Everything Matters In

Patient Care

Effective
**Communication
Tactics**

At Nationwide Children's, we use effective communication strategies to create Best Outcomes.

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Pictured left: Clear and effective communication is essential between providers, patients and families to ensure the highest quality of care.

Effective Communication Strategies

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In 2017, Nationwide Children's Hospital joined other pediatric hospitals to use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience tool to measure parent and patient satisfaction with care. The adult version has been in place since 2008, with adult hospitals publicly reporting data so the consumer can make decisions based on objective measurement from patient perspectives on care. In 2014, a pediatric version of the tool was researched, developed and approved for use in this population. Boston Children's Hospital received funding to study this tool from a grant through the Centers for Medicare & Medicaid Services (CMS). The pediatric data is different from the adult population, in that it is not mandatory to report the results of these surveys to consumers.

The main purpose of the survey is to measure the patient-centeredness of hospital care for pediatric patients. Topics include asking parents/guardians about communication with doctors, communication with nurses, hospital environment, and age-appropriateness of care, pain management and other domains that parents viewed as important aspects of their child's care. Dr. Tom Bartman and I (as well as previous physician leader, Dr. Kerry Rosen) saw the more consumer driven behavioral questions, especially around communication, as a direct correlation to our strategic initiative on transforming patient/staff interactions under Treat Me With Respect.

We now have a year's worth of data and are beginning to see areas of focus for our teams direct changes in our behaviors with our patients and families. It comes as no surprise both physician and staff interactions with families receive higher ratings than our communication with the children. Our previous three years focused on changing our rounding process to engage the parents and young adult patients to be included in developing the daily plan of care.

What a wonderful opportunity to remind ourselves of the fun of being in pediatrics and engaging the children in our daily conversations and understanding what he/she wants to happen for the day! Giving the clinicians the opportunity to answer questions in a way that eleviates the patient's fear and anxiety as well as allowing them to learn about their environment through play and wonder.

In the past several months you may have had the opportunity to attend one of our grand rounds on interactions with children. In this issue of *Everything Matters In Patient Care*, you will learn about many of our strategies around communication. Communication is the crux of safe and effective patient care whether between team members or team member to family. But most important, let's not forget the communication with the primary consumer of our care: the child. Together, we can ensure every communication matters with every child.

Together, we can ensure every communication matters with every child.

Communicating as a Professional

Jamie Welsh, Senior Consultant, Organizational Development

What is going to happen to my little girl? Is she going to be okay? How are we going to pay for this? Why are those two staff members arguing?

Professionalism & Tact: a keen sense of what to say or do in order to maintain good relations with others as well as a skill in dealing with difficult or delicate situations.

Imagine for a moment your child has just been admitted to one of the largest children's hospitals in the country. You are waiting on answers and have been told your daughter likely has an unknown bacterial infection and will need to be hospitalized for several days for testing and treatment. The past 24 hours have been a whirlwind. You have no idea how you are going to juggle it all – work, the house, not to mention the three other children you have at home. Thoughts keep going through your mind. What is going to happen to my little girl? Is she going to be okay? How are we going to pay for this? Why are those two staff members arguing?

Wait. Hold on just one minute. Two staff members arguing? How could this happen? What led to this unfortunate moment for this child's mother? How does this unprofessional behavior affect the patient experience? How does it affect patient safety?

Everything matters in patient care, including professionalism and tact. Our individual habits and behaviors have a direct impact on the outcomes of our patients and families. When we communicate and behave in an unprofessional manner, we negatively affect patient care, even if we do not intend to. This type of behavior affects team culture and the environment in which we work. Professionalism and tact, in this context, is defined as a keen sense of what to say or do in order to maintain good relations with others as well as a skill in dealing with difficult or delicate situations. A notable point within this definition is the word skill. This implies if we intentionally practice tact and professionalism, we will become better at it.

During the course of a four-day hospital stay, a patient's family may interact with 50 different employees, including physicians, nurses, technicians, patient care assistants and others. Effective clinical practice involves several handoffs of information. This information needs to be communicated accurately and in a professional manner from clinician to clinician. When health care professionals get it wrong, patient safety is at risk for several reasons: lack of critical information, misinterpretation of information, overlooked changes in status and more. As Zero Heroes, we simply cannot afford errors that negatively influence patient care.

Unprofessional Behaviors Survey

Recently a group of Nationwide Children's Hospital clinical leaders were asked the following questions:

1 How often do you experience unprofessional behaviors in your current work environment?

2 Which parties are most often involved in the unprofessional behaviors?

3 What type of unprofessional behaviors do you encounter most often in the workplace?

4 What would help reduce unprofessionalism in the workplace?

Survey Results

The majority of unprofessional behaviors take place from **staff member to staff member**

20% said they see unprofessional behaviors a **few times each week**

38% said they see unprofessional behaviors **daily**

The most common behaviors reported included:
speaking poorly of others | discussing personal matters publicly poor mood management | unproductive use of technology | gossiping

The data indicated the majority of unprofessional behaviors take place from staff member to staff member. Twenty percent of the respondents reported they see these types of behaviors daily, and 38 percent reported these behaviors occur a few times each week. The most common behaviors reported included speaking poorly of others, discussing personal matters publicly, poor mood management, unproductive use of technology and gossiping.

Most importantly the data tells us a story. We can conclude due to the frequency of this type of unprofessional behavior, many of us will be impacted by or engaging in this type of activity at some point in our careers. As a result, what type of culture are we creating collectively, as One Team? Let us refer back to our opening scenario. Put yourself in the mother's shoes. While trying to manage this incredibly stressful situation, how would you be affected if you witnessed to some of these common behaviors? Would this add to your stress? Would you question the credibility of those caring for your child?

As care providers, each one of us must work intentionally to minimize unprofessional behaviors in our working environment. Please take into consideration the following communication best practices to create a more professional clinical environment.

Model the behaviors you wish to see in others.

Albert Einstein suggested, "Setting an example is not the main means of influencing others: it is the only means." We must ensure we are demonstrating appropriate behaviors at all times. As human beings, we are incredibly influential. When we engage in negative actions, others may reciprocate. Be aware of the shadow you cast and ensure others see how you live the Nationwide Children's One Team Values.

Listen with curiosity and empathy.

As health care professionals, there is no denying just how busy the day can be. Managing multiple patient needs, communication requirements and unexpected surprises throughout the course of the day can be overwhelming. It is imperative to understand there are times when slowing down to listen with understanding is crucial. In his book, "The Energy Bus," Jon Gordon discusses when there is a gap in communication, negativity often fills it. Gaps in communication occur when we are not listening. We must become better listeners by eliminating distractions, remaining present for others, practicing curiosity and recognizing the value of empathy. We should assume positive intent while giving others the benefit of doubt and T.H.I.N.K. before we speak. T.H.I.N.K is an acronym for recognizing the power of the pause and take a moment to consider is it true (T), is it helpful (H), will it inspire (I), is it necessary (N), is it kind (K)?


Practice self-awareness and self-management.

