

Poster: 01  
Title: Fragile Bones Initiative  
Category: Clinical  
Author: Heidi Beris, BSN, RN, CPN  
Co-Author: Arnetta Woodson, RN, MBA

In January of 2010 a patient admitted to the Children’s Hospital of Philadelphia sustained a fracture while under the care of the assigned inpatient team. A root cause analysis was performed, and the need to address the issue of inpatient fractures became clear. Two months later, work group was established and began meeting regularly to develop standard guidance, related supports and an education plan that would promote safe care of children with fragile bones.

By November 2010, the committee had received approval from the Clinical Care Committee to pioneer hospital-wide efforts to reduce fractures. This included the addition of a procedure to the patient care manual, the distribution of job aid and subsequent addendum for nursing staff, production of bedside signs and chart stickers, and the development of a patient family education document.

Hospital-wide education is currently ongoing at many levels. Plans are in place to utilize the institution-wide electronic education system, LearningLink, to reach every employee who comes in contact with patients in all areas of the hospital system. An educational video will be produced in the near future, and will be made accessible to all employees via the Children’s Hospital of Philadelphia intranet.

Given the limitations of the current literature, benchmarking data will be sought by use of a nation-wide survey. Committee members are seeking opportunities to create awareness and engage more health professionals in addressing this issue of patient safety.

Poster: 02      Withdrawn  
:

Poster: 03  
Title: Validation of a Pediatric Opioid/Benzodiazepine Weaning Tool  
Category: Research  
Author: Sandra Como-Fluehr, RN, MSN, APRN-BC

Purpose: To obtain psychometric data on the Pediatric Opioid/Benzodiazepine Weaning Tool (POBWT), a pediatric tool developed to identify and quantify signs of withdrawal.

Methods: A content validity study was conducted to provide constructive feedback about the quality the tool. A definition list was devised and a panel of experts reviewed each item in the tool. A four-point scale was used to determine if each item should be retained or discarded. A Content Validity Index (CVI) was determined on the remaining items. Items that did not achieve the required minimum agreement to obtain acceptable content validity were revised or eliminated. The POBWT was modified and eight items were eliminated. The same experts were asked to reassess the modified POBWT, using the same rating scale as the initial assessment.

Conclusions: The overall Content Validity Index (CVI) of the modified tool was 0.85. The CVI for individual symptom parameters ranged from 0.6 to 1. The panel was in agreement as far as the clarity of each item on the POBWT.

Poster: 04  
Title: A Unit Based Voyage to Decrease CLA-BSI Rates  
Category: Clinical  
Author: Marybeth Vidunas, RN, MSN  
Co-Author: Erica Robinson, RN, BSN

In January 2011, the state of Maryland would require mandatory reporting of central line-associated bloodstream infections (CLA-BSI) to the CDC's National Healthcare Safety Network (NHSN). Our Department of Pediatrics BSI Committee was concerned because our infant/toddler unit had the highest CLA-BSI rate in the hospital. Although, our institution utilizes a Vascular Access Team, which performs the central line dressing changes, the staff nurses are responsible for all central line maintenance and blood draws. Central line education developed by the department nurse educator had been provided to all pediatric units within the last six months. The infant/toddler unit's staff education committee identified that they would need to re-educate their nurses with information specific to their unit. A central line education plan was created, which included an educational theme each week for four consecutive weeks. The topics were selected based on the original "Be A Line Saver" campaign that was developed departmentally, but modified for their patient population. The educational design included; "fast facts" sheets, case studies, posters and powerpoint presentations. The information was posted in the conference room and communicated in person and by email. As a result of the education and the nursing unit's "ownership" of the problem, the unit went from a CLA-BSI rate of 5.61/1,000 central line days to 0/1,000 central line days for the past 25 weeks.

Poster: 05  
Title: Cultural competency in feeding  
Category: Clinical  
Author: Valerie McCormick, MSN, CRNP  
Co-Author: Goldie Markowitz, MSN, CRNP

In an effort to better meet the needs of the growing diverse populations within the Feeding and Swallowing Center, we sought to examine the staff's knowledge base on culture. An educational gap had been identified surrounding cultural awareness, and a self-learning module was developed to address areas in which we felt the team might benefit from support in order to help increase cultural awareness. We utilized a self learning module as the educational tool. The goal of the self learning module was to provide education regarding various cultural feeding practices and how it impacts on the care we provide. Improving cultural awareness is the first step towards becoming more culturally sensitive. We identified the CHOP intranet site on cultural sensitivity as best practice, and utilized its principles within the self learning module to help identify our practice. A posttest was provided to assess the staff's knowledge, and a separate evaluation of the process was obtained. The staff did well on the posttest and felt the self learning module was a valuable learning tool. In the near future, a family survey will be added to determine if our team is perceived as culturally sensitive. In utilizing a culturally sensitive approach, we hope to enhance effective communication amongst our team and with the families, in order to enhance the family centered care we provide. The approach to improving cultural awareness can be duplicated in a number of settings, including inpatient and outpatient.

Poster: 06  
Title: The Self Care of Nurses  
Category: Clinical  
Author: Jill Connolly, RN,BN:

Purpose of the Project: The purpose of this project was to observe nurses attitudes to stress and burnout. A self-care program was implemented to assist nurses in their self care and Healing Touch was an integral part of the program. Nurses' perceptions of their self care needs were assessed prior to education and prior to the establishment of the self care project.

Searchable Question: What are Nurses' perceptions of their own stress level and the need for Self Care?

The hypotheses for the study were that nurses' perceptions about stress and the need for self care become positive after education and the implementation of a self care program.

Literature Review: New research on Burnout, nursing stressors and the need for self care is constantly becoming available.

Key Terms used: Burnout, Stress in Nurses, Self care, Healing Touch.

Search bases: COCHRANE, CINAHL, MEDLINE, GOOGLE SCHOLAR.

Conclusions: Self-Care of the nurse is a concept that is integral to the development of the nurse. To be able to care and be of service to the patients the nurse must take care of themselves in body, mind and spirit.

Nurse burnout is becoming more prevalent as the nurse workloads increase and Healthcare consumers rank this as a major threat to patient safety. The nurse cannot continually give to others without rejuvenating themselves or they become less effective in their caring role.

An assessment was conducted to observe nurses attitudes to stress and a self-care project was implemented with an emphasis on Healing Touch for nurses.

