONN Poster Presentations

UNIVERSITY of NORTHERN COLORADO
School of Nursing

Postpartum Hemorrhage (PPH) Simulation Project

Author: Carolyn Bottone-Post, DNP, CNM

ABSTRACT

Postpartum Hemorrhage (PPH) is a problem of global significance; accounting for 25 percent of maternal deaths and a leading cause of maternal mortality. PPH often occurs in healthy women without significant risk factors.

Because of its relative infrequency, student nurses may miss opportunities to practice critical PPH skills while in a supervised learning environment.

Simulation allows practice of low-frequency, high-stakes events like PPH, where no patient harm results from missteps.

This DNP Capstone Project investigated the effect of simulation on knowledge, confidence, and clinical judgment of 33 third semester traditionally enrolled baccalaureate nursing students.

A one-group, pretest-posttest design assessing knowledge and confidence was performed; knowledge scores showed mixed improvement.

Surveys revealed satisfaction with simulation improved (p< .0 to .003 at .05), although confidence in skills and responsibility for learning did not.. Themes of importance emerged, including prioritization and communication.

PURPOSE & OBJECTIVES

Purpose: To perform an evidence-based investigation of the effect of simulation on student knowledge, confidence and clinical judgment.

Simulation frameworks were used to assist OB nursing students to recognize signs of clinical deterioration during PPH.

Project Goals:

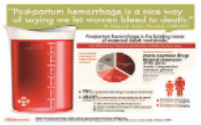
- Enhance knowledge, confidence and clinical judgment of nursing students, demonstrated by the ability to prioritize appropriate care during a simulated PPH
- Provide a simulation experience that was cost-neutral, sustainable and more robust than the simulation in use

METHODS

- Project took place within the UNC's SON in conjunction with Regis University
- Project was open to all students enrolled in OB-Peds course
- Simulation participation was mandatory, but project participation was optional and not compensated
- Students completed usual pre-simulation study sheets
- Simulations occurred during regular class simulation hours
- The project employed
  - A convenience sample
  - Quasi-experimental, mixed methods design
  - A one-group, pretest-posttest assessing the impact of the intervention on knowledge and confidence
  - A one-group survey, self-report of clinical judgement

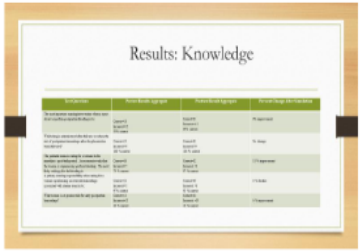
ANALYSIS

- Knowledge was measured by a 5-item test with content validity established by 10 subject matter experts, as a pretest and posttest measure
- Students completed the NLN Student Satisfaction and Self-Confidence in learning Survey as a pretest and posttest measure
  - Students were encouraged to provide comments
- A one-group, self-report of clinical judgement survey was administered using the Lasater Clinical Judgment Rubric (LCJR)
- Forms took 10 minutes or less for each participant to complete
- All surveys were anonymous, and no student identifiers used.



RESULTS

- *t*-test for differences between groups was performed on
  - Pre and posttest knowledge, satisfaction and self-confidence
- Descriptive statistics was done on the self-report of clinical judgement survey
- Results indicated an increase in knowledge after simulation that was not significant



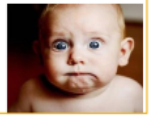
- Wilcoxon signed-ranks testing showed increases in all measures of satisfaction and 5 of 8 satisfaction scores

RESULTS (CONTINUED)

Results of the LCJR Self-evaluation Themes and subthemes of importance were divided into how I felt, what went well, and what could have gone better

- **How I Felt**
  - Helped bridge the Knowledge-Practice Gap
  - Developed Outward Calm while Inwardly Panicked
- **What Went Well**
  - Prepped Well
  - Recognized Clinical Deterioration
  - Prioritized Actions
  - Importance of Calm Communication
- **What Could Have Gone Better**
  - Communication needed improvement
  - Confidence increased although still anxious
- Take-Away on Calm Communication

"I am working on 'calm nurse face' and not reacting too negatively or positively to an observation or patient question. This was difficult today with what we observed, but I was able to curb it by talking to a family member in a calm manner"



REFERENCES

References available upon request.

ACKNOWLEDGEMENTS

Barbara Berg, DNP, PNP, CNE: Capstone Chair
Sheila Postiglione, MSN, CNE: DNP Clinical Mentor.

UNIVERSITY of NORTHERN COLORADO

Colorado AWHONN Poster Presentations

Birthing Suites within a Community Hospital: An Innovative Approach

Betsy De Leon, RNC, Amy Dempsey, RNC MSN , Jules Javernick, DNP, CNM
Lutheran Medical Center Wheat Ridge, CO

Background

Birthing centers offer a home-like, comfortable environment for mothers who desire a low-intervention birth. In the last decade, US birth center deliveries have more than doubled.

Creating this model within the hospital allows low-risk women the opportunity to have the same desired experience with the immediate back-up of hospital resources if interventions are needed.