Emotional intelligence is the ability to understand your own emotions and those of people around you. The concept of emotional intelligence means to have a self-awareness that enables recognition of feelings, which helps manage emotions. A person with a high emotional quotient (EQ) is also capable of understanding the feelings of others and, therefore, is better at handling interactions of all kinds. According to the November 2011 edition of Nurse Education Today, emotional intelligence has the potential to enable individuals to cope better and experience less stress thus contributing to a healthy and stable workforce. We must become hyper-aware of how we show up to situations. Are we bringing our best self? This includes being aware of how we say what we say, our facial expressions, body language and our current mood. The mood elevator is a tool presented in the Nationwide Children's One Team course. This tool teaches us to navigate the world according to our mood, understanding our best thinking happens when we are curious or above. In the higher mood states, we tend to have more perspective, allowing us to listen more deeply, have more wisdom and see the bigger picture.


Respect others.

While this best practice might seem too simple, a lack of respect is a significant source of unprofessional communication in the workplace. Revert to the basics to get it right and begin by genuinely caring about others. The platinum rule suggests we should treat others the way they want to be treated. This means engaging in dialogue with others that keeps their needs in mind, thus understanding the situation from their perspective.
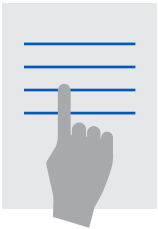
Follow guidelines, standards and policies.

It is imperative to consider all guidelines, standards and policies. If we are unsure or need clarification, we must ask. This proactive approach will prevent making assumptions, which could result in negative consequences.
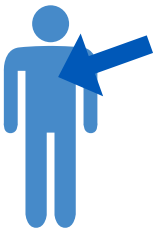
Be accountable.

Practicing accountability in the workplace is more than owning our mistakes. Accountability means being fully committed to our patients and families, as well as each other. It means being resilient when there are challenges and always showing up at our best. It is imperative to avoid placing blame and making excuses if a mistake is made. Instead, we must make it right. In our survey data, leadership suggested accountability was the number one solution to creating a more professional environment. We must be accountable to our interpersonal behaviors, our actions and outcomes.

Communicating with tact and professionalism is an intentional decision made every day. If you feel you are lacking skills, knowledge or tools to maintain professionalism or are unsure how to handle a challenging situation, please reach out to leadership support and resources. Collectively, as One Team, we have the potential to create the very best working culture. A culture in which we have solid relationships built on trust, and where patient care is not negatively impacted due to unprofessional behaviors. A culture where we have commitment to our organizational values of doing the right thing, creating a safe day every day, promoting health and well-being, being agile and innovative and getting results.

Clear Health Communication: Luxury or Necessity

Marcie Rehmar, MS, Director, Community Patient-Family Education, Department of Education

According to the Institute of Medicine, 90 million adult Americans have limited health literacy, defined as the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions.

Although seemingly simple, health literacy is complex. On any given day, our patients and families need to be able to read, understand and analyze new information; decode instructions, symbols, charts, graphs and diagrams; perform calculations; weigh risks and benefits; make decisions and ultimately take action.
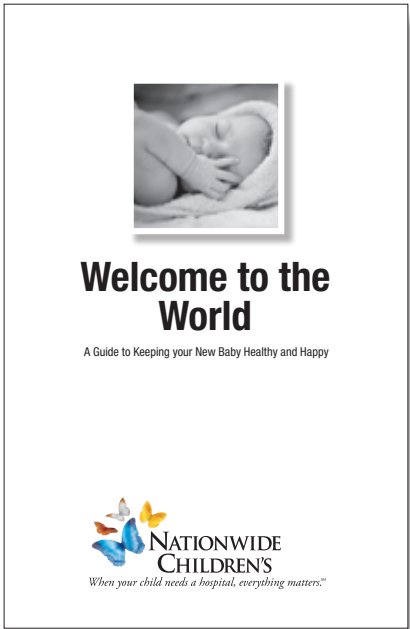
To make it even more complicated, you cannot gauge health literacy by looking at someone. Most "below basic" adults are U.S. born, white and English is their first language. Health literacy statistics tell us that one in two Americans cannot read above a fifth grade reading level. A study published in JAMA indicated and a study by Nielsen and Bohlman found 25 percent of patients could not understand when their next appointment was, 42 percent did not understand the words "take on an empty stomach" and 60 percent could not understand their consent form. To compound this, more than 300 languages are spoken or signed in the U.S., 47 million Americans speak languages other than English at home and 21 million Americans have Limited English Proficiency.
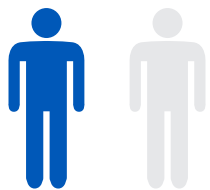
1 in 2 Americans cannot read above a fifth grade reading level.

So what does all this mean?
A person with basic health literacy would have trouble using information in a technically accurate brochure that provides two reasons why someone with certain symptoms might need a specific test.

Welcome to the World
A Guide to Keeping your New Baby Healthy and Happy

NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.

A person with below basic health literacy would not be able to recognize a medical appointment on a hospital appointment form.

Clear health communication, often referred to as plain language, is a strategy for making written and oral information easier to understand. Key elements of clear health communication include:

- Organizing material so that the most important information comes first.
- Making sure content has an obvious purpose. Excluding content that may be interesting but distracts from the main purpose of the material.
- Breaking complex information into understandable chunks.
- Using simple language and defining technical terms.
- Using the active voice.
- Using easy to read text and visual cues (such as uncluttered visuals, simple charts).
- Providing simple instructions with calculations.
- Including at least one action for the reader to take with steps to help the reader take that action.

Why do we care?
Those with limited health literacy report poorer overall health, are less likely to make use of screenings, delay diagnosis, are more likely to need hospital stays, utilize fewer self-management skills; have a poorer understanding of treatment and a lower adherence to medical regimens.

What can you do?
When communicating with patients and families avoid medical jargon, instead use common words; use teach-back; use simple, specific, direct sentences; sequence ideas clearly and logically, give information in manageable chunks as to not overwhelm the family, and be attentive to culture.

How to communicate with patients and families

- Avoid medical jargon, instead use common words
- Use teach-back
- Use simple, specific, direct sentences
- Sequence ideas clearly and logically
- Give information in manageable chunks as to not overwhelm the family
- Be attentive to culture

"Health literacy is the currency of success for everything that we do in primary and preventive medicine. Health literacy can save lives, save money, and improve the health and well-being of millions of Americans. All of us—government, academia, health care professionals, corporations, communities, and consumers—working together can bridge the gap between what health professionals know and what patients understand, and thereby improve the health of all Americans."

– Former Surgeon General Richard H. Carmona, M.D., M.P.H., F.A.C.S.

So now you decide, is clear health communication a luxury or a necessity?

A Day Without Technology — Are You Prepared?

Kristin Maple, GSEC, IS Security Analyst, Information Security and Risk Department

The saying goes "It takes a village to raise a child," and the Journey to Best Outcomes is no different. Delivering the best health care requires many people working together and communicating. With more than 13,000 hospital and medical staff at Nationwide Children's Hospital, it can be challenging, but we overcome many of those challenges by using technology.

