EVIDENCE-BASED SCHOLAR PROJECTS UNDER WAY

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ON THE Cover

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Evidence-Based Scholar projects under way
Amy McAlister, BSN, RN, CPN, CNN, explains a quality of life questionnaire that patient Brooke Hardin will complete for the first time. McAlister received Washington University Internal Review Board approval for a database to store the data collected by the Dialysis Unit staff to determine success of the tool to drive clinical interventions. Tessa Patterson, BSN, RN, CPN, is also pictured.

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Seventh annual Perspectives in Pediatrics conference:
Advancing technology without losing sight of compassion

St. Louis Children’s Hospital is pleased to announce the seventh annual Perspectives in Pediatrics Conference to be held April 25 and 26, 2013, at the Eric P. Newman Education Center. The event will focus on the challenges and rewards of providing interdisciplinary care to the pediatric patient and family.

For more information and to register, visit:
https://www.stlouischildrens.org/classes-events/perspectives-in-pediatrics-conference

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At St. Louis Children’s Hospital, we care for children and families from all walks of life. That is pretty typical for an urban academic medical center. Most of our patients and families are engaged partners in their care and give us positive feedback about their experiences with us. Once in a while we encounter a patient or family who is struggling with their situation in a way that clashes with our expectations. When this happens, our team also struggles. Some of us try different ways to approach a patient and family, some of us withdraw, and some of us become angry or fearful.

While we certainly do not want staff to be afraid of our patients and families, the reality is that some of the behavior we see can be unsettling. Some of this anxiety comes from not feeling confident about how to care for a person exhibiting unusual behavior. We also have had some experiences where patients have injured a staff member, heightening everyone’s concerns about caring for that individual in the future.

In the coming months you will be hearing about a new training program called S.T.A.R.R. and a new policy called “Code White.” These are two important steps we are taking to improve everyone’s confidence and skill in taking care of patients who may become agitated or even violent.

S.T.A.R.R. stands for Safe Training and Responsible Restraint and is an approach to managing an agitated patient or visitor so that both staff and the agitated person remain safe. Code White is a pager notification that will summon people nearby who are S.T.A.R.R. trained so that there is an immediate team of people available to help with an escalating situation.

The primary group of people to be trained in S.T.A.R.R. include Public Safety, administrative supervisors, Emergency Unit EMTs, paramedics, RNs, patient care technicians and charge nurses from all units. We want to be sure to have five or more people on every shift who know how to handle these challenging situations. These are the same people who work most closely with our behavioral health patients already, or who respond to parents or visitors who present threats to our employees.

Yes, it is unfortunate that there is a need for this type of training. In today’s health care environment, however, we are seeing more and more cases of workplace violence nationally, and it is important that we put systems in place to address this issue. With this being said, I hope that St. Louis Children’s Hospital will continue striving to provide a superior patient experience for every patient, every family, every day.

We should always strive to look beyond a hostile appearance to see the person inside. If we can reach the positive strengths inside, we may be able to help them recover. To quote Mary Duffield, RN, from BJC Behavioral Health, “Let’s always honor the resilience of the human spirit, and never question whether others are worthy of our service!”

Peggy Gordin, MS, RN, NEA–BC, FAAN, is SLCH’s Vice President of Patient Care Services. She can be reached at pgordin@bjc.org.
Evidence-Based Scholars program advances to fellowship status

The Evidence-Based Scholar (EBP) program has evolved over the past few years as a result of continual evaluation of the program via participant focus groups and verbal feedback. Since the program’s inception in 2007, numerous changes have occurred including advancement to fellowship status in 2012. Instead of a six-week curriculum, the program has expanded to 12 months. As a result, there is more built-in time for participants to follow through on their projects and create the necessary changes in practice.

The grid on page 5 highlights the scholars, their clinical questions and the progress on their projects. Since facilitating change is such an important part of the evidence-based practice process, the curriculum now includes the Accelerating Change and Transitions Course, available through the BJC Center for Lifelong Learning. Five new scholars initiated projects in 2012, and evaluations of the changes are currently in process. Early indications demonstrate the changes have actively engaged the EBP fellows and their team members on project completion.

Special thanks to the St. Louis Children’s Hospital Foundation for financial support of this program.

For additional information, Karen Balakas at kabalakas@bjc.org or Lisa Steurer at lisami@bjc.org.

Nikki Danis, BSN, RN, is developing a protocol for the proper volume of blood waste to discard to improve the accuracy of coagulation blood studies drawn from a central venous access device.

