SCREENING BABIES FOR HEART DISEASE

See page 4
ON THE Cover

Heart Center patient Beckett Ludwig gives nurse Kari Vigna, RN, a big smile as she checks his arterial oxygen saturation and pulse rate. St. Louis Children’s Hospital supported a bill that is now a law to ensure that newborns are screened for critical congenital heart disease. For more information, see page 4.

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Jenny Kelahan Kaatman, MOT, OTR/L, and Suzie Kisslinger, MPT, took a sabbatical to improve the hospital's program for children with birth injuries. For more information, see page 10.

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As I reflect upon the challenging year we had in 2013 and anticipate the year ahead, many thoughts run through my mind. Health care reform is upon us, whether we like it or not. Many of us are wondering what it will mean for St. Louis Children’s Hospital (SLCH). Despite all the changes that have occurred, it seems more change is inevitable.

One thing I do know is the staff at SLCH are up for the challenge! We have some of the most innovative and talented professionals in the country. This issue of Pediatric Perspectives includes stories about new programs you have developed and cutting-edge care you provide to our patients. You are creating the changes we want to see in pediatric health care. Continuous learning is one of our core values and also an important part of professional growth. An article on critical congenital heart disease provides an update for those of us looking for some additional clinical knowledge.

Another important article provides an overview of our updated Nursing Professional Practice Model (NPPM). This was included in the documents we submitted earlier this year for Magnet re-designation. As we begin the process of preparing for the site visit that we hope will occur sometime in late summer, we want you to become familiar with the new version of our NPPM. It is a graphic representation of how we integrate family-centered care into our overall goal of providing a Superior Patient Experience (SPE) through Safe Care, Effective Care and Exceptional Service. The values that help us to achieve this goal are included in the model.

As a leader, I am always striving to be my best and to serve the needs of our professional staff. To that end, I subscribe to a daily meditation I find helpful, and I would like to share one with you:

“When you are living the best version of yourself, you inspire others to live the best versions of themselves.”

– Steve Maraboli, author and speaker

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As we face the uncertainties of the year ahead, remember that this is all any of us can do: Be our best. If we achieve this, the future will take care of itself. It may or may not be the way we want it, but if we are open to change and to “be our best selves,” we are most likely to land on our feet!

Peggy Gordin, MS, RN, NEA-BC, FAAN, is SLCH’s Vice President of Patient Care Services. She can be reached at pgordin@bjc.org.
New parents prepare for discharge from the Barnes-Jewish Hospital Women and Infants Services Mother-Baby Unit.

EXEMPLARY PROFESSIONAL PRACTICE

Screening babies for critical congenital heart disease (CCHD)

Babies can present as completely healthy in the first day or two of life but still be at risk for a life-threatening heart condition. That is why it is important each newborn is tested for critical congenital heart disease (CCHD) before discharge home from the nursery. Each year, 7,200 babies are born in the U.S. with the condition.

In 2013 St. Louis Children’s Hospital supported a bill in Missouri mandating newborn heart screenings throughout the state. That bill became a law and ensures babies are screened for CCHD by using a device already in every hospital – a pulse oximeter. The mandate is particularly important for newborns in hospitals that don’t have heart programs.

Congenital heart disease (CHD) is the most common severe birth defect occurring in nine per 1,000 live births and resulting in more deaths than any other congenital malformation. One-fourth of these babies have CCHD, lesions with unstable blood flow patterns requiring surgical or cardiac catheter interventions in the first year of life. With advances in prenatal ultrasound screening, approximately 50 percent of the babies with CCHD are diagnosed before delivery. Others develop clinical signs shortly after birth; however, as many as 25 percent of these babies show no abnormal clinical signs during the first days after delivery and are discharged before diagnosis. Over time, as a baby’s fetal circulation transforms, the heart defect will cause severe hypoxemia and/or circulatory compromise.
Many babies with CCHD have mixing of venous and arterial blood resulting in a lower than normal oxygen saturation, although cyanosis may not be visually apparent. Screening healthy babies with pulse oximetry is a simple and accurate test for detecting desaturation especially when performed after the first 24 hours of life. Saturations are recorded in the right hand and either foot and may be done simultaneously or sequentially. The baby passes if either saturation is 95 to 100 percent with three percent or less difference between the two sites. If a saturation recorded at either site is under 90 percent, the baby needs immediate evaluation for possible causes. When the higher saturation is 90 to 94 percent and/or difference between sites is more than three percent, the baby should have a repeat screening in one hour. This may be repeated one more time, for a total of three screenings. If passing saturations are not obtained after three screenings, the baby is referred for further evaluation.