Poster: 07  
Title: CPR in the NICU for all Families  
Category: Research  
Author: Chantel Murray, RN, MSN, MBA

Purpose of the Project: The purpose of this evidence-based nursing practice project is to improve the comfort of parents and significant others (SOs) of Alfred I duPont Hospital for Children NICU patients and increase the safety of these infants at home by teaching parents and SOs CPR prior to the infants' discharge. Significant others include other family members and close friends who expect to care for the infant at home and ask for CPR training. In order to move forward with this quality improvement change we hypothesized that there is an increase in feelings of safety and comfort in parents and SOs of NICU infants when parents and family receive CPR training prior to discharge compared to those who do not. We put the hypothesis in a PICO format to guide a review of relevant literature.

Review of Current Practice: Based on a retrospective review of data from April 2009 to April 2010, about 37 families out of 102 infants discharged from the NICU at Al duPont Children's Hospital received training in the NICU based Friends and Family CPR Program. This represents only 37% of families. About 63% of families were sent home with no formal emergency training for their once critically ill and fragile infant.

Literature Review and Significance of the Problem: Using search engines like COCHRANE, CINAHL, MEDLINE, EBSCOHOST and the NANN Listserv we performed a literature review and obtained current information about this topic. The skill of CPR is especially important for parents, because breathing cessation, difficulty breathing, or blocked breathing is the primary cause of cardiac arrest in young children and infants" (Nadkarni, 2010). Many NICUs are not proactive in teaching CPR to all parents or families of these infants prior to discharge (Esignet@lists.nann.org, 2010). Rather, there are select criteria in every NICU that allow infants' families to receive CPR from certified BLS Instructors when ordered by the physician once those criteria are met (Sneath, 2009). However, other evidence shows that routinely teaching CPR to all parents is advisable prior to the infants' discharge from the hospital.

Proposed Practice Change: All parents and SOs (as designated by an infant's parents) of infants in the NICU will be taught CPR by certified CPR instructors prior to the discharge of an infant from the NICU.

Evaluation: To collect baseline data on parents' feelings of comfort and safety in taking their infants home in regard to an emergency, telephone-based surveys will be conducted for parents that received CPR and those that did not but had infants discharged from the NICU between August 11, 2010 and September 30, 2010. The structured interview schedule uses 7 Likert-type questions plus two yes/no questions and one open-ended question. This tool will be used again with the same method, approximately 12 weeks after an infant goes home following the implementation of the practice change. The data will be analyzed descriptively to determine if there has been a change in parental/SO perceptions of comfort and safety. If

positive changes occur, it will become policy to teach all parents/SOs CPR prior to an infant being discharged from the NICU. Current Status of Project: The project proposal was just reviewed by the IRB and determined not to be research. Baseline evaluation data collection began on November 29, 2010 and is ended by December 25, 2010. Data will be analyzed and summarized. The data and practice change proposal will be presented to the unit based leadership council for approval. The proposed practice of providing CPR for parents/SOs of all infants prior to discharge will be implemented. When at least 19 parents/SOs have received CPR instruction under the new guidelines, follow-up data will be collected. Results will be summarized and, if changes are positive, the new practice will become part of standard care in the NICU. Negative findings will result in additional problem-solving in order to provide the most comfort and perceptions of safety for parents/SOs of discharged infants in the future.

Poster: 08  
Title: Developing a Nitrous Oxide for Program for Pediatric Procedural Sedation  
Category: Clinical  
Author: Michelle Rhoads, MSN, APRN-BC  
Co-Authors: Keith Fishlock ,MSN, PCNS-BC & Kelly Sewell, RN, BSN

To many children, anxiety and fear of pain are foremost in their thoughts when going to the hospital. Our Day Medicine nursing team faced this reality daily while starting intravenous lines, placing urinary catheters, and assisting with other invasive procedures. We became aware of the use of nitrous oxide for treating pediatric procedural pain and anxiety, and developed a nitrous program as a team initiative. Nitrous, while similar to midazolam in its anxiolytic, sedative and amnestic properties, is also an analgesic, titratable, and non-allergenic. It works almost instantly upon inhalation, and rapid and complete recovery occurs within minutes of turning it off. Armed with this knowledge five staff members traveled to the Children's Hospital of Minnesota for a conference on the use of nitrous for pediatric sedation.

After attending this conference, we felt strongly that adequately trained nursing staff with appropriate multidisciplinary oversight could mitigate considerable discomfort and psychological distress that occurs with invasive procedures. We prepared a business plan, researched equipment systems, developed competency criteria, and chose a trial population of patients. The initial trial was a great success. We've since expanded its use, and improved the initial delivery system to allow nitrous use in patients who may not have cooperated with the original system.

Our high patient satisfaction scores reflect the effectiveness of nitrous oxide sedation. Its use has decreased patient/family anxiety, alleviated pain and discomfort associated with procedures, increased staff efficiency, and increased patient, family, and staff satisfaction while maintaining patient safety and quality procedural outcomes.

Poster: 09  
Title: Promoting Breastfeeding in the NICU Best Practice to Support Breastfeeding for Preterm & Term Infants  
Category: Clinical  
Author: Theresa D'Ambrosio, RN, BSN, CPN  
Co-Authors: Jennifer Davis, RN, CBC & Kimberly Bradley, RN, CBC

Human milk is the preferred form of nutrition for all infants including those born preterm or otherwise ill. However, many infants fail to receive their mother's own milk. Beneficial effects of breast milk on cognitive skills and behavior ratings have been demonstrated in preterm infants. The preterm infant is known to be at increased risk for developmental and behavioral morbidities (Vohr, Poindexter, Dusick, McKinley, Wright, Langer, & Poole, 2006). Despite these documented health advantages actual breastfeeding rates in neonatal intensive care units (NICU's) for NICU babies is low. The purpose of this paper is to identify that nurse's lack the knowledge surrounding breastfeeding. It has been well documented and it is important that nurses possess the skills to effectively care for this population of preterm infants and promote increased breastfeeding practices in the NICU.

Poster: 10  
Title: Holey Moley, Remove that Foley Preventing Catheter Associated Urinary Tract Infection  
Category: Clinical  
Author: Heidi Martin, RN, MSN

Hospital acquired urinary tract infections affect approximately 600,000 patients each year with 80% related to indwelling urinary catheters. Approximately half of the patients affected do not have valid indication for insertion. Each day the urinary catheter is in place the risk for a catheter associated urinary tract infection (CAUTI) increases by 5%. Evidence shows that incorporating evidence based performance bundle helps to reduce the number of infections. The elements of the CHOP bundle, adopted from the Institute of Healthcare Improvement (IHI), include four recommended components: avoid unnecessary urinary catheters, insert urinary catheters using aseptic technique, maintain urinary catheters based on recommended guidelines and review urinary catheter necessity daily and remove promptly. In 2009, the PICU was concerned with the increase rate in CAUTI and formed a team to develop improvement strategies. After implementation, the PICU was able to reduce the number of infections by 25% over a three month period. Recognizing there was an opportunity to reduce healthcare acquired infections throughout the organization, an improvement initiative was launched. Based on the evidence from the IHI and the PICU experience, the focus is on compliance with the elements of the bundle. Since the improvement project was launched in September 2010, the rate of CAUTI has decreased significantly. Due to the success of the 2009 improvement initiative, the PICU has been successful in both decreasing catheter use and increasing performance in daily review and prompt catheter removal.

