

..... Everything Matters In

Patient Care

**Best Practices for
Best Outcomes**



Nationwide Children's Hospital is accelerating its strategic plan and continuing our Journey to Best Outcomes by utilizing best practices to improve our care.

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Pictured left: At Nationwide Children's Hospital, our employees strive to provide best care. We evaluate and evolve our practices and adopt new ideas to ensure best practices.

Using Best Practices to Provide Best Care



Linda Stoverock
DNP, RN, NEA-BC,
Senior Vice President,
Patient Care Services,
Chief Nursing Officer

At Nationwide Children’s Hospital, we developed a strategic plan three years ago to Journey to Best Outcomes. In the past three years, we have witnessed tremendous change. Achieving best outcomes requires us to continually look at all of our practices and adopt new practices to help us improve the outcomes of care.

Sometimes the journey is not always straightforward. It would be nice if we could always go to the literature and find the evidence in meta-analyses and randomized control trials that support the practice change we are adopting. Often, the evidence isn’t there. However, we do have many colleagues across the country with whom we can network. Together, we can share our care practices and learn exactly what practice change was made that helped someone else improve their care process. This type of collegial sharing has been a key

Achieving best outcomes requires us to continually look at all of our practices and adopt new practices that help us improve the outcomes of care.

to our success in driving down occurrences of blood stream infection from central lines, catheter-associated urinary tract infections, medication errors, surgical site infections and pressure injuries. It is the basis of our quality improvement model, Plan-Do-Study-Act cycles. In order to achieve “best practice,” we need to be specific about what we are measuring and the point the practice change was implemented to ensure our results were a desired outcome of the practice change. It is then important to spread the practice change beyond the unit or units where it was originally tested.

An imperative phase of our Plan-Do-Study-Act cycle of best practice is spread or disseminate. Best practices often exist in one area of our organization, but we have not successfully spread them to other areas. An example is when one department achieves great employee engagement survey results, but does not share the structures and practices that created that success with other departments. Other examples are how one department has successfully organized and managed a unit council while another department struggles, or how one department effectively coached staff to achieve safety and culture goals; whereas another department is challenged in meeting those same outcomes. Conversely, it is also important to communicate what hasn’t worked. Best practices can be shared internally through our meeting structures and, by staff reaching outside of their department to learn from others when their practices are not achieving the results they want, and through publications, such as *Everything Matters In Patient Care*. We can also share them externally with other colleagues and professional organizations through external publications and conference presentations.

The one thing Nationwide Children’s Hospital is rich in is talented employees with great ideas who have the drive to ensure we are providing the BEST care. Collaborating outside of our role, shift and department and, even externally with our professional organizations can help us learn what practice changes have been adopted in other areas and lead to improved care. Collaboration, rigorously applying change and communicating about those changes continually moves us forward on our journey to best outcomes!

Bedside Report: For the Safety of the Patients

Gretchen Firchau, RN, MS AE-C, H8 Inpatient Pulmonary Clinical Nurse Specialist
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Bedside report is something that happens routinely in adult hospitals, but what about in the pediatric facilities?

An article in *The Wall Street Journal* titled “The Most Crucial Half-hour at a Hospital” discusses the importance of conducting nurse change of shift report at the bedside with the patient and family as a core safety strategy in hospitals today.

At Nationwide Children’s Hospital in June 2015, a multidisciplinary team was developed to help implement an initiative to move care-giver shift report to the patient’s bedside. There was representation from many different areas throughout the hospital including nursing senate, Emergency Department and the Intensive Care Units. Also on the team was a representative from the Family Advisory Council to ensure the family perspective was included in the decision making process.

2,050 staff responded to the bedside report survey

In the initial phase of the project, Registered Nurses (RN), Respiratory Therapists (RT) and Patient Care Assistants (PCA) were asked to complete a survey. We had a total of 2,050 respond, and 669 of those that responded were nurses. The goal of the survey was to determine what the current process was for completing bedside report prior to implementing a new change in process. The survey results identified that there were many inconsistencies in how staff performed bedside report. In fact, it was discovered that there were staff that did not do bedside report at all. Another problem identified was patients and families were rarely included in the report process. The survey showed patients and families were included in bedside report only 12 percent of the time.

The survey showed patients and families were included in bedside report only 12% OF THE TIME

An important reason to require report to be given at the bedside was for increased patient safety. If the nurses are doing bedside report correctly, there is opportunity to discover errors and decrease the chances of these errors reaching the patient. The components for the bedside report includes the caregiver to caregiver double check of the lines, drains, airways and dressings. This crucial step has been shown to decrease errors from going unnoticed for long periods of time.

After gathering all the data, the team was divided into subgroups to look at the different strategies for implementation. The two main goals were to standardize bedside report house wide and to encourage family involvement during the handoff process. These subgroups then reported their recommendations for implementation and a format was determined that each unit would use as a guide for the handoff.

The next phase of the project was to implement the decisions that the groups had made. The biggest challenge for implementation was that this was a culture change for care givers at the bedside. Initially, all the RNs and RTs attended mandatory training. The content presented during training included a defined process for sharing report at the bedside and evidenced based research which supports performing bedside report. Additionally, the presentation offered short vignettes in which staff demonstrated the do’s and don’ts of bedside report and parents declared the value of the families involvement during caregiver to caregiver handoff.



After the completion of this training, the staff returned to their units with the tools to begin this transformation of the bedside handoff process.

In order to achieve a successful implementation, the families needed to be included in the implementation of this new process. The parental educational process was integrated into the standard unit orientation which included written materials and verbal orientation to the room. The Get Well Network, our television-based educational system for the patient and families, has a reminder message about bedside report which occurs prior to the standard shift changes of 6:45 a.m. and 6:45 p.m. for the first 48 hours of the patient’s admission. Each unit was supplied with cards that discussed the bedside report process, which were added to the welcome packets that are given to the families upon admission. During bedside report, white boards are used for messages, identification of the caregivers for the shift and the patient goals for the day. The off going nurse introduces the oncoming nurse in order to help families and patients feel more involved in the handoff and comfortable with the new caregiver.

The same survey was then sent out to the staff six months after the change in process. The results showed improvement in all of the areas of the survey with some units having more significant improvement than others. This past year has brought an increase in awareness of the importance of bedside handoff but it has also uncovered some other challenges. Some of the most frequent concerns that staff reported in the survey are waking a sleeping parent, changing the reporting process, increasing the length of time of report, and issues with confidentiality.

Staff Concerns from the Bedside Report Survey

- Waking a sleeping parent
- Changing the reporting process
- Increasing the length of time of report
- Issues with confidentiality

Parents have reported through Family Advisory Council that they want to be involved in the report process and do not mind if staff report off in the room.

