

..... Everything Matters In .....

# Patient Care



*Celebrating Nursing  
Excellence at Nationwide  
Children's Hospital*

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Our nurses, like Zach Marchiando and Jacob Dixon of H10B, are at the forefront of everything we do at Nationwide Children's.



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# Celebrating Nursing Excellence! Celebrating You!



**Lee Ann Wallace**  
**MBA, BSN, RN, NEA-BC**  
Senior Vice President,  
Patient Care Services,  
Chief Nursing Officer

Often say, “Excellence is in our DNA.” Nationwide Children’s Hospital has a long history of commitment to excellence across all areas, including nursing. This issue features a window into examples of that excellence included in the Magnet document we are submitting in June. ANCC Magnet Designation is a testament of nursing excellence at Nationwide Children’s and a celebration of you! The reviewers who read through our document and subsequently come for a site visit will see first-hand how our expert nurses deliver high-quality, evidenced-based, safe care and how we are leading the *Journey to Best Outcomes* through pediatric nursing care.

We are more than 3,500 nurses strong at Nationwide Children’s and practice in diverse settings. Your skill and passion are woven into the story of more than 1.5 million patients annually, and that work has contributed to Nationwide Children’s being recognized by the U.S. News & World Report Top 10 Children’s Hospitals Honor Roll. During the past few years, you have weathered a global pandemic and thrived in some of the most challenging times in the history of health care! You accomplished this while living our values and demonstrating your commitment and excellence in creating the best experience for our patients and families.

We are excited for a bright future for nursing at Nationwide Children’s. In the past year, we created a new Professional Practice Model, developed by nurses for nurses as a template for how we practice and make decisions. We launched a new five-year strategic plan to guide our path forward. This plan has four main aims. The first is to recognize nursing’s unique contribution in achieving and leading *Best Outcomes* for our patients and families across the many and diverse practice settings. The second is to create an infrastructure to support an environment in which our nurses can grow, thrive and advance their practice. The third focuses on maximizing the professional practice environment for our nurses, an environment that supports nurses practicing at the top of their scope, measuring and reporting your direct contribution to patient outcomes, expanding opportunities for fellowships and professional advancement, and the development of a formal structure for nursing research. We know our aspirational vision for nursing can only happen through our final aim around ongoing recruitment and retention of the best and the brightest. We have the best nurses and we want you to find your forever career home Nationwide Children’s, so we commit to developing clear pathways for advancement across our many different practice settings in areas like clinical excellence, education, research and leadership. You are the key to making this new strategic plan a success and thanks to you, we are already on our way.

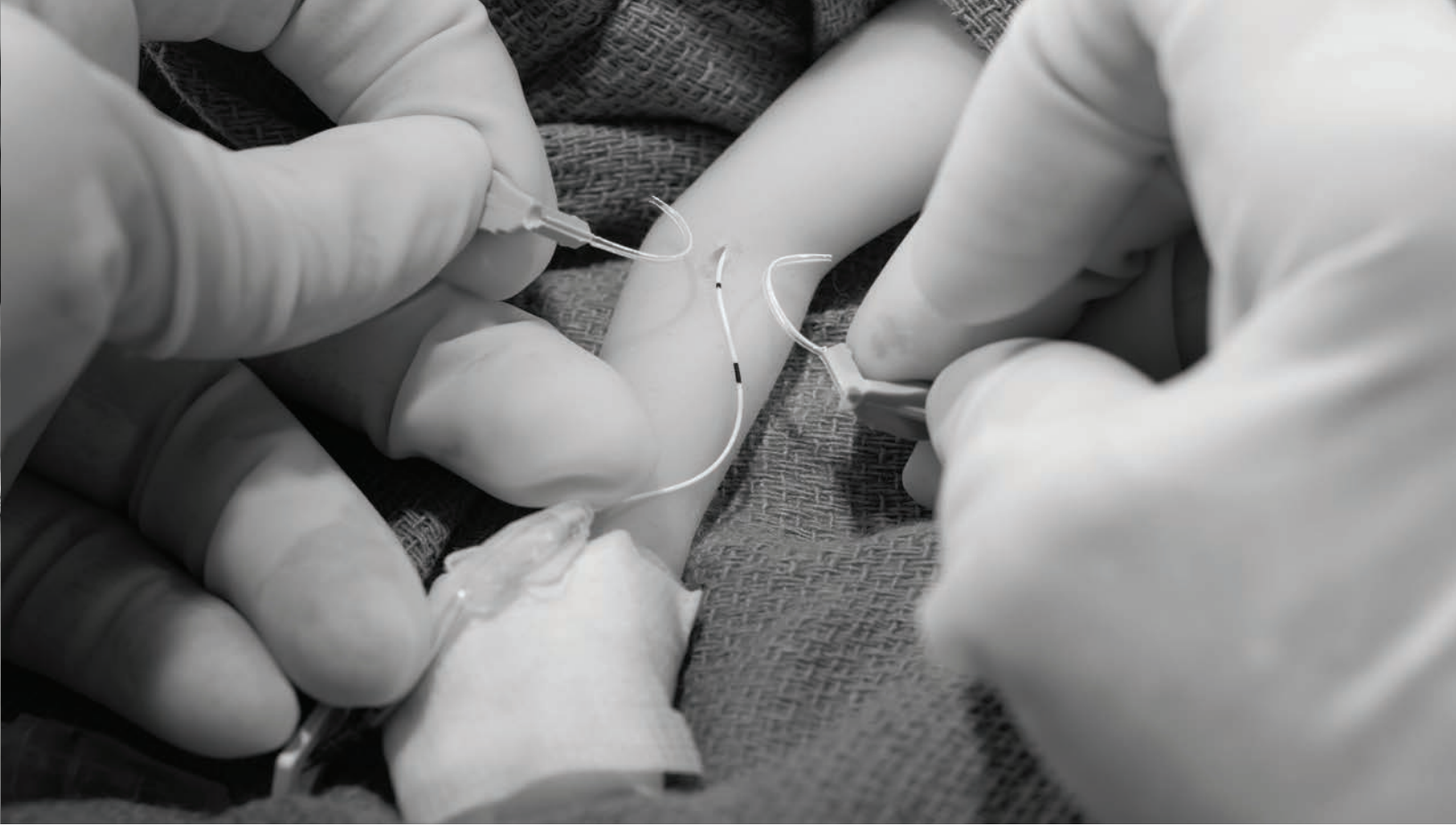
This issue highlights just a few of the examples of nursing excellence that we are submitting to Magnet. We are living the new strategic plan already. Nurses like Mindy Bibart, RN, Maureen Cantwell, RN, Danielle Dennison, RN, Emily Smith, RN, and Melinda Triplet who received recognition from the Association of Pediatric Hematology/Oncology Nurses for their work with the Mid-Ohio Food Collective and Children’s Hunger Alliance in addressing food insecurities in our area are featured. Maria Vegh, RN, and Becca Patton, RN, helped lead and coordinate interdisciplinary teams to ensure that International Dysphagia Diet Standardization Initiative (IDDSI) were implemented for patient safety. Mary Church, RN, from the Plastics Clinic applied for and obtained a very competitive national grant to obtain specialized education and further her professional growth. And, JoAnn Davis, CPNP, Stephanie Peters, CPNP, Sabrina Winters, CPNP, and Keisha Tully, RN, coordinated the care of a very special patient across multiple service lines with an eye for insuring safe and ethical care. Excellence is in our DNA! Let us show the world what we do every day. Let’s celebrate!

# Keeping Babies Safe One PICC at a Time

**Debra Armbruster, PhD, APRN-CNP, NNP-BC, CPNP-PC, C-NNIC, C-ELBW,**  
Neonatal Nurse Practitioner, Nationwide Children’s Newborn Intensive Care Unit at  
The Ohio State University Wexner Medical Center







Peripherally inserted central catheters (PICC) are important venous access devices in neonates. Many neonatal patients require long-term intravenous therapy with a central venous catheter (CVC) for various medical reasons, such as prematurity, congenital anomalies, postsurgical nutrition and hydration, and long-term antibiotics (>7 days). The catheters are typically inserted into an infant's extremity or scalp vein. The catheter is advanced through venous pathways to the superior vena cava (SVC) from an upper extremity or scalp insertion, or the inferior vena cava (IVC) from a lower extremity insertion. Malpositioned PICC tips can cause complications, such as cardiac arrhythmias, cardiac effusions and venous infiltrates.

As a neonatal nurse practitioner (NNP) inserting PICCs for more than 20 years, I noticed that infants of similar gestational ages had comparable PICC depths. An informal list was kept including an infant's weight, length and the depth of the PICC to confirm my assessment. The similarities made me think that there may be an association between a neonate's weight or length and the resultant PICC depth. At the time, I was not sure if this association was related to the infant's weight, length or both. Therefore, I wanted to explore the relationship between an infant's anthropometric measures of weight and length and the resultant PICC insertion depth.

