ACHIEVING A VISION OF REDUCING PREVENTABLE HARM

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ON THE Cover

Charlita Dunn, MSN, RN, with Kacyn Dierking, a 5-year-old Emergency Unit patient.

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Over the past year and a half as your president, I have been impressed with the extraordinary care that our staff provide to patients and families. I am honored and proud to serve as your leader.

At the same time, I am increasingly aware of how much work we still have ahead to eliminate harm in our health care system, while simultaneously making it more affordable. Health care today requires a new vision, and our hospital leadership team has been developing that vision for St. Louis Children’s Hospital. We believe that all of us need to find a healthy balance between pride in the work we do and the humility needed to know we can always do better. I frequently ask myself and our leadership, are we creating a culture of continuous improvement? How can we do this and maintain pride in the work we do? This will drive us toward our common goal of a superior patient experience.

Recently we have been working to build a new Center for Clinical Quality and Safety that will help us develop the systems needed to support all of you in your quest to deliver highly reliable and safe patient care. This includes a stronger partnership with Washington University School of Medicine, aligning hospital resources to better support patient care improvement projects, and helping us use our clinical information systems to make that work easier.

At the same time, as you are all aware, we have been working to find ways to reduce costs without harming the quality of our care or service to our patients and families. Many of you may have heard of the “Making BJC Better” initiative that has been underway for the past year. This is a huge project that covers every aspect of BJC and the work we do. Major gains have been made in reducing supply costs and improving various business functions.

However, we are still learning how to create more nimble, flexible staffing systems so we can ensure the right numbers of staff with the right skills serve widely varying patient volumes throughout the year. The surge in patient volumes over the past couple of months has challenged all of us, and I want to thank you all for your hard work and teamwork as you flexed up to cover those needs. Our patient care leadership team is working to develop some new systems and staffing models that will improve our ability to flex so that we can balance the two important goals of cost and quality.

While all this focus on improving clinical quality and reducing costs is important, that will only be possible if we take as good care of our clinicians as we do of our patients. Our hospital leadership team wants to hear from you and is always willing to listen to your ideas and feedback about what is important to you. We hold employee forums and town halls throughout the year to provide opportunities for dialogue, as well as our annual employee survey, but you do not need to wait for one of those opportunities if you have an idea to share! I welcome your emails and hallway conversations at any time.

Thank you for all you do for our patients and families, every day.

Joan Magruder, President,
St. Louis Children’s Hospital
She can be reached at jxm8044@bjc.org.
Gordin was determined that this would be an area of focus for her work here. Over the past five years she has promoted the development of advanced training for staff (MANDT and STARR training) to better manage patients who become agitated. She has also been instrumental in developing resources to support care planning for children and youth with special behavioral needs. The St. Louis Children’s Hospital and Washington University School of Medicine Department of Child and Adolescent Psychiatry departments collaborated to develop:

- a psychiatric consultation service
- a multidisciplinary behavioral consult team
- a PNP to provide support and education for nursing staff

Gordin had extensive experience in accessing mental health resources for her late son, Michael. After being awarded a Robert Wood Johnson Foundation fellowship for nurse executives, she decided to use her experience with her son and the fellowship resources to do a community project that would improve access to mental health services for children and youth. Over the next two years she met with community leaders.
and providers of youth mental health services to learn about the structure and funding of the mental health system in the region. It appeared there were a lot of agencies providing services, but access was complicated, and it was difficult for families and pediatricians to identify the appropriate resource for a particular child. For example, Gordin saw that youth who needed inpatient acute psychiatric care often had to wait many hours for a bed to be identified, even when professionals who were familiar with the system were handling the referral.

Currently Gordin is working with a large group representing most of the providers of child and adolescent mental health and substance abuse treatment services in the region, under the authorization of the regional Behavioral Health Network, to develop an online application that will speed access to services. They are piloting a group texting application as an approach to speed up identification of open psychiatric acute care beds. Once that concept is proven useful, the group plans to work with a vendor to build a more comprehensive app that would also help people identify and connect with community resources. This application would be used across the continuum of care to improve access to and discharge from inpatient care, as well as residential and outpatient treatment facilities. If successful, more youth could receive mental health services in a timely manner.

Later this year, SLCH and Washington University will begin a joint strategic planning process for neurosciences and child mental health. Gordin hopes to identify ways that SLCH can contribute to the range of resources available in St. Louis for children and youth with behavioral and mental health challenges.

For additional information, contact Peggy Gordin at PGordin@bjc.org.
According to the Centers for Disease Control and Prevention, as many as one in five children experiences a mental health disorder in a given year. In Missouri, nearly 9 percent of children have a serious mental health condition that can cause significant impairment in the child’s functioning at home or school, with higher rates reported for St. Louis.

Children in pediatric hospitals are at increased risk for having co-occurring behavioral health symptoms directly related to their underlying medical condition (e.g., brain injury, epilepsy), due to the emotional strain of a new or enduring condition (e.g., having cancer or diabetes), or because the hospital setting may be particularly overwhelming or stressful (e.g., for children with autism spectrum disorders). In these contexts, children may present challenging behaviors that include decreased cooperation or avoidance of medical procedures. In more extreme situations, children may show tantrums, aggression or self-injurious behavior as they respond to the demands of their care. These behaviors may create stress for patients, families and staff, and interfere with children receiving safe and high quality medical treatment.

