

Pediatric PERSPECTIVES

ADVANCING PATIENT CARE SERVICES AT ST. LOUIS CHILDREN'S HOSPITAL



**Patient-driven
airway clearance
protocol**

See page 8



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ON THE Cover

► **Holly Lehmuth, BS, RTT**, places a chest physiotherapy vest on a patient as part of a new airway clearance protocol with the help of **Michelle Marty, RRT**, (also pictured on page 8.)

WINTER 2015 VOLUME 12, NO. 1

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Pediatric Perspectives is published by the St. Louis Children's Hospital Marketing department.

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From Peggy Embracing patient- and family-centered care

St. Louis Children's Hospital has a long history of being a leader and champion for patient- and family-centered care. It is one of the core elements of our professional practice model for nursing and patient care services. However, even leaders in this area must continually strive for growth and innovation in order to stay on the cutting edge. To that end, this issue of *Pediatric Perspectives* includes two articles that demonstrate how SLCH is moving forward in this arena.

Liz Kravand writes about her journey, first as a parent and today as an employee. Her title is Patient- and Family-Centered Care Coordinator. Taking over this role in the past year, Liz has brought many new ideas and great energy to our Patient & Family-Centered Care Council. She notes that our parents who work with us would prefer to be considered full partners in the work of running the hospital, rather than simply as "advisors." When we partner with someone, we join with them as co-equals in a relationship, working together toward common goals. This is the ultimate relationship we want with

all our patients and families, where each of us contributes our unique talents and knowledge to the care of a child.

The second article, written by the 8 West leadership team, describes how they implemented patient- and family-centered rounds. They share their experience with an initial successful implementation that was not sustained, and the steps they took to define the process more clearly that helped to regain and then advance their rounds to a consistent successful practice.

Not surprisingly, their process improved even further in 2013 with the addition of their family partner, who provides useful feedback to the team from other families on the unit.

Being good partners with our patients and families is a huge part of what it means to work in a children's hospital, or health care in general. However this work also comes with challenges, especially with the high volumes and acuity we see here. We have to allow time and develop our skills to facilitate family participation in the care of their child. Everything from the design of our

building to our interactions with each family needs to convey our respect and commitment to this partnership. I regularly see and hear stories of the wonderful relationships our SLCH staff have made with families during their visits with us. There are also a few times when I hear about situations where we could have done a little better.

In the coming year, we will be enhancing our staff training and support for working with people who are different from ourselves. This will include enhanced interpreter services and cultural competence resources, as well as some initiatives to improve our care for youth with gender issues. I am excited that SLCH is taking on this work and moving to an even greater level of partnership with patients and families.

Thank you for all you do to partner with our patients and families!

Peggy

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

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"Everything from the design of our building to our interactions with each family needs to convey our respect and commitment to this partnership"

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The 8 West Family-Centered Rounds leadership team includes, from left: Kim Sauder, BSN, RN, CPN; Roben Harris; Kara Nichols, BSN, RN, CPN; and Dr. Mike Turmelle.

► EXEMPLARY PROFESSIONAL PRACTICE

Family-centered rounds: increasing patient and family satisfaction

The staff on 8 West has long embraced the philosophy of family-centered care (FCC), an approach in which patients, families, and the health care team are partners. For pediatric patients and families, family-centered rounds (FCRs) represent a key component that involves patients and families partnering with the health care team to share information and make decisions about care. The 8 West team strongly believes that implementation of family-centered rounds is critical to providing excellence in care. Through continued evaluation and collaboration over the past several years, 8 West has established a standard approach to family-centered rounds that provides benefits to the patient and family as well as to the health care team.

In 2010 the team took steps to initiate FCRs on the unit. A process was developed that included creating a guideline, defining roles, and educating all members of the team about the goals of FCRs. Shortly after implementation, data was collected indicating a notable increase in the patient/family perception of overall teamwork among physicians, nurses and staff. Patient satisfaction scores increased. However, as time progressed, the process became dependent upon the healthcare team and their appreciation of their role in conducting FCRs. The rotation in physician team members led to challenges with consistency in practice and eventual frustration. Direct care nurse attendance and family participation decreased, and patient satisfaction scores remained flat.