An ongoing misconception identified by the staff for completing bedside handoff was talking in the room while families were sleeping. However, parents have reported through Family Advisory Council that they want to be involved in the report process and do not mind if staff report off in the room. They feel that this inclusion allows them to understand the plan for the shift and helps decrease communication issues that may occur between the different care givers. Staff is encouraged to give bedside report in a quiet manner when a patient or family is sleeping. The parents do not have to be awakened for the nurses to give handoff unless they have requested to do so. If the parents ask staff to leave the room and give report outside, they are to reassure them they are doing this for the safety of the patient and to visualize lines and equipment. The change in handoff practice also requires positive reinforcement, and change takes time. Regular updates are sent to staff from leadership, highlighting good catch stories and sharing positive comments from parents and staff. Staff is encouraged to respectfully explain to the families that

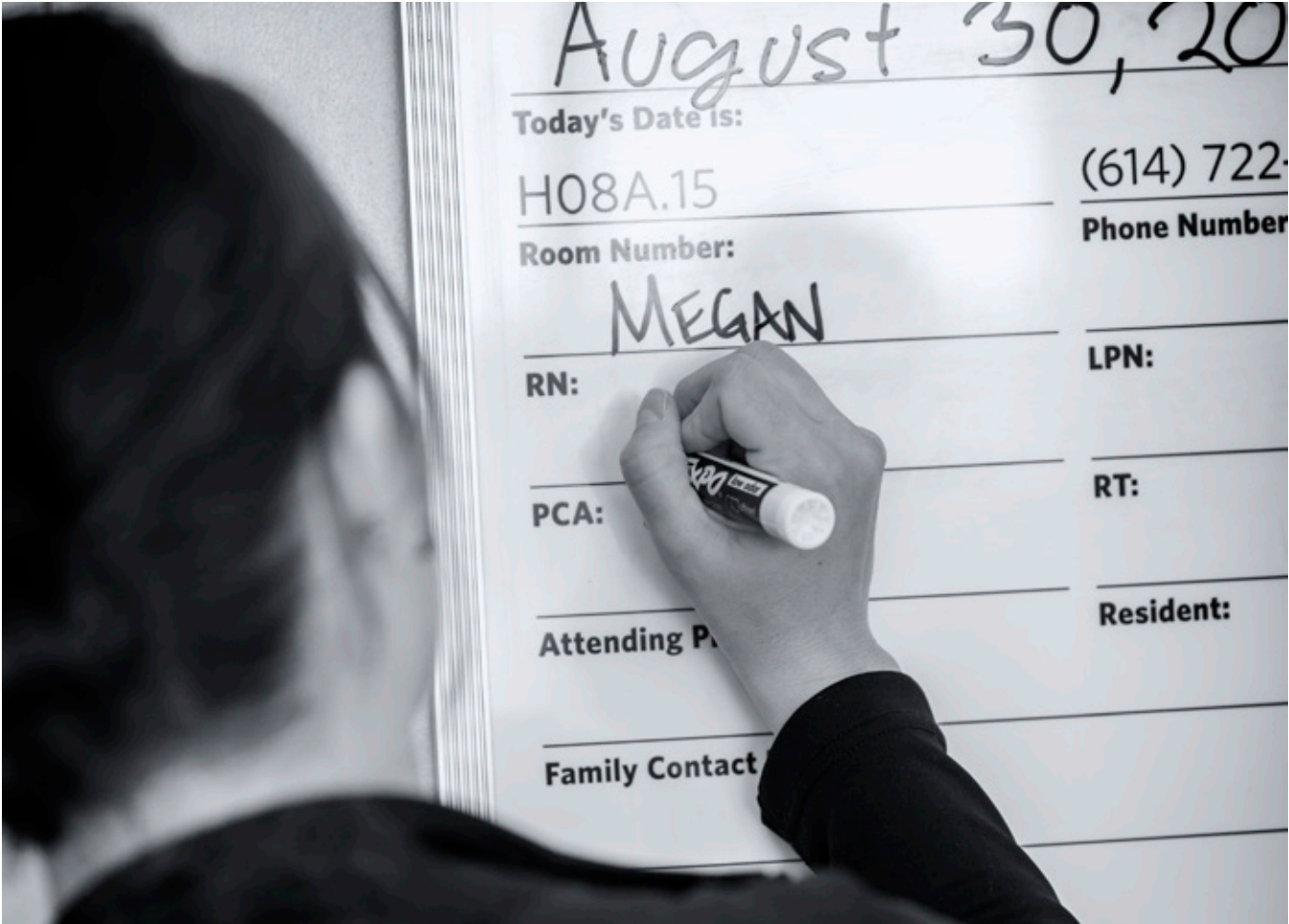
Current Bedside Reporting Survey

The survey revealed that some staff did not do bedside report at all

they are completing a handoff and the oncoming nurse will be back in to discuss more in-depth situations. The components that should be included in the handoff continue to be reinforced since staff report the need to stay later because they feel they have to do a full assessment during bedside report. The focus should be on the lines, dressings, pertinent assessment related to admission, and not the completion of a full assessment. This discussion along with other sensitive information can be uncomfortable to discuss in the presence of family. However, in most cases the family already knows the sensitive issues, and it's more about how the

sharing this information is handled during handoff. There has never been harm brought to a patient from doing bedside report. Families don't complain about being involved in the care and being present during the exchange of information about their child.

In the Zero Hero culture exemplified at Nationwide Children's, there is no reason not to do bedside report. It is our goal to keep our patients safe, our families informed and involved while keeping the door open for collaborative care between patients, families and caregivers. Bedside report supports all of this.



In the Zero Hero culture exemplified at Nationwide Children's, there is no reason not to do bedside report.

Pharmacy IV Barcode Scanning: Ensuring Best Medication Outcomes

Shelly Morvay, PharmD, Medication Safety Pharmacist
Josh Ilenin, PharmD, MS, Pharmacy Manager, Inpatient Services

The Nationwide Children's Hospital Pharmacy Department is committed to achieving zero preventable patient harm from adverse drug events. Errors, especially “wrong drug” errors, may lead to catastrophic patient harm or death. Drugs with similar sounding names or similar packaging contribute to potential preparation errors. Barcode scanning during preparation of compounded sterile products is a best practice recommendation from the American Society of Health-System Pharmacists, although less than 10 percent of hospitals utilize barcode scanning throughout the dispensing process.

Verification of manufacturer barcodes for products used to prepare oral liquids was implemented in the pharmacy department in 2015, resulting in zero “wrong drug” errors in areas utilizing barcode scanning since the first quarter of 2015. Soon after implementation of oral liquid barcode scanning, the pharmacy department began planning for the implementation of barcode scanning for compounded sterile products in 2016.

The preparation of intravenous compounded sterile products is arguably the highest risk activity in the inpatient pharmacy. This risk is often amplified in the pediatric setting due to the need for specialized dilutions to meet the specific dosing needs of this patient population. The majority of ingredients used to prepare intravenous compounded sterile products are clear and colorless, making detection of errors after a product leaves the pharmacy unlikely. Traditionally, the accuracy of these preparations has been dependent on a manual two-person check conducted by a pharmacy technician and a pharmacist.

Incorporation of barcode scanning into an already complex process is challenging and requires a critical review of current processes. Specialized equipment suitable for use in a clean room, such as a barcode scanner and computer able to withstand regular cleaning with isopropyl alcohol had to be identified and tested. Products used for preparation had to be linked to the

compounded sterile product as described in the electronic medical record and adjustments were made to the clean room workflow. Sterile products that could previously be made more than one way now must follow a standardized process for preparing the product that matches the electronic medical record. Time studies were performed to estimate the impact of barcode scanning ingredients for more than one thousand compounded sterile products each day on existing workflow.