Poster: 11  
Title: One NICU's Strategies for Improving Family Satisfaction in the Hospital Setting  
Category: Professional Development  
Author: Margaret Wuest, BSN, RNC-NIC  
Co-Authors: Tina Keane, BSN, RNC-NIC & Barbara Rowland, BSN, RNC-NIC

Achieving and maintaining high satisfaction scores is always a great challenge with patient families, who are faced with arduous circumstances involving their child's hospitalization. Through development and utilization of key strategies, our NICU has contributed to the Press Ganey patient/family satisfaction scores, making Nemours/Al duPont Hospital for Children ranked in the top 1% nationally. We consider family satisfaction an important part of practicing the art of neonatal patient care. This ultimately promotes positive outcomes for our patients, families, and staff. We will detail several strategies utilized in the NICU which have helped maximized satisfaction scores for our hospital. Some of the key patient families care strategies address professional behaviors and accountability training for staff, matching nurse's strengths to family needs, maximizing communication of patient and unit report, optimizing direct family centered care, and follow up support. Together, these elements illustrate how the staff has incorporated into practice the hospital mission and commitment to our patient's families. In a challenging environment our NICU makes every effort to strive for maximum family satisfaction..

Poster: 12  
Title: The ABCs of EBP  
Category: Professional Development  
Author: Mei Lin Chen-Lim, BSN, RN, CCRC  
Co-Author: Katherine Davis, PhD, RN, CPNP

Purpose: Nurses are now expected to practice in an evidence based manner regardless of educational background, experience, or practice setting. Novices to the EBP process will gain basic foundational knowledge and skills to help them engage in the EBP process.  
Content: This educational presentation will cover: What is EBP, definitions of frequently used terms, steps involved in the multi-step process (developing the clinical question, finding the evidence through literature searching, critically appraising the evidence through leveling and grading, applying the findings to clinical practice, and evaluation). The Iowa model of evidence based practice will be used as a guiding framework (Titler, 2001).  
Outcomes: At the end of this presentation, attendees will be able to understand the terminology used in EBP, develop a

clinical question using the PICO format, be familiar with the concept of search terms and using an electronic database to locate relevant literature, understand the basics of grading and leveling the evidence, and be introduced to the process involved in deciding whether to make a practice change based on the evidence and the subsequent evaluation.

Implications: Professional pediatric nurses need to practice in an evidence based manner. To do this, they must have the basic knowledge about the EBP process and how to successfully navigate the steps involved in a successful EBP project.

Poster: 13  
Title: Two Patient Identifiers: How Proper use can result in decreased medication errors  
Category: Clinical  
Author: Anne Krajewski, BSN, RN, CPN  
Co-Author: Susan Cannon, MSN, RN, CPN

Our hospital's medication error rate had remained stagnant for 5 straight quarters. Upon review of the errors we discovered that many were related to the ineffective use of the 5 rights of medication administration. We hypothesized that our staff was not following the policy accurately. Historically, our data collection was obtained by direct peer observation of medication administration. Despite having data that implied we were 98-99% compliant with all components of medication administration, our medication error rate did not reflect this. The nursing department's Performance Improvement Council developed and implemented a new data tracking tool which involved interviewing a patient/family after a medication was administered to identify if all components of 2 patient identification were completed. Prior to implementing this we educated the staff and we placed the results on our nursing department scorecard which shows monthly compliance rates. Since implementation, our first quarter (2011) medication error data reflected a 50% reduction in our medication administration and transcription rate! This was the first decrease in 6 quarters.

Poster: 14  
Title: ECMO Intra-Hospital Transport: Minimizing Risk  
Category: Clinical  
Author: Dominick Carella, MSN  
Co-Author: Christine Small, BSN

The transport of critically-ill patients is a potentially hazardous event and carries inherent risk. Risk reduction can be achieved and all risk virtually eliminated by a set of guidelines that consistently plan for safe transport and prevention of adverse events. Intra-Hospital transport of the ECMO patient can be safely performed by the ECMO team and can benefit by methodologies of situational awareness and crew resource management. Human performance and the reduction of human error has been extensively studied by the aviation industry.

The concept of Crew Resource Management (CRM) has been widely used to improve the operation of flight crews by facilitating team member communication, mandatory briefing and debriefings, and the extensive use of standard operating procedures. The intra-hospital transport of an ECMO patient is an interdependent process carried out by a team of individuals with advanced technical training. Their group dynamics is similar to other technically complex high-stress endeavors with a high potential for error. We think that the ECMO community can benefit from the application of CRM theory with regard to the intra-hospital transport of an ECMO patient.

Poster: 15  
Title: Sedated Children: Oxygen or Not?  
Category: Clinical  
Author: Deborah Wagner, BSN, CPN

Based on the Evidence: What are the indications for use of Supplemental Oxygen in the Sedated Pediatric Patient?

Purpose: The purpose of this study was to determine if sedation providers should be administering supplemental oxygen as a routine therapy for their sedated pediatric patients.

Background/ Significance: The administration of supplemental oxygen to the sedated patient is often a provider driven

practice as opposed to a patient driven one. The provider may administer oxygen in a prophylactic manner prior to evaluation of pulse oximetry or end tidal carbon dioxide measurements. This Evidence Based Practice Project was undertaken to research the literature about current practice and it's efficacy with the pediatric sedation population.

Method: An extensive literature review of randomized controlled trials and observational studies was performed regarding the subject of supplemental oxygen administration and its effect on the pediatric patient undergoing deep sedation. Policy # 60.63 Care of Patients Undergoing Procedural Sedation obtained from Nemours/ Alfred I DuPont Hospital for Children (AIDHC) was reviewed to determine if the administration of supplemental oxygen was addressed.

Results: Literature review revealed that pediatric sedation patients are often given prophylactic supplemental oxygen. Large changes in oxygenation may go unnoticed as pulse oximetry may not change despite impending hypoventilation. Nemours/AIDHC policy #60.63 does not address the issue of delivering supplemental oxygen during sedation.

Conclusion: The practice of giving supplemental oxygen to sedated pediatric patients should be carefully considered as evidence shows that the practice may actually lead to prolonged identification of hypoventilation. There is no current evidence to support or refute the use of prophylactic oxygen.