Purpose

To develop a birthing center that provides a high-touch, low-intervention birth within the safety net of a hospital, promoting patient satisfaction, autonomy and family-centered care

Women are encouraged to use a variety of comfort techniques, position changes and non-pharmacologic coping strategies. Intermittent auscultation is utilized for fetal surveillance.

Methods

- Redesign two LDRs into birthing suites. Highlights include:
  - Jacuzzi tubs & queen size beds
  - Labor swing & aromatherapy diffuser
  - Redesigned color palette & designer bedding
  - Medical equipment stored in an ante-room, not visible to the patient.
- Create a "birth center" policy which includes agreed upon inclusion/exclusion criteria for admission and transfer.
- Staff education on policy, labor support and IA
- Women admitted to the birth center are pre-screened and required to attend a birthing class prior to delivery.

Outcomes

- Opened the birth center in July 2018
- Thirteen months after opening (August 2019), the 100th patient delivered in the birthing suites.
- Team celebrated the successful implementation of a low-cost, safe, innovative model of care.

13 months	Delivered Patients	Cesarean Deliveries	3rd/4th degree lacerations	Apgar Score < 7 at 5 minutes
Total number of deliveries	2144	527 (24.5%)	23 (1.1%)	25 (1.2%)
Total number of term deliveries	1954	461 (23.5%)	23 (1.2%)	25 (1.3%)
Birth Center: total number of deliveries	100 +9 transfers to LDR	4 transferred and delivered by Cesarean (3.4%)	0	1

Patient Satisfaction---The Voice of our Patients

- "The birth suites felt so empowering"
- "So supportive of what we wanted"
- "The room was beautiful and I felt as non medical as possible being in a hospital"
- "Everyone felt on the same page as to my birth plan and desires"

Implications for Practice

Birth Center within the hospital is a creative and safe model that aligns with the goal of promoting normal physiologic birth.

Experienced Barriers:

- Queen beds are challenging for management of perineal laceration repair, shoulder dystocia and postpartum hemorrhage. A stretcher is preferred.
- Colorado state requirements for birth centers are different than inpatient hospitals, preventing discharge prior to 24 hours
- In general, our L&D nurses prefer continuous EFM; intentional focus on building confidence with Intermittent Auscultation
- Some obstetricians on staff are resistant to this model of care

Conclusion-Benefits of Model

- A transfer involves moving rooms, rather than an ambulance or automobile ride.
- Readily accessible additional resources available if needed for emergency scenarios.
- Offers women multiple options and choices for their labor and delivery experience
- Promotes continuity of care; allows providers (physicians and CNMs) the opportunity to care for birth center women within their own institution

Betsy De Leon

Amy Dempsey

Jules Javernick

Colorado AWHONN Poster Presentations

Using education to improve compliance with recommended bladder management practices for laboring patients with an epidural

Andrea Elmore, MS, RNC-OB, C-EFM
Clinical Nurse Educator
University of Colorado Hospital

Joy L. Hawkins, MD
Professor of Anesthesiology
University of Colorado School of Medicine

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Introduction:

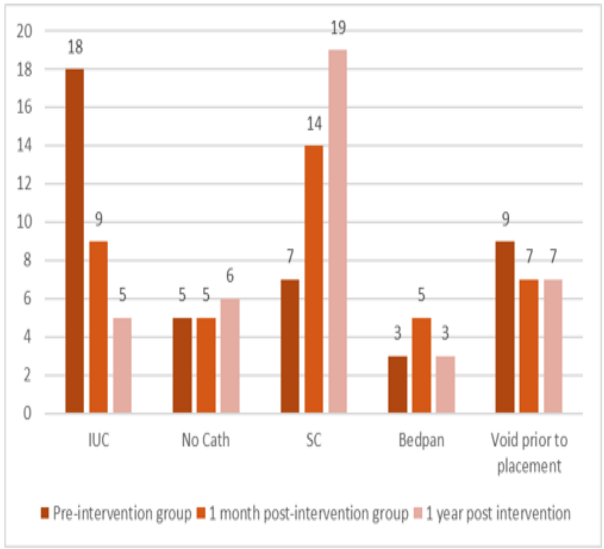
The aim of this project is to change the nursing culture so bladder management interventions are individualized for laboring patients with regional anesthesia. To achieve this aim we sought to improve nursing compliance with intrapartum regional anesthesia bladder management orders that were designed to reduce exposure to indwelling urinary catheters (IUC).

Discussion:

Educational interventions, more than changes to an EMR order set, achieved a moderate change in nursing compliance with bladder management orders for patients with regional anesthesia. Future educational interventions are needed to increase nursing comfort in assessing for urinary retention and offering a bedpan in this patient population.

Methods:

The hospital's regional anesthesia in labor orders were changed to reflect the desired practices for bladder management. Bladder management orders include, void prior to procedure, straight catheter (SC) times 2 for inability to void or palpable bladder, and may place indwelling catheter after 2 straight catheterizations. Electronic health records (EHR) were reviewed for 30 patients who received regional anesthesia in labor, for nursing compliance with orders pre and post-educational intervention. Nursing education was provided in a staff meeting, in an effort to improve compliance with bladder management orders. Education included review of rates of urinary retention during labor with epidural anesthesia, Centers for Disease Controls (CDC) recommendations on catheterization, and review of current bladder management orders. After education, 30 EHRs were reviewed for compliance with orders, at 1 month and 1 year after intervention.