Nurses and other staff may find caring for children with these challenging behaviors difficult in part because of limited specialized training and resources. Staff may struggle to know the best approaches to deliver quality care.

At SLCH, there has been increasing recognition of these needs. This awareness parallels national attention in pediatric nursing journals and other medical outlets. Several grass roots efforts have emerged. In one example, Same Day Surgery staff noticed that some children with autism spectrum disorders had considerable difficulty with the processes and procedures required for their care.
A task force developed the following efforts to improve care for this population of surgery patients:

- staff education
- targeted pre-visit screening
- a menu of behavioral strategies and an individualized plan to decrease the patient distress leading to smoother workflow on the day of surgery

Recently, a partnership of nursing, patient safety and behavioral health was formed to oversee hospital-wide efforts for improved care for individuals with behavioral health needs.

The work is focused in three main areas:

1. Developing resources to support care provided to these patients (e.g., documentation templates to capture relevant behavioral information, individualized hospital plans for patients with behavioral needs, coping toolkits for patients with autism, refined policies regarding safety and sitters)

2. Disseminating staff education and training (e.g., understanding behavioral disorders, how to identify triggers for escalation, common nursing behavior interventions)

3. Refining standard practices to care for these patients (e.g., safe attire checklist, PCT hand-off procedures, public safety/charge nurse coordination, coordination with behavioral health consultants)

Look for regular updates regarding these initiatives. If you are interested in getting involved to help shape these efforts, talk to your manager and contact Tina Klasing (Manager, 12th Floor), Becky Doerhoff (Manager, Patient Safety), or Mary Michaeleen Cradock (Director, Behavioral Health).

Two recent patient experiences highlighted these needs and the success that teams can achieve. On the 8th and 12th floors, patients were admitted with significant developmental delay and behavioral symptoms that interfered with providing medical care. Staff were challenged to figure out how to understand the patients’ behaviors and to intervene. Initial attempts were only marginally successful leading to disappointment, frustration, staff fatigue and some injuries.

“Through time and staff dedication to achieving a better understanding, patients were cared for in a way that significantly improved their behaviors and ability to receive their medical care,” Doerhoff says.

For one team, feedback from home-based caregivers helped in understanding the patient’s needs and how he was communicating with his behaviors. This led to dramatic changes for the patient and staff’s experiences. Mary Blackwell, a 30-year PCT at SLCH, says she and the rest of the team were ultimately successful with another patient when they “approached it as an opportunity to learn. I watched his mom and family care for him and learned how they knew when he was happy or about to get upset,” Blackwell says.

Klasing says the team gradually identified the patient’s triggers and the importance of sharing that information from shift to shift. “It takes patience and a team effort to meet the unique needs of these patients,” she adds.

In Missouri, nearly 9 percent of children have a serious mental health condition that can cause significant impairment in the child’s functioning at home or school, with higher rates reported for St. Louis.
A sampler of current initiatives

- **Partnering with families with the Adaptive Care Screening Tool:** This questionnaire was designed to obtain information from the parent or primary caregiver about developmental or behavioral needs that may affect a child’s care during hospitalization. Originally designed by the same day surgery task force, the tool is available in KiDDOS. Look for more education about this tool soon.

- **Behavioral Coordination Team (BCT):** The BCT is designed to be a resource to units caring for a child with developmental, behavioral, or mental health needs and includes consultants from psychology and psychiatry and representatives from social work, child life, and therapy services. BCT members are available for individual questions at any time during the week. They also meet every Monday from 11 a.m.-noon in the 12th floor conference room. The meeting is open to any staff members from any unit to discuss concerns related to a current patient, regardless of whether that patient is being seen by psychiatry or psychology.

- **Handoff Communication Project:** Becky Doerhoff, manager, patient safety, piloted a program to strengthen PCT handoffs when caring for a patient with behavioral needs. This program will be expanded to other areas.

- **Safe Training and Responsible Restraint (STARR):** This program is designed to train staff in the use of communication and interaction strategies to prevent or to de-escalate challenging behavioral situations. The focus is on understanding patterns of behavior including triggers for escalation, and to develop skills to use this knowledge in the care of patients and families.
In 2012 the Pediatric ICU’s Joint Practice Team created a vision statement incorporating safe care, effective care and exceptional service. To achieve the vision, the group created three teams to focus on:

- patient satisfaction
- reduction of bloodstream infections (BSI)
- stage II and III pressure ulcers (PU)

The pediatric ICU teams, composed of leadership, front line nurses, patient care technicians, a quality improvement specialist and a project manager, monitored monthly patient satisfaction and health care-associated condition (HAC) reports to track progress.

The patient satisfaction team, under the leadership of Michelle Mendonsa, RN, met monthly and created several interventions to improve provision of family-centered care and improve scores.

A 22 percent reduction in hospital-acquired conditions (HACs) was achieved in 2013.

