Prevent Pressure Ulcers

The Kids' Campaign
2007 Pediatric Webcast Series

Wednesday, September 5, 2007
(12:00 noon Eastern; 11:00 a.m. Central; 10:00 a.m. Mountain; 9:00 a.m. Pacific)

https://www115.livemeeting.com/cc/chca/join
Meeting ID: 5MLives090507 (case sensitive)
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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Child Health Corporation of America

NACHRI National Association of Children's Hospitals and Related Institutions

Institute for Healthcare Improvement

Housekeeping

- Phone lines have been muted to reduce background noise
- For larger slides, go to view drop down menu and select full screen mode or hit F5
- For operator assistance, press *0
- Question and answer session at the conclusion of the presentation
- Session is being recorded and will be available on the AAP, CHCA, NACHRI, NICHQ and IHI websites

About The Kids' Campaign

The Kids' Campaign is coordinated by the Pediatric "Affinity" Node of the 5 Million Lives Campaign, which includes AAP, CHCA, NACHRI and NICHQ working together with IHI and leadership hospitals to build a robust knowledge exchange and help pediatric organizations eliminate preventable harm.

Introductions

Marie Oren-Sosebee, RN, BSN, CWOCN
Wound, Ostomy and Continence Nursing Coordinator
Children's Healthcare of Atlanta

Doris Hanna, RN, CPNP, ScD
Vice President, Programs
National Initiative for Children's Healthcare Quality

An Innovative Approach to Neonatal & Pediatric Pressure Ulcer Prevention

Marie Oren-Sosebee, RN, BSN, CWOCN

Wound, Ostomy and Continence Nursing Coordinator

About Us

- Consists of 3 hospital campuses
- Total 430 beds between Scottish Rite & Egleston with expected 500 beds by 2007-2008
- By 2009, pediatric population in Atlanta expected to grow to 120,000 children

Why this project?

- 2004 – Increase in Wound, Ostomy & Continence Nurse (WOC Nurse) consults for hospital acquired pressure ulcers in the Pediatric ICU (PICU) on Scottish Rite Campus
- 2005 – Key Quality Improvement Project for Pediatric ICU, Neonatal ICU (NICU), Technology Dependent ICU (TICU)
- 2006 – Additional Key Quality Improvement Project for Comprehensive Inpatient Rehabilitation Unit (CIRU) and Cardiac ICU (CICU)

2004 Initial Analysis: SR Campus PICU

- ***17 WOC Nurse consults*** for Scottish Rite campus PICU-acquired pressure ulcers & risk for pressure ulcers
- Medical diagnoses included cerebral palsy, respiratory failure, chronic granulomatous disease, quadriplegia, new tracheostomy, leukemia, CVVH, brain injury, malrotation with volvulus, renal failure, status epilepticus, immunodeficiency
- Age range 13 months to 19 years
- Areas of acquired pressure ulcers included posterior occiput, heels, trochanters, sacrum, scapula, spine
- Actual wounds varied from stages I-IV

Project Aim

- Decrease the number of hospital-acquired pressure ulcers by 25% by December 2006.

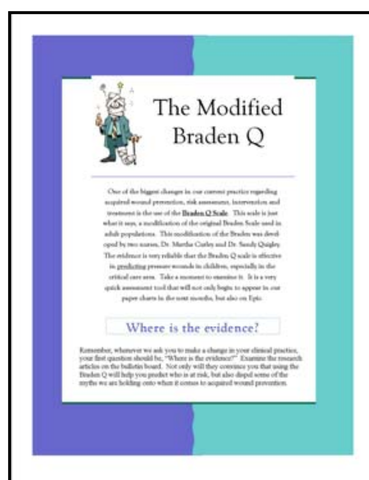
Key Resources

- **Martha Curley, RN, PhD, FAAN**
  - Industry expert for Pediatric Braden Q Scale
- **Texas Children's Hospital WOC Nurse Department**
  - Peer hospital using the Pediatric Braden Q Scale
  - Published pediatric pressure ulcer and skin breakdown prevalence surveys
- **Wound Ostomy and Continence Nurses (WOCN) Society: www.wocn.org**
  - Professional, international nursing society of more than 4000 nurse professionals who are experts in the care of patients with wound, ostomy and continence problems
  - Published "WOCN Clinical Practice Guideline Series: Guideline for Prevention and Management of Pressure Ulcers"
  - Published *JWOCN: Special Pediatric Focus* Volume 31:4 July/August 2004