Results:

The order set changes alone were not effective in reducing usage of IUCs in laboring patients with an epidural. After the educational intervention, IUC use decreased by 50% at 1-month post intervention, and decreased by 72% at 1-year post intervention. Straight catheter use increased by 100% at 1-month post intervention, and by 171% at 1-year post intervention. Bedpan use increased by 66% at 1-month post intervention, though no change was noted at 1-year post intervention. Adherence to having women void before their procedure remains low. The number of patients that didn't receive a catheter did not change at 1-month post intervention, and increased by 20% at 1-year post intervention.

uchealth

Colorado AWHONN Poster Presentations

Improving Inpatient Antenatal Patient Activity and Interdisciplinary Team Communication

Heather Flimlin, BSN, RNC-OB, C-EFM

Background

This QI project aimed to decrease rates of strict bedrest in stable inpatient antenatal patients, as well as improve communication between our inpatient antepartum patients and interdisciplinary care teams (i.e. nursing staff, obstetrical providers and OB navigators). After identifying the issue of high rates of strict bedrest in our inpatient antenatal patients, I compared our practice to current evidence-based practice recommendations. After completion of a literature review; multiple studies claimed the ineffectiveness of bed rest in the antepartum patient population. One review stated the following; "a Cochrane database meta-analysis has concluded that antepartum bed rest is a treatment whose effectiveness have not yet been demonstrated. There is no evidence to support the use of activity restriction during pregnancy during pregnancy at home or in hospital, and practitioners should not assume efficacy for bed-rest treatment until evidence is produced." The journal article goes on to report the physiological and psychological side effects of antepartum bed rest, including; "altered muscle metabolism, increased bone turnover, thrombosis, maternal weight loss, lower infant birth weight, antepartum and postpartum symptoms of deconditioning (i.e. muscle loss, pain and discomfort) prolonged postpartum recovery, depressive symptoms; including anxiety, increased stress, boredom, sense of being a prisoner, family and stress role alterations, financial difficulties, lack of control, concern for maternal and fetal wellbeing, worry about family at home, separation from family and paternal difficulties".

The project also aimed to improve communication between our inpatient antepartum patients and interdisciplinary care teams including; nurses, providers, and OB navigators as nursing staff reported complaints related to inconsistent and an unclear plan of care for patients. The results identified that our current practice was resulting in poor communication between inpatient antenatal patients and interdisciplinary teams caring for the patient. One journal reported "incomplete or delayed information can compromise safety, quality and the patient's experience of healthcare." Evidence suggests that a structured report format can improve communication. Errors in communication are identified by the Joint Commission as a root cause of sentinel events. The Joint Commission has identified "improve staff communication" as a 2018 National Patient Safety Goals.

Method

- After identifying the issue of high levels of strict bedrest in our inpatient antenatal patients I reviewed current evidence-based practice recommendations for our patient population and communicated these findings to obstetrical providers and nursing staff through safety and quality meetings as well as staff meetings. I reviewed our current rates of strict bedrest in our inpatient antepartum population was inconsistent with best practice recommendations.
- After identifying the issue of poor communication between inpatient antepartum patients and interdisciplinary care teams I used multiple interventions and worked with our OB navigators to improve communication, including:
  - Developing an Antepartum Patient Admission Algorithm
    - Goal: Provide RN staff an algorithm for antepartum patient admission and stay to consistently provide quality care.
    - Goal: Improve timing of scheduled Antepartum Care Conferences.
  - Creation of Antepartum patient white board specific to patient population
    - Goal: Clarify plan of care between inpatient antepartum patients, patient's support system, and interdisciplinary care teams.
  - Creation of an Antepartum patient-specific report sheet
    - Goal: Expedite report during emergency (example: stat c-section)
    - Goal: Consistent report from RN to RN between shift and units.

Discussion

Limitations & Future Evaluations

The limitations of the study regarding to timing of scheduled Antepartum Patient Care Conferences was the sample size (pre intervention n size:38, post intervention n size:17), with a small post intervention n size this could potentially effect post intervention data results, further evaluation is needed.

The plans for sustainability related to antepartum activity will be ensure staff and providers communicate proper patient activity levels in the antepartum patient by consistently reviewing their level of activity and communicating effectively with available tools such as the antepartum specific white board and use of antepartum report sheet during shift to shift report. Continuing to review patient activity levels and plan of care with patient and family during antenatal care conferences will also ensure better communication.

PICOT

Topic: Inpatient Antenatal Patient Activity

Identified Issue: High rates of ordered bed rest and limited activity in our antepartum patient population; current practice does not follow evidence-based practice recommendations.

- **Population:** UCHealth Poudre Valley Hospital Women's Care Unit antepartum patients.
- **Intervention:** Education of nursing staff and OB providers related to current evidence-based practice guidelines of antepartum population related to activity and bed rest.
- **Comparison:** The study will compare pre-education selection rates of ordered bed rest (of the antepartum patient population) to post-education selection rates of bed rest (of the antepartum patient population).
- **Outcomes to be measured:** Antepartum patient activity levels will increase in our stable antepartum patient population and, therefore decrease patient's risks related to bed rest.
- **Timeframe:** Project will be completed by 8/1/2019.

