Families as actors in simulation

See page 4

FAMILIES AS ACTORS IN SIMULATION

See page 4
St. Louis Children’s Hospital is recognized among America’s best children’s hospitals by Parents magazine and U.S. News & World Report. For more information about nursing opportunities at a Magnet hospital, visit: StLouisChildrens.org/jobs

Pediatric Perspectives offers continuing education credit

The fall CE issue of Pediatric Perspectives offers nurses an opportunity to earn continuing education credits with in-depth articles on new practice trends and guidelines. This year’s issue contains four articles that address topics of interest to a wide range of clinical staff, and each are important areas for improving practice and outcomes for patients.

Test completion is required by April 1, 2013. To see the Fall 2012 Continuing Education of Pediatric Perspectives, visit StLouisChildrens.org and enter the search term Pediatric Perspectives. The latest issue will appear as the first search result.
From Peggy

Congratulations on an impressive survey

As I am writing this column, St. Louis Children’s Hospital has just completed its triennial Joint Commission survey. It was the most thorough survey we have ever had: three surveyors for one day and two surveyors for four days. The physician and nurse looked at every single clinical program, unit and location in the hospital, as well as pharmacy, lab and radiology and all of our support departments. In every single instance, they commented on the professionalism, passion, and commitment you bring to your work. They were impressed with how knowledgeable employees were about their patients, their job, and the processes we use for providing care. In essence they could see that we “walk our talk!”

While there are times when we are working on our areas for improvement that we get discouraged because it feels like an uphill climb with a heavy backpack, it is important to stop and look back down the mountain to see how far we have come. This week was an opportunity for doing that. St. Louis Children’s Hospital was a wonderful hospital three years ago, but we are an even better one today. We have improved our infection prevention practices, medication safety, procedural safety and patient flow strategies. We now use formal improvement methodologies and data to measure our progress throughout the hospital via the Managing for Daily Improvement (MDI) boards. The surveyors noticed these things and commented on how impressed they were with all of you!

As we move into the New Year, we will continue to spread the MDI approach, and I look forward to the things we will accomplish together. Let’s continue to pursue reductions in adverse drug events, infections, pressure ulcers and falls. We will start to track additional quality measures such as catheter-associated urinary tract infections and venous thromboembolism events as part of a national children’s hospital collaborative, which will bring more challenges for us to tackle. I have no doubt that this team is up to the task!

Happy Holidays!

Peggy Gordin, MS, RN, NEA-BC, FAAN, is SLCH’s Vice President of Patient Care Services. She can be reached at pgordin@bjc.org.

I have never felt more proud to work here than I did at the end of our survey week. You are an amazing team of people, and I am honored to work with you.

Happy Holidays!

Peggy Gordin, MS, RN, NEA-BC, FAAN, is SLCH’s Vice President of Patient Care Services. She can be reached at pgordin@bjc.org.

Cara McCauley, RN, serves as a staff nurse in the hospital’s Heart Center.
The Families as Actors program builds skill and confidence in a health care provider’s ability to communicate with patients and family members. A group of specially trained volunteer family members and patients helped develop the program and serve as advisers. They train other family members and patients to portray roles in clinical simulation scenarios with health care professionals.

Family and teen advisors participate in an advanced training workshop to prepare themselves for these unique educational roles. They are given several opportunities to view and participate in a variety of real-life simulation scenarios and learn how to provide helpful feedback in debriefing after each scenario. Many participants use their own experiences to provide real-life examples and feelings.

Since the program began in June 2010, family actors have regularly played roles in interdisciplinary mock codes and communication-focused scenarios. Educational simulation programs also include exercises in:

- communicating difficult information to family members
- conducting trauma team training to include care for family members present
- de-escalating tense situations involving family members and patients.

Over the past year, family roles were added to new-hire orientation simulations for staff nurses, advanced practice nurses, patient care

---

From left, John Donahue, PCT; Kenneth Meierotte, PCT; Mary Wolf, parent actor; and Brittany Billups, BSN, RN. In this simulation event, Meierotte portrays a parent chaperone, a staff person assigned to care for and assist a parent through a crisis.

**Standardized Family Actor:**

a parent or primary caregiver who has had a child hospitalized with a serious illness and has been trained as a standardized patient actor. While this person has received the same type of training as other standardized actors, they offer the insight, perspective and experience that only a loved one can offer. They can provide real, candid feedback to improve the health care professionals’ communication with family members.