Think about all the different technologies used to accomplish day-to-day tasks: workstations to access Epic™, Vocera to receive alerts from patient rooms, bar code scanners to dispense medication. You might be using some aspects of technology without even realizing it, like the clocks in the operating rooms that require an internet connection. There are countless messages to coordinate care sent through email, faxes, pages and system alerts every day. Now think about what a day would be like if these technologies were unavailable.

While the Information Services (IS) department dedicates a lot of time and resources to preventing system outages, there are some circumstances out of our control that could cause a technology resource to be unavailable. If a natural disaster like a tornado or flood damages our data center, several of the systems you rely on to conduct your job could be impacted. In this type of event, IS will be focused on restoring core functions of critical systems; however, it could still take hours. Other health care organizations have experienced a shutdown of their electronic medical record systems for several days due to ransomware infections. Again, in this situation IS will be prioritizing the recovery of the most critical systems meaning they cannot always assist departments as they navigate how to continue to provide care during this time.

For these reasons, it is necessary for each department to have the conversation – What would we do in the event technology is unavailable? Are there paper forms you can use instead? Are there enough copies readily available in the area? Does the staff know where those forms are kept and how to fill them out? Take the time to define downtime procedures and educate the staff so they are aware of what to do. Periodic testing of the procedures to verify they are still effective and appropriate is also important. The process that worked three years ago may no longer be viable in the current environment.

The variety of threats that could compromise system availability is endless, but at the end of the day, the overall impact of a system going down can be mitigated through proper preparation. Have a plan in place so the dreaded day without technology does not prevent us from providing the best health care to our patients.

Development of a Communication Program to Foster Inclusiveness for LGBTQ+ Families

Avery Anderson, BSN, RN, Registered Nurse, Inpatient Behavioral Health T5A

Communication is the foundation of all interactions. Therapeutic communication requires the engagement of both parties and awareness of the messages they are giving and receiving verbally as well as nonverbally. While this communication is important in every patient encounter, it can be challenging with vulnerable populations. One such vulnerable population is our lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ+) patients. As with all youth, in positive supportive environments, children and adolescents thrive with good mental and physical health; however, LGBTQ+ youth are more vulnerable to negative environments. Negative attitudes toward this population put them at increased risk for targeted violence, which, in turn, can lead to increased symptoms of depression, suicidal feelings and substance use. Unfortunately, these youth fear being misunderstood and even harassed in health care settings and up to a third report negative experiences such as verbal harassment and refusal of treatment when trying to access care. Their fears may be understandable given that most health care professionals do not feel knowledgeable, comfortable or prepared to address the health care concerns of this population. Given our principle that Everyone Matters at Nationwide Children's Hospital, on T5A we developed an educational program and resources for staff to foster positive therapeutic experiences and inclusiveness for our LGBTQ+ patients.

The goal of this program was to provide staff with the opportunity to empathize with these patients and create a foundation for a therapeutic relationship. We implemented the program for two months and it consisted of educational poster, emails and a staff reference manual. The poster was used to educate staff on common terms used within the LGBTQ+ community (Table 1). The staff reference manual described in detail health disparities affecting this community such as risk of violence and psychological distress, terms and definitions commonly used within the community (Table 1), tips for communication with patients and families, and take home points.

Table 1: Common Terms and Adjectives used within the LGBTQ+ Community

Queer	Umbrella term used to describe people who think of their sexual orientation or gender identity as outside societal norms
Gender Identity	Person's internal sense of being male, female, both, neither or another gender
Gender Expression	The way a person acts, dresses, speaks and behaves
Sex Assigned at Birth (aka natal sex)	The anatomy present at birth (male, female or intersex)
Sexual Orientation	How a person characterizes their emotional and sexual attraction to others
Adjectives related to Sexual Orientation:	
Asexual	Describes a person who experiences little to no sexual attraction to others
Bisexual	Describes a person who is emotionally and sexually attracted to people of their own gender and other genders
Gay	Describes a person who is emotionally and sexually attracted to people of their own gender
Lesbian	Describes a woman who is emotionally and sexually attracted to other women
Pansexual	Describes a person who is emotionally and sexually attracted to people regardless of gender
Polyamorous	Describes a person who has or is open to having more than one romantic or sexual relationship at a time
Adjectives related to Gender Identity:	
Agender	Describes a person who identifies as having no gender
Cisgender	Describes a person whose gender identity and assigned sex at birth correspond
Gender Fluid	Describes a person whose gender identity is not fixed
Gender Non-Conforming	Describes a person whose gender expression differs from a given society's norms
Genderqueer/Nonbinary	Describes a person whose gender identity falls outside the traditional gender binary
Transgender	Describes a person whose gender identity and assigned sex at birth do not correspond

The reference manual described tips for talking with patients including strategies to discover a patient's identity and orientation while maintaining therapeutic rapport. These included not making assumptions based on a patient's appearance. Questions such as "What do you like to be called?" and "What pronouns do you use?" are important to understanding a patient's identity. Similarly, if a patient discloses their gender identity or sexual orientation, it is helpful to ask what that means to them, as some of the terminology can be interpreted in various ways. It is important to always ask clarifying questions, which can be as simple as "what does that mean for you?" in order to understand the patient's perspective. Open-ended questions are most effective in these conversations so the child can guide us to accurately understand their situation. Even the common question "do you have sex with men, women or both?" does not appreciate the various other gender identities someone's partner might have. Instead, an appropriate way to ask would be "what are the gender identities of the people you have sex with (or feel attracted to)?"

Key Questions:

What do you like to be called?

What pronouns do you use?

What does that mean for you?

What are the gender identities of the people you have sex with (or feel attracted to)?

Other strategies in the reference manual included understanding needs of transgender youth. Gender dysphoria is when an individual experiences discomfort or distress because there is a mismatch between their sex assigned at birth and their gender identity. To appropriately promote both the physical and mental health of these individuals, it is important to for health care staff to be educated and aware of the unique concerns of this population. For example, patients who are binding their chest should never sleep in or wear the binder longer than eight hours due to health risks. In the same way, for patients assigned male at birth who have gender dysphoria, it is important to know whether they are tucking their penis or engaging in other physically altering routines to, again, identify and care for related health risks. There are safe and medically-supported

ways to manage gender dysphoria, and we should be educating our patients and their families. We can also connect them to Nationwide Children's THRIVE, gender and sex development program for more resources.

Conversing with the parents or family members who are unaccepting of their child's identity can be difficult, and the manual has strategies for this. Interacting can be a challenging situation for staff because hospital policy is to provide a safe space for the child through supporting their identity. Thus, it is one of the few times where providing patient-centered care appears to conflict with providing family-centered care. In conversations with only the parents or legal guardians, you may use the name and pronouns the parents are comfortable with, but if the child is present, we must use the affirming name and pronouns the child uses. This communication is essential to protect the mental health of the patient and to respect the patient who has already disclosed their identity to family. For parents that do not accept their child's identity, educational materials and resources are available through THRIVE. If a patient has not disclosed their identity to their family, we, as advocates, should not do so without the consent of the patient to ensure maintenance of the patient's confidentiality as well as their long-term safety should the family not be supportive.

