

NURS-FPX4025 Assessment 4

# Presenting Your PICO(T) Process Findings to Professional Peers

## Professional Poster and 5-10 Minute Presentation Narrative

|                  |                                                                                                                                                                                                                                                                                   |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Author           | FlexPath Assignment Help                                                                                                                                                                                                                                                          |
| Course           | NURS-FPX4025: Research and Evidence-Based Decision Making                                                                                                                                                                                                                         |
| Assessment       | Assessment 4 - Presenting Your PICO(T) Process Findings to Professional Peers                                                                                                                                                                                                     |
| Clinical focus   | Type 2 diabetes mellitus and continuous glucose monitoring                                                                                                                                                                                                                        |
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| Website          | FlexPathAssignmentHelp.com                                                                                                                                                                                                                                                        |
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**Educational sample notice**  
This original model demonstrates one strong way to organize the assessment. It is not an official Capella University document. Learners must use the current courseroom instructions, their own simulation evidence, their own presentation recording, and their own clinical judgment.

**Primary keyword:** NURS-FPX4025 Assessment 4 Presenting PICO(T) Findings

**Related keywords:** PICOT presentation, nursing poster, type 2 diabetes, continuous glucose monitoring, CGM evidence, professional peers

The learner must record and submit their own video and add the actual Kaltura or approved video link to the narrative. This sample supplies the poster content and complete speaking script, not a recorded performance.

## Deliverables Included

- A one-page professional poster summarizing the diagnosis, PICO(T) question, evidence, answer, and recommended care.
- A complete presentation narrative designed for approximately 7-8 minutes at a clear professional pace.
- An APA reference list and an assessment coverage map.
- A clearly marked place for the learner to add their own video link.

Use the next page as the visual poster during the recorded presentation. The narrative that follows is written to match the poster from left to right.

# Continuous Glucose Monitoring for Adults With Type 2 Diabetes

PICO(T) evidence synthesis and nurse-led care recommendation  
FlexPath Assignment Help | NURS-PPX4025: Research and Evidence-Based Decision Making

## Diagnosis and Clinical Need

**Type 2 diabetes mellitus** causes chronic hyperglycemia through insulin resistance and progressive loss of insulin secretion.

**Major risks:** severe hyperglycemia, hypoglycemia during treatment, kidney disease, neuropathy, retinopathy, cardiovascular disease, infection, and poor wound healing.

**Practice gap:** Fingerstick readings are isolated snapshots. Patients and clinicians may miss overnight and post-meal patterns. Technology access is also unequal.

## PICO(T) Question

**P:** Adults with type 2 diabetes using basal insulin and above their individualized HbA1c goal.

**I:** CGM plus structured nurse education and scheduled data review.

**C:** Fingerstick monitoring plus usual education.

**O:** Lower HbA1c and more time in range without more clinically important hypoglycemia.

**T:** Six months.

**Question:** Does the CGM pathway improve these outcomes compared with usual monitoring?

## Evidence Summary

**Jancev et al. (2024):** 12 RCTs, 1,248 adults. CGM lowered HbA1c by 0.31%, increased time in range by 6.36%, and reduced time above range.

**Uhl et al. (2024):** 14 RCTs. CGM lowered HbA1c by about 0.32%; evidence certainty was moderate.

**Grace & Salyer (2022):** Prospective real-world study found better HbA1c and time in range, but the small single-arm design limits causal inference.

**ADA (2026):** Recommends individualized technology selection, education, and ongoing support.

## Answer to the PICO(T) Question

**Yes, with conditions.** CGM is more effective than fingerstick monitoring alone for improving HbA1c and time in range over three to six months in many adults with type 2 diabetes.

The average HbA1c effect is modest, and evidence about long-term complications is limited. Benefit depends on access, education, safe response to alerts, and clinical review of patterns.

## Recommended Steps of Care

- 1. Assess:** Diagnosis, insulin regimen, HbA1c goal, hypoglycemia, readiness, access, and accommodations.
- 2. Select:** Choose device through shared decision-making; keep a backup meter.
- 3. Teach:** Sensor use, trend arrows, alerts, skin care, confirmatory checks, and hypoglycemia treatment.
- 4. Support:** Nurse contact within 72 hours.
- 5. Review:** Analyze ambulatory glucose profile at two weeks and monthly.
- 6. Coordinate:** Adjust medication, nutrition, and activity with the interprofessional team.
- 7. Evaluate:** HbA1c, time in range, time below range, safety, experience, continuation, and equity.

## Implementation Measures

**Clinical:** HbA1c change, time in range, time below range.

**Safety:** Severe hypoglycemia, urgent calls, skin injury, data errors.

**Experience:** Confidence, burden, alarm fatigue, satisfaction.

**Equity:** Offer, initiation, training, and continuation across insurance, language, disability, and location groups.

## Equity and Shared Decision-Making

Assess insurance, cost, language, vision, dexterity, cognition, smartphone or receiver needs, internet access, skin sensitivity, alarm burden, and caregiver support.

