Act (PDSA) testing we created a standardized ADL process that involved all providers. Interventions included addressing 1-2-3 compliance during rounds, creating accountability in care delivery, creation of an algorithm and order set for oral care, daily text message reminders, and physician intervention with non-compliant and high-risk patients.

Findings & Interpretation: Our baseline compliance with the 1-2-3 initiative was 25%. With our interventions we increased our median compliance to 66% in 90 days. The greatest impact on compliance was seen with text message reminders to staff to complete the 1-2-3 components, designated roles and responsibilities, and physician discussion with noncompliant and high-risk patients.

Discussion & Implications: Our emphasis on patient safety, hospitals are utilizing practice models that incorporate highly reliable (HRO) practices to decrease the potential for human error (Seago, 2008). Additionally, ineffective communication and communication failures are the most commonly cited causes for sentinel events and approximately 50% of adverse events in the United States (JCAHO, 2008). In response to these patient safety concerns, communication during bedside patient rounds was examined on an in-patient Midwestern pediatric bone marrow transplant (BMT) unit. Improving the communication and collaboration within the multi-disciplined patient care team was addressed with the development and implementation of an HRO modeled report sheet, process and nurse lead bedside rounds.

Methods, Intervention, & Analysis: The primary intervention used HRO principles to increase effective collaborative communication by incorporating bedside nursing presence, nursing participation and advocacy, patient/family presence, patient/family participation in bedside rounds, and the implementation of a standardized report sheet.

Findings & Interpretation: BMT nurses were looking for a way to address patient care concerns and increase collaboration during the bedside rounding process. Pre-intervention data was gathered to assess the frequency of bedside nurse presence and participation during patient rounds at 37.5%. A standardized report sheet was developed by BMT nurses and physicians to address patient status, family concerns, and significant findings related to patient prevention standards, JCAHO and CMS compliance. Education was completed by all members of the multi-disciplined team. Post-intervention data collection via daily charge nurse audits is ongoing at 68% measuring nursing presence, participation and use of standardized report sheet.

Discussion & Implications: BMT multi-disciplined teams are using this intervention to address ongoing collaborative communication needs in the complex care of pediatric BMT patients. Utilizing this tool assists in effective communication, forming a culture of safety and reliability using a standardized HRO modeled report process, and addresses JCAHO and CMS compliance.
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**Topic Significance & Study Purpose/Background/Rationale:** Excessive alarms create desensitization and alarm fatigue. The Joint Commission declared a sentinel event alert regarding improper alarm monitoring. We recently reported our work creating and implementing a standardized cardiac monitor care process (CMCP) on a large bone marrow transplant (BMT) unit using the Model of Improvement (Pediatrics). We now report on the sustainability of this process.

**Methods, Intervention, & Analysis:** The standardized CMCP has been sustained for over a year and a half on a 36 bed BMT unit. The CMCP included: 1) process of initial ordering and monitor settings based on age appropriate standards; 2) pain free daily replacement of electrodes; 3) daily individualized assessment of cardiac monitor settings; 4) reliable process for appropriate discontinuation of monitor. We have sustained compliance with the CMCP through standardization of practice and highly reliable interventions including: regular evaluation and mitigation of alarms; scheduled education for the nursing staff on CMCP; clearly defined roles and responsibilities in the execution of the CMCP; and redundancy in the delivery system to ensure compliance. Families are educated on alarm care and
encouraged to voice concerns with alarm issues in daily rounds. Compliance and failures with the process are reviewed regularly with staff.

**Findings & Interpretation:** From January 2013–July 2014, percent compliance with the CMCP increased from 30% to >98% compliance (median=87%). Number of alarms per patient day decreased from 180 to 20 (median=26) alarms/day during this time period. The CMCP has sustained low numbers of alarms per monitored patient day.

**Discussion & Implications:** The results of the CMCP have not only been sustained, but improved with time. The process has been integrated into the daily workflow of the BMT staff. With the number of false alarms down there is an improved work environment and re-sensitization to cardiac monitor alarms.