Family-centered rounds continued to be valued with a potential for success, but progress was halted.

The team wanted to revive FCRs, and in 2011 a family-centered care committee was developed on the unit to focus on enhancing the team's ability to consistently partner with patients and families. A brochure was created and given to families upon admission to introduce the concept of FCRs and encourage participation. The group also shared family-centered care tips to educate staff on the importance and value of partnering with patients and families in decision making.

Although there was a family-centered care committee focused on rounds, there was still not a clear "owner" of rounds. When

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“Family-centered rounds make patients and caregivers feel they have more input into the care/plan of action taking place.”

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barriers were met or changes proposed, there was confusion regarding who should lead the efforts to resolve any problems. The proposed need was brought to the Unit-based Joint Practice Team and accepted as a multidisciplinary project in April 2012. The new team established three overarching goals to provide a foundation in the development of standardization:

- **Patient and family involvement**
- **Communication and coordination of care**
- **Efficiency and effectiveness**

To achieve their goals, the team developed a revised process including:

- A consistent rounding order and a rounding list created daily by the charge nurse allowing participation by direct care nurses
- A starting time was agreed upon (8:30 a.m.) and the primary medical service (GI) begins the day's rounding
- Rounds begin in the conference room and a few minutes are spent discussing any sensitive issues that may not be appropriate for the bedside
- Rounds are led by the senior resident (or the charge nurse if the physician is unavailable at the time)
- Introductions occur with the family, and they are invited to participate
- Presentation of the patient is delivered by the medical student or intern using patient and family-friendly language
- Input and questions are invited from all participants
- Orders are entered by a member of the team and then read back for accuracy

- After rounding, daily huddles are held to reiterate discharges and share new or important information that may impact the rest of the day

Prior to launching the new process in 2012, a series of communications for staff was developed to reinforce the value and importance of family-centered rounds. The roles of the bedside nurse, support staff and charge nurses were more clearly defined as they pertained to rounds. Laminated cards were provided with a list of the important information the bedside nurse could provide or clarify. Physician education was detailed and scripted with attention to condensing the information to a reasonable amount without sacrificing the quality. The FCRs were re-started; yet, despite all of this work, patient satisfaction scores remained unchanged over the next several months.

A significant improvement came in 2013 when a consistent family partner joined the team to provide understanding for the providers as to how the family was interpreting communication from the health care team during FCRs and how comfortable they felt participating in the process. The original observational checklist was revised to assess the consistency of team introductions to family members, order entry and read-

back by the health care team, bedside nurse participation and rounding roles. Also reassessed were the communication of daily and discharge plans, amount and extent of family and patient participation, and length and efficiency of rounding sessions. The family partner also suggested ways to enhance communication with families to ensure better understanding and increased participation in the process.

As a result, 8 West has seen a steady and sustained improvement in communication and teamwork scores. The team closely monitored seven key questions that reflected significant improvement in nurse communication, physician communication and teamwork from 2009 through June 2014. The team shared their success story in August at the 6th International Conference on Patient- and Family-Centered Care in Vancouver, Canada.

Speaking for the team at the conference, Dr. Michael Turmelle shared this perspective: “One of the biggest things is to understand the perspectives of everyone involved. You need to put yourself in the shoes of each member of the team to understand what they need out of rounds. Because of the difference in needs, you must compromise and establish goals that everyone can work to attain. Be willing to change and re-evaluate as you go. You might have what seems like a fantastic idea, and when it fails miserably you are going to feel bad. But you need to dust yourself off and try another approach.”

For more information contact Kara Nichols, BSN, CPN, at klc8012@bjc.org.

The best reward for all of this dedicated and challenging effort comes from the families themselves who shared their thoughts:

“The informative staff made things wonderful.”