Barcode scanning of sterile compounds was implemented in a step-wise fashion in four pharmacy locations, including the hematology/oncology pharmacy, the operating room pharmacy, the critical care pharmacy and the main pharmacy. Pharmacy technician super-users were identified for each area to help facilitate the implementation and adoption of barcode scanning between June and August 2016. Under the new process, pharmacy technicians scan barcodes of the ingredients and confirm appropriate products were selected before beginning sterile product compounding. Prior to mixing ingredients together, the pharmacist also performs a visual check of the drug and volume used which is a best practice recommendation from the Institute of Safe Medication Practices. While the preparation of compounded sterile products is an inherently risky activity, barcode scanning is helping us achieve our goal of zero patient harm from “wrong drug” adverse drug events.




Promoting Infant Safe Sleep as a Best Practice


Gail A. Bagwell, DNP, APRN, CNS – Perinatal Outreach , Neonatal Services

A country’s infant mortality rate is often considered a marker for a nation’s health and well-being. The infant mortality rate is the number of deaths of infants less than one year of age per 1,000 live births. The United States infant mortality rate ranks amongst the poorest among industrialized nations of the world, ranking No. 26 in the most recent rankings with a rate of 6.1 per 1,000 live births. The state of Ohio ranks among the worst in the United States ranking No. 45 out of 50 states with an infant mortality rate of 7.3 per 1,000 live births in 2013. Only Mississippi, West Virginia, Alabama, Arkansas and Louisiana rank worse than Ohio. The news is no better when analyzing local data for Franklin County, where we have an infant mortality rate of 8.3 per 1,000 live births. More concerning is the disparity between Caucasian and African-American numbers, where an African-American infant has two times greater risk of dying before its first birthday than a Caucasian infant.


INFANT MORTALITY RATE:
the number of deaths of infants less than 1 year of age per 1,000 live births



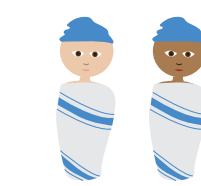
The U.S. is ranked 26th among the industrialized nations of the world
6.1 PER 1,000 LIVE BIRTHS



Ohio is ranked 45th in the U.S.
7.3 PER 1,000 LIVE BIRTHS



Franklin county infant mortality rate is
8.3 PER 1,000 LIVE BIRTHS



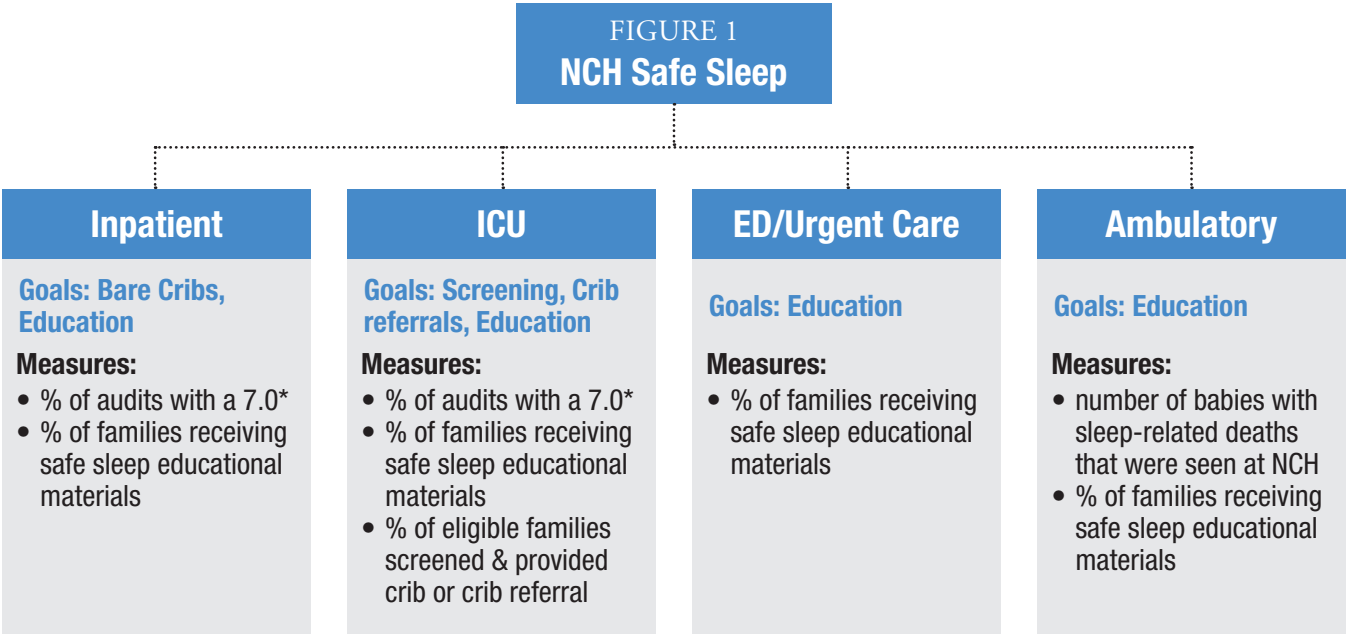
An African-American infant has
2 TIMES GREATER THE RISK of dying before its first birthday than a Caucasian infant



ABC's of Sleep: being Alone, on their Back and in their Crib for all infants under one year of age

The No. 1 cause of infant deaths in the United States, Ohio and Franklin County between one month and one year of age is sudden unexpected infant deaths, or SUIDS. There are three causes for SUIDS: sudden infant death syndrome (SIDS), accidental asphyxiation/suffocation and strangulation, and unknown causes. To help decrease the number of SUID/SIDS deaths, the American Academy of Pediatrics (AAP) instituted in 1992 a “Back to Sleep” program. The guidelines associated with the “Back to Sleep” program are revised on a regular schedule based on the most current scientific evidence available. The most current recommendations were published in 2011, continuing to promote the ABC’s of Sleep: being Alone, on their Back and in their Crib for all infants under one year of age. The recommendations also promote breastfeeding, infants being placed on a firm surface with a fitted sheet, room sharing and not bed sharing, keeping soft objects and loose bedding out of cribs, keeping the head of the bed flat, and pacifier use.

Nationwide Children's Hospital is part of Celebrate One, a Franklin County initiative to decrease infant mortality. The Ohio Department of Health, the Ohio Hospital Association, Ohio Children’s Hospital Association, the Ohio Collaborative to Prevent Infant Mortality, Nationwide Children’s and Celebrate One are all working together by implementing several different



**On a scale of 7.0 for sleep environment*

initiatives to help combat the high infant mortality rate in Ohio. Improving safe sleep practices in and out of the hospital is one of the many such initiatives.

Participating with other agencies to decrease the number of infant deaths related to unsafe sleep is natural for Nationwide Children's Hospital, as our strategic plan outlines the Journey to Best Outcomes for all patients who come in contact with us. Working on safe sleep is not a new initiative at Nationwide Children's Hospital, as the committee was formed in 2012 by a group of dedicated nurses who wanted to improve the sleep environment of infants less than one year of age at the hospital. In 2014, SB 276 was signed into law, requiring all birth hospitals and children’s hospitals to screen for a safe sleep environment for newly born infants before the first discharge home and make a good faith effort to supply a crib for a family that is in need of a crib.

In October of 2015, the structure of Nationwide Children’s Safe Sleep committee changed from a small committee of nurses, doctors and therapists to a larger interdisciplinary team with four distinct committees: in-patient units, intensive care units, emergency room and outpatient clinics. Using quality improvement methodology, all four teams are working on projects to improve safe sleep (Figure 1). The overall aim is to reduce safe sleep related infant mortality in Franklin County by 25 percent, from 16.9 percent to 12.2 percent by December 31, 2016 and sustain.

