ON THE Cover

Mandy Gallagher, BSN, RN, Float Pool, serves as a Resource Nurse in the Emergency Department. Assisting Kristell Guy and her daughter Skylar, Mandy augments the admission process and flow by completing a patient profile and history. Read about the Emergency Department’s commitment to process improvement, and how the team’s efforts resulted in achieving the Barbara Cole Quality Award on pages 10 and 11.

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As the Affordable Care Act and health care reform begin to affect all hospitals, many of us working in health care are anxious about the future. The complexity of reforming our current system to achieve better patient outcomes at a lower overall cost is well known. The precise solutions to the dilemma are not.

It is easy during this time of uncertainty and change to feel overwhelmed and angry. We may find ourselves in conversations that are filled with complaints, criticism of our leaders’ decisions and actions, or a sense of doom. When this happens our focus can shift away from our patients and families without realizing it. It can also lead to a general lack of energy and decline in our willingness to “go the extra mile” at work. None of this helps us to solve the real challenges that are in front of us, but it does feel good to vent!

One thing I have learned over the years is to recognize when I am part of one of those negative cycles in a team where we are feeding each other deflating, de-energizing messages, and to notice that out loud with the group. Often I am as guilty as anyone else participating in this, but by calling myself on it, as well as my peers, it can often change the conversation.

Many things happen in life that we cannot control, but the one thing we can ALWAYS control is our response to those events. Anger and bitterness are understandable but not necessarily helpful in the long run. Those emotions poison our inner space, as well as the space around us, and keep us trapped in what happened, rather than looking down the road ahead.

As our times grow more challenging, I am choosing to take the long view and look down the road ahead to see where I want us to go. As a leader, I view that as my challenge, and I am counting on our team to help us navigate that road. Some of us will be in the front seat steering, others will be looking at the map and navigating, and still others will be providing the energy and ideas to get us to our next destination. I hope that you will take the trip with me and help in one of these roles, as it will be an exciting journey. Let’s shape the future for children’s health care together!

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

Brittany Richardson, MSN, RN, plays with patient Racheal Jamison. Racheal, who died in April, brought smiles and laughter to those who cared for her. Her mother feels this photo is a nice tribute to the care that was provided, for which she is grateful.
Amy Ross, BSN, CPN, RN, presents during family-centered patient rounds in the Cardiac ICU.

The current vision statement for nursing at St. Louis Children’s Hospital was created in 2003. Over the last 10 years, the structure and process to support nursing and all of Patient Care Services (PCS) evolved. Important changes included:

• a new Vice President of Patient Care Services
• establishment of a multidisciplinary shared leadership council structure
• achievement of nursing’s highest honor, Magnet Status

The time had come for a new vision, not only for nursing, but for all of PCS. The processes used to develop the vision needed to be multidisciplinary and reflect the hospital’s commitment to the “Superior Patient Experience.”

Meetings were held with nursing leadership, shared leadership councils and the Magnet Committee to explore concepts to include in a new vision. This information was collated to ensure that major themes were captured. The language of superior patient experience, magnet domains and the Institute of Medicine Future of Nursing report were compared to the themes from our staff and leadership groups. Several draft vision statements were developed, narrowed down and re-evaluated by all groups for final feedback. It was important that the major themes identified by the various groups were incorporated into the new vision.

Through this process, a vision statement was created representing partnerships with patients, families and other health care providers to ensure safe, effective care and exceptional service. By embracing evidence-based, research-driven care, St. Louis Children’s Hospital assists families in using their strengths to achieve and maintain an optimum state of health. Our mission to create the Superior Patient Experience resonates throughout the vision.

