Building and Maintaining a Clinical Resource Nurse Role

The Method Behind the Madness

‘Being a Good Parent to My Seriously Ill Child’
Letter from the CNO

Dear Children's National Nurses,

Our recent Magnet® redesignation, along with all of our 2015 accomplishments, are true testaments to nursing’s teamwork, dedication, and commitment across the organization to the provision of world-class care and exceptional outcomes. Our journey is defined by the strong collaborative relationships that raise the professional practice of nursing at Children’s to new heights. Our Magnet nurses commit to the care of children and their families, take responsibility for their outcomes, and link research and science to the evidence-based care they provide.

Within a collaborative environment, nurses at Children’s empower patients and their families, engage in shared decision-making to advance their professional practice, and value professional development as a means toward continued growth and nursing excellence. Our nurses are leaders in the provision of excellent nursing care across the continuum. In addition to Magnet redesignation our key nursing accomplishments in 2015 were:

- Strengthening the professional practice of nursing;
- Aligning perioperative, emergency room, and inpatient psychiatric nursing;
- Advancing quality and safety;
- Enhancing the patient experience;
- Advancing nursing research;
- Increasing scholarly activities;
- Maintaining accreditation and regulatory readiness;
- Managing unprecedented volumes;
- Right-sizing nurse staffing;
- Enhancing nursing recruitment and retention;
- Implementing the ambulatory electronic health record;

Linda Talley, MS, BSN, RN, NE-BC, Vice President and Chief Nursing Officer

Our journey is defined by the strong partnerships and collaborative relationships that raise the professional practice of nursing at Children’s to new heights.
• Developing a telehealth nursing program;
• Advancing the business of nursing;
• Demonstrating the value of nursing
• Improving collaborative partnerships; and
• Making a community impact.

Beginning in 2016, our Nursing Strategic Plan builds upon the organization’s six strategic priorities- Advance Care, Demonstrate Value, Improve Population Health, Grow Strategically, Implement an Integrated Network, and Transform Health IT. Similarly, our Nursing division goals enable our nurses to advance our organizational mission. In 2016, we will advance several key areas of focus: Access, Community Benefit, Financial Strength, and Talent Optimization. Nursing commits to partnering with stakeholders across the organization to improve patient access and to move toward the new paradigm for patient and consumer experience. Our goal is to be one of the first children’s hospitals to offer clinical access that differentiates Children’s National as a top 10 institution for the future. Our nurses commit to and demonstrate exemplary community benefit. We anticipate the rising thresholds for tax-exempt status for stakeholders (i.e., legislators, regulatory agencies) and nurses serve all children and the community consistent with our mission. Nursing remains steadfast in its attention to financial strength as we develop resources to reinvest and deliver on our mission. And lastly, Nursing supports talent optimization and the desire to become one of the leading children’s hospitals with programs in place to identify, develop, and retain top talent in Nursing. Nursing will focus on these programs and opportunities in the next year to advance our purpose:

• Care Delivery Redesign
• Patient Experience
• Throughput
• Advanced Practice Nursing
• Nursing Systems
• Nursing Education and Professional Development
• Nursing Research and Quality Outcomes
• Collaborative Partnerships
• New Clinical Care Programs
• Recruiting and Retaining Top Talent
• The Business of Nursing

In this issue, you will read many scholarly abstracts and summaries by our nurses in the past year. Let us take this time to reflect on our Magnet redesignation and all of our accomplishments in 2015. This success affirms our nursing excellence and also affords us a very strong platform to demonstrate pediatric nursing excellence to our internal and external stakeholders. I look forward to future opportunities to collaborate and discuss innovative ways to advance nursing at Children’s in support of our mission and into a very exciting future ahead.

Linda Talley, MS, BSN, RN, NE-BC
Vice President and Chief Nursing Officer
The world’s largest Ebola Virus Disease (EVD) outbreak in 2014-15 highlighted that evaluation and care of pediatric persons under investigation (p-PUI) presents additional challenges for which consensus guidelines had not yet fully emerged. This study describes pediatric-specific components of a comprehensive multidisciplinary Institutional Response Plan (IRP) evolved from direct evaluation and management of multiple p-PUIs in a designated pediatric facility.

Children’s National Health System is a freestanding pediatric referral center located in close proximity to five international airports. EVD response was prioritized and implemented beginning August 1, 2014, using a system-wide IRP to screen, isolate, transport, monitor, and treat p-PUI. Following delivered care to four inpatient p-PUI, the IRP was further optimized for pediatric-specific challenges.

Between September and November 2014, four p-PUI patients aged 7-11 years with United States (US) entry from 3-14 days prior were admitted for up to three days in full isolation precautions. Ultimate discharge diagnoses included severe malaria with hyperparasitemia (2), respiratory viral infection (1), and osteomyelitis (1). The initial IRP focused on patient screening, staff education and training on personal protective equipment, and inter-facility patient transport. Staffing care models evolved from exclusively critical care to include blended hospitalist, and neonatal/pediatric critical care physicians and nurses. Public Relations was directly integrated for appropriate messaging for staff and families at screening, intake and isolation. Detailed debriefing after each inpatient p-PUI identified unique challenges in care of p-PUI, requiring input from Language, Child Life and Family Services. Novel solutions included (1) a dedicated Special Isolation Unit (SIU) with unique features for pediatric patients, (2) a unique modular retrofitted ambulance transport solution allowing rapid and effective decontamination, and (3) a multicomponent telemedicine solution to allow safe and effective multidisciplinary consultation and parent-child interaction while limiting exposure. Unique aspects of pediatric Ebola PUI evaluation and treatment must be carefully developed and implemented in institutions caring for pediatric patients suspected or proven to have EVD.
Building and Maintaining a Clinical Resource Nurse Role to Meet the Demands of Our Growing Unit

Justine Mize, MSN, RN, CPN, CCRN; Christine Riley, MSN, APRN, CPNP-AC; Jenna Heichel, MSN, APRN, CPNP-AC; Nancy Francis, BS, RN, CCRN, CPN; Lisa Williams, BSN, RN, MHA, NE-BC; and Melissa Jones, MSN, APRN, CPNP-AC

The national nursing shortage is expected to reach a 20% deficit by 2020. With a scarcity of experienced nurses, many critical care areas utilize novice nurses to meet staffing needs. Our Cardiac Intensive Care Unit (ICU) experienced a 34% increase in average daily census FY12 to FY14, requiring rapid onboarding of nursing staff. From 2012 to 2014 the number of Cardiac ICU nurses with less than two years of experience grew from 28% to nearly 53%. We sought to develop a new model to safely transition novice Cardiac ICU nurses from orientation to independent practice while continuing to develop experienced staff.

The Clinical Resource Nurse (CRN) role was established with two major goals: 1.) provide clinical support and formal mentorship for nurses completing orientation and transitioning to independent practice, and 2.) retain experienced nurses by elevating those who have demonstrated excellent clinical practice and disseminating their expertise during clinical shifts. CRNs are staffed out of a patient assignment with the intent of providing real-time bedside clinical support to staff, focusing on novice staff.