Implemented projects:

1. Education of staff regarding safe sleep for all medically stable infants
2. Education for all families with infants under one year of age
3. Assessing the safe sleep environment of families with infants under one year of age
4. Helping locate cribs for those families in need
5. Role modeling safe sleep practices on all units for medically stable babies
6. Auditing the sleep environments of all medically stable babies to assure they are in a safe sleep environment

Nationwide Children’s supports the AAP SUID/SIDS risk reduction recommendations and all staff need to role model safe sleep practices for all infants less than one year of age. Research shows that parents rely on the health care professional, especially nurses, for information and that our actions speak louder than our words. Make sure that as health care professionals, we are correctly modeling the behaviors that we want parents to embody when they go home with their new baby.

Does Exergaming Work in Reducing Weight in Children and Adolescents?

Vicki von Sadovszky, PhD, RN, FAAN, Nurse Scientist, Department of Nursing Research



Child obesity is a major public health problem. In the United States, approximately 17 percent of children and adolescents are obese. One such factor implicated in increasing obesity rates is the increased amount of sedentary screen time in which children engage, such as television and video games. One possible solution to reduce sedentary screen time is “exergaming,” or active gaming. Exergames are video games specifically designed to increase aerobic activity up to a level similar to light to moderate exercise. These games are increasing in popularity among children and adolescents. While the aerobic effects of exergames are documented, little is known about this type of activity on actual weight reduction. Dr. Risa Bochner and colleagues performed a meta-analysis of randomized controlled trials (RCTs) examining the effects of exergaming on weight loss.

To perform the meta-analysis, the authors conducted an extensive literature search. Only seven RCTs were found that met the inclusion criteria of: 1) participants less than 19 years of age; 2) comparison of an exergaming group

to a no-intervention control group; and 3) collection of pre- and post-weight change. The children across the seven studies ranged in ages from 7 to 19 years. The exergames ranged from dance games (three studies), PlayStation Eye Toy (two studies), EA Active for the Wii (one study) and JOG step for PlayStation or Wii (one study). Only two of the exergames were performed in a structured lab or school setting. The rest were performed unstructured at home. Locations of the studies were the United States (four studies), New Zealand (two studies) and the United Kingdom (one study). Dosing of the interventions ranged from general recommendations to substitute one video game or all gaming time with the exergame to more structured recommendations of 30 to 60 minutes each day. Adherence to dosing and exertion levels during exercise were not reported. Total intervention times ranged from 10 to 28 weeks. All studies reported weight in kilograms at 10 to 12 weeks; hence, that was the endpoint for the meta-analysis outcome.

According to the authors’ findings, exergaming did not have an effect on weight loss. There were no significant differences between the intervention or exergaming group and the control group when the results were statistically combined across the seven studies. In examining the results of the individual studies, only two studies saw significant decreases in weight. Interestingly, these studies had a minimum of 20 weeks for their intervention and were located each in a structured lab and unstructured home environment. The two studies with significant findings also had more structured recommendations for dosing.

The authors concluded that while there is no evidence that exergaming reduces weight, more research is needed. This conclusion is due to the limitations in the current research evidence, such as varied methodologies, a great age span encompassing both school-age children and adolescents, and only one common outcome measure across all seven studies (weight in kg.). For now, in regards to exergaming, proceed with caution.

Clinical Dashboards: A Visualization Tool to Promote Patient Safety

Donna Coglianese, RN, BSN, Clinical Informatics Application Engineer
Stacy Kuehn, RN, BSN, Quality Improvement Clinical Coordinator



These visualization tools allow a quick glance of the organization. Clinicians and leaders can quickly identify risk at all levels:

Patient



Department



Facility



As Nationwide Children's Hospital continues our journey to zero preventable harm, additional advances to our Electronic Medical Record (EMR) have been implemented. Utilizing newer functionality within the EMR has allowed the development of proactive tools to improve patient safety. One of the many tools that has been a focus over the past year is clinical dashboards. Clinical dashboards provide a visualization of data in a manner that is both visually appealing and easy to comprehend. At Nationwide Children's, we have implemented clinical dashboards within the EMR to assist in risk identification and compliance with safety standards. These visualization tools allow a quick glance of the organization, permitting clinicians and leaders to quickly identify risk at the patient, department or facility level.

Watchstander Dashboard

In 2013 the Ohio Children's Hospital Solutions for Patient Safety, a quality collaborative, began process improvement around situational awareness, a bundle to reduce emergency transfers and Serious Safety Events related to unrecognized deterioration. Emergency transfers are defined as a transfer to the intensive care unit (ICU) from an inpatient unit where the patient requires the following within 60 minutes of transfer: intubation, epinephrine, norepinephrine, dopamine, fluid resuscitation greater than or equal to 60mL/kg or CPR. If a patient requires these aggressive interventions in the first hour

Watchstander Dashboard

A dashboard created to help increase situational awareness. Multiple clinicians can access information simultaneously. The dashboard captures assessments and mitigation notes of patients who have been identified as a "watcher." It also provides data regarding patients who may be at risk based on high risk clinical therapies, elevated Pediatric Early Warning Scores (PEWS), recent ICU transfers or consults to the Assessment and Consultation Team (ACT) for evaluations.

of ICU care, it meets emergency transfer criteria. This can be considered a code blue near-miss. The Watchstander program was established to address the situational awareness bundle, and additional tools were developed for the frontline staff to identify and communicate patients who may be at risk for clinical deterioration and prevent emergency transfers.

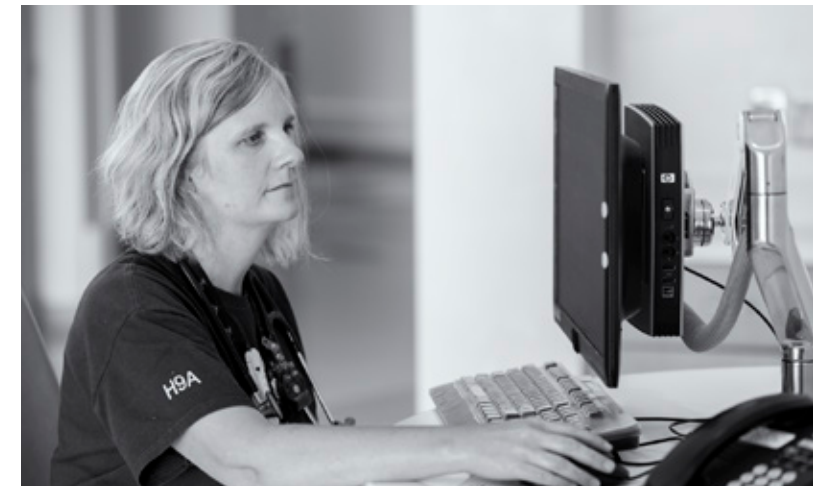
The Watchstander program was the platform for the first clinical dashboard focusing on patient safety at Nationwide Children's. Clinical Informatics and Quality Improvement Services collaborated to create a reporting tool that would help improve visualization of patients at risk for deterioration while admitted to a non-ICU inpatient department. Identifying patients who may be at risk increases the opportunity for early intervention and can lead to mitigation of those risks and ultimately decrease emergency transfers to an ICU.