For the past two years Kathy Park has served as a parent actor in Asthma Action Plan simulations as well as 7E mock codes.
technicians and other direct patient care staff. According to participant evaluations, staff recognize the importance of addressing the unique needs of each patient and family, and want family actors included in a variety of learning activities.

**Family actors add value**

Nurse educators, staff and physicians collaborate with the assigned family/patient actor to develop the scenario and the educational outcome goals. With this behind-the-scenes knowledge, family and patient actors can help redirect the scenario with their actions and dialogue in a realistic manner when the simulation is moving in a direction not intended by the educator. Family actors offer their unique insight as to the importance of certain communication skills expected and appreciated by most hospitalized patients and family members. Family actor feedback helps educators feel confident the proposed educational opportunity will include insight from patients and families that may not be revealed by someone playing the family or patient role. Staff gain a real-life perspective as the scenario unfolds. Drawing on the experiences of these actors who have been through hospitalization and trained in the art of a standardized family member can make simulation learning even more effective. Unlike a standardized actor, a family or patient actor authentically reacts and responds naturally because they have had these hospital experiences.

**Staff offer feedback**

Over the past two years, more than 150 simulation events have offered approximately 1,100 staff members, students and physicians the opportunity to participate in simulation events that have included family or patient roles. Although a small percentage of participants indicate uneasiness about participating in simulations and debriefings with real patients and family members, the most significant survey findings indicate that participants feel real family and patient actors enhance the educational value of their simulation.

For additional information, contact Karen Crow at kmc8279@bjc.org.
Interventional Radiology offers less invasive options

The Interventional Radiology (IR) team at St. Louis Children’s Hospital uses advanced imaging equipment to diagnose deep vessel injury. In the case of David of Branson, Mo., the IR team helped to diagnose and treat injured blood vessels. The 6-year-old began vomiting blood nearly three weeks after a bicycle accident fractured his liver. A computed tomography (CT) scan found the injury had torn an artery within his liver. Working through a 3mm incision in David’s groin, the team guided a 1mm catheter into the hepatic artery and stopped the bleeding by blocking the artery from the inside (see images below).

Image-guided procedures provide a less invasive approach, causing less pain and allowing for a faster recovery. As with any invasive procedure, the risks of IR procedures include pain, bleeding and infection. Most procedures are performed while the child is under anesthesia. To decrease the chance of bleeding, CT, ultrasound and fluoroscopy are used to guide tools around blood vessels. The team follows the same standard of care as the Operating Room (OR) to reduce the possibility of infection. Although children are often exposed to X-rays in the OR setting, IR procedures provide low-dose imaging and frequently use ultrasound to avoid ionizing radiation.

IR procedures can often be performed on the same day they are requested. For those procedures where a drainage catheter is inserted, the IR team monitors the child’s progress by making rounds and coordinating follow-up studies. Although the IR team includes nurses, technologists and interventional radiologists, the team depends on multiple services including Anesthesiology, Same-Day Surgery, PACU, ICU and inpatient units.

David’s progress

Following David’s procedure by the IR team, he returned for a follow-up visit for insertion of a biliary drain. Additionally, a biliary stent was placed via endoscope by a gastroenterology team at Barnes-Jewish Hospital and later removed. David continues to make progress and is doing well.

For additional information, contact James Duncan, MD, PhD, at duncanj@mir.wustl.edu.

A look at David’s procedure

These images were used to help guide a 1mm diameter microcatheter deep into David’s liver and better pinpoint the tear’s location. Blood flow in this vessel was blocked using collagen plugs and three metal coils. The final image shows no further flow into the damaged blood vessel and good flow to the remainder of the liver through a series of channels.
The IR suite at St. Louis Children’s Hospital opened in 2008 and has served more than 2,500 patients. The team performs a wide variety of procedures, including:

- draining abdominal abscesses that occur after appendicitis or other intra-abdominal conditions
- performing percutaneous biopsies of masses deep in the chest or abdomen
- treating vascular malformations
- inserting central venous catheters for dialysis, chemotherapy and nutrition

SLCH calls for hospitals, clinics to track radiation exposure levels for imaging tests

A safe imaging measure from St. Louis Children’s Hospital has been recommended for implementation nationally by a subcommittee of the National Advisory Council for Healthcare Research and Quality.

The measure calls for hospitals and clinics using computed tomography (CT) systems to record the intensity of X-ray radiation exposure after each test. The exposure amount would be listed in a pediatric patient’s electronic medical record. St. Louis Children’s Hospital has tracked exposure data since 2009.