Emily Sheppard, BSN, RN, CPN, and Keith Patten, BSN, RN, share a new tool implemented to accurately assess pain in patients with cognitive impairment.

More about the Evidence-Based Practice program

The Evidence-Based Practice program was created in 2007 at St. Louis Children’s Hospital. The program leaders instruct staff on the process of reviewing and synthesizing literature to make a determination on best practice for an aspect of care or care delivery. The educational program consists of instruction and one-on-one mentoring with the goal of completing an evidence-based practice project at the department or hospital level. Since the program’s inception, approximately 30 staff members have been trained, and numerous projects have been completed. Many of these projects have been presented at local and national conferences and are eligible for publication.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Clinical Question</th>
<th>Project Status</th>
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<tr>
<td>Keith Patten, BSN, RN</td>
<td>For hospitalized cognitively impaired children, does the use of the rFLACC scale more accurately diagnose pain and increase parent/caregiver satisfaction compared with the FLACC scale? The rFLACC is a revision of the current FLACC pain tool and incorporates assessment of children with cognitive impairments. • The goal is to pilot test the new tool and, if determined to improve patient care, replace the current FLACC scale for use on all units</td>
<td>The 12th floor staff has been educated on use of the new scale. Pilot testing began in August 2012. A tool for evaluation of the scale by families and staff has been developed. A process is in place to measure outcomes. It is anticipated that it will greatly support more accurate pain assessment for many children and result in improved patient care. • Pilot testing has been initiated • Data collection complete • Analysis in process</td>
</tr>
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<td>Nikkole Danis, BSN, RN</td>
<td>For pediatric patients with a central venous access device (CVAD), are blood specimens for coagulation studies obtained from the CVAD as accurate as a venous sample? • There is inconsistency in the site of sample collection, and the amount of blood waste to be discarded when obtaining the sample from a CVAD</td>
<td>Nikki has been working closely with SLCH laboratory clinicians, physicians, and nursing colleagues to examine the evidence and create a guideline for obtaining blood samples for coagulation studies to be used throughout the hospital based on external (research) and internal evidence. • Guideline development will proceed after evaluation of the new safe draw system (Closed blood sampling system) • Safe draw pilot testing is currently under way</td>
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<td>Amy McAlister, BSN, RN</td>
<td>In pediatric dialysis patients, does implementation of the PedsQL® End Stage Renal Disease (ESRD) module to assess quality of life (QOL) drive clinical interventions and track changes resulting in improved patient scores? • Treatment has traditionally focused on medical care. There is an increased focus on quality of life in an effort to improve patient health outcomes and improve the services offered</td>
<td>Amy has been working with a team of nurses, physicians and a psychologist to identify the tool to assess QOL with patients. Amy is now developing a database and an Internal Review Board application so that future research would be possible using the data. The next step will be to establish score cutoffs and develop appropriate interventions. • Internal Review Board approval obtained for database • Data collection initiated in the dialysis unit</td>
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<td>Shannon Duffy, BSN, RN</td>
<td>For pediatric intensive care patients with a central venous access device, does the use of chlorhexidine in alcohol for hub disinfection reduce the rate of catheter-related bloodstream infections compared to the use of alcohol alone? • The Pediatric ICU has experienced an increase in bloodstream infections and is identifying best practices to reduce infection</td>
<td>Shannon has been working with nurses and physicians from infectious disease to examine the evidence and make a practice recommendation. The practice change was supported; the medical supplier and educator are currently meeting with staff. Bloodstream infection rate is automatically tracked; however, a tool to measure compliance needs to be developed. • Practice change started in October 2012 • Monitoring results • If successful, the goal will be to establish this practice hospitalwide</td>
</tr>
<tr>
<td>Danielle Dolosic, BSN, RN</td>
<td>Will the implementation of a staffing model that promotes continuity of care and incorporates personal preferences improve satisfaction, teamwork, and retention for nurses in the float pool?</td>
<td>Dani has surveyed staff and met with all nurse managers and administrative supervisors to review the plan. • Pilot testing started in September 2012 and is now complete • Data collection is ongoing from supervisors, charge nurses and float pool nurses</td>
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When it comes to the transport of neonatal and pediatric patients, St. Louis Children’s Hospital (SLCH) offers the most comprehensive and experienced team in the St. Louis region. For more than 30 years, the SLCH Critical Care Transport Team has been a leader in inter-facility transfers of critically ill or injured patients. Each transport is tailored to meet the needs of the patient. The specially trained team, which completed over 2,200 transports in 2012, consists of two registered nurses and a paramedic. Three fully-staffed teams are available to respond 24 hours a day, seven days a week by ground or air, based on the patient’s level of acuity, distance and weather. The team travels in mobile intensive care unit ambulances, helicopters and a fixed-wing aircraft.