“Whatever questions or concerns we had were answered completely.”

“I liked the way the different departments work so fluidly with one another.”

“The concept was not only a genius idea for a children’s hospital, but should spread to all medical facilities.”

“Family-centered rounds make patients and caregivers feel they have more input into the care/plan of action taking place.”

► TRANSFORMATIONAL LEADERSHIP

Partnerships with families enhance patient care, patient experience



Liz Kruvand

I was a molecular microbiologist who spent over ten years working with various parasites using DNA microarrays to study how they changed with drug treatment,

life cycle and pretty much anything I could throw at them. I came to St. Louis 10 years ago and met my husband. You may wonder what on earth this has to do with being a Patient- and Family-Centered Care (PFCC) coordinator. That part of my journey started about five years ago when my pregnancy took a rapid and life-threatening turn at 28 weeks.

My day started with what everyone thought was heartburn and ended 19 hours later with the birth of my daughter. Maya weighed only 2 pounds, 2 ounces and was 13 inches long. It turned out I had a condition known as HELLP syndrome, which stands for hypertension or hemolysis, elevated liver enzymes, and low platelets. It's a form of preeclampsia, a dangerous condition in which hypertension arises during pregnancy.

The thing I remember most about that day is the doctor at my first hospital. He told me they "didn't want my baby." Those were the most devastating words I could have ever heard. On the positive side,

they set me on a path of partnering with our medical team here in the newborn ICU that continued even after Maya was discharged 12 weeks later. That comment has never left me and has fueled my passion for PFCC ever since.

PFCC is an approach to care where patients, families and health care professionals form a working partnership that benefits everyone involved. A "family" is recognized as anyone whom patients regard as significant in their lives. Families are not considered "visitors" but essential nurturers and equal partners in the care and decisions that affect the total healing of the patient.

In 2010, I became a family partner and learned about all of the amazing programs that families were involved in here. After a few years of volunteering, I was asked to lead the Patient- and Family-Centered Care Council (formerly the Family Advisory Council). Our program was realigned under guest services, and I started in my present role six months ago.



My day started with what everyone thought was heartburn and ended 19 hours later with the birth of my daughter.



In my role, I coordinate the partnerships and programs related to the advancement of PFCC. This includes collaboration across all levels of SLCH to raise awareness of PFCC core values and behaviors. I work on programing to educate staff and families, facilitate the council, and coordinate the family partners programs which includes family mentors, the family-centered rounds initiative and families as actors in simulation. I also represent SLCH patients and families on a national level.

I am fortunate to work under supportive leaders and to manage a great team of lead family partners and council members. With their help, we have had an amazing period of self-reflection, restructuring, process development and growth. We are re-examining our mission, our focus and even the language we use.

For example, we used to refer to our parents as advisors. Today we call them partners—people who take part in an undertaking with others with shared risks and profits. Every individual can affect patients and families, and we want to learn about what makes each unit amazing and unique. We want to invest time and money in our partnerships to increase patient and family engagement and experience.

Patients and families come to us expecting superior care, but no one really wants to be here. Families each have different journeys, but each team member, in partnership with PFCC, can help our families feel like SLCH is a home.

For additional information contact Liz Kruvand at lkruvand@bjc.org.

► TRANSFORMATIONAL LEADERSHIP

Debbie Linck, RN, on safety

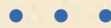
Co-lead, bloodstream infection team

I have been a staff nurse for 32 years. In that time, I have worked as a central line nurse, and co-chair of the Newborn ICU Peripheral Insertion Central Catheter (PICC) team. As co-chair of the PICC team, I oversee the PICC and bloodstream infection (BSI) data in the newborn ICU. I also joined the house-wide central-line care team as a newborn ICU representative. I am acutely aware of how nurses can affect an infant's course and outcome. We are changing the culture by making everyone aware that by using evidence-based guidelines, we can decrease our rate of bloodstream infections. As a result of our efforts, BSIs have significantly decreased because staff are more vigilant about occlusive dressings and more proactive with

advocating for the early removal of the catheter when it is no longer essential for continued care. The greatest challenge



We are changing the culture by making everyone aware that by using evidence-based guidelines, we can decrease our rate of infections.



has been getting staff to believe that the elimination of BSIs is an achievable goal. The newborn ICU staff is seeing the results of their efforts by sharing the infection rates. BSI reduction is a hospital-wide collaborative that is fully supported by SLCH leadership, and this can help reduce hospital-acquired conditions.