Low saturations may result from several conditions. Complete review of the perinatal history, clinical course, physical examination and additional studies are needed before a diagnosis can be determined. Providers and parents should also be aware that pulse oximetry does not detect all forms of CCHD or CHD.

Besides Missouri, Illinois and 28 other states now require all newborn infants to have the CCHD screening. The Missouri Bill is called “Chloe’s Law” in honor of the family whose efforts helped ensure its passage. Routine pulse oximetry screening will help identify those babies that need additional care.

For additional information, contact Sherrie Hauft, MD, at hauft@kids.wustl.edu.

**Benefits of the CCHD screening**

Prior to implementation of the critical congenital heart disease screening before discharge, nurses relied on patient assessment to detect cardiac abnormalities on otherwise well-appearing infants. Today, all newborn infants discharged at BJC hospitals are screened through pulse oximetry.
Why is a Professional Practice Model important?

Today’s health care climate is bringing practice, economic and cultural challenges that are creating an opportunity to envision a new direction for nursing. The commitment to Superior Patient Experience (SPE) and inter-professional collaboration led St. Louis Children’s Hospital to revise the Nursing Professional Practice Model (NPPM).

The NPPM is an organizing framework that guides nurses in decision making to ensure consistency of practice across all settings. The hospital’s NPPM exemplifies the key domains of nursing practice that support delivery of a SPE and connects nursing to the patient and family, to other health care providers, to their own practice, and to the mission, values and vision of the organization.

Our journey

With the introduction of Unit-based Joint Practice Teams, the infrastructure for decision-making was shifted to the unit level, therefore, a revision of the NPPM was needed. The process began with establishing a Shared Leadership structure that was fully integrated into the hospital operations and patient care delivery. Additionally, the hospital mission statement was developed to reflect commitment to a “Superior Patient Experience for every patient, every family, every day.”

Next, a new vision statement for Patient Care Services (PCS) was developed. With these steps accomplished, attention was directed to further develop the NPPM.

The evolving transformational NPPM now encompasses values from the newly developed mission and vision statements. The new NPPM is reflected throughout the organization as a structure for integrating patient care services, and supporting delivery of nursing care and the environment in which the care is delivered. This transformational NPPM is a framework for developing leaders and front-line staff and maintaining a focus on optimal patient outcomes.

For additional information, contact Karen Balakas at KaBalakas@bjc.org.
Nursing Professional Practice Model (NPPM) definitions

- The center of the model represents the vital relationship with the Patient and Family and recognizes each individual’s experiences, values and beliefs as integral to the plan of care. The patient and family are the focus of nursing care. Establishing relationships between the nurse and the patient and the nurse and family is essential to success in providing a superior patient experience.

- **Family-Centered Care** is the philosophy from which SLCH developed a framework for care delivery. It is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families and defines the relationships in health care. Nurses at SLCH believe that families are critical for the patient’s wellness and that helping families build on their strengths leads to optimal health outcomes.

- **Shared Leadership** is a philosophy signifying that the best decisions in an organization come from front-line staff and leadership facilitates those decisions to fruition. Shared Leadership supports an enriched practice environment and is a vehicle for communication in all directions. It is transparent and empowers nurses within the organization to lead at all levels.

- **Interprofessional Collaboration** demonstrates recognition that relationships with colleagues are a vital element in the PPM and that all members make essential contributions toward optimal patient outcomes. These relationships contribute to the establishment of a healthy work environment and directly influence the relationships formed with patients and families and thus impact our success in the delivery of exceptional care.