In fourth quarter 2012, the team ventured into three new service lines to provide more extensive programs to community and referring facilities. These capabilities are:

- “Early launch” for trauma patients
- Maternal-fetal transport
- Neonatal and pediatric patient extracorporeal membrane oxygenation (ECMO) transport

“Early launch” accelerates activation of transport services

The Trauma “early launch” program under way with four BJC hospitals — Missouri Baptist Sullivan Hospital, Christian Hospital, Northwest Healthcare, and Progress West Healthcare Center — builds on the relationship SLCH’s Transport Team has with community hospitals and local EMS systems. This new program is a joint effort between the Transport Team and Trauma Services, and allows quicker response and transfer for pediatric trauma patients to highly specialized care.

If a child has suffered critical injuries from a traumatic accident that require the care of SLCH, the local EMS or the referring hospital emergency department has been empowered by an early launch process for the Transport Team. This quick activation system deploys a Transport Team within minutes of the call.

The Trauma “early launch” mirrors the field triage guidelines that have been established through Time Critical Diagnosis (TCD) legislation. The goal of TCD is to get the patient to the right place at the right time. In pediatrics, this can be a challenge knowing there are limited pediatric trauma resources in the region. “The protocols for pediatric trauma have changed with Time Critical Diagnosis,” says Diana Kraus, BSN, RN, SLCH manager of Trauma Services. “When an EMS crew is deciding where to take a severely injured patient, it’s no longer just about the closest hospital but where the patient can get the most specialized care, and that really means pediatric patients need to come to a Level 1 pediatric trauma center.”
Trauma “early launch” takes this a step further. The local hospital emergency department can utilize the same criteria while the Transport Team en route is able to assist with the transition to highly specialized care.

The Trauma “early launch” mirrors the field triage guidelines that have been established through Time Critical Diagnosis (TCD) legislation. The goal of TCD is to get the patient to the right place at the right time.

Maternal-Fetal Transport

Barnes-Jewish Hospital (BJH) and SLCH launched the region’s first maternal-fetal transport service that includes pediatric trained personnel. The service provides transport to the specialized labor and delivery unit at BJH for high-risk mothers with prenatal needs. The transport offers a safer delivery for the mother, and easier transport of the baby to SLCH’s Newborn ICU. Pregnant women requiring emergency transport include those with pre-eclampsia, pre-term labor and any other health conditions that may complicate the pregnancy. Each Transport Team will include a high-risk obstetrical nurse from BJH and a neonatal nurse and paramedic from SLCH. The new transport service is an extension of an existing relationship between BJH, SLCH and Washington University for fetal and newborn care.

ECMO Transport

SLCH’s Transport Team started an ECMO transport service to provide patients with complex cardiac conditions and advanced lung disease an option for specialized transport. The ECMO Transport Team includes a critical care physician, perfusionist, critical care transport nurse and paramedic who are specially trained in ECMO. The team uses Cardiohelp, a mobile, FDA-approved device, to support the patients’ cardiopulmonary needs. The compact and portable device monitors critical blood parameters including venous oxygen saturation, hemoglobin, hematocrit, and arterial and venous circuit line pressures.

SLCH offers leading, high volume transplant and heart/lung failure programs. Often these patients require ECMO and currently only a handful of centers across the country provide pediatric ECMO transport. Developing the ECMO transport service supports SLCH’s commitment to provide advanced care to the most critically ill children.

“As a leading transplant center, the hospital’s respiratory and heart failure population has substantially increased, along with a growing number of patients on ventricular assist devices and paracorporeal lung assist devices,” says Celeste Capers, MD, medical director, Transport Services. “Patients may require ECMO prior to definitive care, and currently only a handful of centers across the country provide pediatric ECMO transport.”

For additional information, contact Kathy Donovan at kjd8661@bjc.org.

Transport Team members prepare for their first ECMO transport. They include Teri Aguiar, BSN, RN; Jeff Atwood, BSN, RN; Dr. Celeste Capers; and Mark Shepard, perfusionist.
1. Describe your journey as a nurse that ultimately led you to St. Louis Children’s Hospital (SLCH).