The 4 focus areas of the CRN Role are: clinical excellence, mentorship, leadership, and professional development. The CRN staffing model provides 24/7 clinical support in our high acuity 26-bed unit, without the distraction of administrative duties, making the CRN role distinct from the charge nurse or unit-based educator role. The CRN facilitates positive peer-to-peer interaction, role models safe practice, and provides formal mentorship with the goal of integrating and supporting new staff.

One hundred percent (100%) of CRNs surveyed report that the role impacts their professional development and 63% of CRNs report that the role contributes to increased nursing retention. Staff reported 23 new formal mentoring relationships exist. Though the role was successfully staffed for 63% of shifts May 2013 to August 2014, consistently staffing a CRN when the unit is busy and assignments are heavy, remains challenging. In conclusion, this role leverages the talent we have available by efficiently disseminating expertise, strengthens novice nurse practice, and provides the CRNs a pathway to undertake the challenges of clinical leadership. These challenges include: staffing availability and CRN practice variation.
In his call to Action, “Step it Up”, the Surgeon General of the United States, Vivek Murthy, MD, makes the connection between healthy people and the social determinants of health. In his address to the Walking Summit held in Washington, DC, October 2015, Dr. Murthy noted that complex problems don’t always have complex solutions. He pointed to walking as an example: walking is simple, free, and is part of the solution to alleviating some the chronic health problems Americans face. Two of the leading causes of morbidity and mortality in the United States are directly related to inactivity: heart disease and type 2 diabetes.


Walking takes place within the larger social context. Issues concerning pedestrian safety (walkable neighborhoods, safe streets, etc.) make the goal of increasing walking more problematic for many people. Remarkably, Dr. Vivek has included a statement in the Call to Action that addresses the social and economic equity aspects of walking. The Call to Action “…recognizes that everyone should have access to spaces and places that make it safe and easy for us to walk or wheelchair roll—whether in urban, suburban, or rural settings. This means that the people who design our cities and neighborhoods should include well-maintained sidewalks, pedestrian-friendly streets, access to public transit, adequate lighting, and desirable destinations that are close to home. It also means that law enforcement and community leaders should work closely together to ensure that none of us has to walk in fear for our safety. Walkable communities are good for social connectedness, good for business, good for the environment, and, most importantly, good for our personal health.” (Forward to the Call to Action, http://www.surgeongeneral.gov/library/calls/walking-and-walkable-communities/call-to-action-walking-and-walkable-communities.pdf , accessed November 17, 2015)

The Surgeon General’s Call to Action fits nicely with the American Nurses Association’s (ANA) HealthyNurse™ Initiative: “A healthy nurse lives life to the fullest capacity, across the wellness and illness continuum, as they become stronger role models, advocates, and educators, personally, for their families, their communities, and work environments, and ultimately for their patients.”

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Nurses at 3.4 million strong and the most trusted profession, have the power to make a difference! By choosing nutritious foods and an active lifestyle, managing stress, living tobacco-free, getting preventive immunizations and screenings, and choosing protective measures such as wearing sunscreen and bicycle helmets, nurses can set an example on how to BE healthy. (http://www.nursingworld.org/healthynurse accessed November 17, 2015) Visit the HealthyNurse site for more information on many topics including: diet and nutrition, fatigue, environmental health, and stress management.

Susan Keller, MLS
Children’s National Nurse Named National Magnet Nurse of the Year®

In October 2015 the American Nurses Credentialing Center (ANCC) named June Amling, MSN, RN, CNS, CWON, CCRN, an advanced practice registered nurse with more than 25 years of experience at Children’s National Health System, with one of its five 2015 National Magnet Nurse of the Year Awards. This is the third time in four years that a Children’s National nurse has been honored with this distinction.

The ANCC National Magnet Nurse of the Year Awards recognize outstanding contributions of clinical nurses for innovation, consultation, leadership, and professional risk-taking. To qualify, a nurse must be working at a Magnet-designated hospital. Awards are presented in each of the five Magnet model components: Transformational Leadership; Structural Empowerment; Exemplary Professional Practice; New Knowledge, Innovations & Improvements; and Empirical Outcomes. June was recognized in the Empirical Outcomes category for her dedication and accomplishments in pediatric wound care nursing. “We are so proud to see one of our nurses honored for her passion and tireless commitment to improving the art and science of nursing. June’s clinical excellence and passion for mentoring nurses has positively impacted the lives of so many of our patient families and team members” said Linda Talley, Vice President of Nursing and Chief Nursing Officer.

Since 1989, June has served in a variety of roles at Children’s beginning as a direct-care nurse in critical care and now as a nationally-recognized expert in pediatric wound care. June formed the first interdisciplinary team aimed at pressure ulcer reduction in 2006 focusing initially on the Pediatric, Cardiac, and Neonatal Intensive Care Units. In 2010, she implemented these strategies house-wide, initiating a Skin and Wound Team comprised of over 40 direct-care nurses as pressure ulcer experts. By 2013, June led this team to successfully reduce pressure ulcers from eight percent to less than 0.35 percent across 13 inpatient units, well below national benchmarks.

June is actively involved in research including her ongoing collaborative and translational research to produce a groundbreaking Mobile Structure Sensor for Real-Time 3-D Wound Assessment. She is also a member of the National Pressure Ulcer Advisory Panel, the Society for Advanced Wound Care, and the Greater Washington Wound Ostomy Continence Nurses Association.

Children’s National Employee of the Year Honors a Nurse

Courtney Jones, BSN, RN was recently recognized as the Children’s National employee of the year. Courtney was recognized at the Children’s Annual Awards Luncheon held in March 2015. Courtney previously worked at Dunbar Senior High School in Ward 5 where she created the “Ladies of Dunbar,” a mentoring and support group for female students. Group session topics included life skills, college preparation, and women’s health. In addition to her regular duties as a school nurse, Courtney also mentored newly-hired nurses and trained colleagues in using the electronic nursing documentation system. “Courtney is a champion for children’s health through her dedication to the students at Dunbar and her fellow nurses from Children’s School Services,” said Mina DeShazo, Vice President of Human Resources. “We are proud of her work to care for more than just the physical needs of children, but to help them grow into healthy adults, emotionally and physically.”

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In October 2015, a desire of the conference planning committee became a reality for more than 75 outpatient nurse colleagues, as they attended the first ambulatory-focused conference at Children’s National Health System titled “The Future of Ambulatory Nursing: Doing It Different, Better, and With Purpose.” Conference planning spanned over a year’s time, and is a true testament to the supportive and collaborative interprofessional environment that lives within our organization. Linda Talley, Dr. Randhawa, Jeanne Ricks, Dr. Biddle, and Dr. DiFazio provided the planning committee with resources, support, mentorship, and encouragement which resulted in the actualization of this first-ever and successful conference. This conference serves as a real example of Structural Empowerment within our Magnet-designated organization.

There were five objectives for the conference:
1. Provide a venue for nurses, clinicians, community leaders, and staff to increase knowledge about ambulatory care.
2. Explore the landscape of health care today on a national, regional, and local level.
3. Compare and contrast strategies to lower cost and improve quality of care.
4. Examine safety avenues as it relates to policy, protocols and procedures across the health care setting.
5. Examine best practices in the ambulatory care setting.