Use interpreters, teach-back, accessible education, receiver devices, financial navigation, and a safe alternative plan when CGM is not feasible.

The patient may decline. Device choice must reflect goals, preferences, and ability to respond safely.

## Why the Evidence Is Credible

The strongest sources are peer-reviewed meta-analyses of randomized trials. They used explicit database searches, defined eligibility criteria, risk-of-bias methods, and confidence intervals.

The guideline is current and evidence graded. The prospective study adds practice relevance but carries greater bias risk.

**Key limitations:** Open-label device trials, short follow-up, inconsistent reporting of hospitalizations and long-term complications, and possible technology-industry conflicts.

## Practice Recommendation

Offer a six-month CGM pathway to eligible adults with type 2 diabetes using basal insulin and above goal. Do not use a device-only approach.

**Essential components:** access review, nurse-led onboarding, teach-back, 72-hour troubleshooting, scheduled data review, prescriber coordination, and outcome monitoring.

**Bottom line:** CGM can improve glucose control when the care system helps the patient understand and use the information safely.

## Presentation Narrative

**Estimated speaking time:** approximately 7-8 minutes at a steady professional pace.

**Video link:** [Learner inserts the Kaltura or approved video URL after recording.]

### 0:00-0:50 | Opening and Diagnosis

Hello, and thank you for reviewing this evidence-based practice poster. My topic is continuous glucose monitoring for adults with type 2 diabetes who use basal insulin but remain above their individualized glycemic goal. Type 2 diabetes is a chronic metabolic disorder caused by insulin resistance and progressive loss of adequate insulin secretion. When glucose remains high, patients face acute hyperglycemia and long-term complications such as kidney disease, retinopathy, neuropathy, cardiovascular disease, infection, and impaired wound healing. Treatment can also cause hypoglycemia, so the goal is not simply to lower every glucose value. The goal is safer, more stable control that fits the patient's needs and daily life.

### 0:50-1:45 | Practice Problem and PICO(T) Question

The practice problem is limited glucose pattern recognition. Fingerstick monitoring gives a value at one moment, but it can miss overnight changes, post-meal spikes, and symptom-free hypoglycemia. Continuous glucose monitoring, or CGM, displays repeated glucose values, trend arrows, and alerts. My PICO(T) question is: In adults with type 2 diabetes treated with basal insulin and above their individualized HbA1c goal, does CGM combined with structured nurse education and scheduled data review, compared with traditional fingerstick monitoring and usual education, reduce HbA1c and increase time in range without increasing clinically important hypoglycemia over six months? The population is adults with type 2 diabetes using basal insulin. The intervention is CGM plus education and review. The comparison is fingerstick monitoring. The outcomes are HbA1c, time in range, and safety, and the time period is six months.

### 1:45-3:30 | Evidence Sources and Credibility

I located current evidence in PubMed, CINAHL, the Cochrane Library, and the American Diabetes Association Standards of Care. I evaluated peer review, methods, sample size, comparison groups, outcome measures, risk-of-bias procedures, publication date, disclosure, and relevance to the question. The first strong source was the 2024 systematic review and meta-analysis by Jancev and colleagues. It included 12 randomized trials and 1,248 adults. Compared with self-monitoring of blood glucose, CGM lowered HbA1c by an average of 0.31 percentage points, increased time in range by 6.36 percentage points, and reduced time above range. This source is credible because the authors registered the review, searched several databases, used independent screening, applied the Cochrane risk-of-bias tool, and graded evidence certainty.

The second source was the 2024 meta-analysis by Uhl and colleagues. It included 14 randomized trials and found that real-time and flash CGM lowered HbA1c by about 0.32 percentage points. The authors used GRADE and examined device types separately. The similarity between these two independent meta-analyses increases confidence that CGM has a real, although modest, average effect.

The third source was a 2022 prospective study by Grace and Salyer. Thirty-eight adults using basal insulin or noninsulin treatment used real-time CGM for six months. HbA1c and time in range improved substantially. This study adds practical relevance because it reflects routine care, but it is less persuasive than a randomized trial because it had no control group and involved a small sample. The fourth source was the 2026 American Diabetes Association technology guideline. It supports individualized device selection, education, and ongoing training. The guideline is current and authoritative, but it must still be applied to each patient's

access, preferences, and ability to use the device safely.

### 3:30-4:25 | Answer to the PICO(T) Question

Based on the combined evidence, the answer is yes, with important conditions. For many adults with type 2 diabetes using basal insulin and above goal, CGM is more effective than fingerstick monitoring alone for improving HbA1c and time in range over three to six months. The expected average HbA1c improvement is modest. Patients with very high baseline values may improve more, but that should not be promised. Evidence about severe hypoglycemia and long-term kidney, eye, cardiovascular, or hospitalization outcomes remains limited because device trials are usually short and serious events are uncommon. The evidence therefore supports improved glucose control, not a guarantee that CGM alone prevents every complication.