- **Evidence-Based Practice** (EBP) is the thoughtful use of scientific knowledge encompassing both external research and internal data combined with clinical expertise and patient preferences in the delivery of nursing care. At SLCH, EBP is the standard of care and the organization strives to create a culture that sustains the use of evidence for direct care decision making.

- **Innovation** is an element of the environment indicating that nurses at the unit level are empowered to further develop new roles, provide exceptional patient care, foster patient and family involvement in care, and evaluate the outcomes of their care.

- The **Scope of Practice** component demonstrates the organizational commitment to establish a setting in which professional nurses’ daily work activities reflect the full range of functions, responsibilities and activities that a nurse performs in delivering patient care. Nurses are enabled to demonstrate leadership in relevant ways in concert with educational preparation.

- The key drivers of SPE: safe care, effective care, and exceptional service, along with care delivery across the continuum of care from the revised vision statement, are represented in the inner circle of the model.

- The core SPE values of Personal Ownership, Working in Partnership, Commitment to Continuous Improvement and Research, On-going Learning, Embracing Change and Disciplined Resource Stewardship are reflected in the outer circle of the PPM.

Shared Leadership Council co-chairs, from top: Jill Wiethuchter, CCLS, Child Life Specialist, and Lyndsey Saunier, BSN, RN, CPN, CIS Coordinator; Kelly Burgio, PT, Therapy Services, and Ashley Goebel, BSN, RN, Heart Center; Bobbi Williams, LCSW, Social Services, and Julie Stumpf, BSN, RN, Heart Center; Cookie Muntges, Lab, and Peggy Conroy, BSN, RN, Family Resource Center; and Megan Rennie, CCLS, Child Life Services, and Luke Hoffman, BSN, RN, 9th floor.
Sabbaticals offer profound experience in professional growth

The St. Louis Children’s Hospital (SLCH) Sabbatical program is designed to create an opportunity for staff with a proven record of excellence in job performance to pursue their passion. Through generous funding from the SLCH Foundation, the program provides a unique professional development opportunity for both clinical and support staff. Front-line staff are eligible for up to 12 weeks of paid leave and financial support to complete a project that achieves hospital, department or patient-care goals. To get started, participants submit a brief description of a sabbatical idea along with a letter of support from their manager. Full information about applying for a sabbatical is accessed on the SLCH intranet home page under Clinical Resources. On the following pages are highlights of three sabbaticals recently completed. For more information about sabbaticals, contact Susan Hibbits at SusanBH@bjc.org or 314.454.4855.

Collaboration results in creation of new Inter-Professional Residency program

Soon after the Shared Leadership councils began meeting at St. Louis Children’s Hospital in 2010, the Education Council members were developing as an inter-professional team and seeking ways to apply shared leadership concepts to other areas and programs throughout the hospital. At the same time, the Clinical Education department was considering implementing a residency program which would support new graduates as they start their careers and transition from the academic setting into their clinical roles.

Residency programs specific to nurses were growing in popularity across the country, but with the multidisciplinary focus of the SLCH Shared Leadership Councils, the Clinical Education department was interested in the possibility of an inter-professional residency program. Literature review results contained multiple references for nursing residency programs but none about inter-professional residency programs. The Education Council and Clinical Education department collaborated to create an Inter-Professional Residency program at SLCH. A subcommittee began intensive work to create the three components that comprise the program today.

First, Core Orientation was redesigned to include participants and facilitators from all Patient Care Services professions (Nursing, Pharmacy, Radiology, Respiratory, Child Life, Therapy Services, Dietary, and Social Services/Chaplaincy).
Non-licensed assistive personnel (Patient Care Technicians and Pharmacy Technicians) also participate in Core Orientation. The content was determined by the front-line staff subcommittee based on the common orientation needs of all Patient Care Services staff. Topics include ethics, child protective services, infection prevention, end-of-life care, care of the hospitalized child, communication and safety. Sessions use engaging teaching strategies that are interactive and participant-led. The final day of Core Orientation is spent in the Simulation Lab working through scenarios as an interprofessional team.