Throughout the conference, attendees had the opportunity to explore the future of ambulatory care, network with interprofessional colleagues, participate in simulation events, review poster presentations, and discover new approaches aimed at sustaining meaningful resolute practice. We were honored to have esteemed expert speakers from local and national ambulatory arenas, who shared their thoughts with us regarding innovative approaches regarding best practices, interventions designed to navigate practice challenges, and techniques to optimize patient outcomes. Keynote speaker, Dr. Kathleen Bower, DNSc, RN, FAAN, opened the day with an outstanding presentation regarding the role of the nurse in the future of healthcare and specifically as it applies to the essential role of care coordination in the ambulatory arena. Linda Talley, Vice President and Chief Nursing Officer, provided an excellent and insightful endnote presentation focused upon ambulatory nursing priorities, and the role of data collection and analysis in support of the nurse care coordinators. Linda’s presentation emphasized key recommendations for top of licensure practice and encouraged all nurses to find ways to enjoy their work along our journey for continued nursing excellence.

Attendees experienced a variety of learning strategies— from didactic presentations, video clip reviews, focus group sessions, case studies, to panel discussion— in an effort to convey information in an engaging format. During the tabletop simulations, conference participants were able to practice technical skills related to tracheostomy care, and gastrostomy tube management, as well as an opportunity to practice CPR and review emergency oxygen delivery device set-up.
Conference attendees were able to view and discuss nine ambulatory-focused poster presentations that included: improving health outcomes in the medical home, responding to emergencies in clinic settings, telehealth nursing, patient education, pilot studies for children with autism, optimization of patient experience for cardiac patients, IV insertion boot camp, childhood behavior interventions, and nurse-sedated echocardiograms. In addition, there were six focus sessions for participants to choose and attend related to: asthma updates, ambulatory surgery options, legacy mapping, diabetes care trends, autism care, and writing to succeed.

At the end of the day, the participants overwhelmingly recounted the value they found in attending the conference, and how this transfer of knowledge could be incorporated into their practice moving forward. The planning committee believes wishes do come true at Children’s, and we are proud to be part of an organization that provides us with tools and venues to achieve excellence on a professional as well as within individual platforms.

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<thead>
<tr>
<th>Poster Title</th>
<th>Poster Presenter &amp; Credentials</th>
<th>Ambulatory Area</th>
<th>Poster Objectives</th>
<th>Brief Poster Summary</th>
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<tbody>
<tr>
<td>Improving Health Outcomes in a Pediatric Medical Home: 2014 &amp; Beyond</td>
<td>Renee’ Clark, MPH, RN; Teresa Graves, MDN, RN; Kira Hendrie, MDN, RN, CPN; Pamela Kyme, MS, RLCP, CNP; Claudette Neeley, MPH, RN, CPN; Patricia Powell, MSN, RN, Junda Pryor, MSN, RN, CPN, CHGC</td>
<td>Goldberg Center</td>
<td>To explore the challenges that arise when attempting to match quality healthcare services, to the needs of the population across a large demographic area with multiple sites.</td>
<td>This poster will summarize four collaborative initiatives that were launched to meet the diverse needs of the medical home population in the following areas: Immunization Compliance, PMHI Redesignation, Nursing Documentation, and Emergency Response</td>
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<td>A Simulation-Based Approach to Ensure Optimal Staff Response to Medical Emergencies within the Ambulatory Setting</td>
<td>Pamela Kyme, MD, BSN, OPHEL; Rebecca Nash, MDN, RN, PCCN-SC, DCHS &amp; Cara Biddle MD MPH</td>
<td>Goldberg Center</td>
<td>To describe a simulation-based curriculum of three common patient emergencies in the ambulatory setting that allow the interprofessional team to identify red flags associated with patient deterioration, lead as a first responder, and to function effectively and competently until appropriate handoff to a higher level of care can be achieved.</td>
<td>Ambulatory Services is experiencing an increase in acuity and complexity of patients receiving care in primary and specialty clinic arenas. Patient safety requires that high reliability organizations prepare for the unexpected emergency. To this end, all staff need to have access to a safe simulated environment in which to practice skills related to assessment of the emergent patient, as well as interventions such as necessary to support airway, breathing and circulatory support.</td>
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<td>Emerging Telehealth Nursing in the Medical Home</td>
<td>Elna Bailey, RN; Teresa Graves, BSN, RN; Pamela Kyme, MS, BSN, CPN; Juanda Pryor, MSN, RN, CPN, CHGC</td>
<td>Goldberg Center</td>
<td>To define Telehealth nursing in the medical home setting.</td>
<td>This poster will list the lessons and along with the numerous tool and resources necessary to implement a successful call center in an ambulatory setting.</td>
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<td>Teaching patients and Families: &quot;The Real Deal&quot;</td>
<td>Wayne A. Neal, MAT, BSN, RN, FNP, FON; Shari Washington, MSN-Ed, RN, FNP</td>
<td>Goldberg Center</td>
<td>All areas of ambulatory care can provide this simulation based on the need</td>
<td>Demonstration and process for a new nurse in training a skill or diagnosis to a patient/family in a simulated environment. This poster describes a formal simulated teaching process utilized in the Nurse Residency program. This process provides the new nurse with skills and methods to effectively teach a patient/family about their care or treatment.</td>
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<td>Childhood Healthy Behaviors and Interventions in a Pediatric Primary Care Setting: Impacts on Provider Practice</td>
<td>Nadine L. Camp, DNP, APRN, CPNP-PC; Janice Aguiar, PhD; Rebecca R. Roberts, PhD; Kimberly F. Kelly, PhD; Jessica E. Nach, MD; Cara B. Lichtenstein, MD</td>
<td>Goldberg Center, Good Hope Road Clinic</td>
<td>To improve the consistency of healthcare providers’ delivery of healthy behaviors messages targeted at prevention and treatment of Childhood overweight and obesity, and to improve consistency of documentation of weight classification.</td>
<td>The high prevalence of childhood overweight and obesity, the known association of weight consequences as a result of obesity, and primary care provider behavior inconsistences in addressing these health concerns were the basis for this quality improvement project. The Childhood Healthy Behaviors Intervention (CHBI) introduced a targeted evidence-based practice initiative for children 2 through 9 years that included parental completion of a short questionnaire to assess dietary and exercise behaviors, BMI assessment by the primary care provider, and healthy behaviors goal-setting with the provider and parent based on behavioral goals.</td>
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<td>Understanding Family Satisfaction with Nurse-Sedated Echocardiograms</td>
<td>Sheila Stringer, RN, BSN</td>
<td>Cardiology Clinic</td>
<td>A review of the outpatient experience for quality improvement/patients.</td>
<td>Sedated echocardiograms are performed in the outpatient setting at Children’s National Health System to improve the image quality in a population that is not able to cooperate for diagnostic quality studies. Oral moderate sedation monitored by a credentialed nurse is an attractive alternative to general anesthesia or intravenous sedation for many low-risk patients. Survey implementation was useful in identifying areas for improvement. Families overwhelmingly rate the experience of the nurse sedated echocardiogram outpatient experience as a positive one and can be refined through a continuous feedback and improvement loop. A pilot was completed May 31, 2014 that focused on individualized plans of care for children with autism in need of ECHO studies with analysis. The focus was largely on pre-procedure preparation to support the child’s ability to cope with the medical setting and ECHO procedure. The goal was to have the child and family feel prepared so that the child willingly participated in the process of vital signs and placement of the ECHO leads as well as reduce child and parental stress and anxiety.</td>
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<td>A Nursing Driven Pilot Study to Evaluate the Impact of a Personalized Plan of Care for Children with Autism Spectrum Disorder Preparing for Out-Patient ECHO with Asystole</td>
<td>Audrey M. Scully, BSN, RN, CPN; Eileen C. Wolitzky, BSN, RN, CPNCHGC</td>
<td>Neurology</td>
<td>Inform others that despite the challenges faced by children with autism, they have an exceptional ability to cope with medical procedures and hospital visits provided they and their caregivers receive advance planning and preparation.</td>
<td>Sedated echocardiograms are performed in the outpatient setting at Children’s National Health System to improve the image quality in a population that is not able to cooperate for diagnostic quality studies. Oral moderate sedation monitored by a credentialed nurse is an attractive alternative to general anesthesia or intravenous sedation for many low-risk patients. Survey implementation was useful in identifying areas for improvement. Families overwhelmingly rate the experience of the nurse sedated echocardiogram outpatient experience as a positive one and can be refined through a continuous feedback and improvement loop. A pilot was completed May 31, 2014 that focused on individualized plans of care for children with autism in need of ECHO studies with analysis. The focus was largely on pre-procedure preparation to support the child’s ability to cope with the medical setting and ECHO procedure. The goal was to have the child and family feel prepared so that the child willingly participated in the process of vital signs and placement of the ECHO leads as well as reduce child and parental stress and anxiety.</td>
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<td>Optimizing the Patient Experience for Cardiac Patients and Families during the Transition between Acute and Out-Patient Care Settings</td>
<td>Yatta Vincent, RN, BSN</td>
<td>Cardiology Clinic</td>
<td>Improve the patient and family experience during the transition between in-patient acute care and the first out-patient visit.</td>
<td>Optimizing the patient experience through transition of care is challenging. Challenges include educating parents on medications, home care instructions and directions on follow-up visits with specialists during clinic visits. Cardiac clinic nurses and acute care nurses on our Heart and Kidney Unit (H&amp;KU) worked with an interdisciplinary care team to develop and implement a “Preparing for your Cardiology clinic visit” brochure that was reviewed with families anticipating discharge.</td>
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<td>Development of a Peripheral Intravenous (PIV) Start Boot Camp</td>
<td>Mary Santorine, MSN, RN; Jamie LePratte, MSN, BSN; BJN, RN-BC</td>
<td>Education</td>
<td>Describe the process for using low fidelity simulation to stimulate participative confidence in peripheral intravenous placement.</td>
<td>The process of starting a PIV on a pediatric patient is intimidating for most clinicians. The IV Start Boot Camp was developed to allow clinicians the opportunity to learn specific IV start skills and practice the critical techniques on artificial arms prior to interacting with a patient.</td>
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The role of the professional nurse is a complex combination of technical, emotional and intellectual abilities. The refinement of this triad of abilities through clinical experience creates the expert nurse. There are specific activities that enhance each type of nursing ability; scholarly writing is one such activity that helps to develop the intellectual capacity of professional nurses. There are multiple opportunities for a nurse at Children’s National to engage in scholarly writing through preparing manuscripts for publication or abstracts of work for presentations at local, regional and national conferences. A related activity that builds intellectual engagement for professional nursing is reviewing the scholarly writings of a peer.