PICCs have been used in neonatal care since the 1970s. In 1973, Shaw published an article discussing the use of

topographical measures as a means of identifying the distance required for the depth of a neonatal PICC. A topographical measure is an external measure on an infant along the venous pathway from the planned site of catheter insertion to the cavoatrial junction of the SVC or the IVC, depending on site of insertion. These measures can differ among inserters, depending on the skill of the measurer and the anatomy of the neonate. The current standard for measure of a PICC is the topographical measure introduced by Shaw in 1973.

After reviewing the literature, I found the evidence behind this nearly 50-year-old practice and discovered the foundational supporting evidence using topographical measures was lacking. Several reports demonstrated associations among anthropometric measures of weight and length in estimating appropriate CVC tip location within the SVC. These reports have focused on pediatric patients, not neonates, and denote anthropometric associations with either the internal jugular (IJ) site or the subclavian site. Numerous peripheral venous sites can be used for neonatal PICC insertion, but as a peripherally inserted catheter, neither the IJ site nor the subclavian insertion site is valid, thus abating these anthropometric correlations for use when estimating neonatal PICC tip insertion depth. Despite the vast amount of CVC literature in pediatrics, there was a deficit in the neonatal PICC literature asserting neonatal anthropometric correlations for use in estimating proper PICC tip insertion depth.

In contrast, a neonate's weight, length and surface anatomy have been used to estimate the appropriate insertion depth of both umbilical venous and arterial catheters. Although umbilical catheter insertion studies have supported various methods for estimating catheter insertion length, neonatal PICC literature continues to support the surface anatomy method of measure reported in 1973. Despite the lack of evidence in the literature to support using the topographical measure, this method of measure remains the current standard of practice for PICC placement in neonates.

After review of the neonatal literature for evidence supporting the use of an infant's anthropometric measures to determine PICC depth, I found the evidence to be sparse. Chen and colleagues (2019) reported an examination of using an infant's length and weight to estimate PICC depth and found the highest correlations in the lower extremities. This research found varying high correlations among neonatal weight and length measures and PICC insertion depth, with the highest correlations for PICCs inserted in the lower extremities compared to the upper extremities. Therefore, the purpose of this investigation was to further examine the association

between a neonate's weight and length and the corresponding PICC tip insertion depth, while examining the use of a neonate's surface anatomy measures to estimate proper PICC insertion depth. The use of anthropometric measures for PICC estimation would abate the need to measure surface anatomy.

The study was approved by Nationwide Children's Hospital Internal Review Board through an expedited process. Since there was little risk to the enrolled participants, no consent was required for subject enrollment. Neonates qualified for study enrollment if a PICC was inserted in the saphenous vein in the leg (at the ankle or knee) or inserted in the cephalic or basilic veins in the arms (antecubital region). The enrollment criteria included that the PICC insertion site be within one centimeter (distal or proximal) of the identified enrollment sites. An independent group comprised of a pediatric radiologist, a neonatal physician and myself, reviewed PICC insertion films for appropriate placement for study inclusion. A PICC site was included only if all three reviewers agreed on appropriate position of the PICC tip. All PICCs were placed by the Nationwide Children's Neonatal Travel PICC Team for consistency.

**After reviewing the literature, I found the evidence behind this nearly 50-year-old practice and discovered the foundational supporting evidence using topographical measures was lacking.**





**This investigation may decrease the need to manipulate a neonatal PICC after insertion, thus reducing the risk of line infection in this population.**

We recorded 49 PICC placements including 14 ankle, 16 knee and 19 antecubital insertions. The gestational age of the enrolled infants ranged from 23 to 39 weeks. Neonatal weights ranged from 510 to 3870 grams and neonatal lengths ranged from 31 to 54 cm. Regression statistics were used to review the correlations between an infant’s weight and length and the resultant PICC depth. Pre-insertion external surface anatomy or topographical measures were strongly associated with PICC insertion depth, validating this method of measure (P < .0001).

The antecubital site was used as the insertion point of reference for the regression model. We found that both an infant’s weight and length were strongly associated with the resultant PICC depth, both denoting a significance level of  $p < 0.00001$ . This study supported a means for PICC tip depth estimation using the neonate’s body weight or body length, which are routine measures in the NICU and readily available for calculation at the bedside.

The regression statistics produced formulas for estimating a PICC depth for each study site using an infant’s weight and length. For use in clinical practice, the identified equations need to be easily calculated at the bedside, otherwise the practicality of using an anthropometric measure for neonatal PICC insertion would be difficult. The length model produced the most practical application for clinical use demonstrating that a knee placement formula would be half the infant’s length in centimeters minus 3 centimeters; for an ankle placed PICC,

the formula would be half the infant’s length centimeters plus 1 centimeter. These two formulas provide an easy method to estimate an infant’s PICC tip depth pre-insertion at the bedside.

Caution is warranted in the clinical significance and application of these formulas as the sample size for each PICC site in this study was small. Also, the antecubital site as a reference site did not consider the differences between a right antecubital fossa and a left antecubital fossa appropriately placed PICC. The distance between the right antecubital fossa to the targeted SVC PICC tip position is shorter than the distance between the left antecubital fossa and the targeted SVC PICC tip position. It is also important to note that the exact placement of all the PICCs examined in this study varied based on the 2-centimeter insertion zone; thus, the regression formulas may underestimate or overestimate the exact PICC depth by 1 to 2-centimeters.

Further examination of the findings with a larger sample size per insertion site would more precisely describe the resultant formulas and the clinical application of such formulas. A replication study based on a power analysis sample size of 216 PICC sites is currently underway. The use of a larger sample may further explain the relationship between an infant’s weight and length, and the required PICC depth for appropriate tip position at placement. This investigation may decrease the need to manipulate a neonatal PICC after insertion, thus reducing the risk of line infection in this population.

**Creative Caring to Meet Patient and Family Needs**

Jo Ann Davis, MS, CPNP-AC, Single Ventricle Program Nurse Practitioner

Pediatric nurses, respiratory therapists, physicians and all other caregivers are committed to ensuring patients are safe and receive excellent care at Nationwide Children’s Hospital. Family-centered care principles are central to the treatment plan for each child in a collaborative relationship between the care team and the patient/family unit. Each family has unique education needs and styles in which they learn best. Families may identify barriers to receiving the typical training and education such as visual or hearing deficits, physical limitations or even limited reading skills. Given these potential barriers, staff are agile and innovative in their approach to family education. One family presented with parents who are legally blind and thus unable to see drawings of heart diagrams. The Cardiology and Radiology departments collaborated to create three-dimensional prints of a typical heart and a diagram specific to the child’s congenital heart defects to assist in teaching the family.

**Each department has unique ways in which staff members went above and beyond to address learning barriers and ensure equity of care for patients and families in a One Team spirit.**

Language barriers often require extra time and effort to ensure families receive accurate information to care for their child. One family, who did not speak English, had a child with complex health needs requiring multiple cardiac medications throughout each day. The pharmacy and nursing staff placed matching color labels on the medications and syringes to help the parents ensure accuracy in medication delivery. There are also language differences that prevent direct translation. One example: The Somali language does not have specific words for artery and vein, rather one word meaning blood vessel. It is important to understand these translation challenges when educating families on complex heart defects and explaining blood flow differences.

At times there are learning differences that require a hands-on approach. The single ventricle team utilizes technology with their home monitoring program (HMP). One family had difficulty understanding how to enter the patient’s heart rate and oxygen levels into the HMP app. As a work-around, the team collaborated with the parent and had her send a secure video of the pulse oximeter readings while it was on the child. This enabled the team to monitor and identify patient concerns in a timely manner.

There are many more stories that could be shared from every area of the hospital. Each department has unique ways in which staff members went above and beyond to address learning barriers and ensure equity of care for patients and families in a One Team spirit. This caring effort enables Nationwide Children’s to achieve *Best Outcomes* for patients everywhere.



# A Simple Tool with a Major Impact

Mary Church, BSN, RN, Cleft Lip and Palate Center

The Cleft Lip and Palate Center and the Center for Complex Craniofacial Disorders are large multidisciplinary centers under the directorship of the Department of Plastic and Reconstructive Surgery at Nationwide Children’s Hospital. The Nationwide Children’s team of craniofacial surgeons and providers treats patients with a variety of facial differences, including cleft lip and/or palate. Families travel from across the country and from other parts of the world to be cared for by our team, and ours are two of the largest and most comprehensive centers approved by the American Cleft Palate-Craniofacial Association (ACPA). Surgical repair and long-term management

of care are required to achieve best outcomes in speech, feeding, hearing, orthodontics, psychosocial development and quality of life.

When I first joined the cleft and craniofacial team, I had little experience with craniofacial anomalies and their impact on children and their families. For these children, long-term treatment begins soon after birth and often includes multiple surgical repairs, lengthy multidisciplinary appointments and coordination with other specialties. In addition to reconstructive surgery, patients may be involved with other

specialty areas including genetics, feeding therapy, speech therapy, otolaryngology, audiology, dentistry, orthodontics, ophthalmology, radiology, sleep medicine, complex care, gastroenterology and psychology. Compliance with care is time-sensitive and essential to ensure that growth and development will support the stress of multiple surgical procedures and to achieve best outcomes. This complex coordinated care is frequently difficult for families to navigate, and the burden of care can put these children at risk for being lost to follow up as they grow.