Key Resources

- **Agency for Healthcare Research and Quality (AHRQ) (formerly AHCPR): www.ahrq.gov**
  - Lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans
- **National Pressure Ulcer Advisory Panel (NPUAP): www.npuap.org**
  - Authoritative voice for improved patient outcomes in pressure ulcer prevention and treatment through public policy, education and research
  - NPUAP Advisory Panel "Pressure Ulcer Prevention: A Competency-Based Curriculum," "Pressure Ulcer Treatment: A Competency-Based Curriculum," & "Pressure Ulcer Prevention Points"
  - NPUAP White Paper: "Pressure Ulcers in Neonates and Children"
- **Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): www.awhonn.org**
  - Professional nursing society aimed to improve and promote the health of women and newborns and to strengthen the nursing profession through the delivery of superior advocacy, research, & education
  - Published "Evidence-Based Clinical Practice Guideline: Neonatal Skin Care"

Education Materials



Message:

- The Pediatric Braden Q Scale** is a modification of the Braden Scale*.
- Consists of seven areas of evaluation, which yields a numerical value. Patients scoring a 7-16 are at HIGH RISK for skin breakdown.

*Based on adult Braden Scale by Bergstrom & Braden

**Adapted by Quigley & Curley

Pediatric Braden Q Pilot Results

9 Initial Challenges in Practice

1. Decision to implement 'risk' score for 7-16 based on pilot results & current published research data
2. Method for concise education plan for critical care & rehab staff versus patient care area staff
3. Method for evaluating nurse education & compliance
4. Method for nursing documentation of skin assessment score in paper chart

Pediatric Braden Q Pilot Results

5. Method for nursing documentation of performance of General Interventions (for patients scoring 'at risk') in paper chart
6. Develop standard reporting & tracking method for pressure ulcer P&I systemwide (including critical care areas and patient care areas)
7. Decision to use different neonatal/infant skin risk assessment scale in NICU
8. Apparent need for WOC Nurse services on Egleston campus
9. Decision to incorporate CICU and CIRU (Rehab) into initiatives based on identified risk population (i.e. ONS reports & admission data)

Develop Interventions for High Risk Patients

- Created CHOA Braden Q General Interventions for High Risk Patients

GENERAL INTERVENTIONS FOR HIGH RISK PATIENTS
(MODIFIED PEDIATRIC BRADEN Q SCORE 7-16)

- Turn q2hrs (minimal shift of 15 degrees with head shifts). Document actual position change on flow sheet.
  - *Exception neonates per NICU protocol*
  - *For CIRU patients:* Turn q2hrs in bed. Increase turn times ½ hour every week to maximum of q4hrs as tolerated
  - *For wheelchair-bound patients:* Wheelchair tilt with weight shifts every 20 - 30 minutes
- Float heels OFF mattress with pillows.
- Decrease HOB while repositioning patient.
- Use draw sheet to reposition and avoid dragging patient across bed.
- Remove urine/stool q2hrs and prn.
- Prop all tubing off patient.
- Evaluate pulse ox probe sites q12hrs and alternate sites q24hrs (policy 20.08). Document location on flow sheet.
- Avoid use of donuts on head or under bony prominences.
- Use moisturizers with AM care except on Neonates (< 1 month age).
- Cushion bony prominences with pillows or gel cushions.
- Avoid placement of feet at foot of bed rest.
- Evaluate need for pressure reduction mattress overlay or bed & obtain physician order when indicated.
- Complete an ONS for hospital-acquired pressure ulcers.
- For active pressure ulcers (Stages I-IV), obtain a WOC Nurse consult.

Perform initial identification of high-risk patient on admission then general reassessment q12hrs using Pediatric Braden Q.
(PICU, TICU/TDICU, CICU, & CIRU Departments only)

CHOA Braden Q General Interventions

- Turn q2hrs (minimal shift of 15 degrees with head shifts). Document actual position change on flow sheet.
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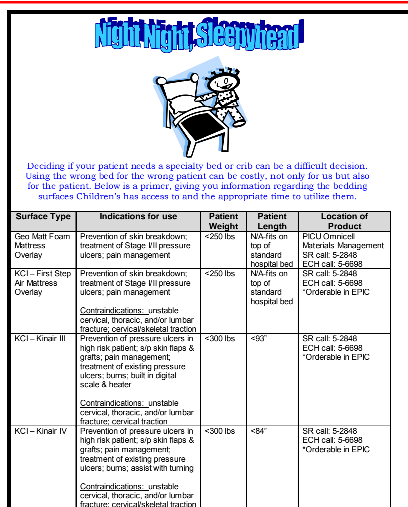
- Evaluate need for pressure reduction mattress overlay or bed & obtain physician order when indicated.
- Complete an ONS for hospital-acquired pressure ulcers.
- For active pressure ulcers (Stages I-IV), obtain a WOC Nurse consult.