The recommendation, forwarded in September, calls for including the St. Louis Children’s Hospital measure in the Children’s Health Insurance Program Reauthorization Act 2013 Core Set of Children’s Health Care Quality Measures. The act includes provisions to strengthen the quality of care provided and health outcomes of children in Medicaid and the Children’s Health Insurance Program (CHIP).

St. Louis Children’s Hospital began a campaign to make parents aware of the hospital’s safe imaging practices and low-dose imaging. The safe imaging campaign, featuring Mr. Potato Head, has appeared in billboards, print ads, websites and television.
Caring for others can be rewarding and fulfilling, but there is a cost to caring. A review of the literature leaves little doubt that this work can take a toll on the psychosocial and physical health and well-being of the health care provider. Direct care providers are secondary witnesses to trauma and serious illness experienced by others. Few of these caring professionals anticipate the mental and physical health complications that come from close interpersonal relationships with patients and families.

Compassion—the feeling of empathy for the distress of another—commonly gives rise to an active desire to alleviate another’s suffering and is considered a cornerstone of the health care profession. However, the continuing stress of meeting the sometimes overwhelming needs of patients and families may result in compassion fatigue. It emerges suddenly and without warning, and encompasses a sense of helplessness and confusion. The presence of compassion fatigue has been widely documented among nurses, physicians, social workers, chaplains, emergency medical technicians and other ancillary health-care providers.

Burnout versus compassion fatigue

Burnout, another component of compassion fatigue, is a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment. Early research led to the belief that burnout was the result of worker characteristics and work-place factors. However, recent studies indicate work-place conditions are the primary causative factor. These factors include insufficient resources (i.e., staff and supplies), poor design of work areas, poor inter-professional relationships, and management conflicts. The onset of burnout is more progressive and may cause indifference, disengagement and withdrawal from patients and the work. Burnout is a chronic condition of perceived demands outweighing perceived resources and is associated with job dissatisfaction. The impetus for burnout stems from conflict within the work setting while secondary traumatic stress results from emotional engagement and interpersonal intensity associated with witnessing tragedy within the work setting.

Compassion fatigue is the final result of prolonged and intense contact with patients and exposure to stress. The more empathetic the caregiver, the greater risk for developing compassion.
At work, the provider may be cynical, pessimistic, show low self-esteem, demonstrate anger toward coworkers, and verbalize a dread of going to work. Providers who experience compassion fatigue may demonstrate changes in job performance, increased mistakes, noticeable personality changes, a decline in health and a desire to leave the profession.

fatigue; those who suffer the most are often those with the highest standards of care. The health-care provider experiencing compassion fatigue suffers physically, emotionally and mentally. Research indicates that long-term effects of compassion fatigue negatively impact the health, well-being and performance of employees.

At work, the provider may be cynical, pessimistic, show low self-esteem, demonstrate anger toward coworkers, and verbalize a dread of going to work. Providers who experience compassion fatigue may demonstrate changes in job performance, increased mistakes, noticeable personality changes, a decline in health and a desire to leave the profession.

At home, the affected caregiver may be unable to sleep, experience bad dreams, lose interest in social events, and experience changes in appetite and relations with others.

Hospitals today are beginning to realize compassion fatigue has significant implications in efforts to retain a competent and caring professional staff and that development of programs to provide education, support and skill-building are a valuable investment of resources.

For additional information, contact Karen Balakas at KaBalakas@bjc.org.

SLCH colleagues attend workshop

St. Louis Children’s Hospital sponsored seven colleagues from nursing, social work, psychology, and chaplaincy to participate in an educational workshop on compassion fatigue program development. The team will assess the prevalence of compassion fatigue within the hospital and create a program for all providers to learn about the signs and symptoms of compassion fatigue. A multi-faceted approach will be used to maintain the personal and professional health of staff. The new program will be designed to help health-care workers recognize the signs in themselves and take action.
Pediatric Perspectives

Handoff communication and processes are critical elements in providing safe, effective and exceptional patient care. At St. Louis Children’s Hospital, a number of initiatives have focused on handoff communication. St. Louis Children’s Hospital and Washington University School of Medicine are participating in a national research study called “I-PASS,” a process and document utilized by the pediatric residents and interns integrated within the electronic medical record application. I-PASS is a National Institute of Health funded study at eight pediatric academic medical centers. I-PASS tests the hypothesis that deployment of a resident handoff bundle (TeamStepps training, use of mnemonic and a standardized electronic or paper handoff tool) reduces medical errors and increases resident satisfaction.