Topic: Inpatient Antenatal Patient Communication

Identified Issue: Poor communication between inpatient antenatal patients and interdisciplinary care teams.

- **Population:** UCHealth Poudre Valley Hospital Womens Care Unit antepartum patients and interdisciplinary care teams.
- **Intervention:**
  - Antepartum patient admission algorithm
  - Creation of Antepartum patient white board specific to patient population
  - Antepartum patient-specific report sheet
- **Comparison:**
  - The study will compare pre intervention rates of timing of scheduled Antepartum Patient Care Conferences to post intervention (i.e Antepartum Admission Algorithm) rates of timing of scheduled Antepartum Patient Care Conferences.
  - The study will compare pre intervention RN staff survey results related to communication between providers, nurses and the antepartum patient to post intervention RN staff survey results related to communication between providers, nurses and the antepartum patient.
- **Outcomes to be measured:**
  - Pre/post education inpatient antenatal ordered activity levels.
  - Pre/post intervention timing of scheduled Antepartum Patient Care Conferences.
  - Pre/post intervention nursing staff survey questions regarding interdisciplinary team communication.
- **Timeframe:**
  - Patient activity (post-education/ intervention) data collection period: January 2018- May 2019.
  - Communication data (post-education intervention) data collection period April 2019- May 2019.

Results

Topic: Inpatient Antenatal Patient Activity

The QI results related to antepartum activity compared pre-education selection rates of ordered bed rest (of the antepartum patient population) to post-education selection rates of bed rest (of the antepartum patient population). After analyzing the data received related to antepartum patients activity level, the data showed from pre-education to post-education; our rates of bed rest with bathroom privileges decreased from 61% to 38%, bed rest with bathroom privileges and wheelchair privileges decreased from 8% to 6%, patient may walk on unit increased from 12% to 17%, patient may walk on unit with off unit wheelchair privileges increased from 0% to 6%, activity as tolerated increased from 12% to 23% and no activity level ordered increased from 2% to 6%. The results from the education intervention were positive; our antepartum patient population has overall decreased rates of bedrest and increased rates of activity; including use of a wheelchair or ambulate on/off the Women's Care Unit. Our current practice has aligned with current evidence based practice standards related to inpatient antepartum patient activity levels. The clinical outcome goal was met by increasing antepartum patient activity levels in stable antepartum patient and, therefore decreasing patient's risks related to bed rest.

Topic: Inpatient Antenatal Patient Communication

The study compared pre intervention rates of timing of scheduled Antepartum Patient Care Conferences to post intervention (i.e Antepartum Admission Algorithm) rates of timing of scheduled Antepartum Patient Care Conferences. Data showed that pre-intervention; 11% of our antepartum patients were receiving antenatal care conferences to post intervention data showing 47% of patients received antenatal care conferences.

The study compared pre intervention RN staff survey results related to communication between providers, nurses and the antepartum patient to post intervention RN staff survey results related to communication between providers, nurses and the antepartum patient. In the question asked; "In the last six months, communication on the Women's Care Unit has been clear between providers, nurses and patients regarding antepartum patient orders.", pre intervention 55% of staff strongly agreed or agreed, post intervention 82% of staff strongly agreed or agreed. In the question asked; "In the last six months, I have had an antepartum patient complain of inconsistencies in plan of care. i.e: plan of care changing daily or not knowing plan of care." Pre intervention; 54% of staff strongly agreed or agreed, post intervention 9% strongly agreed or agreed. The process outcome goal to improve communication between providers, nurses and antepartum patients was met.

In the question asked; "In the last six months, my antepartum patients have verbalized satisfaction is being able to ambulate on/off the Women's Care Unit", 82% of staff reported always or usually; more than half the time. In the question asked; "The Antepartum Admission Algorithm has clarified what consistently needs to occur during the care of an antepartum patient. (i.e room setup, IP Women & Children's Nurse navigator order, applicable screening/ vaccine schedule)", 82% of staff reported strongly agree or agree. In the question asked; "The antepartum specific patient white board has clarified the plan of care between providers, nurses and patients, and patient's support systems", 95% of staff reported strongly agree or agree. In the question asked, "The Antepartum Report Sheet has provided a consistent form of report from RN to RN (i.e shift to shift report or during patient transfer)", 64% of staff reported strongly agree or agree.

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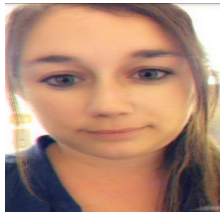
UCHealth Poudre Valley Hospital

Women & Children's Service Line

Colorado AWHONN Poster Presentations

Implementing a Nurse Staffing Acuity Tool on the Labor and Delivery Unit

Rainy Tieman DNP, MSN/Ed, RNC-MNN, RNC-OB, C-EFM



Practice Problem

Staffing on Labor and Delivery prior to the implementation of the acuity tool was subjective. The charge nurse and clinical shift supervisor (CSS) determined staffing needs for the oncoming shift based off of opinion and experience. Therefore, staffing was not consistent, which caused issues with budgeting and appropriate staffing from shift to shift.