Develop Mattress and Bed Selection Guideline

- Created CHOA Pressure Redistribution Mattress and Bed Selection Guideline



Night Night, Sleepyhead!

Deciding if your patient needs a specialty bed or crib can be a difficult decision. Using the wrong bed for the wrong patient can be costly, not only for us but also for the patient. Below is a primer, giving you information regarding the bedding surfaces Children's has access to and the appropriate time to utilize them.

Surface Type	Indications for use	Patient Weight	Patient Length	Location of Product
Geo Matt Foam Mattress Overlay	Prevention of skin breakdown; treatment of Stage I/II pressure ulcers; pain management	<250 lbs	N/A-fits on top of standard hospital bed	PICU Omnicell Materials Management SR call: 5-2848 ECH call: 5-6698
KCI – First Step Air Mattress Overlay	Prevention of skin breakdown; treatment of Stage I/II pressure ulcers; pain management Contraindications: unstable cervical, thoracic, and/or lumbar fracture; cervical/skeletal traction	<250 lbs	N/A-fits on top of standard hospital bed	SR call: 5-2848 ECH call: 5-6698 *Orderable in EPIC
KCI – Kinair III	Prevention of pressure ulcers in high risk patient; s/p skin flaps & grafts; pain management; treatment of existing pressure ulcers; burns; built in digital scale & heater Contraindications: unstable cervical, thoracic, and/or lumbar fracture; cervical traction	<300 lbs	<93"	SR call: 5-2848 ECH call: 5-6698 *Orderable in EPIC
KCI – Kinair IV	Prevention of pressure ulcers in high risk patient; s/p skin flaps & grafts; pain management; treatment of existing pressure ulcers; burns; assist with turning Contraindications: unstable cervical, thoracic, and/or lumbar fracture; cervical/skeletal traction	<300 lbs	<84"	SR call: 5-2848 ECH call: 5-6698 *Orderable in EPIC

Neonatal Skin Risk Assessment Scale (NSRAS)

NEONATAL SKIN RISK ASSESSMENT SCALE (NSRAS)

					Score
General Physical Condition	**4. Gestational age < 28 weeks**	**3. Gestational age > 28 weeks but < 33 weeks**	**2. Gestational age > 33 weeks but < 38 weeks**	**1. Gestational age > 38 weeks to posterm**	
Mental Status	**4. Completely limited** Unresponsive (does not flinch, grasp, moan, increase blood pressure, or heart rate) to painful stimuli due to diminished level of consciousness or sedation.	**3. Very limited** Responds only to painful stimuli (flinches, grasps, moans, increased blood pressure or heart rate).	**2. Slightly limited** Lethargic.	**1. No impairment** Alert and active.	
Mobility	**4. Completely immobile** Does not make even slight changes in body or extremity position without assistance (e.g., Pavulon).	**3. Very limited** Makes occasional slight changes in body or extremity but unable to make frequent changes independently.	**2. Slightly limited** Makes frequent though slight changes in body or extremity position independently.	**1. No limitations** Makes major and frequent changes in position without assistance (e.g., turn head).	
Activity	**4. Completely bed-bound** In a radiant warmer with a clear plastic “saran” tent.	**3. Limited bed bound** In a radiant warmer without a clear plastic “saran” tent.	**2. Slightly limited** In a double walled isolette.	**1. Unlimited** In an open crib.	
Nutrition	**4. Very poor** NPO on intravenous fluids.	**3. Inadequate** Receives less than optimum amount of liquid diet for growth (formula/ breast milk) and supplemented with intravenous fluids.	**2. Adequate** Is on tube feedings which meet nutritional needs for growth.	**1. Excellent** Bottle/breastfeeds every meal which meets nutritional needs for growth.	
Moisture	**4. Constantly moist** Skin is moist/damp every time infant is moved or turned.	**3. Moist** Skin is often but not always moist/damp; linen must be changed at least once a shift.	**2. Occasionally moist** Skin is occasionally moist/damp. Requiring an extra linen change approximately once a day.	**1. Rarely moist** Skin is usually dry, linen requires changing only every 24 hours.	