Poster: 16  
Title: Nursing Care of the Patient with a Halo  
Category: Clinical  
Author: Michele Cimino, RN, BSN  
Co-Author: Mara Cianfarra, RN, BSN, CPN, CPEN, CEN

Halo Traction is an orthopedic device used to manage cervical spine injuries or spinal deformity management to minimize neurological damage requiring long-term immobilization. The Halo Traction application is based on a longitudinal force to the axis of the spinal column to stabilize or change the alignment of the spine. Primary indications include but are not limited to: correction of scoliosis, spinal deformity, cervical spine surgery and in management of spinal trauma and pain.

This poster presentation will give nurses the comfort level required to work with the increase need of Halo use in the pediatric orthopedic population. Some of the areas of education include how and why halos are placed, pin care, cranial nerve assessment, weight application, complications and emergency care. This presentation will also give nurses the knowledge to instruct families and patients on the care of the halo.

Poster: 17  
Title: The Journey Continues Through Mentoring of New Nurses  
Category: Professional Development  
Author: Kate Mann, BSN, RN, CPN

Based on the recent increase in nurses being hired into the PICU, and after performing a comprehensive literature review of mentoring, it was decided that a mentorship program would be beneficial. A survey was also distributed to staff, and the results showed an interest in formal mentoring. A mentorship program was developed for new PICU nurses with the goals of promoting nurse retention, improving nurse satisfaction, and easing the transition of new nurses into a critical care environment.

As a result of evidence based research, it was decided that PICU nurses with 2 years of experience could volunteer to be a mentor, providing they could agree to a one year commitment. Mentors participated in an in-service describing their expectations and providing education about the program. Upon completion of orientation, all newly hired nurses are automatically enrolled as a mentee, as the mentorship program is mandatory.

Upon completion of a questionnaire and feedback from staff, mentors and mentees are paired together by the mentorship coordinator. It is then up to the mentor/mentee to set goals and meet together monthly, preferably outside of work. This encourages open discussion and a more confidential atmosphere. The mentorship coordinator also arranges quarterly meetings for the entire mentor/mentee group in a social setting to promote cohesiveness among the group.

Currently the program is entering its sixth month and the coordinator is meeting with mentee/mentor pairs to assess their progress towards goals. An evaluation of the program will also be performed at this time.

Poster: 18  
Title: Tonsillectomy in Children  
Category: Clinical  
Author: Terri Giordano, MSN, CRNP, CORLN

Tonsillectomy is one of the most common surgical procedures in the United States with more than 530,000 procedures performed annually in children younger than 15 years of age. A clinical practice guideline on Tonsillectomy in Children has been developed with its primary purpose to provide clinicians with evidence-based guidance in identifying children who are the best candidates for tonsillectomy. The practice guideline will also emphasize the need for evaluation and intervention in special populations, improve counseling and education of families and reduce inappropriate or unnecessary variations of care.

Poster: 19  
Title: Omegaven: An Innovative Nutritional Therapy for Children with Short-Bowel Disease  
Category: Clinical  
Author: Kimberly Palermo, BSN, RN, CPN  
Co-Authors: Nancy McCormick, RN & Heather Curry, BSN, RN

Total parenteral nutrition (TPN) is an essential, and many times, life-saving, component of the medical management of children with short-bowel syndrome. TPN is frequently necessary for these children as they are unable to tolerate enteral feedings due to the anatomical and absorption alterations of their gastrointestinal tract. Traditional lipids used in TPN have been demonstrated to contribute to the development of hepatotoxicity and parenteral nutrition associated liver disease (PNALD). Omega-3 fatty acids, or Omegaven, are currently being investigated as an alternative to traditional lipid therapy in patients who require long-term use of TPN. Omegaven has been associated with several benefits which include a decreased incidence of PNALD, reversal of established PNALD, and a decrease rate of liver transplantation in children with short-bowel syndrome. This poster will compare traditional lipids with Omegaven. Additionally, a case study will be used to demonstrate the benefits of Omegaven in a child with short-bowel syndrome. Clinical guidelines will be presented which include: patient criteria for initiation, administration and nursing considerations, and implications for future management of PNALD in the pediatric population.

Poster: 20  
Title: Supporting Newly Hired Nurses: A Post Orientation Program  
Category: Clinical  
Author: Courtney Geetter, BSN, RN, CPN  
Co-Authors: Jena Koury, BSN, RN & Caryn Ross, BSN, RN

Newly hired nurses (NHNs) often have limited clinical experience and only text book theory when entering the medical field for the first time. Although an orientation process is designed to help develop these skills, NHNs often require further education post orientation. Furthermore, NHNs often face a lack of support from colleagues when transitioning off of orientation. On a general pediatric unit at the Children's Hospital of Philadelphia, an innovative post-orientation education program (POEP) was developed to address these concerns. The program focused on continuing education regarding common diagnoses of the primary patient population, while fostering trusting relationships. The goals were to expand both knowledge and critical thinking skills of NHNs, cultivate supportive relationships between NHNs and their colleagues, and increase self confidence of NHNs. Eighteen NHNs participated in this program and were evaluated based on pre and post tests. This assessment was designed to determine the clinical knowledge gained throughout the program. The average pretest score was 66% and after completion of the program the average score increased to 92%. In addition to pre and post tests, each participant completed a qualitative program evaluation. The participants reported increased communication skills, increased knowledge regarding each diagnosis, improved critical thinking skills, increased ability to teach at the bedside, increased ability to anticipate patient needs, and stronger relationships with colleagues across the institution. The results from the test scores in addition to the qualitative analysis show an increase in clinical knowledge, growth of supportive relationships among colleagues, and increased self confidence among NHNs.

Poster: 21  
Title: Nursing and Parent Partnerships  
Category: Patient Education  
Author: Georgina Capraro, RN, BSN, CPN

Often time's parents and caregivers on the rehabilitation unit experience medical stress because of their critically ill child. Parents often become isolated, or experience misdirected anger along with frustration because of a prolonged hospitalization. Literature reveals parents of critically ill children have rated nursing support as an important influence on their experiences. Research demonstrates a direct correlation between parents' effectiveness in coping after discharge and the nursing support they received. NAPP (Nursing and Parent Partnerships), a parent support group, was created. This provided an opportunity for parents to share their experiences of having a critically ill child with other parents and a nurse facilitator. The goals of the group were to improve family support and coping strategies. The training for the nurse facilitator included a study of group dynamics and concepts of grief and loss. The nurse facilitator developed a script to guide the group encouraging communication, respect, confidentiality, and redirection when necessary. An anonymous parent survey was developed and disseminated to measure group effectiveness. Results of the survey demonstrated parents felt empowered to ask questions, more supported, and increased their comfort level in learning. Parents were able to network and develop supportive relationships with other parents, feeling less isolated. The NAPP group sessions support the research that parents are more effective in coping with their child's illness and hospitalization when they have nursing support.