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**560**

**Piloting a Clinical Resource Nurse Role**

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**Topic Significance & Study Purpose/Background/Rationale:** In April 2014, the Bone Marrow Transplant medical team began patient-engaged, bedside rounds. This inhibited the primary nurse from attending rounds and decreased nursing presence during key discussions and decision making. Rounding occurs between 8:00 am and 11:00 am, a peak time for clinical needs such as medication administration, chemotherapy infusion and stem cell transplant. Nursing involvement during rounds was further challenged due to vacancy rates, training requirements of inexperienced staff, and a new electronic medical record. Charge nurse support was available but individuals in this role struggled to meet all clinical needs. The purpose of the Clinical Resource Nurse (CRN) is to facilitate primary nurse presence at bedside rounds by ensuring clinical tasks are completed in a safe and timely manner.

**Methods, Intervention, & Analysis:** A job description was created and a member of the nursing leadership team was selected to pilot the role based upon clinical and leadership expertise. The pilot role was established as an 8 hour day, Monday through Friday, for 12 weeks. Effectiveness of the CRN role was evaluated during a charge nurse focus group and through collection of anecdotal reports from staff. Additionally, feedback was solicited through a post-pilot survey.

**Findings & Interpretation:** The implementation of this role enhanced the charge nurse’s ability to supervise rounds and manage patient flow. The charge nurse group felt that they were more effective in leading rounds and supported through the presence of an available clinically competent nurse. Frequency of the patient care nurse attending bedside rounds increased. Patient care nurses reported satisfaction with consistently attending bedside rounds, receiving uninterrupted lunch breaks, and having a clinical resource available. Barriers to successful implementation of this role were more logistical and unit culture related.

**Discussion & Implications:** To further enhance utilization of the role, an increased focus on patient education and meeting discharge needs will be addressed. Expanding the role to seven days a week in order to facilitate continuity of care is also being considered. At the end of the pilot phase, the CRN role was found overall to be beneficial and plans are to dedicate a permanent position for this resource.

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**561**

**Picture This: A Better Transplant Experience for Pediatric Patients**

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**Topic Significance & Study Purpose/Background/Rationale:** Successful care of Pediatric Blood and Marrow Transplant (PBMT) patients involves a multi-disciplinary care team of providers. The New York State Patients’ Bill of Rights stipulates that all patients have a right to know the names, positions, and functions of any hospital staff involved in their care. When creative strategies have been used to establish patient rapport and introduce patients to new providers, these have been met with some success. We developed a tool to assist PBMT recipients recognize their many care-team members and promote a therapeutic alliance.

**Methods, Intervention, & Analysis:** Upon admission for PBMT, a poster-board was placed in the patient’s room. Each day during the admission a photo featuring a member of the patient’s care team holding a positive message was taken and placed on the board in calendar format, with a caption indicating the day pre or post BMT the photo was taken. At discharge, a photo was taken of the patient holding a positive message he/she had written about him/herself; the patient was given a scrapbook to hold all photos to commemorate the PBMT experience.

**Findings & Interpretation:** The patient, family and staff were interviewed post discharge. The patient reported the project helped him identify his healthcare team members over his prolonged hospitalization; he also reported that the messages were motivational and helped him feel connected to his team. He especially enjoyed funny messages that helped lift his spirits when he didn’t feel well. The patient reported that he would not change anything about the project. The patient’s family members reported that the photos assisted them in identifying team members they had not previously met who were caring for their son. They felt the messages staff wrote were very inspiring, and both they and their son looked forward to getting a message each day. No adverse effects were reported.

**Discussion & Implications:** As a quality improvement project, we plan to use this tool prospectively with all admitted PBMT patients. We plan to assess for improvement in patient satisfaction related to identification of team members. We believe that this project can easily be replicated at other institutions and has a low overhead cost in relationship to the potential improvement in patient experiences.

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**“When the Going Gets Rough the Tough Get Going,” a BMT Unit’s CLABSI Reduction Quest**

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No adverse effects were reported.