Take home points for staff to remember and carry out in their practice were also included with the educational program and in the reference manual. These tips assist staff in navigating potentially challenging exchanges in communication and practicing excellence in building therapeutic environments for all of our patients (Figure 1).

Figure 1: Take-home points

Do NOT assume the identity of any patient

Always use affirming name and pronouns

Let the patient's needs direct our interactions and questions

Ask questions respectfully to learn which terms are appropriate to use with each and every patient and how they define those terms

Apologize if a mistake is made and when in doubt ask for help

The educational program was successful with staff. There were significant increases in comfort in caring for patients who are transgender and in talking with parents of patients who are LGBTQ+. Staff evaluated the intervention as very helpful and beneficial. They also had wonderful ideas about additional information topics they would like to learn about in the future.

When communication is the foundation of all interactions, it is paramount that all patients and families feel included. By developing strategies to communicate with patients and families we can truly provide care in an environment where Everyone Matters.

To learn more about the THRIVE program and find resources, visit **NationwideChildrens.org and search THRIVE**.

Parent Perspective: End of Life Communication

Nancy Noyes, MS, PPCNP-BC, PMHCNS-BC, APP Behavioral Health Manager, Fellowship
Director, Child & Adolescent Psychiatric Nurse Practitioner Post-Graduate Fellowship

We have all heard the term life can change in an instant, but little did I know how much this would personally impact my family until the afternoon of June 12, 2002. My 18-year-old son, Matthew, had just completed his first year of college. Two days prior to coming home, he called to tell me that he was experiencing double vision and ringing in his ears. As a former pediatric oncology nurse, it was both a curse and a blessing, because I knew this was not a good sign. As I saw him get off the plane, both my nursing and mother's intuition told me that it was time to worry. The next day he was diagnosed with a brain tumor called Anaplastic Astrocytoma. This began his long six-year journey and battle with cancer.

As both a Psychiatric Nurse Practitioner and parent who has lost a child, I am often asked the most helpful as well as hurtful things that were said to me and my family during those last few days and hours of his precious life. Although most health care professionals have good intent, I would like to share some of these in the hope that it will either reinforce or perhaps change your communication with parents who are in so much pain and feel such helplessness. After all, parents are supposed to protect their children and yet, despite all attempts, my husband and I could not.

Although we were grateful that those caring for Matt had such kindness and empathy, unless you have gone through this experience, you cannot begin to understand what we are feeling. Please avoid saying that you know how the parent feels. Most parents would also tell you they would never want anyone to experience this degree of pain. Acknowledging that you cannot understand how they feel but that you are there to listen, support and comfort is the most effective way to communicate your concern.

At times, as health care providers, we have "agendas" for what we think has to be accomplished prior to a child's death. However, it is best to meet the parents where they are and not impose our values or decide what steps they need to make in the moment. Listen to parents and validate their feelings, wishes or concerns even if they differ from your own. Parents are often asked, "What do you need?" I can tell you from personal experience I was so overwhelmed I could not think or begin to communicate what I needed. Offering to call other family members, helping to arrange the transportation to the funeral home and any other things the family may have previously identified as being helpful once the child passes is very comforting for parents.

Allow parents time to grieve their own way. Often, when parents cry or scream at the time of death, staff feel their own discomfort and want to attempt to quiet the families or take them to another room. This type of communication often makes families feel as if they are being rushed, their child was not valued or it is not OK to express grief openly. Parents want to be with their child at the time of death. It is essential that staff come up with a plan for other children and families who may be in close proximity that will allow for this privacy.

Other helpful communication when Matt died included those staff members who did not necessarily speak but just sat with us, often in silence for several minutes. Staff told us Matthew would always be remembered and that what they learned from him would help another child. Although painful, this gave us a sense that our child's experience had meaning.

It is important not to equate a child's death with that of a loved pet, elderly parent or grandparent. Although all of these are terrible losses, there is no loss as difficult as that of a child. Dr. Alan Wolfett, an expert in grief, often reminds us that it is important to remember that grief is a life-long journey and that no one "gets over it and moves on," it just becomes more bearable.

Healthy Communication to Decrease Caregiver Distress

Alice Bass, MSN, RN, CPNP, APRN, Advanced Illness Management (AIM) Team, Palliative Care

The experience of having a child hospitalized can be extremely distressing for parents and caregivers. Not only is there the stress of seeing a loved one so vulnerable, but also feelings of helplessness in an often unfamiliar environment. In addition, caregivers have to continue to manage life and family outside of the hospital and are therefore at high risk for burnout. Because supporting the caregiver can directly impact patient outcomes, it is important to make strong efforts to minimize distress when possible. Often this can be done by providing excellent care to the patient, and improving or maintaining strong communication between providers and caregivers as deficits in the latter can contribute significantly to caregiver distress.

Healthy communication starts with the invitation and commitment to partner with the caregiver, establishing trust and rapport. This foundation allows caregivers to feel comfortable accepting support, information and anticipatory guidance. This can promote effective coping and ease some of the inherent stress over circumstances that are already out of their control. Communication consists of what is being communicated as well as how. Here are some things that can be done to maximize effective and positive communication:

The "What"

- **Awareness:** Becoming aware of each other's primary concerns and goals at the start of a discussion sets the stage for successful communication. The first step often missed is listening. It may be important to ask first, "How do you think [name] is doing today?", "What questions do you have?", or "What is your understanding of the current plan of care?" Identifying and addressing what may be most distressing for the caregiver paves the way for improved communication and provides peace of mind.

- **Clarity:** Relaying information directly and seeking clarification on both sides shows a desire to understand the caregiver's perspective. It is also important to ensure that all treatment team members are relaying a similar message to minimize confusion regarding the plan of care.

- **Honesty:** Studies have shown that while some parents seek limited information, most would like to know more about their loved one's illness as it helps them to better cope, regain some control and ease uncertainty.

The "How"

- **Tone:** A warm, empathetic tone that does not appear rushed will promote discussion, allowing caregivers to feel they can express their questions and concerns.

- **Language:** This includes verbal and nonverbal language. Using terms that are best understood by the caregiver and being conscious of your posture (i.e. taking a seat versus standing), facial expressions and eye contact can aide communication.

- **Sensitivity:** It is important to consider every family's journey is unique and shaped by past experiences as well as culture, spirituality and values. Caregiver trust increases when information is delivered in ways that are aligned with the preferred style of communication. For instance, some families may appreciate numbers and details, while others prefer discussions about the "big picture." Additionally, you may find some caregivers choose not to burden the patient with information versus wanting them to be included in all decision-making.

Patient and Family Centered Care is at the heart of excellent patient care, particularly in pediatrics. In order to successfully partner with parents we must ensure that communication is effective. Allowing families to express their concerns in an open manner can invite further discussion, promote collaboration, and increase adherence to both education and instruction for the caregiver and child. Utilizing healthy communication strategies when working with families not only positively impacts our patients, but also improves caregiver distress in an already stressful situation.