For patients already at risk for missing continued evaluation and care, the disruption from COVID-19 pushed us to consider how we follow patients. In the early days of the pandemic when care was interrupted, we spent long afternoons as a team reviewing patients’ charts, calling families for updates and reaching out to other providers to ensure care was completed. Smoothing

over the cracks caused by the pandemic helped us build rapport with families and our team. It also demonstrated that our typical workflows needed some modification for the sake of sustainability in a post-pandemic world.

Epic’s reminder and patient list tool was one simple, yet revolutionary, solution we discovered to keep up with our families. The list enabled me to map when patients’ care, therapies and education were due, months or even a full year out. As a result, I had more capacity to help my team and to explore other aspects of craniofacial care. Along the way, I shared this strategy with other nurses who manage their caseloads with Epic lists. Using this organizational tool also helped me build stronger relationships with families, as I was able to answer questions and provide ongoing support more efficiently. Consequently, my understanding of the range of cleft-related care deepened quickly and allowed me to become more involved with ACPA.

In 2022, I received the Donna Pruzansky Memorial Fund for Maternal and Child Health Nursing Grant through the ACPA. The award is designed to further the professional development of nurses who are new to the craniofacial field. It includes a membership to ACPA and financial support to attend its annual conference. I returned from the conference feeling inspired by the efforts of others to improve craniofacial care across the United States and throughout the world. Networking with other craniofacial nurses, many of whom have paved the way in patient care for newer nurses, was especially valuable. The Donna Pruzanky Memorial Fund highlights the impact craniofacial nursing can have on patients and families. I remain motivated to explore how the nursing role can improve patient outcomes even further.

Often in nursing, we simply do what we can to make things a little easier for our patients and families. Sometimes we just try a new approach and hope it makes a difference. I can’t say that I was selected for an ACPA grant because I started using Epic lists, but I do think that finding an efficient system helped me to find and flex some other muscles in my craniofacial nursing practice. The big takeaway is this: if there’s a part of the job that seems complicated, keep seeking ways to improve the process. Finding the right tools for the job can make all the difference for patients and families, as well as for the growth of all of us who care for them.

Finding the right tools for the job can make all the difference for patients and families, as well as for the growth of all of us who care for them.

# Utilizing a Simulation Experience to Reduce Medication Administration Errors

Dorcas Lewe, RN, DNP, CPPS, EBP (CH),  
Clinical Value Analyst, Patient Care Services

One of the ways that nurses exemplify excellence in patient care is through the safe administration of medications. As an organization focused on patient safety and staff well-being, a clinical inquiry was initiated to look for new strategies to further reduce medication administration errors. Utilizing an evidence-based practice model, the literature was reviewed to determine if a simulation experience would be effective to reduce these errors. Following a synthesis of this evidence, which supported the ability of a simulation to achieve our goals, a simulation experience was created to be incorporated into a unit education day.

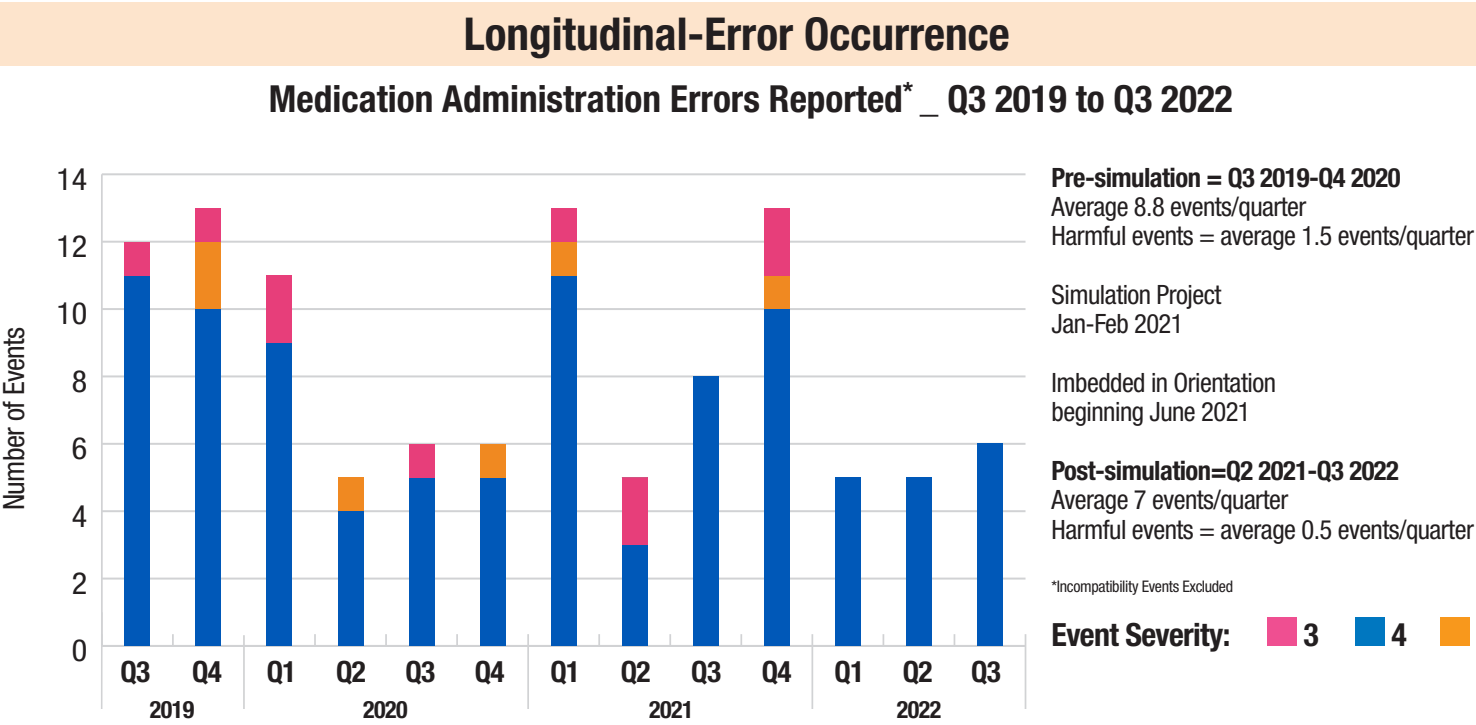
Medication errors occurring on one unit were reviewed and utilized to develop a realistic, high-fidelity simulation to be held in the Simulation Center. Medication errors were strategically imbedded throughout the experience. The experience was planned for one hour to include time for a debriefing discussion after the 20-minute simulation. The simulation focused on critical thinking to identify unknown medication errors using medication administration best practices such as barcode scanning, line tracing, medication order review and distraction management.

During the debriefing, nurses endorsed the realism of the simulation. Post simulation, participants completed a validated survey which confirmed that 73% of participants strongly

agreed that they had increased confidence in providing safety interventions and 81% strongly agreed that the debriefing session improved their clinical judgment. Most importantly, observations of adherence to medication administration best practices demonstrated a statistically significant improvement during the three months of post-simulation participation. Patient outcomes were measured by comparing medication administration error frequency during the three months pre and post the simulation experience. Data revealed that errors were reduced in both frequency and severity.

Since the success of the initial simulation experience in January/February 2021, the unit incorporated this simulation experience into the final weeks of RN unit orientation. In addition to the original staff participants, 30 orientees have now participated in the simulation and medication administration errors continue to trend downward when reviewed longitudinally (see figure).

Our experience revealed that excellence in nursing can be promoted through evidence-based simulation experiences to increase nursing confidence through patient safety interventions, improved clinical judgement, and a reduction in medication errors. Areas looking for an innovative way to reduce errors should consider reviewing event reports annually to identify themes and then partnering with the Simulation Center to create a safety simulation specific to their service.





# Advanced Practice Provider (APP) Utilization: When All The Work Counts

Jennifer Young, MS, CPNP-AC, CPHON, Hem/Onc Lead APRN

Advanced Practice Providers (APP) provide direct and indirect patient care throughout a hospital or health care system. APPs include nurse practitioners, certified registered nurse anesthetists (CRNA), certified nurse-midwives (CNM), clinical nurse specialists (CNS) and physician assistants (PA). APPs contribute to direct patient care through physical assessment and medical decision making in inpatient, ambulatory and home settings. They contribute to patient care in meaningful and impactful ways through indirect patient management activities such as patient education or coordination of care. When considering how to measure the utilization of APPs within a practice setting, direct clinical care is often the standard. Services are quantifiable through measures such as sessions or relative value units (RVUs). Indirect patient care activities are difficult to measure which may lead to a misunderstanding and underappreciation of the value of the APP. To fully measure utilization of APPs in a practice setting, both direct and indirect patient care must be recognized and respected.