Poster: 22  
Title: The Trach Time-Out: first change, every change  
Category: Clinical  
Author: Janet Boyce, RN, MSN, CCRN, CNS  
Co-Authors: Joseph Bolton, MBA, RRT, CRS & James McCarrick, RRT

Artificial airway safety is imperative. Tracheostomy (trach) tubes vary in size, length, and cuffs which allows for multiple opportunities for incorrect tube placement. Tracheostomy safety involves critical thinking during routine changes and emergency placement. Based upon the evidence based universal time-out checklist prior to surgical procedures, the Trach Time-Out (TTO) checklist was developed collaboratively by nursing and respiratory therapy to prevent trach tube placement errors. Joint Commission and National Patient Safety Goals stress the importance of clear communication. The TTO incorporates a two caregiver dialog to identify the child using 2 patient identifiers, verification of the correct trach tube size, length and cuff and the clarification of each of the two caregiver's roles prior to the change. The TTO was developed in response to an incorrect tube placement in 2008. In a unit of tracheostomy and ventilator dependent children and performing approximately 600 trach changes per year, airway safety is a high priority. The TTO checklist includes the mandatory "6 rights" of trach tube changes: patient, trach tube size, manufacturer, length, cuff and a check for tube patency. Following development, introduction, education of staff and families, and piloting of the TTO in 2008, there have been 6 trach tube change related safety events occurring over 1200 trach tube changes and no events since August 2010. The Trach Time Out has been adopted as a best practice within the safety culture of the unit and will be adopted as a standard of care for all units with tracheostomy patients.

Poster: 23  
Title: USING SIMULATION TO IMPROVE SAFETY & QUALITY OF PATIENT CARE  
Category: Clinical  
Author: Regina Flynn-Roth, RN, MSN, CPAN

Peri-Anesthesia Care Unit (PACU) nurses recognize and manage serious, sometimes emergent medical - surgical conditions. Simulation-enhanced educational sessions optimize caregiver skills in managing low frequency or high risk conditions. High-tech manikins, with pulses and chest wall motion, dynamic vital signs display, and the capability of physiologic responses to interventions, help participants engage in an active process of treating the patient. Simulated cases are based on recent patient events and take place in PACU patient care rooms. Each month, a new scenario is repeated three days in a row with different groups of nurses. A scenario typically involves recognizing clinical deterioration, prioritizing interventions, and accessing and using medications, equipment, additional personnel and other resources. Debriefing follows the simulation

and addresses components of optimal medical or nursing care, articulation and reinforcement of safety behaviors including teamwork principles, and identification of latent conditions or systems hazards that did or could adversely impact the ability to provide optimal care. Simulations have resulted in knowledge and process improvements. The information gained from the participation of a small number of nurses at each simulation is leveraged by providing that information to the larger PACU group via written feedback, staff meetings and newsletter. A post simulation evaluation and follow-up survey using a five point Likert Scale was developed to assess comfort and confidence with components of the simulation experience. Staff consistently reported an increase in confidence and comfort ( 4 to 5 on Likert Scale) with all measures.

Poster: 24  
Title: CVC Dress Rehearsal: Every Line Counts  
Category: Research  
Author: AnneMarie Monachino, MSN, RN, CPN  
Co-Author: Amy Scholtz, MSN, RN, WHNP-BC, CNS-BC

Reports have shown that Hospital Acquired Infections (HAIs) can be prevented through adherence to evidence-based best practice standards. Central line-associated blood stream infections (CLABSI) are one of the HAIs of concern for hospitals today. At this children's hospital we observed inconsistency in central venous catheter (CVC) knowledge and dressing change practice. A changing healthcare delivery system and a need to educate nurses across the continuum prompted the CVC Dress Rehearsal program in which nurses practice a CVC dressing change on a simulated patient. The goal of this program was to test the use of this bedside simulation based education and its impact on nurses' knowledge, confidence, psychomotor skills and consistency of practice. Participants' practice was assessed using a self evaluation, written knowledge test and psychomotor skills evaluation as well as observations of actual patient dressing changes. Nurses were given immediate feedback and perfect compliance with no corrective prompts was required. 525 nurses participated and reported improvement in knowledge (Pre: 4.1 +/- 0.7, Post 4.6 +/- 0.5,  $p < 0.0001$ ) and confidence (Pre: 4.1 +/- 0.8. Post 4.6 +/- 0.5,  $p < 0.0001$ ) and were more apt to correctly perform a dressing change on a patient (201/1673, 12% with dress rehearsal vs. 385/1673, 23% without dress rehearsal  $p < 0.001$ ). CLABSI rates decreased from 5/1000 line days to 2.9/1000 line days post implementation. This innovative method of education helped to eliminate variations in practice and improve clinical performance on both a manikin and a patient, thus promoting a culture of safety and excellence in nursing.

Poster: 25  
Title: Care of the Disruptive Pediatric Patient using Healing Touch and other additional Interventions  
Category: Clinical  
Author: Mary King, BSN

The pediatric nurse faces many challenges in today's health care arena. Disruptive patients are becoming increasingly violent and uncontrollable on the general pediatric units. Healing Touch incorporated into the lives of children who cannot control their actions such as the autistic population will derive only positive encounters. Use of Healing Touch with the Geriatric Population and other groups who exhibit similar behaviors give promise to the collection of new data providing our research questions and the disruptive impulsive patients. While causing no injury or negative impact to this population; the serene benefits of the Healing Touch program will exude only positive energy to the patient, family, and staff. After intervening with the autistic and similar populations of patients I believe we will see a decrease in anxiety and stress and positive change to their energy field. We who practice nursing at AI DuPont Hospital for Children have an obligation to do "whatever it takes" and follow through with "Your child our promise" to even the most difficult of patients. "Be in the moment" is our promise to each other and to our patients and families. Using the Evidenced Based Practice interventions such as healing touch and other complementary therapies will be a positive NIC. Complementary interventions assure the patient, family, staff and administrators the patient will be cared for using the least invasive interventions to achieve the best NOC.

Poster: 26  
Title: A comprehensive oral care Program for patients at risk for VAP in the Pediatric Intensive Care Unit.  
Category: Research  
Author: John Ramney, MSN

Purpose of the project: The purpose of this evidence-based practice project is to develop a comprehensive oral care protocol for patients at risk for ventilator-associated pneumonia (VAP) in the Pediatric Intensive Care Unit of A I DuPont Hospital for Children. The current VAP rate in the PICU for the period of January 2010 to June 2010 is 1.9 per 1000 Ventilator days and our goal is <1 per 1000 ventilator days per quarter. We hypothesize that with the introduction of the comprehensive oral care protocol, we can achieve our goal.