### 4:25-6:20 | Recommended Steps of Care

The care recommendation is a six-month CGM pathway, not a device-only intervention. First, the nurse assesses the current insulin regimen, HbA1c goal, hypoglycemia history, reasons for poor control, readiness to learn, vision, dexterity, cognition, skin sensitivity, language, and caregiver support. Second, the team reviews insurance, out-of-pocket cost, smartphone compatibility, internet access, and whether a dedicated receiver is needed. Third, the patient selects a device through shared decision-making and keeps a backup blood glucose meter.

Fourth, the nurse provides structured onboarding. Teaching includes sensor placement, trend arrows, alerts, skin care, medication safety, hypoglycemia treatment, and when to confirm a reading with a fingerstick. Teach-back and return demonstration are essential. Fifth, the nurse contacts the patient within 72 hours because early alarm fatigue, sensor failure, and anxiety can lead to abandonment. Sixth, the nurse and prescriber review the ambulatory glucose profile at about two weeks and monthly until patterns are stable. They focus on repeated patterns, time in range, time below range, meals, activity, medication adherence, and the patient's goals. Treatment changes stay within the appropriate scope and are coordinated with the licensed prescriber, pharmacist, and diabetes care and education specialist.

Finally, the team evaluates HbA1c, time in range, time below range, severe events, skin problems, urgent calls, patient confidence, burden, and willingness to continue. The team should also examine whether device offer, initiation, training completion, and continuation differ by insurance, language, age, disability, race or ethnicity, or rural location when those data are available.

### 6:20-7:20 | Equity, Assumptions, and Limitations

Health equity is central to this recommendation. CGM should not be reserved for people who speak English, own a newer smartphone, or have commercial insurance. The clinic should use professional interpreters, visual and written teaching, receiver devices, caregiver training, financial navigation, and safe alternative monitoring plans. Patients must understand what information is shared, who can view it, and how alerts work. They may decline the technology if the burden is greater than the expected benefit.

This recommendation assumes the patient can obtain supplies and the clinic can respond to dangerous patterns. It also assumes education and follow-up are available. Limitations include open-label trials, relatively short follow-up, inconsistent reporting of hospital use and long-term complications, and possible industry involvement. These limits are why the practice change should be monitored rather than treated as universally successful.

### 7:20-7:55 | Closing

In conclusion, the PICO(T) process produced a focused question and a clear answer. Current evidence supports continuous glucose monitoring with structured education and scheduled clinical review over

fingerstick monitoring alone for many adults with poorly controlled type 2 diabetes using basal insulin. The most appropriate nursing action is to offer an equitable, patient-centered CGM pathway and evaluate clinical outcomes, safety, experience, and access. Thank you.

## References

- American Diabetes Association Professional Practice Committee for Diabetes. (2026). 7. Diabetes technology: Standards of Care in Diabetes-2026. *Diabetes Care*, 49(Supplement 1), S150-S165. <https://doi.org/10.2337/dc26-S007>
- Grace, T., & Salyer, J. (2022). Use of real-time continuous glucose monitoring improves glycemic control and other clinical outcomes in type 2 diabetes patients treated with less intensive therapy. *Diabetes Technology & Therapeutics*, 24(1), 26-31. <https://doi.org/10.1089/dia.2021.0212>
- Jancev, M., Vissers, T. A. C. M., Visseren, F. L. J., van Bon, A. C., Serne, E. H., DeVries, J. H., de Valk, H. W., & van Sloten, T. T. (2024). Continuous glucose monitoring in adults with type 2 diabetes: A systematic review and meta-analysis. *Diabetologia*, 67, 798-810. <https://doi.org/10.1007/s00125-024-06107-6>
- Uhl, S., Choure, A., Rouse, B., Loblack, A., & Reaven, P. (2024). Effectiveness of continuous glucose monitoring on metrics of glycemic control in type 2 diabetes mellitus: A systematic review and meta-analysis of randomized controlled trials. *The Journal of Clinical Endocrinology & Metabolism*, 109(4), 1119-1131. <https://doi.org/10.1210/clinem/dgad652>

## Assessment Coverage Map

This table shows where the sample addresses the major assessment expectations.

| Requirement                                                     | Location in Sample                                                 |
|-----------------------------------------------------------------|--------------------------------------------------------------------|
| Explain the diagnosis with outcomes, risks, and complications.  | Poster: Diagnosis and Clinical Need; Narrative opening             |
| Describe and map the PICO(T) research question.                 | Poster and Narrative: PICO(T) Question                             |
| Summarize more than three credible and relevant sources.        | Poster: Evidence Summary; Narrative evidence section               |
| Answer the PICO(T) question and identify assumptions.           | Poster and Narrative: Answer, equity, assumptions, and limitations |
| Describe evidence-based steps of care and explain why they fit. | Poster: Recommended Steps of Care; Narrative care section          |
| Provide a coherent poster and complete written narrative.       | Poster page and timed presentation narrative                       |
| Provide the learner video link.                                 | Marked video-link field at the start of the narrative              |