Originally I had enrolled in school to study physical therapy, planning to go away to college. I changed my mind the month before I was to go, and decided to attend the Deaconess College of Nursing in St. Louis with my best friend. Since then, I have been a nurse for 13 years, eight of which have been as a neonatal nurse practitioner. I completed my bachelor’s degree in nursing at the Deaconess College of Nursing and completed my master’s degree in nursing at the University of California. I moved to Phoenix to begin practice as a neonatal nurse practitioner, but in 2007, my career broadened as I took on the challenge of subspecializing in neonatal cardiac care. At that time I had the amazing opportunity to develop a comprehensive fetal heart and high-risk cardiac infant program. My focus was infants with hypoplastic left heart syndrome, single ventricle and two ventricle shunt-dependent lesions. In addition, I was actively involved in the expansion of the Eller Congenital Heart Center at St. Joseph’s Hospital & Medical Center in Phoenix and learning to grow into a leadership role.

2. What attracted you to St. Louis and ultimately SLCH?

I am originally from St. Louis but have lived away for my entire nursing career. The idea of getting back to St. Louis with my husband and three children to be close to family was extremely important to me. The vision SLCH has for its Heart Center attracted me because the opportunity to become a part of something so rich and special is rare. It’s exciting to not only have the chance to work with and lead talented people, but to be able to serve heart and lung patients and their families on a much larger level than my previous role allowed.
3. The task of managing both the Cardiac ICU and 7 West is likely both exciting and demanding. What skills equip you to handle such a challenge?

My previous experience, clinical knowledge and leadership skills allow me to dig into to such an expansive role. This role affords me an incredible opportunity to work side by side with great people in the Heart Center and throughout SLCH.

4. In your new role, what are you most passionate about?

I am most passionate about supporting and advocating for my team and our patients and families we serve.

5. What keeps you up at night?

Keeping myself and the team centered and balanced both professionally and personally.

6. As the Cardiac ICU and 7 West manager, what is your vision for these units and their role in the future as part of the Heart Center team?

My vision includes building upon our Heart Center’s foundation of patient and family-centered care. We want our patients and families to call our Heart Center their home away from home. In addition, it is equally important that I support our team members to foster an environment that affords them multiple opportunities within our Heart Center to grow and develop professionally as individuals and as a team... this is key to our patients and families believing and trusting in us.

7. What is the one thing you find most rewarding or are most proud of?

My husband and children.

8. What would Beth Rumack’s mission statement say?

My mission statement: Providing full access to an immediate and comprehensive continuum of care for infants and children living with congenital and acquired heart and lung disease. We work in partnership to provide the full spectrum of services to meet the challenges of raising a child with a chronic illness, across the continuum to a smooth transition into adulthood.

My tag line: Partners providing a life line to children with heart and lung problems and their families.

9. What person was most influential on your life and why?

The single most influential person in my life is my mother. As a single mother with a GED education, she sacrificed to afford me the opportunity to be successful. She provided me a strong work ethic and taught me perseverance as well as how to be humble and not to judge. She worked hard to give me a solid education because she knew that education was key to a successful future.

10. In one sentence, describe who Beth Rumack is:

Entrepreneurial spirit.
A young mother with a critically-ill infant in the Newborn ICU sits at the bedside struggling with anxiety and overwhelming sadness. Initially, staff inquire how she is doing. The mother says she is okay, though the staff can tell she needs support. Rather than waiting for the mother to admit she needs help, she is connected with a new program designed to increase access to mental health treatment for a population that is rarely identified.

Although it is natural for women to experience changes in their mood during the perinatal period, including feeling irritable, tired or worried, symptoms are sometimes serious enough to require treatment. The symptoms of perinatal mood disorders, including depression and anxiety, primarily affect mothers. These symptoms also detrimentally affect their child’s overall health, cognitive and social-emotional development and parent-child interactions.

Postpartum depression is a significant public health issue with rates between 10 percent and 15 percent. Risk factors include a prior history of depression, life stress, poor social support, marital discord, single marital status and low socioeconomic status. Additionally, mothers with infants in the Newborn ICU are at increased risk for developing postpartum depression and anxiety as they suffer the stress of having a critically ill infant.