Nursing and Healthcare Implications

Primary: Evaluate if implementing an acuity tool will assist in safer staffing practices on the Labor and Delivery Unit at Saint Mary's Hospital and Medical Center.

Secondary: Determine if completing the acuity tool every four hours will impact the charge nurse's workflow inappropriately.

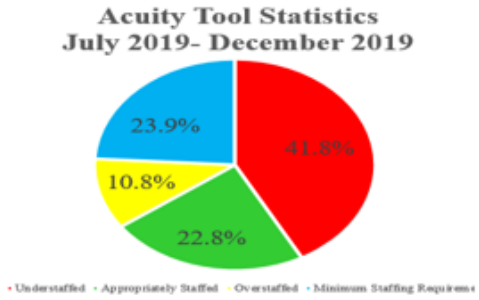
Project Description

An acuity tool, based off of AWHONN's nurse staffing guidelines was developed and implemented.

The charge nurses were educated on the use of the acuity tool, including how each patient was "graded" according to their acuity.

From there, patient acuity was determined every four hours by the charge nurse and staffing was adjusted, if needed.

Data gathered and interpreted on how appropriate the charge nurses were staffing the unit, based off of the staffing and acuity guidelines set forth. The charge nurses were also surveyed three months after the implementation of the acuity tool to determine if they felt that implementation of the acuity tool had increased their workload inappropriately.



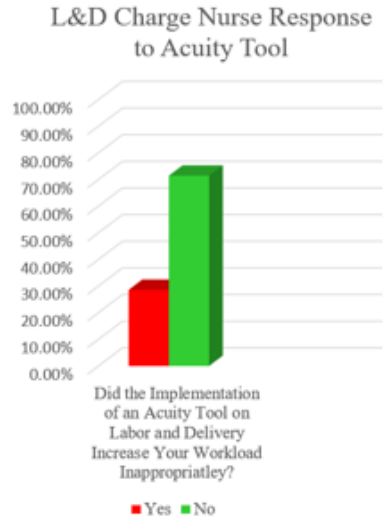
Project Evaluation

Quantitative:

How many days did the acuity tool indicate that the Labor and Delivery unit was overstaffed, understaffed, or staffed adequately (including designating minimum staffing requirements in use).

Qualitative:

Survey sent out to the ten nurses that are designated charge nurses to determine if they felt their workload increased inappropriately due to the implementation of the acuity tool.



Conclusion

Data gathered was alarming as it determined that after taking into account acuity, only 22.8% of the time the Labor and Delivery was appropriately staffed with RNs. In addition, the acuity tool proved that the Labor and Delivery unit was understaffed 41.8% of the time.

The data gathered was presented to our finance department and therefore FTEs were not reduced on Labor and Delivery.

Alternatively, charge nurses on the Labor and Delivery unit now have more autonomy when it comes to making decisions regarding staffing and safe staff ratios.

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SCL Health

Colorado AWHONN Poster Presentations

Swaddle Bathing in the NICU

Macy D. McKim MSN, RNC-NIC, C-ELBW

Neonatal Intensive Care Unit

Practice Problem

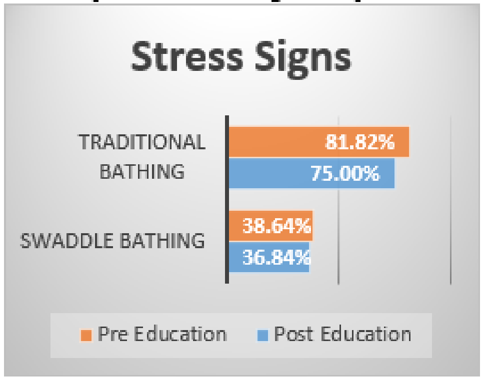
The current bathing policy was up for review. Traditional bathing has been found to stress newborns as evidenced by behavioral signs such as crying, arching of the back, extended limbs, and splayed fingers, as well as physiological signs such as temperature instability, apnea, hypoglycemia, and hypoxia.
The most current guidelines recommend swaddle bathing to help with the feeling of securement and containment, which may help prevent uncontrolled motor activity. Swaddle bathing is the action of bathing an infant swaddled while in a flexed, midline position. The infant is submerged to the shoulders in a tub of water.
There was an expressed interest in developing and implementing a swaddle bathing protocol by nursing administration and the neonatal skin champions.

Nursing and Healthcare Implications

Primary: Evaluate current bathing practices in the NICU including pre- and post-temperature and stress signs.
Secondary: Evaluate for parental involvement.