The Watchstander dashboard, created to help increase situational awareness, allows multiple clinicians access to information simultaneously. The dashboard captures assessments and mitigation notes of patients who have been identified as a "watcher." It also provides data regarding patients who may be at risk based on high risk clinical therapies, elevated Pediatric Early Warning Scores (PEWS), recent ICU transfers or consults to the Assessment and Consultation Team (ACT) for evaluations. The extrapolated data allows communication throughout the organization of potential risk points. Prior to dashboard reports, a clinician was only able to see the data related to one patient at a time. The development of the dashboard now allows organizational, unit and individual patient drill down for review of data elements. Additional reporting available via the Watchstander dashboard includes patients with elevated asthma clinical scores and patients with orders for high flow oxygen via nasal cannulas.

Additional proactive safety tools developed within EPIC includes documentation of the PEWS. PEWS is a validated scoring tool that helps to identify patients at risk for deterioration. Performing an early warning assessment can help provide early interventions for patients at risk for needing rapid interventions or emergent transfer to the ICU. Several updates to the EMR have been implemented to improve accuracy and visibility of PEWS scoring for the care team. In order to improve usability for the bedside team, Quality Improvement Services, Nursing Informatics and Clinical Informatics collaborated to develop additional EMR tools to improve the accuracy, timeliness and visualization of PEWS scores outside of the individual patient chart flowsheets. These improvements include the time of the last PEWS assessment on both bed boards and system lists, will help clinicians identify increasing score trends and allow a greater situational awareness and wingman opportunities to the team working alongside the direct caregivers to intervene early.

Inpatient Manager Dashboard

The adaption of dashboards has increased, and more were developed to target patient safety. The inpatient manager dashboard was created to allow leaders to identify patients at risk for safety issues and ensure documentation associated with quality initiatives were completed in real time. The medical record shows the patient's journey along the care continuum. There are many facets to EMR documentation and many are requirements set forth by accreditation bodies in order to uphold patient safety. Missing documentation could be an indicator that a safety measure was not provided — which could lead to harm — or the safety measure could have been provided but was not documented. Previous to the inpatient manager dashboard, a retrospective, time-intensive chart audit process was in place to evaluate compliance and learn about opportunities



for improvement. This type of manual audit is no longer necessary. Additionally, retrospective chart audits focused on a small sampling of patients, and the dashboard allows review of every patient in real time.

The Inpatient Manager Dashboard is not limited to identifying patients with missing nursing documentation. The dashboard also identifies patients with other safety risks such as unexpected weights, heparin drips, insulin therapy, active isolation, restraints, elevated risk for skin breakdown and elevated risk for falls. Identifying

Inpatient Manager Dashboard

A dashboard that allows leaders to identify patients at risk for safety issues and to ensure documentation associated with quality initiatives is completed in real time.

these populations assists with an improved situational awareness on the unit and allows for earlier interventions to facilitate safety.

The Inpatient Manager Dashboard also highlights hospital acquired conditions (HAC), many of which are preventable. Well known HACs include: central line associated blood stream infections, ventilator associated pneumonia, catheter associated urinary tract infections (CAUTI), and pressure injuries. The mentioned



HACs have been well studied through evidenced based practice and other quality collaboratives and initiatives and all have required documentation of a prevention bundle. The concept of bundles was developed to reliably deliver care to patients who receive treatments with known risks. The bundle is created through evidence based practice and provides a structured check list that, when followed, reduces the risk for complications. The Inpatient Manager dashboard contains reports that reflect particular bundle elements. The dashboard reviewer can quickly identify and audit documentation related to the bundle elements such as in the pressure injury prevention bundle: physical skin assessments, skin interventions, pulse oximetry probe placement and patient positioning to prevent pressure injuries.

Hospital Flow Dashboard
Another dashboard to highlight is the Hospital Flow dashboard. This was built to satisfy a requirement set forth by Joint Commission to monitor patient census and patient flow across the institution. This dashboard targets data from inpatient units, the emergency department and the surgery department in order to identify potential bottle necks in patient flow and allows leaders to allocate resources and mitigate unnecessary length of stays.

Hospital Flow Dashboard
A dashboard that targets data from inpatient units, the emergency department and the surgery department in order to identify potential bottle necks in patient flow and allows leaders to allocate resources and mitigate unnecessary length of stays.

Components of the Hospital Flow dashboard focus on expected admissions, expected discharges, occupancy rate summaries by unit and nursing workload by unit. The Hospital Flow dashboard allows quick visualization of areas of high census and high acuity, to determine which units have the capacity to care for incoming patients.

Conclusion
Dashboard functionality within the EMR promotes early intervention and mitigation of patient safety risks in many ways. Leveraging this functionality promotes a team approach through easy to comprehend data which can be displayed at the patient, department or facility level. Using this data, proactive decisions can be made to increase patient safety and compliance real-time which also facilitates improved resource allocation and utilization.

Zero Hero: Getting Results and Getting Recognition

Sharon Dooley, RN, BSN, MA, CEN, Director of Clinical Support Services, Co-Medical Director Patient Safety



Our Zero Hero program continues to grow and mature. In 2015, Nationwide Children’s Hospital was one of only five hospitals from all applicants in the country chosen for a site visit for the American Hospital Association Quest for Quality prize. Nationwide Children’s received a Citation of Merit as one of four hospitals (adult and pediatric) and we were complimented for our work in Zero Hero harm reduction, work in health disparities and population health.



We have come such a long way since we implemented our Zero Hero program in 2009. Zero Hero has prevented more than 500 events of harm, including 100 serious safety events. During the Zero Hero time period, overall hospital mortality has decreased 40 percent, and we’ve achieved a 50 percent reduction in actual harm and an 85 percent reduction in serious safety events.

We began our efforts in Situational Awareness in 2015 to focus on early recognition of our at-risk patients and continue to cultivate this Zero Hero tool. We successfully rolled out the Watchstander Dashboard to the Medical/Surgical nursing units to enhance our mindfulness regarding these at risk patients. This dashboard is located in the electronic medical record and is available to all staff that have access. This particular

dashboard helps clinicians identify a patient who is showing signs of decline, mitigate their deterioration by huddling and forming a plan and then escalate when a patient does not show signs of improvement. Also important in improving our Situational Awareness is the dissemination of information to appropriate stakeholders and changing the mindset for calling a consult to the Assessment and Consultation Team (ACT) and timely transfers.

Another focal point for 2016 is the re-energizing of the Zero Hero Safety Coach Program. We began our Safety Coach training in 2010 and now have more than 400 Zero Hero safety coaches! Many of these original informal leaders continue to coach on safety even today. Now that it’s been six years, we have asked our existing coaches, as well as new coaches, to commit or re-commit to the Zero Hero Safety Coach program by signing a safety coach commitment letter acknowledging their willingness to uphold the duties of being a Zero Hero safety coach. These duties include holding the safety of all patients and employees as well as their own as a top priority. Staff serve as a resource and an advocate for use of the Zero Hero tools and as a role model for good communication with co-workers, patients and families. In addition, we are also working to increase attendance and participation at our monthly Zero Hero safety coach meetings by providing topics and presentations based on feedback from the coaches themselves.

We are doing some amazing things here at Nationwide Children’s, but we still have some opportunities in order to reach zero preventable harm. We have struggled over the past year with central line associated blood stream infections (CLABSI), surgical site infections from gastrointestinal surgeries (SSI-GI) and unplanned extubations (UE). We have clinicians working diligently with the quality team to review each individual case to develop action plans and improve practice to eliminate patient harm once and for all. With our One Team approach to patient safety and becoming a high reliability organization, our goal of zero harm and being the safest hospital will be achieved.