Women with perinatal mood disorders often go untreated because only half of mothers with symptoms report them to their clinicians. For women to benefit from mental health services, those with mood disorders must first be identified. The new Washington University Perinatal Behavioral Health Service (WUPBHS), co-directed by Dr. Cynthia Rogers, Division of Child Psychiatry and Dr. Kelly Ross, Division of Hospitalist Medicine, provides education,
screening and referral services to mothers of infants in the St. Louis Children's Hospital Newborn ICU and in the newborn and special care nurseries at Barnes-Jewish Hospital.

The program expands the services of the current Newborn ICU Behavioral Health Clinic, which has been treating mothers with perinatal mood symptoms referred by the Newborn ICU social workers since 2010. The Newborn ICU social workers instituted a universal screening program for mothers in the Newborn ICU utilizing the Edinburgh Postnatal Depression Scale (see next page). They found that 40 percent of the screened Newborn ICU mothers have mild to moderate depressive symptoms.

Newborn ICU social workers successfully arranged referrals for mothers with postpartum and preexisting mental health symptoms to the newly expanded Newborn Medicine Behavioral Health Clinic for care. The Newborn ICU social workers refer mothers to the patient coordinators who provide education about perinatal depression and coordinate referrals for mental health, substance abuse and supportive services. Cases are discussed with the Newborn ICU medical, nursing, and social work staff at weekly psychosocial rounds.

A WUPBHS staff therapist provides brief psychotherapy within the Newborn ICU to referred mothers. Mothers with more impairing symptoms are treated by staff psychiatrists in the Perinatal Behavioral Health Clinic. To date, 80 percent of mothers referred by Newborn ICU social workers for mental health and support services have used these resources.

For example, a new mother reported that her experience with the WUPBHS was helpful. She appreciated the support and said staff were attentive to her needs. “To be able to talk to someone, unbiased, was helpful…it felt good to vent,” she says. The WUPBHS is also providing similar services for mothers with infants in the regular and special care nurseries.

Postpartum mood disorders are under recognized and undertreated. There exists a serious need for more education and treatment services for mothers suffering with these disorders, particularly in the early postpartum period before symptoms become more severe. The WUPBHS seeks to address this critical need and enhance the access to quality care for both mothers and babies.

For additional information, contact Jamie Jackson at jacksonj@psychiatry.wustl.edu or Cynthia Rogers, MD, at rogersc@psychiatry.wustl.edu.

More about postpartum depression

Postpartum depression is a moderate to severe form of depression in a woman after she has given birth. It may occur soon after delivery or up to a year later, but generally occurs between one to three months postpartum. Symptoms include:

- sad or depressed mood
- anxiety
- extreme fatigue
- difficulty concentrating
- trouble sleeping
- feeling withdrawn
- thoughts of suicide
- possibly feeling emotionally detached from the baby with little interest in providing essential care

If you suspect a parent is struggling with postpartum depression, contact your department social worker for further follow-up.

Forty percent of the screened Newborn ICU mothers have mild to moderate depressive symptoms.
Edinburgh Postnatal Major Depressive Disorder Scale (EPDS)

The aim of the EPDS is to assist primary care teams in detecting mothers with Postnatal Major Depressive Disorder. Any score >10 or a response other than “Never” to question 10 is an automatic referral for further services. This quiz is available online: http://www.testandcalc.com/etc/tests/edin.asp.

INSTRUCTIONS

As you have recently had a baby, we would like to know how you are feeling now. Please choose the answer that comes closest to how you have felt IN THE PAST WEEK, not just how you feel today.

**Question 1**
In the past week I have been able to laugh and see the funny side of things:
- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

**Question 2**
In the past week I have looked forward with enjoyment to things:
- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

**Question 3**
In the past week I have blamed myself unnecessarily when things went wrong:
- Yes, most of the time
- Yes, some of the time
- Not very often
- No, never

**Question 4**
In the past week I have been anxious or worried for no good reason:
- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

**Question 5**
In the last week I have felt scared or panic for no very good reason:
- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

**Question 6**
In the past week things have been getting on top of me:
- Yes, most of the time I haven’t been able to cope at all
- Yes, sometimes I haven’t been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

**Question 7**
In the past week I have been so unhappy that I have difficulty sleeping:
- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

**Question 8**
In the past week I have felt sad or miserable:
- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

**Question 9**
In the past week I have been so unhappy that I have been crying:
- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

**Question 10**
In the past week the thought of harming myself has occurred to me:
- Yes, quite often
- Sometimes
- Hardly ever
- Never