Jenny McDowell, BSN, RN, CPN, LNCC, 7 East, and patient Jacob Kheriaty.
This exercise proved useful in identifying and addressing solutions for issues identified by families such as sleeper chairs, cleanliness of restrooms or a need for hot water in the parent lounge.
• the reason for immobility
• what alternative interventions could be used
• an acceptable intracranial pressure parameter for the patient
• the anticipated length of the immobility

Teamwork was another area targeted for improvement. Patient care technicians (PCTs) were empowered to “own” the visual audit data collection process. Instead of performing traditional audits, PCTs were asked to partner with nurses and offer assistance with turning the patient, bathing, linen changes or device rotation such as changing leads or moving a pulse oximeter. This approach provided leadership with reliable, visual data on the care being provided. It also promoted teamwork and gave PCTs a meaningful purpose in the patient’s overall plan of care. Historically, PCTs did not have a role in direct patient care. In this case, they enjoyed being part of the care team, and their involvement reduced the pressure ulcer occurrence rate by more than 50 percent, from seven in 2012 to three in 2013.

This work by the Pediatric ICU teams required development of multiple observation logs to improve the efficiency and effectiveness of data collection. Collaboration with performance improvement colleagues moved visual observation from a leadership task to a front-line task performed by the PCTs. This was effective in driving bundle implementation while promoting rounding on patients to obtain data. This work also resulted in a HAC workbook that will be used as a model for other units. As a result of these efforts, the Pediatric ICU Unit-based Joint Practice Team received the 2014 Barbara Cole, MD, Leadership Award for advancing measures to reduce preventable harm.

For additional information, contact Cindy Brooks at cynthia.brooks@bjc.org.

Judy Johnston, director, retires

Judy Johnston, MBA, BS, RN, FACHE, patient care services director, retired in September after 39 years with St. Louis Children’s Hospital — not including the times she worked as a candy striper or nursing student.

Johnston officially joined the hospital in 1975 in the newborn ICU.

She fell in love with caring for premature infants. And, as her career grew, the newborn ICU grew, from 13 beds when she was in nursing school to 70 beds today. She became newborn ICU manager in 1989 and advanced to director in 1996. Johnston was also one of the hospital’s first transport nurses in 1979 and went on to manage the transport team for almost a decade before serving as patient care services director.

In this capacity, she had responsibility for the following areas:
• diagnostic center
• emergency services
• hospitalist pediatric nurse practitioner program
• newborn ICU
• transport

Johnston championed the family-centered care that first evolved in the newborn ICU. Families are involved in the planning and decisions related to the infant’s care and are encouraged to be in the unit at all times — even when the patient is in distress.

For her efforts, she earned the SLCH Nursing Leadership Award in 1990 and the SLCH Leadership Award in 2011. Johnston loved her job because she helped make a difference in the lives of children and families, just as she did as a staff nurse.

“Even in my administrative position, I could make an impact on patient care by making sure staff had the resources they need for our patients,” she says. “The people here have always been like family to me — I couldn’t imagine working anywhere else. It’s been a wonderful ride!”

For her efforts, she earned the SLCH Nursing Leadership Award in 1990 and the SLCH Leadership Award in 2011.
Each year more than 40,000 children will develop sepsis, a diagnosis that carries with it a 5-10 percent risk of mortality. This puts sepsis in the top five causes of pediatric mortality, and is particularly important to large pediatric centers, like St. Louis Children’s Hospital (SLCH), because patients with chronic conditions are more likely to develop sepsis or even die from it. As a result, the Emergency Unit (EU) joined the Pediatric Septic Shock Collaborative (PSSC), a national effort by 21 large pediatric hospitals to improve the care of patients in septic shock.

The PSSC’s main goal is to reduce the overall mortality of pediatric sepsis by 20 percent nationwide by improving both early recognition and timeliness of important early interventions. Recognizing sepsis in children can often be difficult, because children often develop hypotension later in their disease process when compared to adults. Because of this, members of PSSC have developed a sepsis identification tool that is used to screen all patients who may be at risk for sepsis.

The other key piece to the PSSC efforts is improving the timeliness of care. Hospitals escalate the level of care and mobilize resources for patients in cardiac arrest or severe trauma; similarly, patients with sepsis need a high level of care and multiple resources. It is well established in the medical literature that early antibiotics and aggressive resuscitation with IV fluid boluses can reverse the sepsis process and improve mortality. However, because it is often not obvious that a patient has sepsis, it’s challenging to know when to mobilize these resources. By having a standard protocol, similar to the PALS or ATLS algorithms, the health care provider understands what needs to happen and that it needs to happen quickly.

Efforts to develop a sepsis protocol at SLCH started when the hospital joined PSSC in 2013. Working with leaders in other divisions, a protocol was developed that uses the PSSC sepsis identification tool and resuscitation guidelines.

Since the protocol “go-live” at the beginning of March, EU staff have become more comfortable with recognizing sepsis and using the protocol when it is appropriate. The next challenge is to expand these efforts to include inpatient units.

For more information contact Scott Thomas, MD, at Thomas_S@kids.wustl.edu

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