Review of current practice: Based on a retrospective chart review of all 51 patients admitted in PICU between January 1st and March 31st and intubated for at least 24 hours the documented oral care for each 24 hour period is 2.8 times (mean) and 4 times (mode) out of required 6 times a day. A survey on a convenience sample of 30 RNs in the unit revealed that 19 out of 30(63.3%) provide oral care to the intubated patient at least 3 times in a 12 hour shift and 11 out of 30(36.7%) two times a shift. 73.3% (n = 22) stated that they document the oral care in the flow sheet and 25.6% (n= 8) do not document. Among the 8 who do not document, 3 stated they forget to document.

Literature review and significance of the problem: To guide the review of literature, a research question was formed using the PICO format and a literature review was performed using search engines like COCHRANE, PUBMED and CINHAL. Seven articles were selected and one of them was a systematic literature review of 55 articles (11 prospective control trials, 20 observational studies and 24 descriptive studies). Literature strongly supports meticulous oral hygiene to decrease the incidence of VAP. Use of a comprehensive oral care protocol and staff compliance with the protocol can significantly reduce rates of VAP. (Garcia et al 2009). However, there is no strong evidence suggesting the use of chlorhexidine over any other pharmacological agents for oral care.

Proposed change in practice: The proposed change in practice involves brushing the teeth with a tooth brush and tooth paste once a shift for all intubated patients over one year of age and moisturizing the oral cavity every four hours when brushing is not done. All RNs will be instructed to document the oral cavity assessment and oral care given differentiating oral cavity moisturizing and brushing. This teaching will be included as part of the unit orientation for the new hires.

Plan for evaluation of practice change: An audit form adapted from an AACN practice alert will be used to audit the oral care documentation in intubated patients. The plan is to audit the charts of all intubated patients 3 months after implementing the procedure. The audit will be continued for a period of 3 months and then the data will be analyzed for improvement.

Current status of the project: An oral care procedure for the unit has been written and is approved by the PICU Practice Committee and the hospital-wide Nursing Practice Council. The Education Committee will take over the education of the staff through skills fair. The project will be implemented in the unit in July 2011 with support of the Quality Committee.

Poster: 27  
Title: Do you want to be a member of the Pain Patrol?  
Category: Clinical  
Author: Jennifer Hartman, BSN, RN, CPN  
Co-Author: Stephanie Mathis, BSN, RN

In 2007 at this hospital data collection was started on pain assessments for NDNQI. The goal was to be in the ninetieth percentile when compared to other like hospitals. The results showed that the medical surgical units in this hospital were not meeting this goal.

A decision was made to make pain assessments the fifth vital sign to increase the number of documented pain assessments to at least six in twenty four hours. The results did show improvement.

In the medical surgical units, 4south was most often the unit with the lowest number of pain assessments compared to the other three units. In 2010 the Pain Patrol initiative was launched to improve these results. Every time a nurse documented a pain assessment every four hours during their shift, a police badge would be awarded and that nurse would become a member of the pain patrol. At the end of the month, the top 5 nurses with the most badges would have a chance to win a five dollar gift card to WaWa. At the end of the quarter the top ten nurses with the most badges would have a chance to win a ten dollar gift card to WaWa.

By the third quarter of 2010, 4south improved to having the second highest results of the four medical surgical units. This improvement has been maintained to date. In fact the first quarter NDNQI data was recently published showing 4south to have the highest results of the four medical surgical units.

Poster: 28  
Title: Improving Hand Hygiene and Sustaining Effective Behaviors Among a Multidisciplinary Team  
Category: Clinical  
Author: Kalli Bass, BSN, CPN, RN  
Co-Authors: Ashley Cobb BSN, RN, & Christine Correale BSN, RN, CPN

Review of Evidence: The importance of hand hygiene is evident in many aspects of the health care field, but most importantly to the safety of the patients and families cared for and reducing the risk of infection. Clean hands are the single most important factor in preventing the spread of pathogens and antibiotic resistance in healthcare settings (CDC, 2007). In order to provide a realistic view of hand hygiene performance, measuring adherence to hand hygiene guidelines is critical in the effort to improve health care providers practice.

Summary Evaluation of Evidence: National focus on hand hygiene performance has shifted to the local level. Prior to 2011, a 15 bed general pediatric unit at an urban academic pediatric hospital yielded traditionally a compliance rate great than 90%, when measured by unit based nurses. In order to truly assess hand hygiene compliance, the hospital implemented three trained auditors. The first three months of data collection greatly differed from the past years of performance and it was Xa %, Xb%, Xc%. The data concludes that hand hygiene practices were not efficient and patients were at an increase risk of acquiring a HAI.

Clinical Practice Implications: The 15 bed general pediatric unit has designed and implemented multiple strategies which has improved hand hygiene performance to a rate of \_\_\_\_Xd %

Center for Disease Control and Prevention. (2007). Hand-washing recommendations to reduce disease transmission from animals in public settings. *Morbidity and Mortality Weekly Report*, 56(5).16-17. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5605a4.htm>.

Poster: 29  
Title: Safety and Effectiveness of Colonoscopy Bowel Preparation for in Children  
Category: Research  
Author: Denise Ciavardone , BSN, RN  
Co-Authors: Frances Jannelli, BSN, RN & Salina Esch, BSN, RN

Evidence-based review of the literature revealed few scientific studies about best practices for pediatric bowel preparations. A tolerable, safe, and effective bowel preparation combined with expert nursing knowledge and education to assure patient adherence to treatment is essential to obtaining an accurate diagnostic colonoscopy. A prospective, randomized, single-blinded, study set at a large urban children's hospital compared the safety, effectiveness, and tolerability of PEG-P (Miralax, Schering-Plough HealthCare Products, Inc) against senna for colonoscopy preparation for children. An interdisciplinary team of physician, GI nurses, and research staff collected data from patient tolerance questionnaires, blood specimens to evaluate electrolyte abnormalities, and a standardized bowel cleanliness tool (Aronchick scale) rated by a blinded endoscopist. Power calculations targeted 166 subjects; however, interim analysis of 33 subjects revealed significant findings: 88% (14/18) of PEG-P patients received an excellent/good score compared to 29% (4/14) with the senna preparation (p=0.002). The study was halted prematurely based on this result. Quantitative safety data related to patient demographics, labs, and patient tolerance along with qualitative data from parent/patient comments regarding satisfaction and ease preparation use will be discussed. Nurses' rewards and challenges of conducting research at the point of care will be also be highlighted in the presentation.