If score ≥ 13 begin infant on Standard of Care of Neonate at risk for skin injury.

Used with permission from “The Neonatal Skin Risk Assessment Scale for Predicting Skin Breakdown in Neonates” Issues in Comprehensive Pediatric Nursing Volume 20 Issue 2, 1997

- 6 Subscales
- Range 6-24
- High score = High risk
- Score ≥ 13 = Risk

*Based on adult Braden Scale by Bergstrom & Braden

Develop Neonatal/Infant General Interventions

- Created CHOA NSRAS General Interventions for High Risk Neonates/Infants

GENERAL INTERVENTIONS FOR HIGH RISK NEONATE/INFANT
(NSRAS SCORE ≥ 13)

- Reposition q2-4hrs (minimal shift 15 degrees, including head)
- Document actual position change q2-4hrs
- Cushion bony prominences & occiput with gel cushion
- Initiate use of sheepskin or foam, gel, or air mattress
- Remove urine/stool q2-4hrs and prn
- Prop all tubing off patient
- Evaluate pulse ox probe sites q12hrs and alternate sites q24hrs (policy 20.08). Document location on flow sheet.
- Minimize use of adhesives

Perform initial identification of high-risk patient on admission then general reassessment q12 hours using Neonatal Skin Risk Assessment Scale (NSRAS) (NICU Department only)

CHOA NSRAS General Interventions

- Reposition q2-4hrs (minimal shift 15 degrees, including head)
- Document actual position change q2-4hrs
- Cushion bony prominences & occiput with gel cushion
- Initiate use of sheepskin or foam, gel, or air mattress
- Remove urine/stool q2-4hrs and prn
- Prop all tubing off patient
- Evaluate pulse ox probe sites q12hrs and alternate sites q24hrs (policy 20.08). Document location on flow sheet.
- Minimize use of adhesives

Standardize Skin and Wound Products

- Standardized wound dressings
  - WOC Nurse met with Equipment & Technology Committee
  - Evaluated & initiated standardized silicone dressings
- Standardized topical wound care products
  - WOC Nurse met with Pharmacy Manager & Pharmacy Clinical Practice Council
  - Evaluated & initiated standardized topical wound products for enzymatic debridement, amorphous wound gel, antimicrobial ointment, & moisture barrier

Justify WOC Nurse

- WOC Nurse coverage initially for Scottish Rite campus
- WOC Nurse kept spreadsheet of phone calls from Egleston requesting assistance with patient care
- Compared O.R. reports & ICD-9 diagnosis codes of skin, wound & ostomy patients unable to receive WOC Nurse services due to limited coverage—tabulated lost revenue and quality impact
- Compared rental bed/mattress statistics between campuses—excessive spending on Egleston campus due to lack of WOC Nurse role in education and inservicing
- Wound Prevention Team efforts unable to be thoroughly implemented at Egleston without WOC Nurse role—less compliance with using skin risk assessment scales and general interventions
- Justified Egleston campus WOC Nurse position to provide fair & equal services between campuses—Magnet

Timeline

Aug 2005	Pressure Ulcer Prevention Education began and Braden Q Pilot in PICU
Sept 2005	Implementation of Pediatric Braden Q Scale in PICU, NICU, TICU
Oct 2005	Education and implementation of General Interventions for Braden Q Scale. Baseline incidence data collected.
Nov 2005	Standardization of Pharmacy formulary topical wound care products
Dec 2005	New WOC Nurse Role on Egleston Campus