The Clinical Improvement and Nursing Research Council (CINRC), a system-level Shared Nursing Leadership council, is tasked with the work of facilitating and supporting the dissemination of nurse-led research and quality knowledge internal and external to Children’s National. CINRC accepted the charge from Nursing Professional Practice in 2014 to take responsibility for providing peer review to nurse authors preparing abstracts for presentations at conferences. CINRC’s primary goal through peer review is to provide a professional benefit to nurse authors regarding clarity of abstract content. A secondary benefit for CINRC members is the pleasure of contributing to the quality of written work to be submitted, nursing scholarship and gaining valuable skills through critique.

CINRC developed a process for peer review that focused on creating a realistic timeline from author submission to council review of abstracts that would precede the abstract submission date of the specific conference. CINRC members use the details of each individual call for abstracts to create an evaluation rubric where a) the content of the submitted abstract is reviewed for its’ match with the requested content in the abstract call, b) grammatical and spelling errors are detected and c) applicability to pediatric clinical practice is addressed. The submission of abstracts for peer review is a voluntary process for nurse authors independent of conference reimbursement or any other nursing administrative approval.

Since CINRC began providing peer review as a resource for nurse authors in January 2014, we have had the opportunity to review more than 21 abstracts for five national conferences; we are aware of 16 that were accepted for presentation. Nurses interested in having their scholarly writing peer reviewed by CINRC can submit abstracts along with the conference details and abstract criteria to cinrc@childrensnational.org no less than three weeks prior to the conference abstract submission deadline.

“CINRC provided an opportunity for an open peer review of my abstracts where comments and the reviewers were visible to me. As a result, two abstracts were accepted without revision for poster presentation.”

Elaine Williams, PhD, RN
previous nurse author

“The review process was created to be non-threatening and educational for the novice as well as the experienced nurse author. One the most rewarding contribution from the perspective of a new writer was the encouraging feedback from the committee. The exercise of submitting the first time made it less daunting to submit during subsequent calls for abstracts.”

Marlene Lee, MSN, RN
previous nurse author
Training Registered Nurses for Recovery of Non-Operating Room Anesthesia

Kristin Laheta, BSN, RN, CPN; Dianne Cochran, BSN, RN, CPN; and Lisa Banta, MD

Non-Operating Room Anesthesia (NORA) is a relatively new practice in healthcare. Articles on staffing, education, procedures, and research relating to NORA are scarce, even though sedation is utilized in relatively simple procedures such as GI cases, lumbar punctures, and bone marrow aspirations. Many articles discuss the risks and benefits of NORA procedures, but little about necessary training for nurses and the healthcare team. An interdisciplinary program should be instituted which includes training in airway management, education on anesthesia pharmacology, and demonstration of skills in simulation (Metzner 530).

The Perioperative and Hematology/Oncology teams at Children’s National deemed it imperative that nurses have a structured orientation to cover airway management and recovery from general anesthesia/deep sedation. Collaboratively, the two teams developed a four-week orientation focused on airway management for Hematology/Oncology nurses caring for patients recovering from NORA, oncologic medication administration, bone marrow aspirates, and additional clinical testing.