Every Word Matters: Video Interpreting as One Critical Communication Tool

Jeanette Foster, MSW, LISW-S, Director of Social Work & Language Access Services
Valerie Huang, MA, CHI, Manager of Language Services

"A hospital must embed effective communication, cultural competence, and patient- and family-centered care practices into the core activities of its system of care delivery — not considering them stand-alone initiatives — to truly meet the needs of the patients, families, and communities served."

– Joint Commission, 2010

In the past year, Interpreter Services has supported more than 99 different spoken languages as the preferred language by the parent and/or patients seeking care at Nationwide Children's Hospital. The top five languages, in order of representation among spoken languages, are Spanish, Somali, Nepali, Arabic and American Sign Language (ASL). 2018 requests for interpretation are up 18 percent over those in 2017, and the rates of requests have consistently grown over the past dozen years.

IN 2017, INTERPRETER SERVICES AT NATIONWIDE CHILDREN'S SUPPORTED MORE THAN

99 SPOKEN LANGUAGES

The three primary tools for interpretation (spoken word or signing) consist of in-person, video and phone interpreting. Though all three have a place and are complementary services, Video interpreting is the focus of this article. Video interpreting at Nationwide Children's is conducted using an iPad on a portable stand. The user logs in through an app in order to access video interpreters in more than 29 languages. Video interpreters are an important tool. It allows the remote interpreter, via live video, to see the parties and the expressions of the speakers, and the speakers can see the interpreter. In addition, audio-only interpreters are available via iPad and provide more than 200 languages. This is especially helpful when phones are not easily available, as the same portable stand may be wheeled into any area with wireless access.
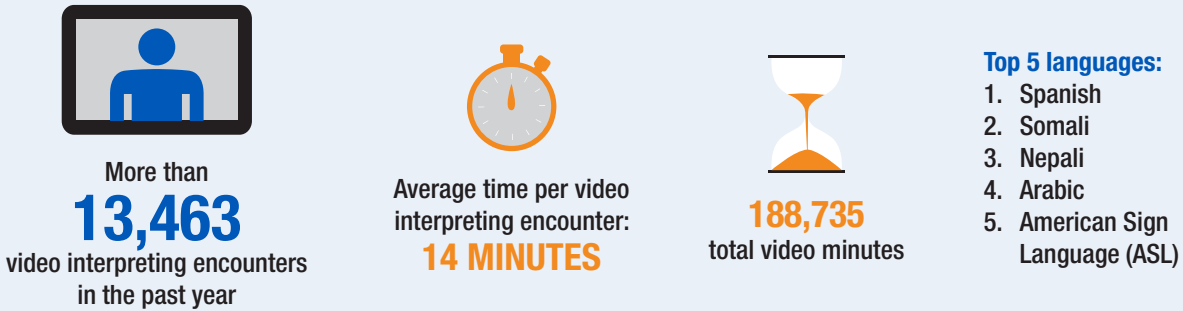
Video interpreting is most appropriate when:

- A qualified interpreter is not available in-person (including when waiting for interpreter to arrive so that care is not delayed).
- There is an immediate need and no interpreter is available (i.e. Emergency Department, Urgent Care, other crisis situations).
- Start/stop times are uncertain within a wide window (such as patient centered rounds).
- The total interpreting time is less than 20 minutes.
- Communication is not complex.
- The patient and family prefer not to involve a local (in person) interpreter in a private matter.

Less appropriate for video interpreting and more suited for in-person interpreting are:

- Situations involving high interactivity, such as multiple participants.
- Situations which are highly emotionally charged.
- Situations with complex dialogue.
- Scheduled outpatient encounters with dense communication.

Video Interpreting at Nationwide Children's

More than
13,463
video interpreting encounters in the past year

Average time per video interpreting encounter:
14 MINUTES

188,735
total video minutes

Top 5 languages:
1. Spanish
2. Somali
3. Nepali
4. Arabic
5. American Sign Language (ASL)

Phone interpreting should be used with simple, brief communication such as scheduling of appointments, registration activities to confirm demographics and contact information, and intermittent simple conversations, or when the language is only available via phone vendors.

- There were more than 13,463 video interpreting encounters in the past year at Nationwide Children's.
- The average time per encounter in video interpreting is 14 minutes, with 188,735 total video minutes.

The National Culturally and Linguistically Appropriate Services (CLAS) Standard in Health and Health Care "which are intended to advance health equity, improve quality and help eliminate health care disparities by establishing a blueprint for health and health care organizations." (U.S. Dept of HHS, Office of Minority Health)

The principal standard indicates that the blueprint will be responsive to "diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs." Consistent with the strategic goals of Nationwide Children's and the focus on communication as central to quality and safety, Interpreter Services ensure that we are using only competent, trained resources for interpretation – including video.

We know that patients who cannot discuss their health care needs in the same language as their medical providers tend to have poorer health outcomes. The quality of video interpreting continues to improve. With improvement and a commitment by health care professionals to use the tool appropriately, we can continue to work together to reduce disparities, improve relationships, promote greater mutual respect and achieve Best Outcomes.

Staff can find more about Interpreter Services on their ANCHOR page
http://anchor.columbuschildrens.net/interpreter-services

Meaningful Best Practice Alerts in the Electronic Medical Record

Jessica Hehmeyer, MHA

Manjusri Nguyen, MBA, RHIA, IS Epic Clinical Informatics

Nationwide Children's Hospital has a long history of using Best Practice Alerts (BPA) within Epic™ to make end-users aware of safety concerns, missing documentation or even routine health maintenance screenings. Alerting has many faces and may present as a pop-up when you open the patient chart, enter/sign orders, or simply appear in a navigator section of the end-users clinical workspace. Alerting sounds great, right? In theory, yes, alerting is a valuable tool that can improve patient care. However, too much alerting can have the opposite effect.

Alert fatigue is a term used to describe situations in which end-users become desensitized to the alerts that are intended to improve patient care. When end-users become desensitized to alerts, they often do whatever it takes to dismiss the alert without actually completing the recommended action. We define intrusive alerts as any alert that pops up or disrupts a user's workflow. In a 30-day period, 50,226 intrusive alerts are fired to our end-users, however; almost 70 percent of these alerts were ignored without the recommended action being completed. This data showed we needed to re-evaluate how and when we were interrupting workflows.