Poster: 30  
Title: Evaluation of Non Urgent Emergency Department Visits in a Pediatric Primary Care population  
Category: Research  
Author: Susan Brennan, RN,CPN  
Co-Authors: Brooke Bazz Park, RN, BSN & Phyllis Slutsky, RN, M.Ed

Ambulatory Care nurses provide primary well child and illness care to assist patients and families in better managing health and illness in the community settings. Despite our best efforts, parents often seek care for their children in the Emergency Department (ED) when their efforts to care for their child at home is not working, particularly during open office hours, when After Hours telephone triage is available, and during flu/respiratory season when clinic volume is at the highest.

At the start of this project we conducted an extensive review of existing evidence to determine why families use the Emergency Department (ED) for their care. This work helped us to identify several themes associated with non-emergent use of the ED including: access to care, confidence in parent in their ability to manage a child's illness, ability of the parent to prioritize, and lack of knowledge.

In this presentation, we will present a mixed method intervention, first reviewing data from ED reports of primary care patients from a large urban Children's Hospital identified as non-acute (rated level 4 and 5 acuity from the ED). ED visits considered as "non-urgent" are followed up with a phone interview asking specific questions about why they went to the ED. Through these methods, we will determine factors influencing parent's decisions to take their child to the Emergency Department.

As a result of this work, we hope to partner with our patients and families to develop "best practice" guidelines for decreasing non-urgent emergency room use when primary care is available to them.

Poster: 31  
Title: Enhancing early recognition of adverse drug reactions to remicade.  
Category: Clinical  
Author: Linda Schneider, RN, BSN, CPN  
Co-Authors: Maria Doe, RN, BSN, CPN &

Remicade is a routinely administered medication in the ambulatory care setting. Serious adverse reactions to Remicade are a high risk, low volume occurrence. For this reason, it is difficult to prepare staff for this uncommon event. Therefore, collaboration between the Day Medicine Unit and the Simulation Center led to development of a realistic ADR simulation for Remicade. The key aims of this simulation were early recognition of the signs and symptoms of an ADR, identification of the appropriate personnel resources needed and correct documentation and reporting of the ADR event.

The results of the ADR led to significant practice changes and systems improvements.

Poster: 32  
Title: Growing Up All Over Again: Meeting Milestones after Spinal Cord Injury  
Category: Patient Education  
Author: Joan Talley, RN, BSN, CRRN  
Co-Authors: Krista Fuegal, RN, CRRN & J.D. McCrossin, RN, AD

Parents anxiously wait for their children to reach various 'milestones' of growth and development as their children mature. Eating, drinking rolling from side to side, sitting unsupported, walking and talking are all anticipated in developmental sequence. Being 'potty-trained' is an important social expectation.

After spinal cord injury (depending on level), many of these functions have been extinguished, and it becomes necessary to pursue them again= often in (at least temporarily) a modified way.

Poster: 33  
Title: That Ball is Outta Here! Grand Slam made Possible by Charge Nurse Role  
Category: Professional Development  
Author: Susan McInerney, BSN, RN, CPN  
Co-Author: Lisa Grosso, BSN, RN, CPN

Traditionally, the role of the charge nurse has not been well defined. On any given shift the responsibilities of the charge nurse have been an added duty randomly delegated to a more senior nurse. Assigning this role to multiple individuals resulted in decreased accountability and commitment to the duties of the charge nurse, in particular customer service and staff satisfaction. Increases in patient acuity, and shorter hospital stays resulting in quick patient turnover rates are the evolving trends facing hospital systems today. Established by a group of staff nurses and supported by our nursing leadership, the

permanent charge nurse role was developed. With P.S.M.S. (patient satisfaction measurement scores) soon helping to determine hospital reimbursement, the primary focus of the charge nurse was based on service standards; in particular patient satisfaction. Multiple strategies were initiated including: daily rounding with each parent, an identified point person with increased communication between services and departments, and monthly charge nurse meetings with nursing administration to discuss and implement targeted strategies to improve specific score card areas. Cell phone usage was also initiated to replace traditional pager systems for direct communication between departments thus improving patient flow and decrease patient admit waiting times which is typically a significant factor in customer satisfaction. Coincidentally, staff satisfaction scores have also improved as well. Since the inception of this role, and the interventions in place, we have seen positive results in many areas, particularly those related to patient and staff satisfaction.

Poster: 34  
Title: Pediatric Early Warning System: Enhancing communication. Enhancing Outcomes.  
Category: Clinical  
Author: Jill Wegener, RN, BSN, CCRN  
Co-Authors: Jeremiah Cleveland, MD & Regina Nadal, RN, BSN

The success of preventing cardiopulmonary arrest in children lies in the ability of health care providers to identify the early signs of deterioration and implement prompt intervention. Hospitalized children usually exhibit warning signs in the hours before experiencing critical health problems. If these signs are not identified, or a change in clinical status is not effectively communicated, poor patient outcomes may result.

The Pediatric Early Warning System (PEWS) is a focused assessment tool that compliments clinical decision making. It assists practitioners in identifying children at risk, and provides guidelines for communicating and managing change in status.

Aim of our study will be to establish a relationship between utilization of the Pediatric Early Warning System and timely identification and communication of a change in patient status and formulation of a plan of care, amongst the interdisciplinary team.

Methods :To validate that the relationship between utilization of the PEWS tool, and enhanced communication and interdisciplinary management of care, will be established by:Pre -PEWS and post PEWS -implementation surveys of Residents and Nurses addressing the issues of interdisciplinary communication and measurable plan of care. Weekly audits of staff compliance with assessment, documentation and communication of PEWS scores.

Findings/Results: In early stages of data collection and interpretation. Anticipate preliminary results to be completed by July 2011.

Implications for nursing practice: Utilization of the Pediatric Early Warning System will enhance quality care delivery to the Pediatric population by facilitating identification and communication of change in patient status and development of a measurable plan of care, amongst the interdisciplinary team. The goal is to identify risk of deterioration in a timely manner, and implement therapies to prevent a significant event or admission to the PICU.

Poster: 35  
Title: Radiologists Role in Helping to Limit Healthcare Associated Infections HAIs  
Category: Clinical  
Author: Christine Harris, RT MR (R)  
Co-Authors: Jim Meyer, MD & Sue Durning, RN

Introduction: It has been known for many years that most hospital acquired infections (HAI) are largely preventable. Our ultimate goal should be the elimination of HAIs. Two areas within the Radiology environment with the potential high risk of HAI are 1) the magnet bore of an MRI scanner and 2) gonad (radiation) shielding practices of NICU populations.