In 2020, a team of leaders in the Division of Hematology and Oncology recognized that evaluation of APP utilization was essential. They understood that standardizing utilization practices could be valuable to the overall work of providing high quality patient care. As discussions evolved, division leadership acknowledged that in addition to staffing a clinic or an inpatient service, APPs are often called upon to help fill provider gaps in clinical coverage. They often expand their roles as programs grow and new initiatives are

developed. Division leadership further acknowledged that lack of structure and data to evaluate current utilization practices created a risk of under- or over-utilizing APPs. Therefore, a workgroup collaborated with a Business Process Improvement (BPI) to develop a model to describe and measure hematology and oncology APP utilization. Using the BPI methodology of Define, Measure, Analyze, Improve, Control (DMAIC), the team spent the next year working on model development.

With thoughtful and thorough review and a multi-disciplinary team that considers the clinical, business and process aspects involved, solutions can be developed and implemented in an impactful way.



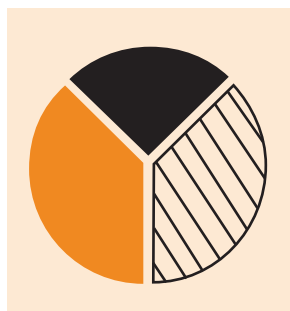
**DEFINE:** In the Define phase of the project, the first task was to gain understanding of the types of work performed by APPs. Define also established a clinical utilization goal for each APP. Since the work done by APPs is mostly clinical in nature, an overall 80% clinical utilization goal was set for each APP. That means in day-to-day operations, 80% of each APP’s full-time equivalent (FTE) would be spent providing clinical care. The remaining 20% of each APP’s FTE would be allotted for project or committee work, professional education or development, and administrative tasks. Given the individuality of the APP roles within a large division, the APP’s individual role and work required evaluation by the project team to ensure that work types were represented and could later

be measured. Evaluation of this led to the development of three categories of clinical work: ambulatory, inpatient and patient management. (See APRN Session Credits figure). Each clinical category was further divided into subcategories to define work completed.

## APRN SESSION CREDITS

<ul style="list-style-type: none"><li>• CLINIC A.M.</li><li>• CLINIC P.M.</li><li>• INFUSION CLINIC A.M.</li><li>• INFUSION CLINIC P.M.</li></ul> <p>4 hours</p> <p><b>AMBULATORY SESSIONS</b> (SESSION CREDIT= 1.0)</p>	<ul style="list-style-type: none"><li>• INPATIENT A.M.</li><li>• INPATIENT P.M.</li></ul> <p>6 hours</p> <ul style="list-style-type: none"><li>• INPATIENT SATURDAY</li></ul> <p>4 hours</p> <p><b>INPATIENT SESSIONS</b> (SESSION CREDITS= 1.25)</p>	<ul style="list-style-type: none"><li>• EDUCATION</li><li>• CARE COORDINATION</li><li>• CLINIC FOLLOW UP</li><li>• INPATIENT ROUNDING</li><li>• DISCHARGE PLANNING</li></ul> <p><b>PATIENT MANAGEMENT</b> (SESSION CREDITS= 1.25)</p>	<ul style="list-style-type: none"><li>• ADMINISTRATIVE TIME</li></ul> <p>4 hours</p> <ul style="list-style-type: none"><li>• PROJECT/ COMMITTEE PER SUPERVISOR APPROVAL</li></ul> <p><b>PROFESSIONAL DEVELOPMENT</b> (SESSION CREDIT= 1.0)</p>
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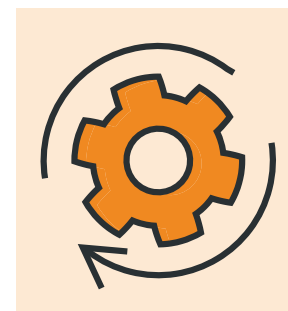


**MEASURE:** In the Measure phase of the project, the team determined that the unit of a “session” was the most relevant measure for APP work within a division that requires frequent physician and APP collaboration for clinical management. Further work then evaluated clinical sub-categories and assigned value in the form of credits to each session. For consistency, the session credit value mirrored that of the physicians’ sessions within the division. Determination of the number of sessions each APP would need to complete to meet the goal of 80% clinical utilization was calculated based on full-time equivalent (FTE) with consideration for paid time off as well as meeting time. As an example, for a 1.0 FTE the annual session goal is 368 sessions.

The Measure phase also brought to light the need for the development of an efficient mechanism by which meaningful data related to completed sessions could be obtained. Within the division, Qgenda® is used for tracking and communicating clinical schedules. Qgenda is also capable of tracking scheduled and completed sessions along with calculating credits. To use Qgenda to gather the necessary data, new work types were within Qgenda to match the work that APPs were completing. Once new tasks were created, an interactive report was developed, allowing for collection of data per APP and by any length of time beyond one month. Clinical work within the category of “patient management” was not easily measured in sessions nor captured in Qgenda. Therefore, it was determined that 10% of all session goals would be accounted for within this category based on reported time spent.

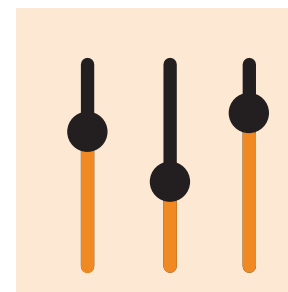


**ANALYZE:** Monthly evaluation of individual and group utilization was completed and reported to key stakeholders during the Analyze phase of this initiative. Monthly review of data was helpful for trending and discovering unexpected variations. Important factors to consider included medical leaves, vacations, coverage of new or growing programs and new APP orientation. Once familiar with the data, intervals were spaced to quarterly reviews.



**IMPROVE:** The Improve phase began six months after implementation of the project. Six months was determined to be adequate time for trending data and then beginning to respond to impact on clinical utilization goals. The project team reviewed APPs that may have capacity to increase clinical utilization as well as those APPs, or groups of APPs (as was the case), that should be further evaluated for reduction of clinical involvement or

level-loaded within the team. Improve is an active process of data evaluation that allows the data to guide the development of and implementation of interventions. Improve still continues at this time based on quarterly review and as needed based on division discussions of growth – this will likely continue for years to come. Data obtained through this work also has the potential to be used when making requests for additional APP resources in the future.



**CONTROL:** Within the Control phase, the team will look to sustain the dynamic data-driven interventions that have been implemented thus far. Control will be achieved when each APP is at their clinical utilization goal as we consider program growth and developing clinical needs. Data will continue to be viewed at regular intervals and interventions will be considered as indicated.

APPs bring immense value to the clinical care and experience of patients and families. They are actively engaged in direct patient care which can be quantified once definitions, measures and reports have been put in place. APPs are also actively engaged in indirect patient management which is less easily quantified but is invaluable to clinical outcomes and patients’ journeys. When APP work is not thoroughly evaluated in a systematic manner with tools such as DMAIC, there is the potential of risk in underestimating an APP’s clinical potential. With thoughtful and thorough review and a multi-disciplinary team that considers the clinical, business and process aspects involved, solutions can be developed and implemented in an impactful way.



# The TLC of PIVs

**Todd Heslep, BSN, RN, VA-BC,** Vascular Access Team Clinical Leader and  
**Samantha Howorka, MSN, RN, CPHON, VA-BA,** Vascular Access Team Education Nurse Specialist

Vascular access is an essential component in the care of our neonatal and pediatric patient population. While there are several types of vascular access devices, peripheral intravenous catheters (commonly referred to as PIVs), are the most common in our patient population. The Vascular Access team alone placed 14,165 PIVs in 2022. PIV use is not without risks, and clinicians must be knowledgeable on assessment and prevention strategies. There are a multitude of complications that can arise from PIV use, the most common involving extravasations (PIV-E). Extravasations occur when infusates and medications administered through any vascular access device, (including PIVs), leak outside the vein into the surrounding tissue. PIV failures related to extravasations can result in delay in care, prolonged length of stay and can cause temporary or permanent patient harm.



**The utilization of peripheral catheters to administer medications and fluids can be one of the more impactful ways we provide care to ill children and adults. They put their trust in us to provide them the TLC they need to recover!**

*A previous patient with a serious PIV-E. He required follow-up by the plastics and wound team.*

In 2020, Nationwide Children's Hospital took a new step in our *Journey to Best Outcomes* by joining the Solutions for Patient Safety (SPS) mission to decrease serious harm related to PIV extravasations. We formally adopted the PIV-E prevention bundle created and published by the SPS.

The PIV-E bundle is comprised of evidence-based strategies that have demonstrated efficacy in identifying PIV complications and intervening to prevent serious harm. These strategies include (but are not limited to), utilizing a standardized percentage measurement-based assessment tool to grade PIV-E as either mild, moderate or severe, educating patients and families regarding PIV-E awareness, notifying a HAC (hospital acquired condition) or vascular access team member for ongoing injury assessment and treatment, and the most important bundle element, the use of Touch/Look/Compare (TLC) to assess the PIV every 60 minutes.

The TLC technique involves three separate assessment types completed at the same time. Touching the site may uncover pain, temperature change or swelling, Looking may help identify bruising or color changes, and Comparing one side of the body or extremity to the other can reveal deformities or size changes. It is one of the most effective interventions we can perform to prevent moderate or serious PIV-Es.