Patient Photos in Epic Enhance Safety at Nationwide Children's

Terri Dachenhaus, BSN, RN, CPEN, Supervisor, Emergency Department
Wendy Lyons, BSN, RN, CPN, RN Nursing Informatics, Patient Care Services

At Nationwide Children's Hospital, part of our strategic plan is to achieve the best outcomes for our patients by promoting safety. One of our values is to “create a safe day every day.” An important component that can aid in promoting patient safety is the use of technology. Initially, the utilization of technology started with documenting a patient’s medical history and care in an electronic medical record (EMR). With improved technology, we continue to find new and innovative ways to ensure safe practices for our patients. One of these new safe practices includes the utilization of a patient’s picture in their EMR.

Currently, the use of two patient identifiers is an important safety check to ensure we are providing care to the correct patient. There is an increased body of research supporting the use of a patient’s picture in their EMR as potentially creating an additional safety measure. Children’s Hospital Colorado in Aurora has incorporated patient pictures within their computerized order entry process. They found that this intervention reduced erroneous placement of orders in a patient’s EMR. Through this type of technology, errors in the prescribing process, such as the wrong patient being ordered to receive medication or a procedure could be reduced. Other potential benefits to this type of technology include decreasing medical identity fraud, which can result in serious consequences due to inaccuracies in the patient’s chart.

Richard Brilli, MD, Chief Medical Officer at Nationwide Children's, applied the lessons learned from other children’s hospitals and wanted to implement a similar process here to improve patient identification. A multi-disciplinary team was developed to formulate a new policy and procedure for using a patient’s photo in the EMR. The team included individuals from the following categories: nursing leadership, registration, information services, nursing informatics and technology training. This group met over a six-month period of time to implement the project. The group reviewed policies

and processes from other pediatric institutions already utilizing patient photos in the EMR. The group then determined that photographing patients for the EMR will be encouraged for all patients here at Nationwide Children’s. There are a few qualifying situations that are appropriate to defer taking a patient’s photo. When these situations arise a generic picture, along with the date, will be placed in the patient’s EMR. As soon as the situation for deferral has passed, staff should make every attempt to take the patient’s photo. If there is a refusal, staff should continue to ask and educate the patient and family on the importance of taking the patient’s photo at each visit or encounter.

In order to standardize and obtain the best quality photograph, guidelines for taking the picture were incorporated in the policy. It was also recognized that due to the quickly changing appearances of infants and children, recommendations of the frequency for taking their photos were also defined. It was determined that:

- A photo should be initiated for the first time when the patient is at least six months of age or when the patient presents for services at Nationwide Children's
- Photos of patients between the ages of six months and six years should be updated every six months unless there are significant physical changes to the patient that alter facial features/identifiers
- Photos of patients ages six years or greater should be updated annually unless there are significant physical changes to the patient that alter facial features/identifiers

Once the policy and procedure for adding a patient’s photo into Epic was formulated, it was decided that this new process would be gradually rolled out to all inpatient and ambulatory areas. The goal for completion of the roll-out was September 1, 2016. Each area is responsible for communicating the new policy to their team and for



discussing how to incorporate the patient photo taking process into their clinic/area workflow. Technology Training developed a step-by-step document on how to take the patient’s photo to aid in the education of staff. Feedback so far has been that the process for capturing the patient’s picture was easily learned and implemented by staff.

We are certain that implementing this policy will add to the culture of safety at Nationwide Children's. There is no intent for the photo to serve as a replacement for the two patient identifiers, but it is an additional layer of safety to ensure the correct patient is identified in order to provide appropriate care.

The use of two patient identifiers is an important safety check to ensure we are providing care to the correct patient. There is an increased body of research supporting the use of a patient's picture in their electronic medical record as potentially creating an additional safety measure.

Implementing Evidence-Informed Behavioral Health Practices

Wendy Cleveland, LPCC-S, MAP Clinical Coordinator, Behavioral Health
Beau Carlson, LPCC, YCSU Clinical Lead Supervisor, Behavioral Health
Hillary Gruss, LISW-S, Clinical Lead Supervisor, Behavioral Health

Life as a teenager can at times be difficult. When a teen has a mood or anxiety disorder, it can be even more difficult to navigate through the routine stressors of adolescence. Youth with mood or anxiety disorders are at a higher risk to experience issues within their relationships, school life and family life. When problems arise, seeking behavioral health treatment may be needed. The Behavioral Health Team at Nationwide Children’s Hospital offers programs proven to specifically address these concerns. Effective treatment builds upon the strengths of each person in order to bring about positive change. It is important to instill hope and guide each family to see the bright future that lies ahead. Three of the behavioral health programs are the Mood and Anxiety Program, Family-Based Intensive Treatment and the Youth Crisis Stabilization Unit.

It is important to instill hope and guide each family to see the bright future that lies ahead.

The Mood and Anxiety Program (MAP) utilizes evidence-based treatment practices such as Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT) to increase the strengths, coping skills and resources available to adolescents who are suffering from a mood or anxiety disorder. The program aims to build the skills necessary to aid in the recovery process by working with clients on a weekly basis. A core philosophy of our approach is family involvement, which can increase the success of the adolescent.

The Intensive Outpatient Program (IOP) is a time-limited, skill-based treatment offered by MAP clinicians for teens requiring an intermediate level of care between traditional outpatient therapy and inpatient care. During IOP, a teen participates in group therapy for nine hours

A core philosophy of our approach is family involvement, which can increase the success of the adolescent.

per week to learn skills to help manage emotions and life stressors. In addition, weekly individual sessions are provided to each teen to help them generalize the skills into their daily life. Caregivers attend a weekly caregiver group where they learn some of the same skills taught to their teen in IOP. It is also a time for them to receive support from other caregivers experiencing similar concerns with their own teen.

Behavioral Health Programs are evaluated using Ohio Scales, which is an instrument used to measure outcomes for youth 5 to 18 years of age who receive mental health services. According to measures collected within IOP, 75 percent of parents endorse a decrease in client’s problem severity and 76 percent report an increase in client’s functioning following completion of this four-week program. Further, clients demonstrate a drop in depressive and anxiety symptoms.

Clients who participated in the Intensive Outpatient Program demonstrated a drop in depressive and anxiety symptoms.

The Family-Based Intensive Treatment Program (FBIT) offers an intensive home-based treatment designed to decrease mental health hospitalizations and address safety concerns related to thoughts of self-injurious behaviors, suicide or homicide. FBIT services are provided in the home, school and community with a treatment duration

of three to six months. The program provides treatment to the youth, family and other supports multiple times per week to decrease the youth’s individual symptoms, while assuring a supportive family response. FBIT treatment includes individual therapy, family therapy, case management, psychiatric services, and 24/7 crisis intervention and response.

The FBIT Program receives 87 percent of their referrals as transfers within Nationwide Children’s Behavioral Health Program, with 50 percent from the Inpatient Psychiatric Unit (T5A) and Nationwide Children’s Crisis Team. According to information taken during FBIT’s intake, the average number of hospitalizations is 2.4. During treatment, the average number of hospitalizations is less than 1 (0.4). Seventy-six percent of youth who completed FBIT were not hospitalized, nor did they present to the Emergency Department during treatment. According to the Ohio Scales, parents consistently identify a decrease in problem severity and an increase in client’s functioning. Similarly, FBIT client’s report the same trend. Referencing Ohio Scales standards, all pre-post change is statistically significant, and the problem severity change for both youth and parent ratings is also clinically significant.