The NORA team is comprised of an anesthesiologist, the Hematology/Oncology licensed independent practitioner, a NORA nurse supporting the anesthesia team, and two Hematology/Oncology clinic nurses. Since the development of the NORA practice, frequent challenges were encountered with regard to meeting the unique and frequently changing staffing needs of the Hematology/Oncology clinic nursing team. The Perioperative and Hematology/Oncology teams recognized that having consistent caregivers were a solution to the staffing challenges for the NORA program. A focus team was developed that consisted of the Chief of Anesthesia, the Director of NORA, the Perioperative Nursing Director, the Perioperative Nursing Manager, the Hematology/Oncology Clinic Nursing Manager, the NORA nurse, the Professional Practice Nursing Specialists (PPS) for both the Perioperative Nursing team and the Hematology/Oncology clinic, the Perioperative Clinical Instructor, and the Hematology/Oncology clinic Clinical Instructor. After a couple of flow chart sessions, the physician group turned the final development over to the PPS nursing teams and the Clinical Instructor nursing teams. The NORA Director supported and participated with the education algorithm as indicated. Evidence-based material was gathered, reviewed, and discussed. The decision was to implement a four-week orientation focused on airway management. A new staffing model was developed: two days per week the Hematology/Oncology clinic nurse is paired in MRI with an anesthesiologist and anesthesia assistant, two days per week the Hematology/Oncology nurse is partnered with the NORA nurse in PACU, and one day per week the Hematology/Oncology clinic nurse partners with the Hematology/Oncology NORA clinic coordinator.

The team received positive feedback from the Hematology/Oncology clinic nurses who completed the four-week orientation. The team unanimously self-reported that they felt competent caring for patients after a NORA procedure. A decision was made to continue the orientation plan that was created for Hematology/Oncology nurses that will be recovering patients from NORA.

Our ultimate goal is that 100% of the Hematology/Oncology clinic nurses will be trained to recover patients from NORA, so they are able to work both in the clinic and in NORA. Our plan is to have one nurse every three-four months complete the four-week orientation. Eventually, we would like to include NORA education into the regular Hematology/Oncology unit orientation to further develop higher competency in recovery room nurses.
The Method Behind Our Madness
Amelia Roberts, BSN, RN, CPN

Have you ever had a situation that posed a significant challenge and you found yourself searching for peace in chaos? This is a situation often faced by many nurses in the complex healthcare environment. In this interview, I examine and discuss how the Cardiac Intensive Care Unit (ICU) at Children’s National excelled in meeting that exact challenge.

I would like to introduce you to Cardiac ICU Clinical Instructors, Ashleigh Butgereit Harlow, BSN, RN, CCRN and Amber Merritt, MSN, RN, RN-BC, CCRN. After having the opportunity to participate in a LEAN project, they were inspired to apply lessons learned to finding solutions to a different and unique challenge, one involving the lives of patients in their care.

INTERVIEW QUESTION: It sounds like within the focus of your LEAN project in the Cardiac ICU, you made a point of emphasizing a topic that was meaningful to the staff.

Ashleigh: Yes, it is definitely our focus for this work to be meaningful to our nurses; because otherwise, due to our acuity, high census, and numerous nurses on orientation, stress levels of the nursing staff could easily run high. Our nurses work overtime, perform extra responsibilities toward council work, and put in a lot of effort. It is about an economy of time. For instance, let’s consider a nurse spending five minutes of his/her time on a project verses spending time getting report on a patient. If I am going to spend five minutes of my time (on a project) while I could be getting report so that my colleague can go home or catch the shuttle, I want those minutes to be meaningful. It needs to be impactful for the nurses and ultimately for the patients and families. This is key.

Our first focus on the Cardiac ICU performance board was the incidence of unintended extubations (airway loss). This goal was meaningful and truly resonated with our nurses. We spent lots of time working on care bundles within the LEAN team and within our daily rounds. The result was that we drastically reduced the number of unintended extubations, and the nurses and team really connected with that because it was immediately relevant.

INTERVIEW QUESTION: How would you describe the impact of going through the LEAN process on this particular project? Would you say it changed the way nurses look at other work processes or their perception of LEAN?

Amber: Going through the LEAN process organizes the work and many times the project just leads you there (to where you need to go). Nurses are taking on these new LEAN projects across the board and in a similar way to following the nursing process, which is how we (nurses) think anyway.

We always try to make things simpler. For instance, “how can I save time and get done what I need to do?” Nurses can then realize that yes, there is an actual process behind things. Through LEAN, nurses can work through challenges and it becomes eye opening for all of us. Nurses realize “oh, there was a methodology to our madness.”

Ashleigh: The performance board is what inspired us. It depicted that we can do this, we already are thinking this way, and we can think this way better.
Negative Pressure Wound Therapy for Sternal Wound Infections Following Congenital Heart Surgery

June Amling, MSN, RN, CNS, CWON, CCRN

This study examines the efficacy of a comprehensive, multidisciplinary wound management team and negative pressure wound therapy (NPWT) for the treatment of sternal wound infections in congenital heart surgery patients. A single-institution retrospective review of all congenital heart surgery patients with post-operative sternal wound infections who were treated with NPWT was performed. Patients were evaluated based on (a) whether NPWT occurred before or after the establishment of a multidisciplinary wound management team, and (b) whether NPWT was initiated early (within 2 days) or late (greater than 2 days) after diagnosis of a sternal wound infection.

The median duration of NPWT was 12 days (range 2-50 days). NPWT was successfully initiated in patients as young as 15 days of age. There was a trend toward shorter duration of both NPWT and antibiotic use following (a) the implementation of the multidisciplinary wound management team, and (b) in patients with early use of NPWT; however, these results did not achieve statistical significance.

NPWT can be successfully utilized in congenital heart surgery patients, including young neonates, for the treatment of sternal wound infections. The trends observed in the reduction of wound therapy duration and antibiotic duration with early implementation of negative pressure therapy and multidisciplinary wound management require further investigation to verify their clinical efficacy in patient care.

Decreasing Hospital-Acquired Conditions by Implementing a Nurse-Driven, Patient-Focused, Web-Based Data Collection Tool

Annierose Abogadie, MSN, RN, CCRN, RN-BC; Amber Merritt, MSN, RN, CCRN, RN-BC; Melissa Jones, MSN, APRN, CPNP-AC; Lisa Williams, MHA, BSN, RNC, NE-BC; Marie King, BSN, RN, CPN; Bill Pastor, MA, MPH; John Berger MD; and Darren Klugman MD, MS

Adherence to care bundles is an important strategy to eliminate Hospital-Acquired Conditions (HACs). Our Cardiac Intensive Care Unit (ICU) HAC rates lacked consistent performance, and we had limited data on bundle compliance. Utilizing a web-based data collection tool, we sought to initiate a paradigm shift to focus assessments and audits on comprehensive patient care rather than auditing individual HACs in order to provide real-time feedback and increase staff knowledge of bundle elements. We conducted a literature review and revised each HAC bundle based on best practice. We created a REDCap web-based data collection tool to assess compliance with the HAC bundles. Our goal was to complete 150 assessments per quarter. Compliance with individual bundle elements and HAC rates were reported to staff monthly.