50,226
INTRUSIVE ALERTS

(in a 30-day period)

70%
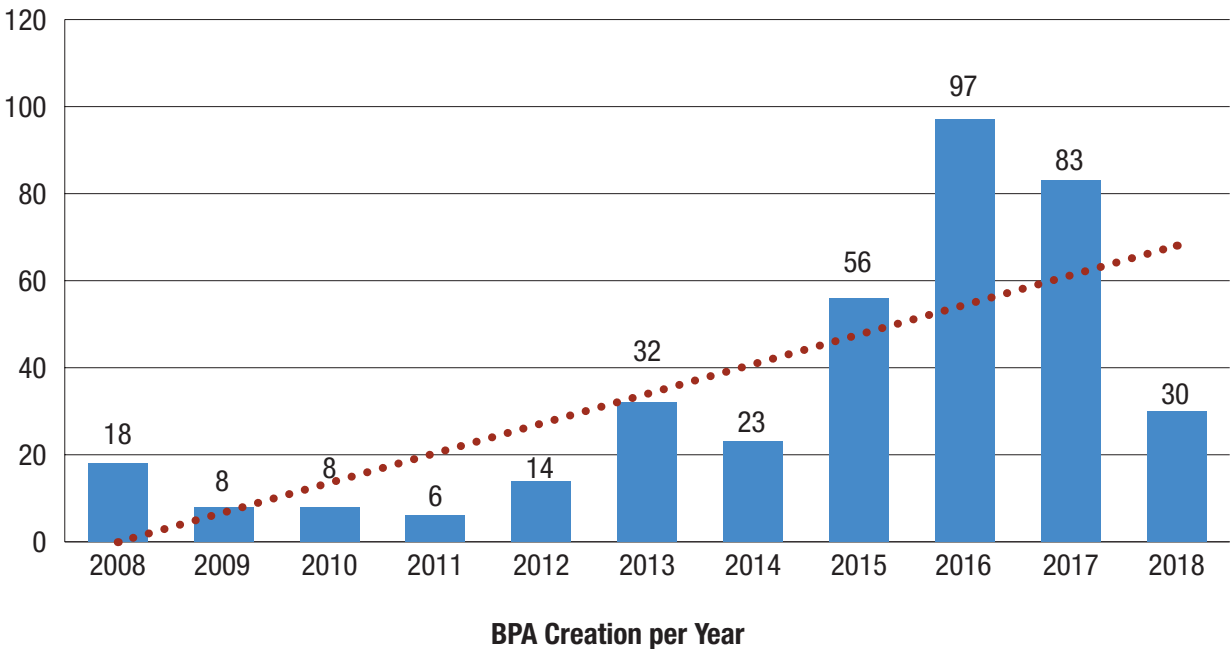of the alerts were ignored
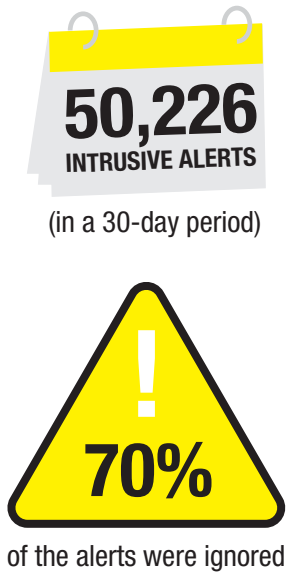
How did we get here?

In 2005, Nationwide Children's began the process of implementing Epic across the organization. At that time, little alerting functionality existed. As Epic improved and evolved over the years, the ability to program the system to alert end-users improved significantly. Suddenly, alerting was a great solution to many problems. Safety issues, meaningful use requirements and incomplete documentation became alerts. Standard documentation even became alerts at times. BPA implementation has increased significantly. For example, 97 alerts were implemented in 2016, in comparison to the eight alerts that were implemented in Epic in 2009.

8 Alerts in 2009

97 Alerts in 2016

What is Nationwide Children's doing to make alerting more impactful in Epic?

Without a doubt, alert fatigue is an issue. In early 2017, Epic Clinical Informatics dedicated resources to begin looking at the impact of BPAs on end-users. Immediately, the team identified that there was room for improvement and innovation to make end-users happier with the alerts they receive. As BPA logic became more sophisticated, so did the team. By taking the knowledge gained from multiple successful clinical implementations, numerous Nationwide Children's customized Epic builds, and help from our clinical staff, we made several modifications to existing processes to help reduce organizational alert fatigue.

Total BPA Creation

BPA Creation per Year

Year	Value
2008	18
2009	8
2010	8
2011	6
2012	14
2013	32
2014	23
2015	56
2016	97
2017	83
2018	30

Impactful Alerts

- All new BPA builds require the completion of an intake form. The form provides transparency regarding BPA rationale and expectations.
- Very specific and standard build specifications were developed.
- Graphics included when applicable and appropriate (e.g. Suspect Sepsis graphic).
- BPAs in new text formatting that clearly states what action the end-user should consider completing.
- Real-time reporting was created to monitor frequency of alerting.
- All modification requests require complete review using new standards.
- All alerting should respect the five rights of clinical decision support: presented to the correct person, at the correct time in the workflow, with useful information, correct format (e.g. BPA), and correct place (e.g. Epic).

By creating advance reporting logic from Epic data, the team has also been systematically reviewing alerts in real-time. Beginning with the alerts that fire most frequently, the above standards are being used to retire and refuel BPAs. End-users should now notice a decrease in the number of disruptive and flawed alerts. As the workgroup continues to tackle alert fatigue, the goal is not to completely eliminate alerts, but to instead present useful, well-timed alerts.

Social Media in Health Care Communications

Diane Lang, Sr. Account Manager, Social Media

Recently, during New Employee Orientation, I asked a group of new hires to raise their hands if they had used some form of social media in the last 24 hours. Every one of them put an arm in the air. It seems the question is no longer if you use social media, but how. As an organization, we use social media to share content with consumers and peers to further our reputation, raise awareness and drive revenue growth. As individuals, our staff acts as advocates to spread these same messages. By utilizing a number of different platforms like blog posts, videos, and innovative tools like infographics and Facebook Live™, we can collectively be a trusted resource for pediatric health care information online.

One of the easiest ways for us to make an impact online is with blog content. Curated by marketing and often crafted by clinicians or research writers, these 400 to 600 word posts can be shared across social media channels like Facebook™, Twitter™ and LinkedIn™. The content can vary from consumer-facing pieces on how to treat common conditions to complex, peer-focused scientific posts. Nationwide Children's Hospital blogs like 700 Children's and Pediatrics Nationwide reach millions of Internet users all over the world and have led to media opportunities and speaking engagements for clinicians. Additionally, LinkedIn provides a platform for long-form posts and offers an opportunity for individuals to share their thoughts on hospital matters. Nationwide Children's CEO, Dr. Steve Allen, is a prime example of a thought leader in the LinkedIn space. His posts about research, the hospital's safety efforts and population health have reached thousands of LinkedIn users. Blog writing can position our staff as experts in the eyes of many readers.