The utilization of peripheral catheters to administer medications and fluids can be one of the more impactful ways we provide care to ill children and adults. They put their trust in us to provide them the TLC they need to recover!

# Mepilex® Ag Use with MRI

**Erica Janita, MSN, RN, CPN,**  
Program Manager, H5B Burn, Trauma, Pediatric Surgery

As an organization, we strive to provide nursing staff the opportunity to participate in the policies and procedures that shape their nursing practice. Additionally, staff are encouraged to approach each day with a questioning attitude, leaning heavily on evidence to drive our patient-focused clinical outcomes. It is because of this organizational focus on *Best Outcomes* and constant improvement that it was important to look deeper into the practice of removing silver-impregnated dressings (specifically Mepilex® Ag) from patients undergoing magnetic resonance imaging (MRI).

In August 2020, I was working as a Clinical Leader and was responsible for reviewing patient care issues. A bedside nurse identified a concern regarding a patient that had gone for an MRI prior to the operating room and had a Mepilex® Ag dressing in place. Because of the perceived risk of patient injury, the organization's process up to that point had been for nursing staff to remove these dressings prior to a patient going for an MRI. With no harm to the patient noted, it was time to examine whether current evidence-based literature still supported the practice of removing these dressings from all patients prior to an MRI. The removal of these dressings can be painful and upsetting for our pediatric patients. To protect our patients from unnecessary harm, I wanted to confirm that removal of the dressings was still considered best practice and not simply something that we continued to do because it is what was always done.

After reading peer-reviewed evidence-based literature that was published and searchable within nursing journals, I reached out to the Wound/Ostomy Team for their input

and received support for my new project as they too felt that the process was outdated. Published evidence confirmed Mepilex® Ag's compatibility with use of an MRI, so after receiving support from the Wound/Ostomy Team, I contacted our organization's MRI leadership. They were very receptive and expressed willingness to review the literature as well as the product's Instructions for Use. After, they were able to test the product utilizing the dressing on a porcine limb in our MRI machines, confirming that the use of the Mepilex® Ag did not heat during the MRI and therefore was not a risk to our patients.

As a result, the process of removing these dressings from patients before to going through an MRI machine, only to have the dressing reapplied afterwards, is no longer practiced at Nationwide Children's Hospital. Based upon the findings, education was presented/disseminated, and the necessary changes were made in our processes so that our staff is aware that these dressings can now remain on patients. All supply Pyxis™ machines were also updated and the message that showed when removing the product that prompted staff to remove the dressing from patients prior to MRIs was removed.

I encourage everyone within the organization to approach the care that they provide with a questioning spirit. You play an important role in the organization's focus on achieving *Best Outcomes*. Avoid behaviors and processes that exist "because it is what we have always done" and instead look at every aspect of your practice as it pertains to patient and family safety and *Best Outcomes*, seeking knowledge and improved clinical results.

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# Local Professional Organization Supports Strategic Goal in Addressing Social Determinants of Health

Mindy Bibart, DNP, RN, CPHON, NEA-BC, CPPS, CSSBB

Professional organizations are an effective way for health care professionals to support their career development, network within their specialty fields and collaborate across multiple institutions. Professional organizations can also provide community support through volunteerism and service work. There are many opportunities for nurses at Nationwide Children’s Hospital to join professional organizations, both locally and nationally. One example is the recently formed Central Ohio Association for Pediatric Hematology Oncology Nurses (APHON). In addition to a focus on professional development, chapter members have a solid commitment supporting the Central Ohio community through volunteerism with agencies providing services to residents and families. This work is an extension of Nationwide Children’s strategic plan. The Central Ohio APHON Chapter supports Nationwide Children’s in Leading the *Journey to Best Outcomes for Children Everywhere*.

The Central Ohio APHON Chapter was established by a group of Nationwide Children’s pediatric hematology/oncology/ bone marrow transplant nurses who were members of the national APHON organization and wanted to expand the members benefits to more Nationwide Children’s nurses. They began the lengthy application process in 2018 and were voted in as a permanent chapter in late 2020. Early chapter goals focused on strengthening relationships across different nursing roles and work locations, offering specialty-specific education, aiding nurses in developing professional presentation skills, mentorship, nurse-specific collaboration with regional organizations, and supporting the communities where our patients and families live. Establishing a professional organization during the global pandemic created additional obstacles; however, the founding chapter members were determined to create a nursing organization capable of achieving their ambitious goals.

## Social Determinants of Health

According to the World Health Organization (WHO), the unequal distribution of power, resources and wealth directly impacts health, creating disproportionate illness and premature death in members of economically challenged communities (Commission on Social Determinants of Health, 2008). The interplay of social, physical and economic conditions that impact health are collectively known as social determinants of health (SDOH) and account for as much as 30% to 50% of overall health status and 80% of modifiable health status (WHO, n.d.). The U.S. Department of Health and Human Services’ Healthy People 2030 has an increased focus on addressing SDOH compared with previous versions of the national program. Their five broad domains of SDOH include economic stability, education access and quality, health care access and quality, neighborhood environment, and social and community context. With such an immense potential impact on the overall health of all communities, SDOH has become a primary international focus of research and clinical innovation.

At Nationwide Children’s, addressing SDOH is a central component of our Stand Against Racism, Stand for Health Equity initiative. One intervention in this work is screening all patients annually for social needs that could impact their health. The screening assesses resource insecurity in housing, food, transportation and utilities. A social worker further evaluates patients experiencing resource insecurities to help obtain critical resources for the family. This screening is routinely completed in the Hematology/Oncology/Bone Marrow Transplant ) clinics. The insecurities identified in the screening tool were a logical focus for Central Ohio APHON Chapter community service efforts.

## Central Ohio APHON Chapter Assists with SDOH

The Central Ohio APHON Chapter Community Service subcommittee is co-chaired by Emily Smith, MS, BSN, RN, and Danielle Dennison, MSN, RN, both Program Managers for Nationwide Children’s Hematology/Oncology/Bone Marrow Transplant (HOB) Division. Prior to the start of the pandemic, the sub-committee aimed to host at least six community service events to help address SDOH in Central Ohio. Events were coordinated with Columbus Gives Back, a volunteering-focused non-profit organization in central Ohio. All events were open invitation for any chapter member, HOB employee and their adult friends and family.



As many as one in five children in Ohio suffer from food insecurity. The community service sub-committee has coordinated several opportunities to help address this disparity. The first event was a department-wide grocery bag drive to support the All-People’s Fresh Market, a community partner for Nationwide Children’s Healthy Neighborhood Healthy Families program. The market’s manager reported a lack of shopping bags to distribute fresh produce to area families. Central Ohio APHON collected hundreds of plastic shopping bags for produce distribution. Building on the initial success of the bag drive, the sub-committee coordinated several events where attendees volunteered at the Mid-Ohio Food Collective. This organization provides more than 140,000 nutritious meals per day in our community. Volunteers play a significant role in operations at the Mid-Ohio Food Collective. Event attendees helped unpack donations in the warehouse, greet shoppers in the market, process individual food orders, and load orders into recipients’ cars. The chapter’s support became even more crucial with the onset of the pandemic when even more families experienced food insecurity. Chapter volunteers worked alongside the Ohio National Guard in serving central Ohio community members in need.

Participation in professional organizations benefits nurses in many ways, including professional development and opportunities for collaboration. Organizations benefit from professional organizations when they align initiatives to address strategic goals. Most importantly, communities benefit from professional organizations when nurses work together to address their overall health and wellness.





## Tissue Adhesive Utilization in the Neonatal Intensive Care Unit

Emily Hass, BSN, RNC-NIC, CNPI and Jill Jones, MS, APRN, NNP-BC,

In the Nationwide Children's Hospital Newborn Intensive Care Unit (NICU), it has been standard of care to change central line dressings every seven days regardless of age. For the main campus NICU, this was completed on Sundays. A Peripherally Inserted Central Catheter (PICC) dressing team RN was pulled away from the bedside to complete these dressing changes for all patients with a central line. For example, a 24-week infant would have a central line placed on a Friday and the dressing would be changed Sunday regardless of if the actual dressing needed to be changed. This practice increased the risk of infection, skin tears and potential for migration or dislodgement of the central line. This standard of care was not only increasing the risks of potential safety events, but it was not in alignment with the latest evidenced-based practice and national guidelines on the topic.

In 2019, members of the Nationwide Children's Neonatal PICC Insertion team were introduced to SecurePortIV (SPIV) at the Association for Vascular Access conference. The Neonatal PICC RN coordinator reached out to the manufacturer of the neonatal PICCs to discuss the use of SPIV on these types of lines. Since there was no data available,

the manufacturer agreed to test the strength of the catheters that we applied SPIV. In February 2021, a three-month trial was approved by NICU medical directors and the Central Line Associated Blood Stream Infection (CLABSI) leadership team. Education was provided to the PICC insertion team that would be applying the SPIV upon insertions as well as bedside staff caring for these lines. In March, the SPIV representative was present at Nationwide Children's main campus and Riverside Methodist Hospital NICU for in-services and hands on demonstration. Bedside signs were created to alert staff that their patient had SPIV on their central line and an evaluation form was created to monitor for complications, length between dressing changes and ease of application.