After implementation, quarterly audits increased from an average of 25 to >150. The increase in audits temporally correlated with a reduction in multiple HACs. Compared to historical data (FY13 Q2 to FY15 Q4): Cardiovascular-Surgical Site Infections (CV-SSIs) decreased from 8.6 to 0 per 100 procedures. Central Line-Associated Bloodstream Infections (CLABSI) increased from 0 to 0.69 per 1000 central line days (two events in a year). Catheter Associated
Decreasing Laboratory Specimen Errors: A Safety Initiative Using Lean Methodology in the Cardiac Intensive Care Unit

Annierose Abogadie, MSN, RN, CCRN, RN-BC; Justine Fortkiewicz, MSN, RN, CCRN, CPN; Lisa A Horn, BSN, RN, Esq; Katherine Worten; and Lisa Williams, MHA, BSN, RN, NE-BC

Laboratory specimen labeling errors are common in our organization and are a concerning patient safety event. This is defined as samples with either incorrect patient identification (mislabeled), or no patient identification (unlabeled). According to Safety Event Reporting in FY14, the Cardiac ICU had 28 laboratory specimen labeling errors that potentially led to delays in patient care and repeated work for nurses. Using A3 as a guide and a problem-solving document, our team identified multiple barriers and non-value-added steps in our process. The staff was included in problem-solving and with their input we have implemented several “Just Do Its” and performed multiple tests of change. Since we started the A3 project, the number of events reported decreased significantly to only 5 for the past year. Addressing this issue by engaging in collaborative, in-depth problem solving using Lean Methodology can be very useful and effective. It enables problem solvers to address the root causes of problems which surface in day-to-day work routines and defines and clarifies the value to stakeholders.

Epinephrine Safety in the Cardiac Intensive Care Unit

Evan Hochberg, BS, RN, CPN; Andi Velazquez, BSN, RN-BC, CCRN; Nida Tejada, BSN, RN, MAN, CCRN; Lucy Burrell, RN, Cheryl Fimian, RN, Gary Pilkington, RN, Amber Merritt, MSN, RN, RN-BC, CCRN; Justine Mize, MSN, RN, CCRN, CPN; and Annierose Abogadie, MSN, RN, CCRN, RN-BC

Epinephrine is commonly involved in potentially lethal medication errors. The use of alternative concentrations and dosages potentiates the danger associated with the drug. Intravenous epinephrine is the first line medication used in resuscitations while ultra-low dose (ULD) epinephrine is also commonly used to treat hypotension and bradycardia in the Children’s National Cardiac ICU. Confusion surrounding varying terminology, concentrations, and preparation of this drug led to several medication errors in the Cardiac ICU. The Cardiac ICU Safety Council surveyed the physician and nursing staff to determine baseline knowledge of epinephrine dosing and ULD epinephrine preparation, and guide interventions. Respondents were grouped as MD/NP Staff, bedside nurses (RNs), or nursing resources (charge nurse, resource nurse, management) (RN resources).

Survey results showed that 68% of RNs and 84% of RN resources properly described standard code dosing of epinephrine 65% of RNs and 77% of RN resources prepared the proper dose of ULD epinephrine in the written case scenario 75% of physicians/NPs, 53% of RN resources, and 48% of RNs recall a situation where they were unsure the dose of epinephrine delivered was the same dose which was ordered. Extensive one-on-one education was provided to every nurse in the unit focusing on the safe administration of epinephrine. Pre-made ULD epinephrine syringes are now stocked in the unit to reduce the need to dilute code concentration epinephrine. We also met with our physician leaders to standardize the process and the terminology. By providing education, standardizing terminology, and stocking prefilled syringes, knowledge levels increased and confidence in the safe administration of epinephrine improved.

Decreasing Hospital-Acquired Conditions ...from p. 11

Urinary Tract Infections (CAUTIs) maintained at zero per 1000 Foley days. Continual assessment of patient-centered HAC bundle compliance is associated with a reduction in Cardiac ICU HAC rates. We speculate this association is due to increased staff knowledge and real-time feedback to ensure compliance with bundle elements. Our current goal and project includes the creation of a real-time dashboard to generate an automatic data collection from the electronic health record (EHR) to improve our bundle compliance.
The Pathway to Nursing Care Excellence (PNCE) fellowship program encourages clinical nurses to think creatively and with meaningfulness about safety and quality as a top priority for a healthcare organization. In the United States, quality and safety is a driver for change that is mandated by regulation, accreditation, and reimbursement. It is essential to educate all healthcare professionals, faculty, and students about contemporary approaches to improve safety and quality in support of the goal to transition quality improvement out of the ‘nursing quality department’ and into the ‘hands of the professionals who deliver care’.

Through a year-long course the PNCE fellows explore the current forces driving quality outcomes and accountability at all levels and settings of healthcare, while focusing on the philosophy of continuous improvement through teamwork, statistical analysis, and critical thinking. Fellows use structural tools for analysis, decision making, and performance measurement to guide their work and assume a leadership role within their clinical area and among their identified interdisciplinary team to implement a quality improvement project. Fellows use management tools and techniques, identify the data required to analyze the problem, and develop innovative, practical, and cost-effective solutions to address a needed improvement by developing an incubator project geared toward analyzing a specific process that is producing a less than optimum outcome. The 2015 PNCE fellowship projects demonstrate ongoing support for improvements in safe, high-quality care for our patients and families.

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Left to right: Mia Waldron, Lael Coleman, Tina Humbel, Marlene Lee, and Kathy Kelly.
Nurses in the Cardiac Intensive Care Unit (ICU) face unique stressors due to the intensive care environment and specific nursing demands that lead to a higher rate of job dissatisfaction and burnout. The purpose of this study was to improve nurse satisfaction and prevent nursing burnout through registered nurse home support person visitation. Through home support person visitation to the Cardiac ICU, we hoped to foster a greater understanding of the environment and daily routine and challenges of being a Cardiac ICU nurse in order to facilitate greater empathy and communication between nurses and their home support persons.

Methods included a pre-survey, a tour of the Cardiac ICU, and a post-survey. Sixteen bedside nurses from the Cardiac ICU with nineteen accompanying home support persons were in attendance. The intervention included an introduction, a video of a mock code and ECMO deployment, a tour, and a debriefing session. By improving coping mechanisms such as the ability to debrief, job satisfaction can be increased and the rate of nursing burnout can be decreased, improving staff functionality and limiting fiscal strain on an organization. By increasing the awareness of home support persons on the environment and stressors related to being a Cardiac ICU nurse, nurses can be equipped with better coping mechanisms. Bringing home support persons directly into the nurses’ environment and exposing them to the sounds, routine, and efforts of the bedside nurse creates a unique opportunity for home support persons to better empathize with the bedside nurses’ stressors.

A new four-year RO1 research grant funded by the National Institutes of Health (the National Institute of Nursing Research) was awarded on 9/29/15 to Dr. Pamela Hinds and her team for the constructivist grounded theory study titled: How Parent Constructs Affect Parent and Family Well-Being after a Child’s Death. This work represents a continuation of federal grant funding for nurse-led research here at Children’s National as well as an extension of previous research by Dr. Hinds and others on the construct ‘being a good parent to my seriously ill child’.