Support for Success sessions were also redesigned. These ongoing educational opportunities had existed for nurses in the past but were expanded to include content focused on inter-professional needs. Today, all newly-licensed professional staff within Patient Care Services attend these monthly learning opportunities for nine months following their orientation. The half-day sessions offer in-depth learning about topics and situations new employees will encounter during their work life.

The final component of the residency incorporates a Mentor Program. SLCH had a nursing mentor program several years ago, but it was small and used materials from another center’s program that no longer met the needs of the hospital. Peggy Conroy, BSN, RN, and Sarah Flatt, MSN, RN, CPN, shared a sabbatical to build a Mentor Program. Today, newly-licensed professionals are paired with a mentor for nine months after orientation. They meet monthly – sometimes with other protégés and mentors – for group discussion. Like the rest of the residency program, the Mentor Program involves mentors and protégés from all disciplines within Patient Care Services.

The program also provides guidance beyond graduation. Participants set goals and share their plans at graduation. The residency committee is currently building resources for participants beyond graduation from the program.

The residency program began in January 2012. To date, 105 participants have graduated from the program. Survey data has shown improvements in the following areas since program implementation:

- Communication-Leadership
- Organizing-Prioritizing
- Stress
- Support

Program graduates are currently involved in research, serving as preceptors and charge nurses, participating in the SLCH Evidence-Based Practice Scholar Fellowship, and pursuing advanced degrees.

The residency committee continues meeting to improve the program based on participant feedback. Residency committee goals include publishing experiences and results, completing a project to support participants beyond graduation, building academic partnerships, and incorporating a multimedia approach.

For more information about Core Orientation or Support for Success, please contact Beth Hankamer at bah8876@bjc.org.

For more information about the Mentor Program, please contact Peggy Conroy at peggyc@bjc.org and Sarah Flatt at slt8614@bjc.org.

2013 Spring Residency Cohort participants: front row, from left: Laura Porte, RN; Lauren Polczynski, RT; Brieann Lloyd, RN; Kayla Cagle, RN; Amanda Blaise, RN; Andrea Greaser, RN; Jessica Wallace, RN; Angela Ruffino, RN; Allison Palisch, RN; Lauren Wisdom, RN; Caitlin Kenney, RN; and Mark Heisohn, RN.

Back row: Brendon Whalen RN, Harley Fleming, RN; Sophie Kamer, RN; Tricia Bergmann, RN; Jolyn Vonder Haar, PT; Jessie Fossum, RN; John Gransbach, RN; Kyle Wood, RN; Dorothy Valvo, RN; Vincent Craig, RN; and Kelly Read, RN.
Helping patients with birth injury

Suzie Kisslinger, MPT, and Jenny Kelahan Kaatmann, MOT, OTR/L, took a 10-week sabbatical together to improve the hospital’s program for children with a birth injury called brachial plexus palsy. The injury affects the nerve network that controls movement and sensation in the arm. The main result of the injury is weak or paralyzed muscles in the shoulder, arm and hand. Physical and occupational therapy can help with varying degrees of arm weakness.

The goal of the sabbatical was to improve care in the form of new resources, treatment techniques, updated supplies and research. Since brachial plexus palsy is a birth injury, most resources are geared toward infants. Much of the need focused on patients 2 years and older. Patients often receive surgery for the injury and then are seen at least monthly by Therapy Services. Eventually, patients make annual follow-up visits. Their challenges include:

- arm length differences
- difficulty in using hands and arms well in two-handed activity such as dressing, typing and cutting
- poor self-image due to teasing when an arm is severely affected
“Even though we at the hospital are primarily here to treat the injury, we want to look at the whole child and give appropriate resources and referrals to families,” Kaatmann says. “For example, we collaborate with a child’s local or school therapist to focus on what the child and family deals with on a daily basis.”

As part of their sabbatical, Kisslinger and Kaatmann visited The Hospital for Sick Children in Toronto, which offers an internationally recognized program for brachial plexus palsy patients. They also took a continuing education course that featured information from five leading facilities in North America that treat the injury. The curriculum covered treatment, assessment, history, surgical and orthopedic procedures, and psychosocial care.