St. Louis Children’s Hospital adapted the electronic report to include the I-PASS mnemonic and deployed the I-PASS handoff tool in June 2012. The pilot unit, 8 West General Medicine, has completed six months of data collection on medical errors, resident workflow and resident satisfaction. Data was collected through a combination of chart reviews, surveys and direct observation of staff. Most of the pediatric residents agreed to be involved in the study; participation in the study satisfied the Accreditation Council for Graduate Medical Education (ACGME) requirement for handoff.

In addition to the residents, Respiratory Care and Nursing were involved in handoff projects. In spring 2012, Respiratory Care initiated changes in handoff report at shift change. Through the standardization of processes, staff reduced errors by reviewing current physician orders and identifying changes to orders that had not been communicated. Previously, these order changes may not have been identified in a timely manner.

For nurses, the current electronic MasterKard and handoff process has been in place for more than a year. Although the original goal was to standardize the process and documentation for handoff, these goals were not fully realized. A nursing Handoff Communication Team was formed to accomplish the following goals for shift-to-shift handoffs:

- Reduce handoff related care failures
- Eliminate duplicate/wasteful documentation
- Achieve consistency and compliance in the handoff process

The team includes staff nurses from the inpatient units, a respiratory therapist, clinical information systems coordinators and performance excellence facilitators. Six Sigma process improvement tools are being used to assess and improve shift handoff processes. Changes to the electronic medical record application enhance the process and allow for standardization among caregivers.

EXEMPLARY PROFESSIONAL PRACTICE

Reducing harm through improved handoff communication

The Agency for Healthcare Research & Quality (AHRQ) and the Defense Department have teamed to build a national training and support network called the National Implementation of TeamSTEPPS Project, a teamwork system designed for health care professionals.

The system provides:

- A powerful solution to improve patient safety within an organization.
- An evidence-based team work system to improve communication and teamwork skills among health care professionals.
Reducing harm through improved handoff communication

As feedback was gathered from front-line nurses, several areas of frustration were identified leading to noncompliance with the process:

- Confusion about where specific elements should be documented
- Multiple locations for documenting the same information
- Irrelevant information being documented, specifically in the Kardex “current hospital course” section
- Flow of information did not meet the needs of the users
- Overall process was not timely

While some nurses consistently use the MasterKard tool and process as it was originally intended, many are not. When audited last summer, total process compliance was achieved by staff only 22 percent of the time.

The MasterKard Handoff team has reviewed the process and documentation for handoff, and several improvements have been made. Staff training will take place in January 2013, with implementation in February 2013, and will reinforce the importance of reviewing all pertinent information during handoff in order to be fully prepared to care for patients. Off-going staff recognizes their critical role in preparing the next shift to provide a superior patient experience for every patient, every family, every day.

For more information, contact Susan Hibbits at SusanGH@bjc.org.

Jennifer Cook, BSN, RN, CBIS, left, and Brandi Gregory, RN, use the MasterKard process for shift-to-shift handoff.
Shared Leadership update

Cited below are the accomplishments and ongoing projects led by the Shared Leadership Council at St. Louis Children’s Hospital. The Shared Leadership Councils were created in 2009 to allow for front-line staff of all disciplines to have a “voice” and input into the policy and procedures that govern their practice.

**CLINICAL PRACTICE COUNCIL**
- Trial of temporal scanner thermometers on inpatient units
- Processes to improve interdepartmental handoff
- Review of the Independent Double-Check of Medication Policy
- Reviewing compliance of portable monitors and the connection to nurse-call system
- Investigating non-safety needles located on units

**PATIENT SAFETY COUNCIL**
- Developing local safety programs on each unit
- Integration of Measurement for Daily Improvement (MDI) boards into the work of the council
- Reinforcement of SBAR (Situation, Background, Assessment, Recommendation) as standard communication language among providers and staff

**PROFESSIONAL STANDARDS COUNCIL**
- Increasing staff understanding of the role of Interpreter Services
- Establishing programs to support Professional Boundaries among staff and families
- Creation of standards and expectations regarding “Professional Presence and Appearance”

**PERFORMANCE IMPROVEMENT COUNCIL**
- Revised structure of council and representatives are working on local departmental level projects
- Multiple departmental projects completed including the following:
  - Respiratory Therapy revised their methods of handoffs reducing the number of event reports associated with missed information
  - Same Day Surgery (SDS) developed a handoff procedure with OR to ensure the right people were present and the right information given at the time of handoff
  - NICU developed a standardized tool for closing section of their units during times of low census
  - Child Life completed two 5S projects (organizing, cleaning, and sustaining) in two areas of their department