Phase one of the SPIV trial was initiated in May starting with patients born less than 28 weeks gestation at birth. SPIV was placed at the insertion site of all newly inserted PICCs. Patients only received as needed dressing changes until day of life 14. On day of life 14, the dressing was changed, SPIV was placed at the insertion site and a chlorhexidine gluconate (CHG) disc was placed over the insertion site. Dressings were then changed every seven days. The first patient with SPIV in

place was a 22-week gestational infant, weighing 450 grams. They had an umbilical venous catheter (UVC) in place for 13 days, and SPIV was applied to the umbilical lines shortly after insertion. On day of life 13, a 1.4 Fr. neonatal PICC was placed to the right saphenous with one drop of SPIV applied to the insertion site upon confirmation of placement. The PICC dressing was changed once with zero manipulations. The PICC was discontinued without complications 14 days later, as the patient no longer needed the PICC for therapy.

The data was reviewed with nursing and medical leadership as well as the CLABSI leadership team. With their approval, changes were made to include elimination of CHG disc only when SPIV was utilized at time of insertion and with all subsequent dressing changes, as well as continuation of PRN dressing changes for these lines. The CHG disc would continue to be used on IR/CVL placed PICC lines. The PICC RN coordinator made an educational video of the process to be utilized as a reference for all PICC inserters and PICC dressing team members in the Neonatal Network. With these changes, a three-month trial was agreed upon and phase two was initiated.

Two months into phase two, data from the acute care NICU was submitted to CLABSI leadership. Sixty-four PICCs were placed with SPIV applied upon insertion. At the time of the data, 29 PICCs were removed needing zero or one dressing change prior to removal. There were no CLABSI during this two-month period. The average length between dressings was ten days. In February 2022, it became a standard of care across the neonatal network to change dressings as needed for neonatal placed PICCs when SPIV was placed at insertion site.

The use of SPIV has shown to be a cost saving product as we demonstrated utilization of fewer dressing kits and a reduction in hours for the PICC dressing change team member in addition to more efficient use of time. Lastly, and most importantly, this product has mitigated the risks of skin tears, central line infections and migration/dislodgement of the line which is extremely impactful to our patients and our *Journey to Best Outcomes*.





## IDDSI – One Team Effort to Implement a Globally Significant Change

Rebecca Patton, MSN, RN, CPN, CPST, IS PMO Project Coordinator  
Maria Vegh MSN, RN, CPN Clinical Program Manager, Infectious Disease

**Nationwide Children's was one of the first freestanding pediatric hospitals to implement the IDDSI framework. This project demonstrates Nationwide Children's one team culture, our commitment to best outcomes, and constant improvement in patient care.**

Nutrition is vital in clinical care. Adverse outcomes such as aspiration and inadequate weight gain may result when the patient's diet is not an oral consistency they can safely tolerate. Nationwide Children's Hospital provides care for a multitude of culturally diverse patients from around the world and serves numerous patients from different hospital systems within the United States. In 2020, Nationwide Children's treated more than 1,000 inpatients who were prescribed a modified oral diet utilizing the National Dysphagia Diet (NDD) standards. Operationalizing the NDD standards in all patients and practice settings was difficult and inconsistent. Clinicians had to use their best judgment to assess whether the modified liquid or food was correct to match the diet ordered.

The International Dysphagia Diet Standardisation Initiative (IDDSI) began in 2019 in America, creating a framework for a globally standardized terminology, definitions of texture-modified foods and thickened liquids to be used for individuals with dysphagia of all ages in all care settings and all cultures. Nationwide Children's Clinical Therapy staff advocated for the need to be a leader in standardizing dysphagia diets and the decision was made to implement the IDDSI framework hospital wide.

To operationalize IDDSI, an interprofessional core group of clinicians began the project planning in 2018. The complex nature of the project, which affected all

clinical areas of the hospital, called for a wide range of transdisciplinary staff involvement. Practice policy, staff education, practical training, electronic documentation changes and a wide range of communication channels needed to be planned and created to ensure a successful transition.

In the summer of 2020, during the COVID-19 pandemic, the project was divided into multiple interprofessional teams

and reference badge buddies for all staff; as well a kit of educational materials. An interdisciplinary team created multimodal training for Nationwide Children's physicians. In addition, community physicians received education via a monthly Nationwide Children's newsletter.

To prepare for the transition, classroom education was implemented in February 2021. Over 100 nurses and clinical staff attended IDDSI super user training sessions led by the



led by Rebecca Patton, MSN, RN, CPN. The project was multifaceted and had both a large clinical component as well as a technical/documentation component. It required the teams to be organized into governance consisting of a core team, leadership team, education team, clinical education team, provider work group and an extended team coordinated by the project management team. The teams consisted of over 40 nurses, speech-language pathologists, clinical nutrition, information services, nursing informatics, occupational therapists, physicians, advanced practice nurses, nursing education specialists, pharmacy and Business Process Improvement staff.

A crucial change was the implementation of the new proposed standardized diet orders in which the nursing informatics representative Sarah Eiselstein, BSN, RN, CPN, was instrumental in educating the changes in the documentation.

To reach all of the educators, the Nationwide Children's Clinical Program Manager, Infectious Disease, Maria Vegh, MSN, RN, CPN, and the Inpatient Occupational Therapy Clinical Lead Shelley Coleman-Casto, MS, OTR/L, BCP, CPST, presented the IDDSI concept and education plan during several meetings. The education plan consisted of superuser training with return demonstration, teach-back, competency check-off documents; online learning modules

IDDSI education team of Registered Nurses, Occupational Therapists and Speech Language Pathologists. Superusers trained staff in the affected areas before the March 3, 2021 implementation. The training sessions enabled attendees to obtain innovative tool kits with flow testing supplies and resources designed by the IDDSI education team. Kits included step-by-step instructions, badge buddies, flow test equipment, and supply ordering instructions. Dorcas Lewie, MSN, RN, and her team were instrumental in securing the needed standard supplies. In addition, all staff and families could learn about IDDSI on the digital signage displayed throughout the hospital.

An IDDSI email, VOCERA group and ANCHOR page were developed for additional staff support.

The following facts demonstrate the magnitude of the project: 112 meetings, 125 action items and 40 decisions were documented. There were zero tickets during the three-day go-live support period. Currently, the team only meets to discuss any new changes or improvements needed in the documentation system.

Nationwide Children's was one of the first freestanding pediatric hospitals to implement the IDDSI framework. This project demonstrates Nationwide Children's one team culture, the commitment to the best outcomes, and constant improvement in patient care.

**FOR ANY FURTHER INFORMATION OR QUESTIONS: EMAIL "IDDSI" IN OUTLOOK.**



# H4A Informal Nurse Mentor Program

Amelia Robison, BSN, RN, Clinical Staff Nurse, Cardiac Care Unit

**N**urses are leaving the bedside in record numbers. Why are they leaving and how do we retain them? I found myself asking these questions as peer after peer left the bedside to pursue other avenues of nursing.

In 2018 after graduation, I began my career as a nurse on H4A, a 24-bed pediatric cardiac medical-surgical unit at Nationwide Children's Hospital. We are referred to as a step-down unit due to the high acuity of our patient population. We care for patients on ventilators and administer critical care medications. It is not uncommon for us to take care of the same patients for months or even years at a time, including end-of-life care. As I continued to think about the retention problem, I reviewed a study by Annamaria Bagnasco, PhD, in 2020 that found that nurses working in pediatric cardiology reported very high levels of emotional exhaustion and burnout.

The summer of 2021 was a trying time for nurses across the country. Staffing shortages were regular, turnover was high and morale was low. Informal conversations with my peers over how to improve morale and combat this high turnover spurred a cascade of ideas. As unit nurses we have little control over monetary compensation and working conditions, but we can influence the culture. Thus began the planning of our team building activities and ultimately the development of the informal peer mentoring program.

Jointly with co-workers, I began a One Team effort to plan quarterly social outings such as evenings out at PINS Mechanical, rafting in Hocking Hills, holiday parties and gatherings at my house. Once a month, smaller groups of staff also meet for after-work drinks at a local brewery or trivia night with the one rule being we can only talk about work for 15 minutes.

In the summer of 2021, an extension of this program began - an informal peer mentorship program for the 13 new graduate nurses. We wanted our new nurses to feel empowered by having someone that they could go to inside and outside of work. The goal of this pilot program was to match a new nurse with a mentor and have the relationship grow naturally and not feel forced.

Prior to the team building and mentorship interventions in July of 2021, H4A had a turnover rate of 3.6%. For the three months following the initial intervention, October, November and December, there was a reduction of nursing FTE turnover to 0%. The turnover rate remained at 0% for a total of six months after the intervention.

This October I attended the ANCC Magnet Conference in Philadelphia, the largest nursing conference in the United States. I attended sessions on peer support groups, mentoring programs and emotional wellness within the nursing field.