For additional information, contact Judy Johnston at judyaj@bjc.org.
Magnet Status Update

The Magnet Recognition Program® is a national recognition for hospitals who have achieved the highest standards in nursing for clinical excellence and innovation. The program was developed by the American Nurses Credentialing Center (ANCC) and Magnet designation has the following benefits for organizations:

- Attract and retain top nursing talent
- Improve the quality of patient care and patient satisfaction
- Foster a culture of interdisciplinary collaboration
- Advance nursing standards and practice

We are one team, with a passion for children, that consistently delivers safe, effective care and exceptional service to every patient, every family, every day. We help families build on their strengths to achieve their best health at home, in the hospital and in their community. We will be known as a world leader in pediatric health care through our use of evidence-based and innovative practice models.

SLCH REVISED VISION STATEMENT FOR PATIENT CARE SERVICES

Representing various areas of the hospital, staff gather to meet as members of the Clinical Practice Council, an example of multidisciplinary-based teams and a practice of the shared leadership model.
Disorders of water and sodium balance

Sodium (Na⁺) is the major extracellular cation (a positively charged ion) in the body. Disturbances of serum sodium are common electrolyte abnormalities found in hospitalized patients. Sodium disturbances may provide valuable information as to the nature or severity of the underlying disease process. A few disease processes with associated sodium disturbances include syndrome of inappropriate secretion of antidiuretic hormone (SIADH), central diabetes insipidus (DI) and cerebral salt wasting syndrome (CSWS).

The two main methods to control water balance and maintain plasma sodium concentration are the thirst mechanism and the release of antidiuretic hormone (ADH), which stimulates water retention in the kidneys. Urine output normally reflects water intake. Increased water intake dilutes the blood, causing the hypothalamus to release less ADH. Decreased ADH production triggers increased urine output.

Syndrome of Inappropriate Secretion of Antidiuretic Hormone (SIADH)

SIADH is a disorder of impaired water excretion caused by excessive secretion of ADH in the absence of normal physiologic stimuli. Higher plasma ADH results in more concentrated urine and decreased urine output. Water intake is not sensed appropriately, so secretion of ADH is not adequately suppressed, and the urine remains concentrated. This leads to total body water retention, causing hyponatremia (serum Na⁺ < 135 mEq/L) with hypo-osmolality (serum osmolality < 275 mOsm/L). Urine output is usually less than 1 mL/kg/hr. Urine studies will reveal concentrated urine with a specific gravity (SG) > 1.020, urine Na⁺ > 40 mEq/L and urine osmolality > 100 mOsm/L. The first line of treatment for SIADH is fluid restriction, with a goal intake of less than 800 mL/m²/day. The serum Na⁺ should be normalized slowly over 24 to 48 hours with frequent neurologic checks, strict intake and output symptom management.

Diabetes Insipidus (DI)

DI is characterized by a decreased release of ADH and an inability to conserve water, leading to excessive diuresis. Several different types of DI exist, each with a different cause. The most common type is central DI, caused by a deficiency of ADH related to failed synthesis/production by the hypothalamus or failed secretion of ADH by the pituitary gland. Central DI typically presents with significant polyuria and polydipsia due to increased serum Na⁺ and osmolality.

Decreased ADH release in DI can lead to severe hypovolemia, hypernatremia (Na⁺ > 145 mEq/L) and hyper-osmolality (serum osmolality > 300 mOsm/L). Urine output is usually greater than 3.5 ml/kg/hr. Urine studies will reveal a very dilute urine with SG < 1.010, urine Na⁺ < 40 mEq/L and urine osmolality < 300 mOsm/kg. The treatment for DI is aimed at either controlling the excessive amount of urine output, or replacing it with free water when possible. Desmopressin (DDAVP®) is a form of synthetic ADH and the medication of choice to increase ADH levels. Replacement of previous and ongoing fluid losses is also important with central DI.
Cerebral Salt Wasting Syndrome (CSWS)

CSWS is a rare condition notable for hyponatremia and dehydration in response to trauma/injury or the presence of cerebral lesions, tumors or hematoma. CSWS is a diagnosis of exclusion and can be difficult to distinguish from SIADH. The main clinical difference between the two is the total fluid status. CSWS leads to a relative hypovolemia, whereas SIADH is consistent with fluid retention and a hypervolemic fluid balance. CSWS is due to excessive renal Na⁺ excretion resulting from a centrally mediated process.