“We want to ensure what we are doing is comprehensive and correct for these patients, and we found that much of it already was,” states Kisslinger. “The sabbatical helped us enhance the quality of our tools for assessing our patients’ movement and functional skills.”

Other improvements resulting from the sabbatical include:

- Nine new informational handouts for patients’ families. Topics range from “Future Complications” of the injury to “Tips for One-handed Handling of Accessories” in daily life

- A collaboration with other SLCH departments to enhance care and resources for families. The departments included:
  - Family Resource Center (FRC)
  - Psychology
  - Marketing

The partnership with the FRC resulted in access for patients to a local support group for families, Cameron’s Smile, and new teaching tools on brachial plexus palsy for clinical staff. Following the sabbatical, Kisslinger and Kaatmann organized a Family Day last October that was free to families, thanks to SLCH Foundation funding. Parents and children affected by brachial plexus palsy met one another and shared ideas, struggles and other information from their journey.

“We both have a passion for the pediatric population,” Kisslinger says. “I threw out the broad dream of how we could help these patients, and Jenny fine-tuned the vision in the form of our sabbatical idea.” Working together with their sabbatical program mentor, Russell Hoffmann, PhD, Director of Cultural Transformation, they realized their dream of providing more help for these patients and families.

For additional information, contact Suzie Kisslinger at srk0535@bjc.org and Jenny Kelahan Kaatmann at jsk0313@bjc.org.

Julianna Conner, 3, receives therapy for her birth-related brachial plexus palsy from Suzie Kisslinger, MPT, left, and Jenny Kelahan Kaatmann, MOT, OTR/L, of Therapy Services.
Reducing delays for patients

Kim Hoffmann, RT(R), works in the Radiology Diagnostic department providing care for outpatients, inpatients, and patients in the ED, OR, and Gastrointestinal/Genitourinary. The department receives orders for X-rays from three different electronic health record systems: KiDDOS (inpatient), Allscripts (outpatient /clinic patients), and Wellsoft (ED). Hoffmann discovered these programs described the same X-ray order in three different ways. For example, to enter an order for “Intussusception” in KiDDOS, the care provider needed to search under the term “Colon” to find the correct examination. If the patient was in the ED, a search in Wellsoft under “Intussusception” led directly to the correct order. This was confusing for physicians who rotate throughout the hospital and resulted in treatment delays for patients.

Hoffmann and her colleagues tracked the problem on the department’s MDI board and also found that the words and descriptions in the orders were outdated, which could lead to variations in protocols. The potential for additional or incorrect X-rays was a concern for Hoffmann and her colleagues and did not support the concept of a superior patient experience.

Hoffmann summarized the problem in her sabbatical application saying, “When a doctor or nurse practitioner orders an exam that goes against our protocol or selects the wrong X-ray order, we, as technologists, are responsible for getting in contact with that provider and clarifying the order. This is time consuming and delays patient care. We cannot carry out the patient’s exam until we have the proper order placed in KiDDOS, Allscripts or Wellsoft.”

The purpose of this sabbatical was to synchronize all radiology exams so that each is worded and listed consistently in each program. In addition, synonyms were added next to the descriptions to help ensure the correct exam was being ordered. Over a 12-week period, Hoffmann achieved her goals by working closely with her sabbatical mentor, Leroy Love, Director of Performance Excellence; Marianne Power (KiDDOS); Kevin O’Bryan, MD, Chief Resident; Dwight Doerhoff (Wellsoft); and Karen Reffel (Allscripts).

After establishing a consistent ordering system among all the programs, order entry errors in each system were tracked on the department’s MDI board for three months. By May 2013, the data clearly demonstrated a dramatic decrease in errors that resulted in improved safety, accuracy and timely exams for patients. As part of the sabbatical work, a binder was compiled for each program so that radiology technologists could cross-reference the data for providers.

In reflecting on her sabbatical project, Hoffmann says, “I learned so much more than I expected and had an opportunity to work with so many people who contributed to that learning. And an unexpected and very positive result of this sabbatical project is that now physicians readily call the department for guidance to ensure the correct order is entered. This has been a valuable experience for me personally and professionally.”

For additional information, contact Kim Hoffmann at kdh2124@bjc.org.