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**For the three months following the initial intervention, October, November and December, there was a reduction of nursing FTE turnover to 0%. The turnover rate remained at 0% for a total of six months after the intervention.**

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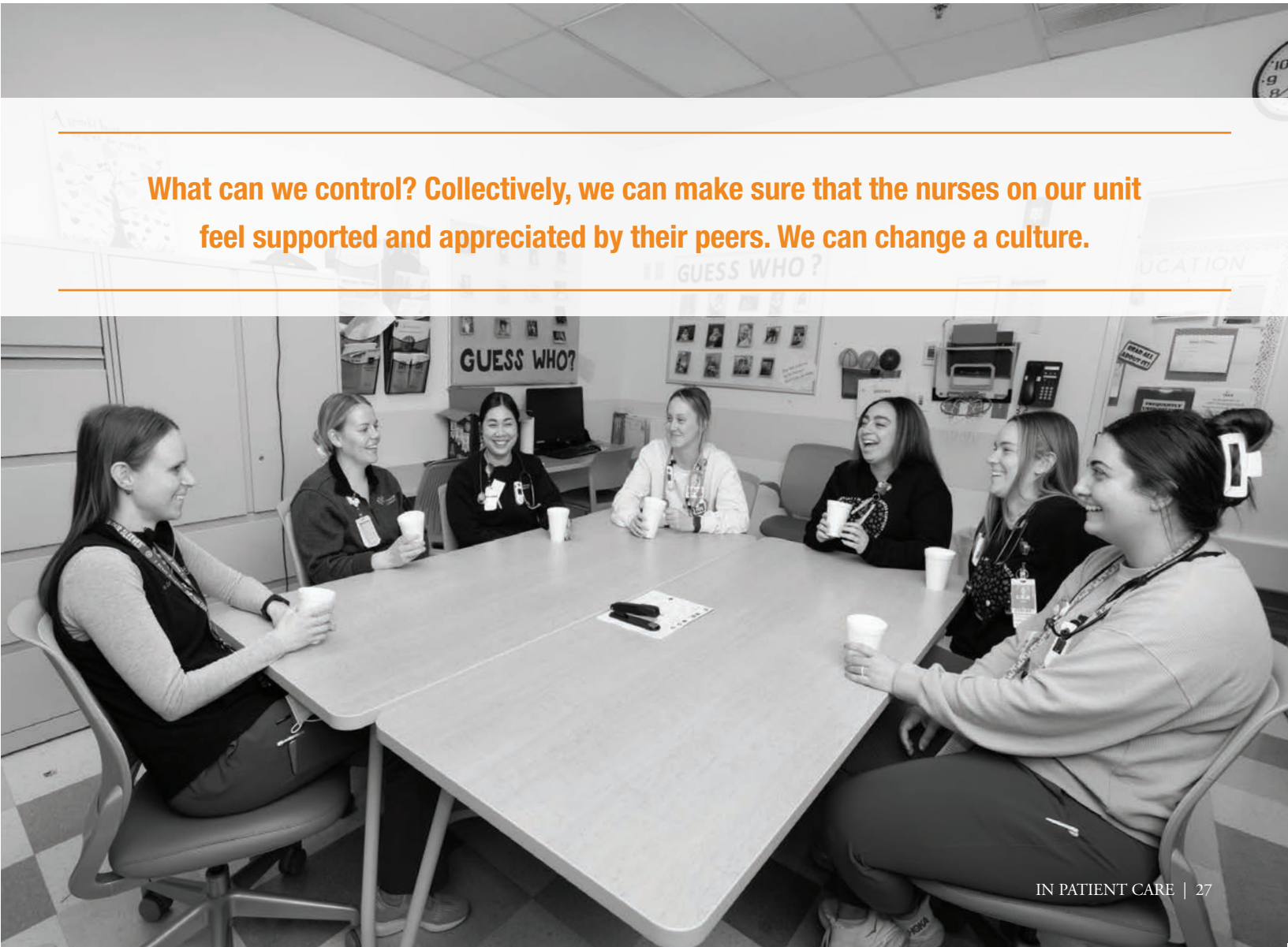
With the information I learned at the conference and help of my co-workers, I have made multiple adjustments to the H4A peer mentorship program. This year the program will be formalized to a six-month period, from December 2022 through May 2023, for our 11 new hires. The mission is to create a network of supportive persons to help new nurses navigate the first six months post-orientation. We have recruited eight volunteer mentors for the 2023 program, each having been a nurse on H4A for at least one year who plans on staying for the duration of the six-month program. The new program has a detailed outline of expectations as well as added mentor incentives. This year the mentor position counts toward unit involvement, which is an expectation toward yearly merit increases. A new approach to the pairing process was also implemented. Each new nurse submitted their top three choices for mentors. They were then paired based on those preferences and shifts worked for ease of meeting and compatibility. Questionnaires will be distributed to the mentees at various time intervals to gather qualitative data for further analysis.

In preparation for next year's program design, I will be collaborating with Cathleen Opperman, DNP, RN, nurse education specialist, Center for Nursing Excellence, to continue to build a more formal mentoring structure using evidence-based practice.

When it comes to nurse burnout and retention, there are plenty of factors that are out of our hands as bedside nurses. We can't fix all the issues within the health care system, and we can't control the personal life circumstances that may lead someone to leave their job. So, what can we control? Collectively, we can make sure that the nurses on our unit feel supported and appreciated by their peers. We can change a culture.



**What can we control? Collectively, we can make sure that the nurses on our unit feel supported and appreciated by their peers. We can change a culture.**





# HIV Viral Suppression During Transition of Care at the FACES Clinic

**Stephanie Byrd, BSN, RN**, Nurse Clinician, Immunodeficiency Clinic and  
**Kim Housden, MSN, MHA, RN, NPD-BC**, Education Nurse Specialist, Professional Development

Nationwide Children’s Hospital’s FACES (Family AIDS Clinic and Education Services) Program has been serving patients and families since 1985. The clinic provides comprehensive family-centered primary care and obstetric and gynecologic services for pediatric, adolescent and adult patients in addition to HIV care for more than 400 clients from over 40 countries living with HIV. The care team provides medical and psychosocial care and wrap-around services to patients through an interdisciplinary team that includes nurses, physicians, nurse practitioners, medical assistant, social workers, peer navigator, pharmacists, dietitian, outreach coordinator and administrative support. They also provide HIV prevention and community outreach services, sexual health promotion and education. The clinic is one of the few access points in central Ohio for HIV prevention services to youth including pre-exposure and post-exposure prophylaxis (PrEP/PEP).

**The FACES Program was awarded a grant from the Ryan White Program, which is part of the U.S. Health Resources and Services Administration (HRSA), to develop a transition planning framework and process for adolescents and young adults living with HIV to improve health outcomes for the 13 to 24 age group as they transition from pediatric care into adulthood.**

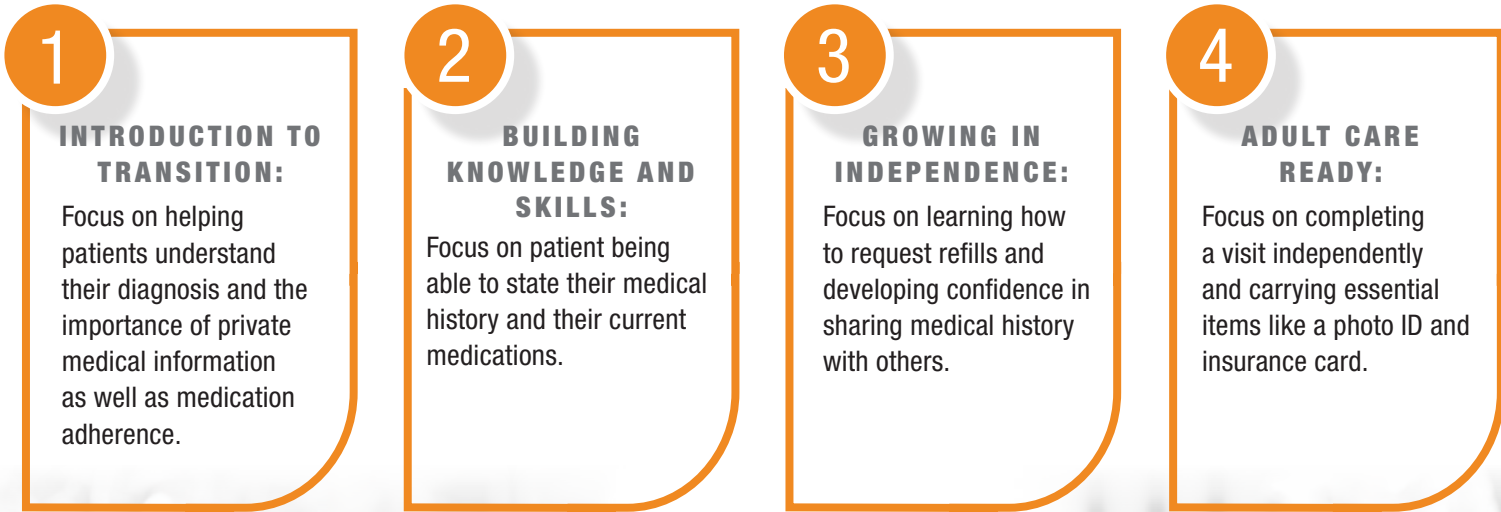
Nurse clinicians in the FACES program provide direct care and education and conduct psychosocial assessments during clinic visits. When not providing face-to-face services, they collaborate with patients and families, interdisciplinary team members and community service partners to provide telephone triage services for all patients and medical case management. Nurses serve as medical resources for patients, families, members of the community and interdisciplinary team members in the program as well as throughout the organization.