Intensive Crisis Intervention (ICI) is a short-term, family-centered treatment provided to patients admitted to the Youth Crisis Stabilization Unit (YCSU). ICI incorporates the use of Cognitive Behavioral Therapy and Motivational Interviewing for the purpose of crisis assessment and intervention, and provides families with ongoing care upon discharge from the YCSU. ICI is facilitated by an interdisciplinary team, including licensed mental health clinicians, psychiatrists, nurses, physicians and other medical professionals. ICI treatment consists of developmentally appropriate

best practices, including the use of research-supported treatment and assessment, medical and pharmacological intervention, psycho-education, individual therapy, family therapy, as well as safety and discharge planning.

Research-supported objectives for the ICI program include the following:

1. Identifying the problem leading up to the crisis. This is implemented by using a therapeutic-guided sequence of events exploring thoughts/feelings/actions prior to, during and after the crisis event. This intervention is also used to aid in alternative cognitive and behavioral restructuring for future distressing events.
2. Developing coping skills to effectively manage the problem, as well as working towards termination of unhealthy coping skills.
3. Establishing a commitment to ongoing treatment post-crisis. Ongoing treatment is key to stabilization maintenance. Emphasis on family involvement is paramount to the program’s success, as research continues to indicate treatment is more effective when families are positively involved in the process.

These three programs highlight the commitment of Nationwide Children’s Behavioral Health Team to implement evidence-informed interventions to treat families. While our primary goal is to attain sustainable family-centered outcomes, we also recognize that science-based practice provides clinical efficiency, program consistency and clinician satisfaction.

These three programs highlight the commitment of Nationwide Children’s Behavioral Health Team to implement evidence-informed interventions to treat families.

Research Journey Towards Best Practice

Lamara Love, BSN, RN, CPN, Comprehensive CP Program Coordinator
Garey Noritz, MD, Complex Health Care/CP Program Medical Director

The process is just as important as reaching the destination

Health care has evolved tremendously over the last few decades, leaving behind old ways and adopting a new journey. No more looking at patients singularly. Providers are looking closer at patients within the context of their family and environment; moving toward achieving a holistic view. Family Centered Care is the gold standard. For nurses, this model has always been the focus. Being an advocate and delivering family centered care is inherent in the framework. The nursing process of assessment, diagnosis, outcomes, planning, implementation and evaluation promotes achieving family centered care and improved outcomes. Mainly due to health care reform, institutions are now rising up to meet nursing in a space nursing has always occupied — specifically, pediatric nursing. We have always cared for our pediatric patients holistically by assessing the big picture and collaborating with family and community.

The Comprehensive Cerebral Palsy (CP) Program evolved from parents wanting improved care for their child. Parents collaborated with administration to develop a vision for a team of professionals that are devoted to providing state of the art holistic care for children, adolescents and adults with Cerebral Palsy. With administrative, physician, social work and nursing effort, the vision became reality. The goal of the CP Program is to emphasize excellence in clinical care while focusing on translational research to improve therapies for children and adults with CP. What makes our program unique is the Interdisciplinary Team Clinic Model that leads to the construction of a holistic CP Care Plan and the research that follows. We are one team.

Cerebral Palsy is an injury or abnormality of the developing brain that affects movement. It is estimated that between 8,000 and 10,000 babies born each year will have CP. Infection, blood clots, prematurity, genetic problems or lack of oxygen can cause CP. There is no known cure for CP, but symptoms can be managed with stretching at home, physical therapy, occupational therapy, speech therapy, feeding therapy, bracing,

medication and surgery. In the CP Program there is an effort to fully embrace seeing the whole child and how body systems are interrelated, therefore affecting the child’s state of wellness. There is a synergy that is created between the interdisciplinary team, the family and community when working on the holistic care plan’s evidence-based goals to achieve optimal outcomes.

The nurse-led development of an electronic care plan that presents patients holistically has contributed to improved outcomes and research. The CP Team has produced admirable results that are documented in our Learn from Every Patient (LFEP) research:

In our study of 131 children with CP who received care in the CP team program, inpatient admissions were reduced by 27 percent, total inpatient days by 43 percent and total costs by \$1.36 million. At the same time, we increased efficiency in clinic, added new clinics and improved documentation for the providers. We believe that the most important part of the team intervention is the proactive care coordination process which engages families in their child’s care and anticipates needs before they become severe problems.

The CP team program helped reduce:

- Inpatient admissions by **27%**
- Total inpatient days by **43%**
- Total costs by **\$1.36 million**

A few decades ago a nurse working clinically did not have the opportunity to use her critical thinking skills to advance research. Today at Nationwide Children’s Hospital it is common practice, thanks to our nursing leadership.

Nationwide Children’s Hospital has an excellent Nursing Research Program that promotes answering research questions and presenting or publishing the results. The nurse scientists encourage clinical staff to think critically and work toward sharing new knowledge to facilitate



improved care. We have presented on the national and international stage. Current research projects:

- **A Nursing-Driven Holistic Approach to Improving the Health Outcomes of Children with Cerebral Palsy:** We implemented a nurse-driven Interdisciplinary Team approach to produce a holistic care plan that facilitates providing optimal care coordination to patients and families.
- **A Descriptive Study of CP Patient's Preferences for Adventures:** First study to examine activities of interest in this population. We are hoping to increase activity levels and socialization opportunities which in turn may affect health outcomes.
- **A Pilot Study of Reiki Therapy on Unpleasant Symptoms in Children with Cerebral Palsy:** We hypothesize that Reiki, an energy therapy based

on Eastern Medicine that has been successful in treating unpleasant symptoms in individuals with other chronic and debilitating conditions, may be successful in treating these same symptoms in children and adolescents with CP.

From an operational oversight perspective, we look forward to the continuation of the CP Team’s proactive approach to improving care and cost savings. The next step in our journey is to maintain the recent recognition obtained from the National Committee for Quality Assurance (NCQA). We are honored to have achieved Patient Centered Specialty Practice Recognition, level 3. NCQA measures quality with the goal of improving health care. Nursing continues to play a critical supporting role in helping the CP Program meet the challenge of continuous innovation and quality improvement.

Professionalism: A Key Component of Safety Culture

Michael T. Brady, MD, Co-Medical Director of Patient Safety

In 2009, the hospital launched Zero Hero and Nationwide Children’s became the first pediatric institution to aspire to zero preventable harm and make it a public goal. Since Zero Hero began, we’ve achieved a 50 percent reduction in actual harm and an 85 percent reduction in serious safety events. But we aren’t to zero yet.

In 2015, Nationwide Children’s took a fresh approach to the Zero Hero program. Root cause analysis of the serious safety event data found our processes and workflows were performing as expected but a frequent variable in these scenarios was the human factor. With this in mind, the new approach included the Watchstander program, increased staff visibility of the Zero Hero Tools, improved Safety Coach Engagement and a Commitment to Professional Behavior contract.

On the surface, professional behavior is an obvious given, but a deeper dive on the impact of unprofessional behavior revealed the true value of professionalism.