According to the previously completed research, parents of children who have a life-threatening or life-ending illness or health condition have an internal definition of being a good parent to their seriously ill child. Achieving that definition prior to the ill child’s death may be a protective positive factor for parent well-being before and following the death of their child. To learn if this is true, we will interview parents in the oncology and pediatric intensive care units. Team training and study activation will be completed in November, 2015 followed by screening and recruitment for eligible participants beginning in December, 2015. There will be two research teams, one for oncology and one for the PICU; Drs. Katherine Kelly and Vanessa Madrigal will co-lead the PICU team; and Drs. Pam Hinds and Deborah LaFond will co-lead the oncology team. Research Coordinators for the oncology and PICU teams will be Dr. Catriona Mowbray and Mia Waldron, respectively. Research team members who will serve both the oncology and PICU teams will be Dr. Hinds as study Principle Investigator (PI); Dr. Kathy Knafl at the University of North Carolina, Chapel Hill; Cheryl Reggio as Study Follow-Up Coordinator; Susan Keller, Librarian; and Dr. Jichaun Wang, Biostatistician. Study consultants include Dr. Kathy Charmaz (Sonoma State University), Dr. Roberta Woodgate (University of Manitoba), Dr. Suzanne Feetham (Nursing Research Consultant at Children’s National), Dr. Chris Feudtner (Children’s Hospital of Philadelphia and PENN), and Dr. Lori Wiener (NIH Clinical Center).
Kristen Crandall, MSN, RN, CPEN, CPN achieved a Master’s of Science in Nursing with a Nurse Executive Leadership concentration from Benedictine University in August 2015.

EDUCATIONAL ADVANCEMENT

PRESENTATIONS, POSTERS, AND PUBLICATIONS

Podium Presentations:
• Ashleigh Harlow, BSN, RN, CCRN presented Care of the Young Child Requiring a Ventricular Assist Device: It’s Not that VAD! at the Southeast Pediatric Cardiology Society’s Annual Conference in September in Birmingham, AL
• Martha (Martee) Goldberg, MSN-Ed, RN, CCRN presented Designing a Training Program for Mentor Development at the Northeast Pediatric Cardiology Nurses Association Annual Conference in October in Washington, DC and at the Nursing Mentoring Institute Conference in Philadelphia, PA
• Justine Mize Fortkiewicz, MSN, RN, CCRN, CPN presented Post-Operative Protocols in the ICU at Southeast Pediatric Cardiology Society’s Annual Conference in September in Birmingham, AL; Video Debriefing after Critical Events in the Cardiac ICU at the Northeast Pediatric Cardiology Nurses Association in October Annual Conference in Washington, DC; Maximizing Oxygen Delivery in the Post-Operative Cardiac Patient & Not All Volume is Created Equal at Contemporary Forums Pediatric Critical Care Conference in November in New Orleans, LA
• Melissa Jones, MSN, APRN, CPNP-AC presented Sepsis, Stroke or Heart Disease: the Different Faces of Myocarditis at the Northeast Pediatric Cardiology Nurses Association Annual Conference in October in Washington, DC and Contemporary Forums Pediatric Critical Care Conference in November in New Orleans, LA
• Lisa A. Hom, RN, Esq presented two oral abstracts at the 12th World Congress of Perinatal Medicine in Madrid on Critical Congenital Heart Disease Screening
• Barbara Snapp, DNP, NNP-BC provided a podium presentation at the Virginia Neonatal Collaborative in Richmond Virginia in May, 2015 titled Children’s National Health System Multi-center Continuous Quality Improvement (CQI) Team

Posters presented at the Southeast Pediatric Cardiology Society’s Annual Conference in Birmingham featured the following:
• Caring for an Adult in a Pediatric Cardiac Intensive Care Unit by T. Grasty, BSN, RN, CPN, CCRN, CSC, J. Gooden, BSN, RN, K. Higgins, BSN, RN, CCRN, CPN, J. Magno, BSN, RN, K. McDonough, BSN, RN, C. Samuels, BSN, RN, RRT, CCRN, CPN, J. Fortkiewicz, MSN, RN, CCRN, CPN
• Unfractionated Heparin Management: PTT, UFH or Combination?, by Amber Merritt, MSN, RN, CCRN, RN-BC, Ashleigh Harlow, BSN, RN, CCRN, Justine Fortkiewicz, MSN, RN, CCRN, CPN

Podium and posters presented at the ANCC Magnet Conference in October of 2015 in Atlanta, GA featured the following:
• Old MacDonald Had an Outcome; EO, EO, Oh! podium presentation by Pamela Petto, MEd, BSN, RN; Tangee Pruitt, MHA; and Renee Roberts-Turner, DHA, MSN, RN, CPHQ, NE-BC
• Decreasing Hospital Acquired Conditions by Implementing a Nurse-Driven, Patient-Centered, Web-Based Data Collection Tool poster by A. Abogadie MSN, RN, CCRN, RN-BC; A.D. Merritt MSN, RN, CCRN, RN-BC; M. Jones MSN, APRN, CPNP-AC; L. Williams MHA, BSN, RNC, NE-BC; M. King BSN, RN, CPN; B. Pastor MA, MPH; J.T. Berger MD; D. Klugman MD, MS
PRESENTATIONS, POSTERS, AND PUBLICATIONS

- Building and Maintaining a Clinical Resource Nurse Role to Meet the Demands of Our Growing Unit poster by Justine Mize, MSN, RN, CPN, CCRN, Christine Riley, MSN, APRN, CPNP- AC, Jenna Heichel, MSN, APRN, CPNP- AC, Nancy Francis, BS, RN, CCRN, CPN, Lisa Williams, BSN, RN, MHA, NE-BC, Melissa Jones, MSN, APRN, CPNP-AC

Posters presented at the Northeast Pediatric Cardiology Nurses Association in October 2015 in Washington DC featured the following:

- Improving Outcomes with Noise Reduction Interventions in the Cardiac Intensive Care Unit by Julene Radziewicz RN, BSN, CPN, Shea Dougherty RN, BSN, CPN, Betsy Kannen RN, BSN, CCRN, Justine Mize MSN, RN, CCRN, CPN
- Opening the Doors for the Day to the Cardiac ICU: Visitation Day for the Loved Ones of Cardiac ICU Nurses by Leah Arold BSN, RN, CPN, Erin Esposito BSN, RN, CPN, Emily Schwartz BSN, RN
- Decreasing Hospital-Acquired Conditions by Implementing a Nurse-Driven, Patient-Centered, Web-Based Data Collection tool by A. Abogadie MSN, RN, CCRN, RN-BC; A.D. Merritt MSN, RN, CCRN, RN-BC; M. Jones MSN, APRN, CPNP-AC; L. Williams MHA, BSN, RNC, NE-BC; M. King BSN, RN, CPN; B. Pastor MA, MPH; J.T. Berger MD; D. Klugman MD, MS
- Epinephrine Safety in the Cardiac Intensive Care Unit, Evan Hochberg, BS, RN, CPN, Andi Velazquez, BSN, RN-BC, CCRN, Nida Tejada, BSN, RN, MAN, CCRN, Lucy Burrell, RN, Cheryl Fimian, RN, Gary Pilkington, RN, Amber Merritt, MSN, RN, RN-BC, CCRN, Justine Mize, MSN, RN, CCRN, CPN, Annierose Abogadie, MSN, RN, CCRN, RN-BC
- Caring for an Adult in a Pediatric Cardiac Intensive Care Unit, T. Grasty, BSN, RN, CPN, CCRN, CSC, J. Gooden, BSN, RN, K. Higgins, BSN, RN, CCRN, CPN, J. Magno, BSN, RN, K. McDonough, BSN, RN, C. Samuels, BSN, RN, RRT, CCRN, CPN, J. Fortkiewicz, MSN, RN, CCRN, CPN
- Decreasing Laboratory Specimen Errors: A Safety Initiative Using Lean Methodology in the Cardiac Intensive Care Unit (CICU), Annierose Abogadie, MSN, RN, CCRN, RN-BC, Justine M Fortkiewicz, MSN, RN, CCRN, CPN, Lisa Hom, BSN, RN, Esq., Kat Worten, Lisa Williams, MHA, BSN, RN, NE-BC
- Culture of Nursing Excellence Teams: Improving Nursing Satisfaction in the Cardiac ICU Through Collaboration, Cooperation, and Communication by A.B. Harlow, BSN, RN, CCRN; A. Abogadie BSN, CCRN, RN-BC; L. Cechak BSN, RN, CCRN, RN-BC; A. Merritt MSN, RN, CCRN; L. Pace, BSN, CCRN, RN-BC; E. Schwartz BSN, RN; Lisa Williams MHA, BSN, RNC, NE-BC
- Cardiopulmonary Interactions Within Congenital Heart Disease, Jenna Heichel, MSN, APRN, CPNP-AC, Melissa Jones, MSN, APRN, CPNP-AC
Posters at The Future Of Ambulatory Nursing: Doing It Different, Better, and With Purpose Conference in College Park, MD in October, 2015:

- Renee’ Clarke, MPH, RN; Teresa Graves, BSN, RN; Regina Hartridge, MSN, RN, CPN; Pamela Kyne, MS, RN,CPEN; Claudette Nealy, MPH, RN, CPN; Patricia Powell, BSN, RN; Juanda Pryor, MSN, RN, CPN, CPHQ titled Improving Health Outcomes In A Pediatric Medical Home: 2014 & Beyond

- Pamela Kyne, MS, BSN, CPEN; Heather Walsh, MSN RN PCNS-BC CHSE; and Cara Biddle, MD, MPH titled A Simulation-Based Approach to Ensure Optimal Staff Response to Medical Emergencies within the Ambulatory Setting

- Edna Bailey, RN; Teresa Graves, BSN, RN; Pamela Kyne, MS,BSN,CPEN; Juanda Pryor, MSN, RN, CPN, CPHQ titled Emerging Telehealth Nursing in the Medical Home

Wayne Neal MAT, BSN, RN-BC, FCN presented a poster titled “Teaching Patients and Families: Instructional Design for New Graduate Nurses” at the Society of Pediatric Nursing Conference in California; April 2015 and at the Ambulatory Conference in College Park, MD in October, 2015.

Brenda Martin, MSN, CPNP, RN presented a poster titled Early Pathogenesis of Sickle Cell Anemia: Absolute Reticulocyte Counts are Correlated with Increased Detection of CD36+ Reticulocytes during the First Two Years of Postnatal Life at the at American Society of Hematology in Florida in December 2015; and Comprehensive Infant Clinic for Sickle Cell Disease: Outcomes and Parental Perspective Foundations for Sickle Cell Disease Research in Florida in April, 2015.


Sarah Hamilton, BSN, RN, CPN presented a poster from the Heart Transplant Quality Committee to the Transplant Quality Institute (TQI) in Dallas, TX in October, 2015

Barbara Snapp, DNP, NNP-BC presented a poster at the Advanced Practice Neonatal Nursing Forum, Washington DC, May 27-29, 2015 & at the Virginia Nurses Association Fall Conference, Richmond, VA, November 20-21 2015, titled: Children’s National Health System Multi-center Continuous Quality Improvement (CQI) Team

Barbara Speller-Brown, DNP, CPNP, MSN, RN presented two posters at the Sickle Cell Disease Association of America (SCDAA) 43rd Annual Convention in Baltimore, MD in September, 2015; one titled Sickle Cell Disease Transition Support Group: Bridging the Gap and the second titled Comprehensive Infant Clinic for Sickle Cell Disease: Outcomes and Parental Perspective.

Publications:


HONORS OR AWARDS

Wayne Neal, MAT, BSN, RN-BC, FCN received an award at the 2015 Society of Pediatric Nursing Excellence in Education.

Wayne Neal MAT, BSN, RN-BC, FCN received an award at the 2015 Nurse.com GEMS as the regional winner for Advancing and Leading the profession.

Courtney Jones, BSN, RN was recognized in March 2015 as the Employee of the Year by Children’s National Health System.

Barbara Speller-Brown, DNP, CPNP, MSN, RN is an Assistant Professor of Pediatrics at the George Washington School of Medicine and Health Sciences as of November 2015.
Situation, Background, Assessment, and Recommendation (SBAR) Tool

Marceletta Mendoza, RN, CNOR, CPN

As a fellow in the Pathways to Nursing Care Excellence (PNCE) program, I have taken on a project to redesign the Peri-Operative Situation, Background, Assessment, and Recommendation (SBAR) Tool to eliminate harm and assist nurses with providing optimal care across Peri-Operative Services. In Peri-Operative services, the nurses faced challenges in effectively communicating the whole “picture” of the patient with the information readily provided to them. Initially, the Peri-Operative Services SBAR tool or ‘green sheet’ as it’s called, only captured the pre-operative patient history with minimal ability to capture all events that could take place in the Operating Room (OR). This made it harder for the nurses to effectively prepare to take care of the patients once they transferred to the Post-Anesthesia Care Unit (PACU). There was a potential for significant patient information to not convey during the transfer of care (i.e. Foley size, nasogastric tube size, isolation, trach size, etc.).

With assistance from peri-operative nurses and patient care technicians, I was able to successfully redesign our SBAR tool. During various phases, I collected data and analyzed the effectiveness of changes within the SBAR tool. By providing education to all of the peri-operative nurses, we now have a detailed script that prompts the nurses to communicate pertinent information about patients; which has helped to improve the culture of safety. Effective scripting has also enhanced the work process design by improving the quality and clarity of clinical communication.

A more recent addition to the tool assists with the prevention of deep vein thrombosis by monitoring the screening and use of sequential compression sleeves before, during, and after surgery. The nurses successfully use this tool for hand-offs at breaks, lunch relief, and during intradepartmental transfers. Our next step and a current work in progress is to collaborate with the interdisciplinary team to make the SBAR tool part of the electronic health record to further assist with streamlining communication within Peri-Operative services.

Left to right: Marceletta Mendoza, Ann Marie Brown, and Mary Shields.