Project Description

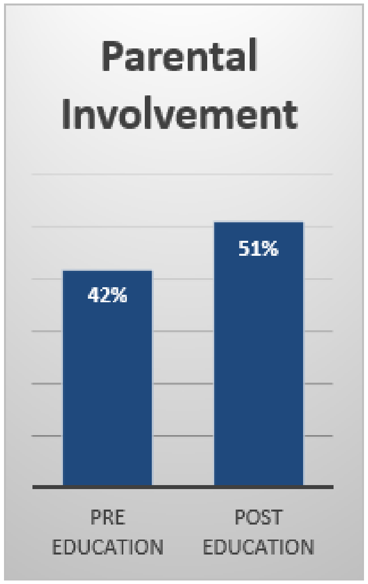
A pre-intervention survey was completed by staff to see what type of bath was being done as well as pre- and post-bathing temperature, stress signs and parental involvement.
A bathing protocol based on AWHONN's (Association of Women's Health and Neonatal Nurses) Neonatal skin care: Evidence-based clinical practice guidelines were developed and implemented. PowerPoint education was provided to all current NICU nursing staff.
After education was complete a post intervention survey was completed again looking at bath type, pre- and post-bathing temperature, stress signs and parental



Temperature change with swaddle bathing	0.84
Temperature change with traditional bathing	-0.03

Project Evaluation

Quantitative:
How often was the appropriate bathing option chosen for the patient and how often was temperature stability, stress signs and parental involvement observed?
Qualitative:
Survey completed for 30 days both pre- education and post-education to evaluate for temperature stability, stress signs and parental involvement.



Conclusion

The initial focus was choosing the right bath based on the patient need. Pre-education there was a 13.6% miss rate, while post-education there was a 7.4% miss rate.
Significant data showed pre-education there were 81.8% of infants showing signs of stress with traditional bathing vs. 38.6% showing signs of stress with swaddle bathing. While post-education 75% showed signs of stress with traditional bathing vs. 36.8% with swaddle bathing.
Parental involvement increased from 42% of baths pre-education to 51% of baths post-education.
Overall there was enough data to show that swaddle bathing was less stressful and more enjoyable for the patient and it was implemented.

References

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SCL Health

Colorado AWHONN Poster Presentations

Unexpected Complications of Long Acting Reversible Contraceptives (LARC): Case Studies of Adverse Events

Mary Claire Wahl, DNP, CNM

BACKGROUND & PURPOSE

- LARCs are highly effective and well-tolerated birth control methods
- Adverse events are rare
- Limited research and guidelines on how to manage adverse events
- Two unique case studies presented

LEARNING OBJECTIVES

1. Describe the incidence of adverse events with IUDs.
2. Describe evidence-based guidelines for managing PID with IUD use.
3. Understand patient populations who may be at higher risk of adverse event with LARC use.

Case #1: IUD, Menstrual Cup, & PID…Related?

History and Presenting Complaint:

- 33 y.o. G3P3 using Paragard Copper IUD for 5 years
- History of uncomplicated PID 10 years ago
- In mutually monogamous relationship with male partner (husband); does not desire future pregnancies
- Has monthly menses with moderate flow, uses menstrual cup
- Presents to primary care (women's health provider) C/O vaginal itching and burning after accidentally leaving menstrual cup in place for 7 days
- Onset of sx 5 days ago (removed cup), symptoms improving, some vaginal discharge
- She self-medicated with OTC Monistat vaginal cream for 5 days and sx nearly resolved now. Used cream last night.

Exam Findings:

- No acute distress, afebrile, vitals normal
- External genitalia: pink, no inflammation
- Vagina: moist, pink, small amount thick yellow discharge, no odor
- Cervix: parous, pink, no lesions, IUD string present
- Bimanual exam: Uterus normal size, non-tender; negative cervical motion tenderness; adnexa normal without masses and non-tender
- Wet mount: pH: 4.0; KOH neg whiff test; few WBCs; no clue cells, no trichomonads, no psuedohyphae

Diagnosis/Treatment/Plan:

- Inflammatory Vaginitis, secondary to retained menstrual cup
- Expectant management
- Discontinue Monistat cream
- Pelvic rest 5-7 days
- Return if symptoms worsen

3 Days Later…

- Pt calls clinic with request for urgent appointment
- C/O lower abdominal pain, achy in pelvic area and thighs, "feel like I have the flu"
- In moderate distress; "hurts to walk"
- Temp 100.0 F
- Abdomen: vague tenderness over lower quadrants
- Pelvic exam: mod amount of *yellow discharge*, *uterus tender*, *positive CMT*, adnexa *mild tenderness* bilaterally
- Wet mount: pH 4.2; neg whiff test; no clue cells, no trich, no yeast, *numerous WBCs*

Diagnosis: Pelvic Inflammatory Disease (PID)

- Met minimum criteria: Lower abdominal pain + uterine tenderness, CMT
- Low grade temp
- Numerous WBCs
- Risk factors: History of PID, retained menstrual cup, IUD?