Method and Results: MagnaWand is a non magnetic MRI safe cleaning tool. MRI personnel now have an alternative method to safely and efficiently clean, sanitize, and disinfect the bore of the magnet and surrounding areas of an MR scanner. After single use the pad is ejected from the tool in a hands free fashion thereby reducing the risk of further contact contamination to the MR staff. Personal gonad shields and anatomical markers can be a potential method to reducing the spread of organisms from patient to patient. These shields have been paired with Left and Right disposable anatomical markers in a patient Rad-Pack which remains at the bedside of each NICU patient for personal use during Radiology portable exams. When the

patient is discharged from the unit, their Rad-Pack is disposed of. With NICU patients no longer sharing gonad shielding and anatomical markers, the potential patient to patient transference of organisms is greatly reduced.

Conclusion: Protecting patients from HAIs requires a concerted effort and diligence by all. This issue deserves attention from the Radiology community to ensure that each patient is provided the highest quality of care possible in the safest manner.

Poster: 36  
Title: Looking Back..... But Moving Forward - A Retrospective Review of Magnet Committee Accomplishments  
Category: Professional Development  
Author: Jaime DiZio, BSN, RN, CPN  
Co-Author: Susan McInerney, BSN, RN, CPN & Lisa Grosso, BSN, RN, CPN

An original force of Magnet focused on community outreach and involvement. Giving back to an organizations surrounding community provides mutual benefits to all parties involved. What started out with our initial efforts to embrace this force has grown into many internal as well as external programs. Looking back on these initiatives we are able to identify the past, present and future direction they are leading us, not only as an individual but as an organization as well.

Poster: 37  
Title: Supporting the Magnet Journey in a Cost Effective Environment  
Category: Professional Development  
Author: Jaime DiZio, BSN, RN, CPN  
Co-Author: Susan McInerney, BSN,RN,CPN & Beatrice Cappella, RN,CPN

With the realities of the severe budget constraints facing all hospitals during the current economic conditions, innovative yet cost effective approaches are being utilized in all aspects of nursing operations. Our challenge has been to creatively engage staff on the new Magnet model, while pursuing our re-designation within a limited budget. Over the course of the past year, our Magnet Steering Committee has developed and implemented original, cost effective ideas to educate the nursing staff about the new Magnet model in our pursuit to continue along the path of excellence.

Poster: 38  
Title: Implementation of Residency Orientation Program  
Category: Research  
Author: Suzanne Gratteri, BSN, CPN, RN  
Co-Author: Amanda Hall, RN & Danielle Montana, BSN, RN

A resident orientation program was designed and implemented by the quality and research committee on 3E within Nemours, AI DuPont Hospital for Children. The nursing Q&R committee designed an informative yet concise orientation that is able to be quickly delivered. Agenda includes: introduction to staff members, individual responsibilities, patient population, policies, entry codes, equipment, and communication devices. Emphasis is placed on the significance of nurse-to-physician communication and maximizing patient care. Utilizing dry erase boards in patient rooms is recognized as improving the family's level of comfort, familiarity, and ability to collaborate with the health care team. Following implementation of resident orientation, thirteen residents were asked to complete 5 question evaluation surveys to assess the need of its continuance and relevance of its contents. Five of these residents received a partial orientation while nine of them received a full orientation. One-hundred percent of participants were in agreement that they received valuable information when

prioritizing nurse participation in patient rounding. Amongst participating residents, the quality and research committee successfully implemented a program which will allow a higher level of patient care to be achieved.

Poster: 39  
Title: Using and Testing Inter-rater Reliability at the Bedside  
Category: Clinical  
Author: Kristen Thompson, RN, MSN, CPN  
Co-Author: Rachel Stoughton, RN, MSN

For the past year and a half the Pediatric Intensive Care Unit (PICU) has been participating in the RESTORE (Randomized Evaluation of Sedation Titration for Respiratory Failure) study. This is a multi-centered NIH funded study that looks at a nurse managed sedation protocol in pediatric patients with acute respiratory failure in hopes of decreasing ventilation time and limiting short and long term risks. The study has two arms, a control arm, and an intervention arm. One of the tools used to

assess sedation is the State Behavior Score scale (SBS). Inter-rater reliability (IRR) is important when there is a measurement process using judgments or ratings by observers. Since establishing IRR requires various raters to demonstrate consistent scoring using a tool, there should be specific criteria for the raters to follow when using the tool, along with in-depth education of the tool itself.<sup>1</sup> This provides less room for error by the raters when using the instrument. In order to establish that IRR exists there must be observation of the raters by an individual well trained in the use of the tool. In order to establish the degree of inter rater reliability two observers rate a patient at the same time and then compare scores for agreement. When the tool is tested, often a percentage of agreement is expected. It is important for each institute using the scale to have IRR agreement; otherwise their data may not be valid.

1. Kimberlin CL, Winterstein, AG: Validity and reliability of measurement instruments used in research. Am J Health-Syst Pharm 2008; 65: 2276-2284

Poster: 40  
Title: Implementing a Standard of Care for Endotracheal Tube Taping to Prevent Unintentional Extubations  
Category: Professional Development  
Author: Kristie Fasano, RN  
Co-Authors: Maryanne Halligan, BSN, RN, CCRN & Kathleen Brady, RN,CCRN

Endotracheal intubation is a common practice in pediatric intensive care units. This practice can come with its own set of complications even if performed successfully. One particular risk factor is unplanned extubations. Until January of 2011 the standard of care for retaping an ETT only allowed Critical Care Attendings, Fellows and Nurse Practitioners to perform the procedure all with different styles and techniques. The year prior it was noted that approximately 6-8 unintentional extubations occurred and all were related to insufficient fixation of the ETT. A multidisciplinary work group consisting of staff nurses, a critical care attending and respiratory therapist decided that it would be beneficial if nurses and respiratory therapists were taught to retape endotracheal tubes.

Methods: A literature search was performed it was noted that there was little to no research available regarding the standardization of ETT taping. A standard of care was developed by the multidisciplinary team, along with a power point presentation. An education board with step-by-step instructions and pictures was displayed to familiarize staff with the process. An initial staff competency was developed that had each RN demonstrate retaping the ETT on a mannequin with the direction of the nurse educator. A second ETT taping was required on an actual patient and would be observed by a physician or nurse practitioner.

Evaluation: Currently in the PICU we have approximately 90% of our staff competent in endotracheal tube retaping. Acceptance of this new practice has been very positive. The nursing staff who have had the opportunity to retape endotracheal tubes state that the process has encouraged more ownership and responsibility of the patient's ETT. The nurses have demonstrated that the need for tape to be changed has been identified in a timelier manner and the process has been addressed more quickly. This new Standard of Care is being utilized daily by the PICU nurses.

Outcome: At the beginning of the implementation we assessed that there were 4 unintentional extubations in the six months prior. It has been noted that there has only been one unintentional extubation and this patient did not have the ETT retaped after the OR.