While providing care, the team noticed that adolescents and young adults (ages 13 to 24 years old) in the FACES clinic had difficulties with both staying in care (retention) and controlling their HIV disease (viral suppression). This is concerning because the retention of patients is critical to treatment adherence, which is a key factor in maintaining the suppression of HIV. Patients who adhere to their antiretroviral therapy (ART) can reduce their HIV viral load to an undetectable level, which helps the patient achieve their best health outcomes and eliminates transmission risk to others. Also, the team recognized that guidance for tailoring transition planning for adolescents and young adults living with HIV was limited and that the needs of those with perinatally acquired HIV and those that acquired it later in life were different.

The FACES Program was awarded a grant from the Ryan White Program, which is part of the U.S. Health Resources and Services Administration (HRSA), to develop a transition planning framework and process for adolescents and young adults living with HIV to improve health outcomes for the 13 to 24 age group as they transition from pediatric care into adulthood. The goal for the program was to improve compliance during the transition and to support treatment adherence and improve viral suppression rates. The multidisciplinary team led by Megan Brundrett, MD, and Laura Hart, MD, developed a transition plan for patients who were aware of their HIV status at the age of 13 years or older as they moved from pediatric care to adult care.

The transition process consists of four stages. The four stages of transition are broken into competencies that patients must meet in order to move to the next phase. The clinic team developed specialty forms in the electronic medical record (Epic™) to document the patient’s progress. Patients and caregivers are given the transition plan outline with educational materials at visits.

## PATIENTS AND CAREGIVERS TRANSITION PLAN STAGES:



The team utilized viral suppression rates of patients in the identified age group to measure the effectiveness of the program. A baseline was established using data collected during the fourth quarter of 2020, which found that 82% of FACES patients in the 13- to 24-year-old age group were virally suppressed. After the implementation, the team found that viral suppression rates increased by four to five percent. During the second quarter of 2021, 89% of patients 13-24 were virally suppressed, and during both the third and fourth quarters of 2021 88% of patients in that age range were virally suppressed.

**THE RESEARCH IS SHOWING THAT THE IMPLEMENTATION IS MAKING A DIFFERENCE AND  
RNS HAVE AN IMPACT ON PATIENT OUTCOMES USING THE PEDIATRIC TO-ADULT TRANSITION TOOLS.**



# Celebrating Michelle McKissick

Leaders in organizations cast a shadow on groups of people, directly affecting the culture, style and values of the teams in their sphere of influence. In this issue, we are celebrating a career milestone for an exceptional leader who shaped her sphere of influence in clinical care for the critical care areas and throughout the organization. In Michelle McKissick's 45 years at Nationwide Children's Hospital, she has championed significant projects leading to Best Outcomes for patients and families. Michelle emulates the Senn Delaney shadow of the leader philosophy in her daily work and has led by example throughout her career. She started her career as a staff nurse on a Pediatric Intensive Care Unit (PICU), transitioned to a manager and is currently the Vice President of Surgical Services at Nationwide Children's.

Throughout her career, Michelle has made innumerable contributions to quality and safety and received the Nationwide Children's 2022 Clinical Excellence award. Michelle was instrumental in co-leading the Code Blue committee and developing the Assessment, Consultant Team (ACT) to mitigate the risk of clinical deterioration

and changed how we electronically document acute patient deterioration in the medical record today. Additionally, Michelle has been the co-chair for pressure injury prevention and the sepsis collaborative with a global focus of mitigating harm to patients, predicting risk and decreasing length of stay. Michelle has maintained a great partnership with Lifeline of Ohio for more than 20 years, serving on the Medical Advisory Board and Governing Board. This partnership has led to the strong collaboration between Lifeline of Ohio and Nationwide Children's that we have today.

Michelle believes she has been able to sustain her career at Nationwide Children's because of the mission and vision of the organization and the relationships she has developed over the years. She enjoys spending time with her family and friends, reading and volunteering. Everything Matters in Patient Care celebrates Michelle's accomplishments over the years. She has provided a legacy of mentoring and leadership to many staff that is immeasurable. It has been an honor to work with an exemplary nurse leader and team player. Thank you for all that you have done for Nationwide Children's patients, families and staff.

## ACCOLADES FOR MICHELLE:

"Michelle was my hiring manager when I was beginning my 30-year career at Nationwide Children's, and she conducted my PICU interview while she was performing bedside care to patients in the PICU because staffing was extremely short and patient care came first. This demonstrates one example of the passion and commitment she has to her team and patients. You have passed the torch in your nursing career and have set up others for success through your guidance. I appreciate all the relentless support, friendship and mentoring over the years!"

**Danielle Rehm, RN**

"It's hard to put into words Michelle's impact to this place and the people, and how much she means to me. Of all the advice I have received from Michelle, the one thing that I will always hold the most dear is her perspective on the importance of family. She has been a mentor and a friend who will be greatly missed."

**Marissa Larouere, RN**

"Michelle has always been a special person to me and the whole Nationwide Children's community. In addition to her outstanding work in nursing, finishing in the highest levels, she has always been an excellent representative of Nationwide Children's to the central Ohio community. Michelle has developed strong bonds to so many here at Nationwide Children's and was willing to help with whatever was needed. She knows no enemy. I know she deserves her time now to reflect and enjoy her family as well as her other interests."

**Bruce Meyer, MD**



"Michelle, I am so excited for your retirement! What a nursing career to celebrate! Probably the most PICUs opened, the most managers mentored, the most committees served or led and so much more. I have always admired your calm reserve and ability to go with the flow. You are truly a model of God's servant, from caring for your brother, your mother, your sister, dear colleagues, and godmother for many, many children. Your priorities have always been clear with God first, family next and then give your all to the service work you chose, nursing.

Thank you for showing care for your staff, your co-workers, physicians, RTs and any member of the team. I never saw you shy away from a difficult project, from inviting families to sleep in the PICU, later be part of the rounds, then calling an ACT, separating PICU and CTICU, getting pressure injuries reduced and supporting sepsis committee to name a few.

Probably the most difficult was predicting staffing for when winter viruses were going to hit. Thank you for supporting patients and staff during

these many, many challenging times and changes.

I wish you good health, and good times as you begin the next journey in your life. I always remember how you said your mother was mother to everyone at your church. I can see you being Mother McKissick at your congregation with so much love and wisdom to share and an ear to listen."

**Linda Stoverock, RN, former CNO**

"Michelle, thank you for all that you have done to help me grow throughout the last five years. I have learned so much from you. One of the things I have appreciated most is sharing life with you during our one-on-one meetings! I was blessed by the times we could laugh, cry and pray for each other. I hope you will keep in touch and let us know about the adventures you end up taking or the about all the extra Aunt Chelle time you have! You will be missed."

**Holly Deem, RN**

"Whenever I am asked if there has been a manager in nursing who has impacted my nursing career, you are the first person that comes to mind. You hired me as a PICU nurse back in 1995, after three years in the NICU. As only the second manager of my young career, what I remember most is how you managed to care for your team while still managing staffing needs and patient care. It was not unusual to come in on a night shift and see you working alongside of us with a patient assignment. Although the work was very hard at times, you led us with compassion. We knew both the patients and families AND your team mattered to you. I have carried these and many other leadership values I learned while working for you with me to the current day where I have been lucky enough in my career to be reporting to you again.

I wish you all the best and hope you can travel everywhere you have always wanted to go, relax and renew your spirit during your retirement! You will truly be missed!"

**Lee Ann Wurster, RN**



## Daisy Award

### Rachael Vance, RN

The quarterly Nationwide Children's Hospital Daisy Award was presented to Rachael Vance, RN, of H11B. The Daisy Award is given in appreciation of the important difference our nurses make in the lives of our patients and families at Nationwide Children's.

Says Rachael's nominator: "In all our hospital admissions, we have never had a nurse that was a bigger advocate for our daughter as we had with Nurse Rachael. Nurse Rachael, with all her past experiences, brought her knowledge and wisdom to our daughter's care every day. Nurse Rachael was kind but straight forward with us throughout our stay. ... We as parents could not be more grateful for having Nurse Rachael as our nurse. Nurse Rachael, THANK YOU THANK YOU for everything!"

To learn more about our Daisy winners, and read their full nomination, visit [NationwideChildrens.org/Daisy-Award](https://NationwideChildrens.org/Daisy-Award)



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