Treatment/Plan:

- Labs: Chlamydia, GC, Trich, BV (NAAT)
- CDC Guidelines for uncomplicated PID
    - Ceftriaxone 250 mg IM

DISCUSSION QUESTIONS

- *Should IUD be removed?*
- *Should husband (partner) be treated?*
- *Should she discontinue using menstrual cup with IUD?*

REVIEW OF LITERATURE

- Literature does not support removal of IUD with PID (unless no improvement with treatment)
- CDC recommends treating sexual partners
- Lack of evidence that menstrual cup is contraindicated with IUD, although product manufacturer advises "caution"

FOLLOW UP

- Returned 48 hours later; sx improved; neg Chlamydia, GC, Trich, BV
- 2nd F/U 48 hours later: sx greatly improved, normal wet mount
- Discussion with patient:
    - She desired to have IUD left in place, but agreed if any further PID episodes should consider a different method
    - Patient decided not to use menstrual cup in future
    - Husband of patient declined treatment

LESSONS LEARNED

- Recognize early signs of PID and don't wait to treat!
- PID may not be caused by the usual suspects…(STIs)
- Lack of evidence in literature does not mean evidence against…
- Caution IUD users about menstrual cup use

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Colorado AWHONN Poster Presentations

Unexpected Complications of Long Acting Reversible Contraceptives (LARC): Case Studies of Adverse Events

Mary Claire Wahl, DNP, CNM

UCCS University of Colorado Colorado Springs

Case #2: Nexplanon & MRSA

History and Presenting Complaint:
- 33 y.o. G0 presented for removal and reinsertion of Nexplanon
- History of using contraceptive implants for 10 years without complications & highly satisfied
- No contraindications for this method
- Removal and reinsertion performed easily without any problems

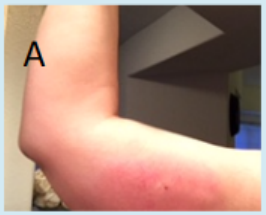
Follow up 1 week post-insertion (A):
- C/O local tenderness
- Insertion site scabbed over
- Treated with Keflex 500 mg TID x 3 days

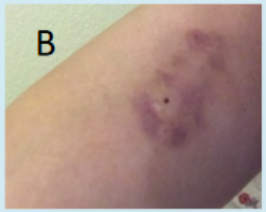
Follow up 2 weeks post-insertion (B):
- Reported improvement in tenderness
- Erythema decreased; some bruising
- Continue warm compresses

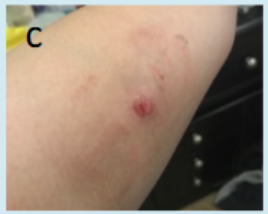
Follow up 3 weeks post-insertion (C):
- Reported redness/tenderness resolved after Keflex, but symptoms resumed
- Oozing at insertion site
- Culture obtained…results 2 days later showed MRSA
  - Pt denies any known MRSA history
- Treated with Augmentin XR BID x 10 days
- Wants to keep implant

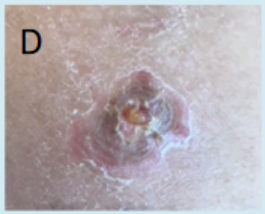
Follow up 4 weeks post-insertion (D:
- Insertion site still oozing
- Culture repeated…Negative for all pathogens
- Continue course of Augmentin XR BID x 10 days
- Implant removed per patient request
- Started on oral contraceptives

Telephone follow-up 2 days later:
- Symptoms much improved
- Site healed over
- No drainage or redness









DISCUSSION QUESTIONS
- What is the incidence of infections or site reactions with Nexplanon?
- Is there a connection between Nexplanon and MRSA?
- Should history of MRSA or atopic dermatitis be a contraindication for implant?

REVIEW OF LITERATURE
- Reaction at insertion site < 1% (Reed, 2019)
- 4 cases of post-insertion infections reported in 2013, all had history of atopic eczema (Chaudhry, 2013)
  - Patients with eczema carry a higher colony count of *S. aureus*, and should be considered higher risk for infection (Richold, 2018)
- 1 case report of infected site, suspected to be caused from the barium in the Nexplanon rod

LESSONS LEARNED
- Identify history of atopic eczema
- Use caution and/or counsel on risks
- Culture any exudate early
- Aggressively treat if MRSA identified

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Membership Matters

Welcome to the new faces of CO-AWHONN Membership Coordination! By: Nicole Downs, BSN, RNC-OB, C-EFM

It has been my pleasure to serve as your Colorado Membership Coordinator these past 5+ years. I have enjoyed the role of Membership Co-ordinator. Mostly, because I have enjoyed getting to know so many of you. And I've LOVED working with this totally engaged group of Section leaders. Whether we are meeting to plan our calendar for the year, or to discuss Section issues, or to dream up an amazing State Conference, I have so appreciated the positive atmosphere created by this group. Everything we need to do to improve the safety and health of women and babies seems possible with these dynamic leaders at the helm.

Thank you all for supporting me in this role.

Now it is my privilege to pass the baton to your new Colorado Membership Coordinator: Sarah Mangat, who is relatively new to our state. I know you will all welcome her warmly. Sarah will be helped in this role by Kami Mogensen, who has served before and has plenty still to offer.

Please allow Sarah and Kami to introduce themselves:

Hello Colorado AWHONN!