Primary symptoms include polyuria due to inadequate Na⁺ retention in the body, polydipsia due to polyuria, extreme salt cravings and dehydration. CSWS usually appears within the first week after brain injury and can spontaneously resolve in two to four weeks. CSWS requires aggressive hydration and Na⁺ replacement to correct the low serum Na⁺ levels.

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Sodium disturbances may provide valuable information as to the nature or severity of the underlying disease process.
Study improves lives of children affected by interpersonal violence

After years of witnessing children repeatedly admitted to the Emergency Department (ED) with gunshots, stabbings and other assaults, Emergency Department Social Workers began to investigate ways to change the path of these children. A professor of social work at Saint Louis University was contacted and discussions were initiated on how to intervene at the moment of crisis when these children may be most open to change. The target population was identified as male and female victims of interpersonal violence between the ages of 13 and 17 treated in the ED.

The pilot study introduced an intervention, Motivational Interviewing, a proven success with other high-risk behaviors.
Motivational Interviewing is a non-judgmental and non-confrontational counseling style focused on heightening clients’ awareness of consequences and problems associated with their behaviors.

The next step was to devise an intervention that was cost effective, easily implemented at other facilities and randomized to determine if the intervention had sufficient impact to change the trajectory of these children’s lives. Tools were chosen to assist the youth in identifying problematic behaviors, as well as personal strengths and weaknesses. The pilot study introduced an intervention, Motivational Interviewing, a proven success with other high-risk behaviors.

Motivational Interviewing is a counseling technique developed by a psychologist working with substance abuse clients. It is a non-judgmental and non-confrontational counseling style focused on heightening clients’ awareness of consequences and problems associated with their behaviors. By using reflective listening and assisting the client to envision how life could be different if they made different choices, the counselor is able to motivate the client to work toward behavior changes and change the circumstances of their life. This intervention can prevent further incidents of violent activity.

Funding from Saint Louis University and St. Louis Children’s Hospital Foundation was secured for a total of two years, allowing one year of enrollment and one year of follow-up for each participant. Institutional Review Board (IRB) approval was obtained and the intervention of working with this very high-risk population began with the assistance of a master’s-prepared social worker who has a passion for helping these children.

With the help of the intervention, some of the children have been able to improve their positive decision-making abilities and secure additional resources to meet their needs. However, it has been difficult, as some of the children lack support and understanding of appropriate behavior and need guidance to gain an appreciation for the help that is available to them.

Thus far, the most successful cases of intervention involve a quick response to the crisis and the interventionist’s ability to structure services on an individual, case-by-case basis.

Children who have been positively affected by this study have reduced violent activity and improved grades and social functioning.

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The Emergency Department (ED) is considered the front door to the hospital and sees approximately 50,000 patients each year. Of this number, approximately 85 percent are discharged and 15 percent are admitted, which represents 50 percent of all admitted patients. The staff realized that inefficiencies within the ED could affect productivity, patient satisfaction, employee engagement, and create financial hardships. By decreasing these inefficiencies, the ED would become better aligned with the organization’s key performance improvements.

The efforts put forth from January 2009 to May 2013 led the ED team to decrease the average left without being seen (LWBS) rate from 5.3 percent to 0.8 percent and length of stay (LOS) for discharged patients from a median 183 minutes to 132 minutes.

Getting started
It was clear that the journey would require leadership involvement, physician commitment and staff acceptance to be successful. The vision was focused on decreasing LOS and the LWBS rate. The Define, Measure, Analyze, Improve, Control (DMAIC) process improvement methodology was used to analyze data to develop improvement processes as well as to establish controls to sustain the improvements. At times, the Plan, Do, Check, Act (PDCA) cycle was necessary to pilot potential new processes before long term implementation.