If users do not want to take the time to read a blog post, we do know exactly how to get their attention – video! Nationwide Children's creates video content to promote revenue-generating campaigns, share physician biographies, patient stories, and even show patient families how to use medical equipment or what to expect when they visit the hospital. Video content is informational, creative and users flock to it. YouTube™ now has more than one billion users who watch a billion hours of video each day and they are not the only player in the video arena. Videos shared on Twitter are six times more likely to be reshared and Facebook boosts a whopping average of more than eight billion video views per day. As social media continues to evolve, so does our use of video technology. Nationwide Children's social media team utilizes newer video platforms like Instagram™ for short clips and Facebook Live to livestream video content that allows users to interact and ask questions of our experts in real time.
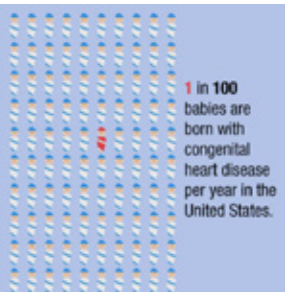
While video creates the highest engagement rates on social media, photography and attention-grabbing graphics also play a key role. Infographics are ideal for sharing a snippet of data in a compelling way. Visually appealing, easily digestible and abundantly shared, they are an excellent medium for raising awareness of conditions, as well as our brand and services. In a marketing field where user engagement is an important metric, social media posts with photos or graphics are crucial; they are ten times more likely to get a click, comment, like or share.

Social media is an efficient way to garner many eyes on hospital content and through a workforce curriculum established in 2016, the social media team at Nationwide Children's has trained more than 8,000 staff members on best practices in the space. Together, we are amplifying hospital news in every area. Our combined efforts have led to international referrals, new connections, collaboration with colleagues and agencies, community activation and stewardship for our corporate partners. Through professional and compliant use, social media continues to help us reach people all over the world as we work toward our vision to deliver the best health care for children.

Challenging Authority Gradient: How Assertive Communication Can Prevent Patient Errors

Kenny Hoffman, MS, BSN, RN, CEN, Paramedic Program Manager, ECC and PBX
Vicki von Sadovszky, PhD, RN, FAAN

According to The Joint Commission, nearly 70 percent of reported sentinel events are a result of communication failure. In 2013, The Institute for Safe Medication Practices reported more than 70 percent of multi-disciplinary respondents experienced communication failures in the past year, attributable to unsafe outcomes and errors in patient care. One underlying reason to explain these communication failures is authority gradient. A term first used in aviation, authority gradient is the lack of communication or appropriate action in teams of individuals with differing seniority, expertise, experience or professional stature. It is most commonly exhibited when a staff member or crew member is hesitant to speak up about concerns or errors due to actual or perceived experience or authority differences. This hesitancy led to several catastrophic aviation errors, including two airliners colliding in Tenerife in 1977 in which 583 people died, as well as engineers not coming forth about issues with "O" rings that ultimately led to the Space Shuttle Challenger disaster.

Authority gradient is a phenomenon common to the health care setting as well. A few studies have explicated the effects of authority gradient and its role in medication errors. This is especially the case when the senior team leader has influence over the career advancement of others within the team. In one case study, a child's death was ultimately attributed to a lack of communication and poor relationships between medical residents and an attending physician due to the residents' fear of challenging an order. In a descriptive study, attending physicians were challenged only 28 percent of the time by residents when there was a concern with an order. The reasons cited most often for not challenging an order was questioning one's knowledge compared to the attending, and deferring to the attending as an authority. In a study performed here at Nationwide Children's Hospital, reasons attributed to following wrong orders in simulation were similar among nurses (e.g., assumption that the person in charge is right, inexperience and uncertainty of one's knowledge), even though the nurses had accurate knowledge about dosages and techniques in the simulation. Hence, authority gradient is an important factor in communication and patient errors.

The good news is there are measures to prevent authority gradient from becoming an issue in patient safety. Simulation exercises can increase assertiveness and reduce authority gradient in actual emergent simulations. Our Zero Hero communication techniques such as SBAR (situation, background, assessment, recommendation), supporting a questioning attitude by stop and resolve (not proceeding in the face of uncertainty) and ARCC (ask a question, request a change, voice a concern, use the chain of command) are useful techniques in assertive communication and reducing patient errors.

EXAM ROOM

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In Recognition

Presentations

Halpin, B., Batterson, N.: "Treating the Complex Picky Eater: Occupational and Behavioral Strategies for Success," April 2018

Tanner, K., Bassi, M., Martin, K., Koss Schmidt, L.: "Systematic Review on Occupational Therapy for Children and Youth (Age 0-5 Years)," April 2018

Coleman, S., Colman, J., Weaver, L.: "An Occupation-Based Approach To Promoting Physical and Mental Health Among Youth With Eating Disorders," April 2018

Tonneman, J., Tanner, K.: "The Clinical Experience of Multiple Episodes of Constraint Induced Movement Therapy for Kids," April 2018

Boop, C., Tanner, K.: "A Review of AOTA Children and Youth Activities and Resources," April 2018

White, K., Lathem, L.: "Life in the ER: Acute Response to Child Physical and Sexual Abuse," Ohio Attorney General's Two Days In May, May 2018

Hall, K., Keys, C., Schroedl, R.: "The Resilient Family," Pull-Thru Network National Conference, July 2018

Hall, K.: "Wake Me Up When My Wound Vac Ends: A Case Study of Ongoing Assessments and Collaboration," Annual Association of Child Life Professionals Conference, May 2018

Moore, L.: "What is Bowel Management?" and "How to Make Long Distance Care Work," Pull Through Network National Conference, July 2018

Booth, K.: "Sacral Nerve Stimulation in the Pediatric Colorectal Patient," Pull Through Network National Conference, July 2018

Shann, E.: "Laxatives, Enemas & Perestein in the Pediatric Colorectal Patient," Pull Through Network National Conference, July 2018

Fisher, M.: "A Nurses Guide to a Standardized Intake Document," American Academy of Ambulatory Nursing Care 42nd Annual Conference (AAACN), May 2018

Chaves, E., Eneli, I.: "Severe Obesity in Preschoolers: Medical and Psychological Characteristics and Interventions," Pediatric Academic Societies, May 2018

McNally, K., Simpson, T.: "Persistent Symptoms after Pediatric Concussion: Contributing Factors and a Cognitive Behavioral Approach to Intervention," 16th Annual Conference and Workshops of the American Academy of Clinical Neuropsychology (AACN), June 2018

Cass, J.: "Quality Improvement: An Introduction," 16th Annual Conference and Workshops of the American Academy of Clinical Neuropsychology (AACN), June 2018

Wrona, S., Hull, D.: "Athletic Trainers Role in the Opioid Crisis," Ohio Athletic Trainer Association Conference, May 2018

Wrona, S., Sebastian, S.: "A Quality Improvement Approach to Reduce Opioids Prescribed at a Pediatric Institution and Improve Opioid Safety Education," Ohio's 2018 Opiate Conference: Strengthening Ohio's Communities, June 2018

Wrona, S., Humphrey, L.: "The Opioid Crisis: Family and Caregiver Risk Assessment and How to Respond to Them," Ohio Council for Home Care and Hospice –Webinar, June 2018

Wrona, S.: "Chronic Pain in Patients with Sickle Cell Disease," National Medical Association Conference, August 2018

Worthington, D.: "Connecting Statewide Nursing Informatics Leaders," Epic User Group Meeting, August 2018

Hall, C., Madhoun, L., Cummings, C., Eastman, K.: "Building a Multidisciplinary Feeding Team for Your Cleft Lip and Palate Program," American Cleft Palate Craniofacial Association Annual Meeting, April 2018