My passion for labor and delivery started over 6 years ago when I was a new graduate nurse hired onto an LDRP of a busy hospital in Toronto, ON, Canada. I worked for a few years in Canada (my home country), before moving to the United States to become a travel nurse. I travelled for over 3 years across the US; working in Washington, Texas and Colorado. Falling in love with Colorado, I took a permanent job at Children's Hospital of Colorado in the Maternal Fetal Care Unit. It is a smaller unit that specializes in pregnancies with complex fetal diagnoses. I had primarily joined AWHONN for the educational resources. But after joining under the Colorado chapter, and seeing all the different events offered; I knew I wanted to become more involved. I was excited to see that CO AWHONN was looking for a new membership coordinator and am thrilled to share the new role with Kami Mogensen. I have found my AWHONN membership invaluable to me, in all the resources, education and events that they offer. And I am excited to share my enthusiasm for the organization with you. I look forward to meeting you all, be it by zoom/e-mail (or one day in person hopefully!)

Sarah Mangat

Mangat.sarah@gmail.com

Hello,

My name is Kami Mogensen. I am so happy and honored to serve on our CO AWHONN section as membership co-coordinator.

I have served Colorado AWHONN on several occasions and I look forward to being an active team member again.

I have been a Labor and Delivery nurse for fifteen years. I currently work on the birth center at UCHealth Longs Peak Hospital.

I am the mom of a wonderful thirteen year old boy, two dogs, and two cats. I currently reside in my hometown of Firestone, Colorado.

I am motivated to not only increase membership numbers, but enhance the current membership experience.

If you have any thoughts or suggestions, please contact me via email or phone.

Kami Mogensen BSN, C-EFM

kmogensen80@gmail.com

720-240-3623

Thank You to AWHONN Sub-Committees and Leadership Team!

Extending a Heart Filled Thank You to Our 2020 Conference Sub-Committee Members!

Nurse of the Year Subcommittee Members

Sarah Trujillo
Cyndy Krenning
Sonya Knight
Isabelle Campanella
Amy Dempsey
Rachelle Woods
Christy Ringler

Poster Subcommittee Members

Rainy Tieman
Erin Emerson
Amber Young Lippincott

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AWHONN COLORADO
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Announcements/Upcoming Events

COLORADO Section Meetings

The American College of Obstetricians and Gynecologists

Register now: https://bit.ly/2ZeVVxV

2020 — Virtual Meetings

August 26, 2020 – Legal Cases in ObGyn with Mark Fogg, CLE
Wear your favorite hat!

September 16, 2020 – Sexual Health with Christine Giesing, MD
Wear your favorite Hawaiian clothing!

October 7, 2020 – PCOS with Eric Surrey, MD
Wear your favorite sports team gear!

November 7, 2020 – Maternal Morbidity & Mortality Summit

2021 — In-person Events

January 25, 2021 – Hot Topics

February 8, 2021 – Legislative Day

April 10, 2021 – Gyn Conundrums

June 17–19, 2021 – Vail Symposium

November 5, 2021 – Maternal Morbidity & Mortality

Register Now — 2020 & 2021 Events!

Register: https://bit.ly/2ZeVVxV

Virtual Meetings will include networking, presentation, and Q&A.
Registration required.

If any events are cancelled, registration fees will be refunded
Dates subject to change.

QUESTIONS, CONTACT:
colo.acog@gmail.com

First 30 people to register will receive a **FREE SWAG BAG!**

Announcements/Upcoming Events

Presented in partnership with: ACOG • ACNM • AWHONN • CAFP • CSA • CDPHE

2020 VIRTUAL
Harvey Cohen, MD
Maternal Morbidity & Mortality Summit

Saturday, November 7, 2020
VIRTUAL EVENT

Harvey Cohen, MD

Topics:
- Update from CDPHE and MMRC Committee
- Thyroid storm and previability concerns
- Anesthetic and AFE complications
- Managing Diabetes in a non-urban setting
- COVID-19 and Pregnancy Case Series

Register: https://acogcolovirtualmmm2020.eventbrite.com

Questions: colo.acog@gmail.com

SUMMIT MISSION STATEMENT:

"Our purpose is to annually meet and collaborate on cases involving maternal morbidity and mortality in order to identify systems issues and create awareness and changes that will improve the health and safety of mothers in Colorado."

AWHONN
AMERICAN COLLEGE of NURSE-MIDWIVES
The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS
CDPHE
CSA Colorado Society of Anesthesiologists
COLORADO ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR COLORADO

Save the Date! 2021 CO AWHONN Conference!

SAVE THE DATE!

2021 Colorado AWHONN Section Annual Conference September 16, 2021 & September 17, 2021

Fort Collins Marriott | 350 Horsetooth Road Fort Collins, CO

Registration Opens Soon!

In Loving Memory of Darlene Dakuliak

It is with a heavy heart that the Colorado AWHONN Leadership team dedicates the 2020 CO AWHONN Virtual Convention to one of our own, Darlene Dakuliak.

Darlene was a true hero for Colorado Moms and Babies. She was well known to many of us, and was on the Colorado AWHONN conference committee from 2014-2020. Darlene's passion was spearheading our philanthropic endeavor and was responsible for providing so many diapers through diaper drives for babies.

Darlene was a member of Colorado AWHONN for twenty-eight years.

She will be incredibly missed.