In her spare time Debbie enjoys music, hanging out with her husband and kids, watching her kids play sports, and short weekend trips.



► NEW KNOWLEDGE

Patient-driven airway clearance protocol: standardizing practice based on evidence

Established airway clearance therapies and principles of their application are comparable for neonates, children and adults. However, the differences in pediatric physiology and pathology require specialized knowledge and the ability to adapt airway clearance techniques and airway maintenance for infants and children. Airway clearance and maintenance techniques have evolved in recent years, making it more difficult to choose a proper disease-specific or age-specific modality. Health care providers without the advanced education held by respiratory therapists may have a limited

understanding of each available modality: how it works, when to use it, how to establish a goal for its use, and how to routinely assess for effectiveness. The inability to clearly differentiate between airway clearance therapy and hyperinflation therapy can create over-ordering or under-ordering of therapy resulting in less-than-optimal care.

Providing timely and correct delivery of respiratory therapy for patients requiring airway clearance is critical in managing the care of these patients. At SLCH, a significant delay in delivering

the best modality for airway clearance was occurring. In reviewing charts, it was evident that respiratory therapists were contacting physicians or nurse practitioners routinely to obtain revised orders for almost all patients, thus delaying the needed care. Additionally, a standardized scoring tool to routinely evaluate patients needing airway clearance therapy was not being used. This impediment to delivery of appropriate clinical care resulted in decreased patient satisfaction, decreased job satisfaction for respiratory therapists, and misallocation of resources.

Continued on next page

► NEW KNOWLEDGE

Patient-driven airway clearance protocol: standardizing practice based on evidence *Continued*

In discussing the clinical concern, it was found that several staff members had previously worked in hospitals that used therapist-driven protocols to improve care delivery. Determining the most effective airway clearance therapy, delivering and monitoring the care, and educating patients, families and other healthcare providers are within the respiratory therapist's scope of practice. This led to the following PICO (patient/population, intervention, comparison, outcome) question used in formulating evidence-based practice:

For pediatric patients requiring airway clearance, would the implementation of an evidence-based patient-driven protocol delivered by the respiratory therapist compared to traditional provider order entry result in decreased time for treatment and increased provider confidence in administering the protocol?

Following an extensive review and appraisal of the literature and consultation with respiratory therapists in comparable pediatric hospitals, a multidisciplinary project team was formed. At the beginning of this project a medical director for the respiratory therapy department was still needed, which presented a significant barrier. Fortunately, Drs. John Lin and Albert Faro accepted leadership appointments and contributed to the success of the project.

Using guidelines from American Association for Respiratory Care and the best available evidence, a new therapist-driven protocol for airway clearance was developed. An evidence-based scorecard was created for assessment and evaluation frequency. Pre-implementation data was gathered to reflect the time from admission until airway clearance orders were obtained. The confidence level of



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therapists in determining appropriate therapy was an important factor. A survey was conducted anonymously with respondents providing feedback to evaluate if education on the use of the protocol and clinical decision making would increase over time. "Super User" respiratory therapists are now educated on how to use the new protocol. In addition, an airway clearance education

blitz for the entire respiratory staff is planned. Anticipated outcomes from this practice change include a reduction in the time from admission to delivery of initial airway clearance treatment and an increase in the confidence level of respiratory therapists in implementing the new protocol.

For additional information contact Holly Lehmoth, BS, RTT, at hlehmoth@bjc.org.