Processes implemented
Several processes were implemented that included more robust staffing models to meet the demand of patient flow. This included piloting providers at triage, implementation of a “fast track” process for less acute patients and the addition of resource nurses to expedite admissions. The ED collaborated with ancillary departments such as Radiology and Environmental Services to assist with delays related to patient escorts for radiographic services and room turnover. A communication center was also developed to centralize telephone calls into the ED. Both acute and long-term triggers for patient delays were identified to proactively respond to surges in patient volume.

Acute Triggers:
- More than six patients per hour arrive for two consecutive hours
- Waiting longer than 60 minutes for room placement in the ED
- NEDOCS (National ED Overcrowding Score) at orange to red for greater than 60 minutes
- Patients waiting longer than 60 minutes to be assessed by the provider

Long-Term Triggers:
- ED census reaches 180 in three consecutive days or 225 in a single day
- House census reaches 220 at any time

As the triage nurse, Becky Schlecht, BSN, RN, describes a plan and an anticipated wait time with Serilla Flanigan and her son Cyrus.
The efforts put forth from January 2009 to June 2013 led the ED team to decrease the average left without being seen (LWBS) rate from 5.3 percent to 0.8 percent.

**Challenging effort yields results**

Building relationships with inpatient units and ancillary services as well as following a continuous process improvement philosophy enabled the ED to achieve an 85 percent improvement for LWBS and a 28 percent improvement for LOS for discharged patients. In addition, patient satisfaction scores increased from 65.2 percent to 68.7 percent with the goal to achieve 80 percent by 2014.

In July 2013, the ED Leadership team began rounding with staff to ensure staff needs are met to best take care of patients. Additionally after piloting, a “sorting” process was implemented August 15, decreasing the door-to-provider time from an average 35 to 20 minutes.

Change is inevitable and sometimes challenging. With continued support, data collection, and a continued vision of being the “best of the best,” the ED has remained committed to process improvement and providing excellent service for every patient, every family, every day.

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The ED established a communication center to centralize all communications and improve efficiency in admissions and discharges. Trained to support the center, Todd Vogt, EMT-B, and Kena Zimmer, RN, TSN, coordinate trauma pages, answer transport calls and monitor the EMS system.
The bed management software within the hospital’s clinical information system provides views of bed status throughout the facility as well as by unit. Veronica Wright, BSN, RN, and Christopher Emke, BSN, RN, administrative supervisor, plan discharges from 8 East.

In 2010, St. Louis Children’s Hospital recognized the need to automate parts of its processes for admissions, establish patient flow metrics and add real-time monitoring to improve a patient’s experience throughout a hospital stay. A search of available products revealed that an opportunity was as close as next door at Barnes-Jewish Hospital (BJH). St. Louis Children’s Hospital partnered with BJH and the other BJC hospitals to implement a system-wide database for automated notification and performance tracking for patient placement and room cleanup after patient discharge. This software package is known as TeleTracking®.

One of the first and lasting improvements brought about by TeleTracking is the speed with which housekeeping can address discharge cleaning. The integration of messaging triggered by a patient being discharged means that a housekeeper is immediately aware a room has been vacated. Cleaning beds sooner during the peak times reduces delays with patient admissions so patients can begin to receive needed therapies earlier.

Since the TeleTracking go-live in late 2011, workgroups comprised of hospital staff have identified ways to continually improve how TeleTracking is used. Some changes have been small but resulted in significant impact, such as directly messaging designated personnel within Environmental Services for bed delivery.

These expectations have created a more consistent workflow through which the ED and the inpatient units can better prioritize the care provided.

Other changes have improved the workflow in different departments. One example involves timeliness of handoff communication between the Emergency Department and the receiving unit. Once a patient is assigned to a unit and identified as “Ready to Move,” the unit team has 20 minutes to review the online documentation and call for verbal report. These expectations have created a more consistent workflow through which the ED and the inpatient units can better prioritize the care provided.

As staff continues to adapt to the changing needs of today’s patients, the information that TeleTracking provides allows care providers to better serve needs of patients and families. Armed with real-time feedback alerts and the ability to report historical performance, St. Louis Children’s Hospital can make informed choices about how patient care is delivered.

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