Madhoun, L.: "A National Survey of Breastmilk Feeding Practices in Infants with Cleft Lip and/or Palate," American Cleft Palate Craniofacial Association Annual Meeting, April 2018

Martin, J., DeNiro, R.: "Common Speech and Language Disorders," Nationwide Children's Hospital Pediatric Residency Training Program, May 2018

Miller, T.: "Unconscious Bias In Therapeutic Recreation," Utah Recreational Therapy and University of Toledo Recreational Therapy Conference, April 2018

Gonzales, A.: "DDAVP vs. Exercise in Mild Hemophilia," 2018 Ohio Hemophilia Treatment Center (HTC) Staff Meeting for Nurses and Social Workers, April 2018

Adams, K.: "Occupational Therapy and Speech Therapy Collaboration: Management of Seating and Positioning in Order to Access Communication," American Occupational Therapy Association Annual Conference, April 2018

Koss Schmidt, L.: "OT: A Solution for Safe Sexual Practices for Individuals with Intellectual and Developmental Disabilities," American Occupational Therapy Association Annual Conference, April 2018

Boop, C.: "Using American Occupational Therapy Association's Official Documents for Advancing Knowledge and Professional Advocacy," American Occupational Therapy Association Annual Conference, April 2018

Johnson, M.: The Young Adult Inflammatory Bowel Disease Conference: Transitions of Care Conference, May 2018

Minot, G.: "Transition in the Workplace: Best Practices for Clinicians in Direct Practice," NASQ National Conference, June 2018

Snow, T., Maxwell, K.: "Stars Come Out at Night: Implementing a Night Shift-Friendly Committee," Magnet Conference Nationwide Children's Hospital, October 2018

Whiting, C.: "How to Build a Better SPC: Insights and Lessons from Personal Experience," Annual Conference for the International Association of Healthcare Central Service Materials Management, April 2018

Quitar, K., Wirthman, B.: "Got Teens? Year Round Teen Volunteer Program," Society for Healthcare Volunteer Leaders (SHVL), National Conference, April 2018

Buck, M., Furru R.: "Transitioning Your Teenager to Young Adulthood," PediaCast CME Episode 402, April 2018

Mould, L., Keels-Lowe, V.: "The Therapeutic Benefits of Sensory Rooms on Disability Populations," The University of Toledo Recreational Therapy Club Conference, April 2018

Mould, L., Schlagbaum, P.: "Addressing Adolescent Suicide: Research Implications for TR Intervention," The University of Toledo Recreational Therapy Club Conference, April 2018

Goettee, C., Borda, J.: "Treating Breathing Dysfunction," APTA NEXT Conference, June 2018

Mansfield, C., Galleher, M., Griffith, S.: "A Fish Out of Water," APTA NEXT Conference, June 2018

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Publications

Baumann, E., Rice, W., Selhorst, M.: "Rehabilitation Considerations for an Uncommon Injury of the Knee: A Case Report Publication," *International Journal of Sports Physical Therapy,* June 2018

Vilanova-Sanchez, G., Gasior, AC., Toocheck, N., Weaver L., Wood R., Reck C.A., Wagner A., Hoover E., Gagnon R., Jaggers J., Maloof, T., Nash O., Williams C., Levitt, M.A.: "Are Senna Based Laxatives Safe When Used as Long Term Treatment for Constipation in Children?" *Journal of Pediatric Surgery,* April 2018

Vilanova-Sanchez, A., Halleran, D., Reck-Burneo, C., Gasior, A., Weaver, L., Fisher, M., Wagner, A., Nash, O., Booth, K., Peters, K., Williams, C., Mayer Brown, S., Lu, P., Fuchs, M., Diefenbach, K., Leonard, J., Hewitt, G., McCracken, K., Di Lorenzo, C., Wood, R., Levitt, M.: "A Descriptive Model for a Multidisciplinary Unit for Colorectal and Pelvic Malformations," *Journal of Pediatric Surgery,* April 2018

Baylis, A., Person, G. D., Hall, C., Madhoun, L.L., Cummings, C., Neal, N., Smith, A., Eastman, K., Stocker, C., & Kirschner, R.E.: "A Quality Improvement Initiative to Improve Feeding and Growth of Infants with Cleft Lip and/or Palate," *The Cleft Palate-Craniofacial Journal,* April 2018

Crerand, C., Kapa, H.M., Litteral, J., Person, G., Eastman, K, & Kirschner, R.: "Identifying Psychosocial Risk Factors Among Families of Children With Craniofacial Conditions: Validation of the Psychosocial Assessment Tool-Craniofacial Version," *The Cleft Palate-Craniofacial Journal,* April 2018

Patton, R., Sims, M., Ryan-Wenger, N., Williamson, J.: "Selection of the Most Accurate Thermometer Devices for Clinical Practice: Part 1: Meta-Analysis of the Accuracy of Non-Core Thermometer Devices Compared to Core Body Temperature," Pediatric Nursing, May/June 2018

Patton, R., Sims, M., Ryan-Wenger, N., Williamson, J.: "Selection of the Most Accurate Thermometer Devices for Clinical Practice: Part 2: Nursing Practice and Policy Change in the Use of Non-Core Thermometer Devices," *Pediatric Nurses,* May/June 2018

Berry, K.: "Evidence-Based Management of In-Toeing in Children Publication," *Clinical Pediatrics,* April 2018

Selhorst, M., Rice, W., Degenhart, T., Jackowski, M., Coffman, S.: "A Sequential Cognitive and Physical Approach (SCOPA) for Patellofemoral Pain: A Randomized Controlled Trial in Adolescent Patients," *Clinical Rehabilitation,* July 2018

Dastgheyb, S., Fishlock, K., Daskalakis, C., Kessel, J., Rosen P.: "Evaluating Comfort Measures for Commonly Performed Painful Procedures in Pediatric Patients," *Journal of Pain,* July 2018

Tumin,D., Drees, D., Miller, R., Wrona, S., Hayes, D. Jr., Tobias, J.D., Bhalla, T.: "Health Care Utilization and Costs Associated With Pediatric Chronic Pain," *Journal of Pain,* April 2018

Nationwide Children's Hospital
700 Children's Drive
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Daisy Award

Miranda Johnson, RN, BSN

The 23rd Annual Nationwide Children's Hospital Daisy Award was presented to Miranda Johnson, RN, BSN of the Emergency Department. The Daisy Award is given in appreciation of the important difference our nurses make in the lives of our patients and families.

Miranda was nominated by a co-worker who commended her use of Zero Hero and clinical assessment skills. "Miranda voiced concerns about recommended care for a patient due to the patient's decreased level of consciousness and unstable vital signs," says Kelli Burkey. "She was met with resistance and incivility. She stood her ground. … She continued to use tools such as ARCC, QVV and stop/resolve.

Her dedication to do the right thing resulted in both the attending surgeon and surgery fellow assessing the patient in the ED. Miranda was also recognized by ED leadership for her outstanding dedication to patient safety."

To learn more about our Daisy winners, and read their full nomination, visit **NationwideChildrens.org/Daisy-Award**