Lack of Professional Behavior Results in:

- Reduced collegiality/teamwork
- Limited “mutual accountability”
- A stifled “questioning attitude”
- Increased Safety Events
 - Literature evidence supports this as does NCH data
- Reduced satisfaction
 - For co-workers, patients and families

To develop the importance of professionalism with staff, the Safety Team, Professionalism Task Force and Nursing Congress worked together on a two-part approach. First, connect with and reinforce our organization’s values, standards of conduct and Graduate Medical Education (GME) code of conduct. Second, align efforts with major initiatives happening at Nationwide Children’s, two of which were Everyone Matters and Treat Me With Respect.

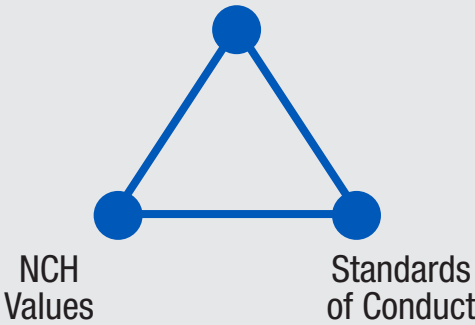
Create a Safe Day Everyday	Do the Right Thing	Accountability
Make a personal commitment to safety	Always act with integrity and honesty	Comply with policies, procedures and regulatory requirements
Always communicate clearly and completely	Are inclusive and respectful of everyone	Honor your commitments
Recognize one’s own limitations and seek input from others when appropriate	Provide open and honest communication with patients, families and members of health care team	Take responsibility for not only your own commitments and expectations but also for your co-workers (“be their wingman”)
Support a questioning attitude by welcoming queries from others and responding respectfully and professionally	Treat others with sensitivity to cultural religious and lifestyle difference	
	Respect confidentiality	

Developing the Importance of Professionalism

The Safety Team, Professionalism Task Force and Nursing Congress Two-Part Approach

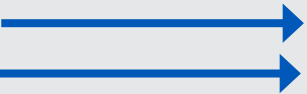
Connect & Reinforce

Graduate Medical Education Code of Conduct



Align Efforts

Treat Me With Respect



Everyone Matters

This information was packaged into a new Professionalism Code of Conduct to be signed by each employee. Managers are to share the document with staff and provide education to empower staff to discuss unprofessional behavior. Ideally, staff will feel empowered to directly address unprofessional behavior with the individual involved. An alternative would be to discuss with their supervisor/manager or possibly the supervisor/manager of the other individual.

Managers play a strong role in setting the tone for their teams by:

- Discussing importance/value of professional behavior
- Serving as a role model
- Empowering staff to not accept unprofessional behavior and to have frank conversations when needed
- Coaching employees whose behavior does not align with the code of conduct

The true value of the Professionalism Code of Conduct is that it gives every employee a fair and consistent expectation. Should a staff member be treated in a manner that goes against this code, then that staff member has a foundation to refer to and a resource they can use to call attention to the unprofessional behavior.

By owning professionalism, teams will work stronger together with less opportunity for patient harm, thus getting Nationwide Children’s closer to our goal to provide perfect, harm-free care. As one team, we can achieve our goal of delivering best outcomes for our patients and staff.

Look for the **Professionalism Code of Conduct** rollout and your manager or Safety Coach will be able to provide more information when the rollout commences.

Controlled Substances: The Responsibility of the Nurse

Matt Sapko, Pharm D, MS, Manager Inpatient and Critical Care Pharmacy Services
Jodi Mascolino, RN, BSN, Legal Risk Management Supervisor



Drug diversion is defined as the unlawful taking of a patient’s medication by a health care professional. Occasionally it is not for the employee’s own use but for someone else such as a significant other. As noted in Nationwide Children’s Hospital’s policy Controlled Substances: Accountability (XI: 36-05), “According to the Drug Enforcement Administration, healthcare professionals have a responsibility to protect our institution from becoming vulnerable to drug diversion. We must be aware of potential situations in which drug diversion may occur and must employ practices to prevent this diversion.”

Health care professionals must ensure compliance with all laws, regulations and policies in relation to controlled substances. They are responsible for the safe administration of controlled substances including recognizing and questioning discrepancies. So, what are the responsibilities to ensure accountability with controlled substances? The following are key reminders to ensure the safe dispensing and administration of controlled substances:

- Administer medication following the five rights:
 - Right Patient: follow Patient Identification (X I:5-35)
 - Right Medication
 - Right Dose
 - Right Time
 - Right Route
- Proper removal of controlled substances from a Pyxis™ machine or Anesthesia back stand
 - YOU are responsible for ensuring your ID/ password remains secure and confidential.
 - Before removing controlled substances from the drawer, you must ensure the count is correct. If not, the discrepancy must be resolved immediately if caused by you or escalated to the areas leadership staff for further follow-up.
 - Any controlled substances not used that remain unopened must be returned to the Pyxis™ or anesthesia back stand.
- All keys for locked boxes, med room lockbox drawers and PCA/NCA/CCA pumps MUST be treated as controlled substances as these keys provide unrestricted access to patient’s controlled substance medications.
- Wasting
 - MUST be witnessed in the presence of another licensed health care professional.
 - Waste should be documented as immediately as possible but within 60 minutes of the wasting occurring. This prevents the health care professional from forgetting to document and ensures compliance. If documentation does not occur, the primary staff removing the medication is responsible for the burden of proof that their witness did, in fact, waste with them.



- Documentation
 - Drug administration should be documented as soon as possible. Documentation must occur on the MAR.
 - Patient’s pain score prior to administration and response post administration must be documented.
- Until approved by area leadership/nursing supervisor, staff cannot leave the unit.
- Administrator on-call/VP will make the decision if a staff should be sent for testing and if any work-related restrictions are required.

Discrepancies: As noted in Nationwide Children’s Policy XI-36:30 Controlled Substance: Procedure for Investigating and Reporting Missing Controlled Substances (XI: 36-30): “All controlled substances and patient controlled analgesia (PCA) key(s) must be accounted for and secure. When controlled substances are missing, the following procedure shall be used in all areas to determine if the controlled substances are lost or stolen.”

- Must be reported immediately to charge nurse or responsible person for the area.

To minimize risk of diversion, staff should remember to complete timely documentation and report any discrepancies that are identified. All health care professionals play a key role in protecting the institution and each other from diversion by being accountable and responsible when handling controlled substances including keys that provide access to controlled substances. Most importantly diversion can result in patients not receiving adequate pain control, so it is critical that we all focus on this potential outcome of drug diversion.

Daisy Award

Gayla Rogers, RN, CPN

The 14th Nationwide Children's Hospital Daisy Award was presented to Gayla Rogers, RN, CPN of the Allergy Clinic. The Daisy Award is given in appreciation of the important difference our nurses make in the lives of patients and families at Nationwide Children's.

Gayla was nominated by her co-worker for demonstrating Nationwide Children's values for more than 30 years in our Allergy Clinic. Gayla embraces the one team approach, has a positive attitude and shares her compassion with both patients and colleagues. Victoria Lizka, the co-worker who nominated her, notes that Gayla went above and beyond to provide continuity of care to a patient who has been a frequent visitor of the



clinic. "Gayla always went out of her way to talk with him, listen and let him know how much she cared about him and that things would get better," says Victoria. "She has made such a difference in his life and the lives of so many other patients and staff."

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