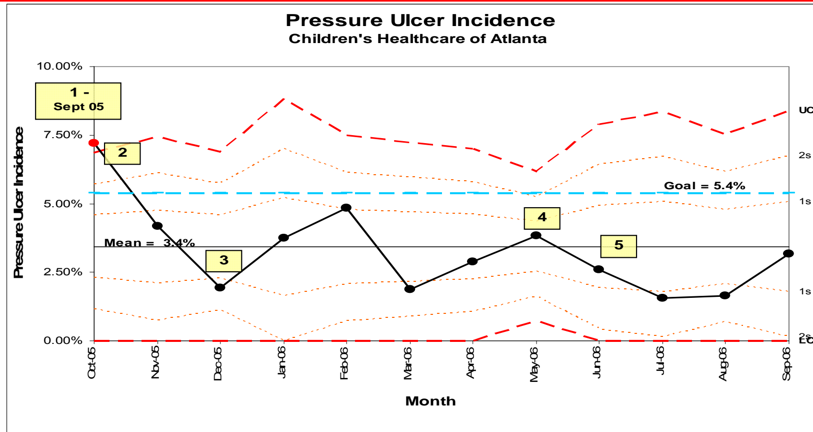
Timeline

May 2006	NSRAS Implemented in NICU and General Interventions
June 2006	CICU Implemented Braden Q and General Interventions
Feb 2007	Implemented Braden Q Scale and General Interventions in CIRU
May 2007	Launched computerized clinical staff documentation

Key Measures

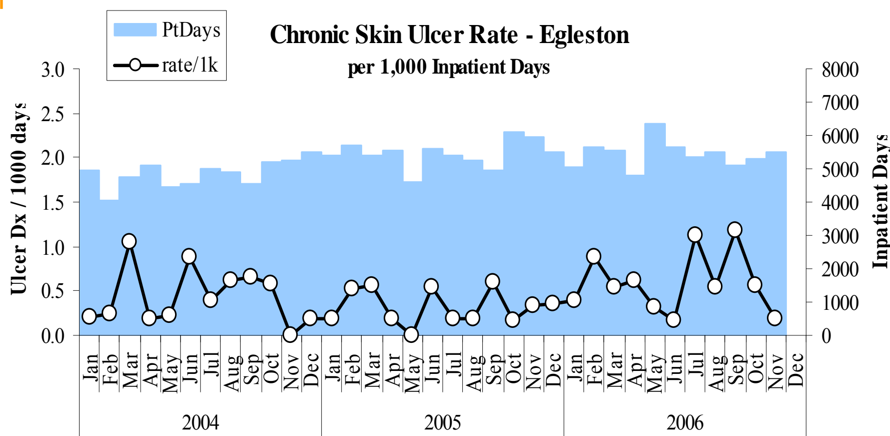
- Pressure Ulcer Incidence
  - Patients that develop pressure ulcers during their admission
  - Initially measured by manual chart audits & weekly surveys by 'super users' in high risk areas
  - Now measured by ONS reports
- Pressure Ulcer Prevalence
  - Patients with pressure ulcers at a point in time, regardless of whether the pressure ulcer developed during or before the current admission
  - Measured by ICD-9 codes
- Percent of patients scoring at risk
  - Initially measured by manual chart audits & weekly surveys by 'super users' in high risk areas
  - Now measured by computerized chart audits

Results – Surveyed Incidence

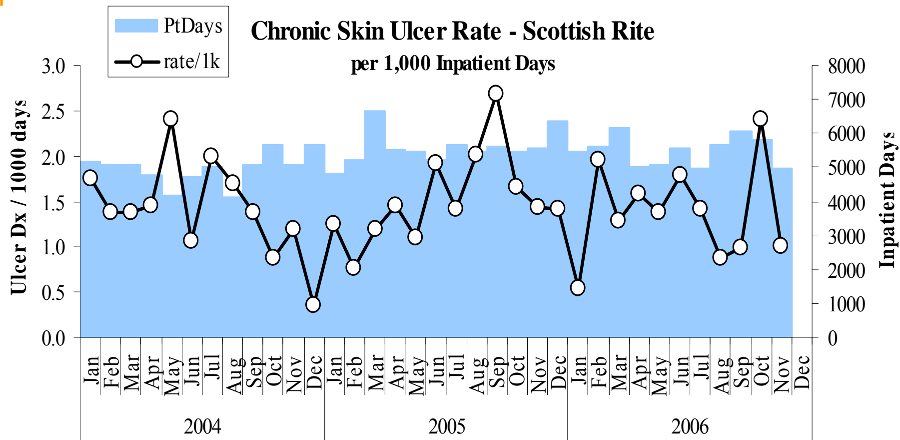


1 - Pediatric Braden Q implemented in Pediatric ICU, Neonatal ICU, and Technology Dependant ICU
2 - Education and implementation of General Interventions for High Risk Patients
3 - New WOC Nurse role on Egleston campus
4 - NSRAS and General Interventions for High Risk Patients implemented in Neonatal ICUs
5 - Pediatric Braden Q and High Risk Interventions implemented in Cardiac ICU

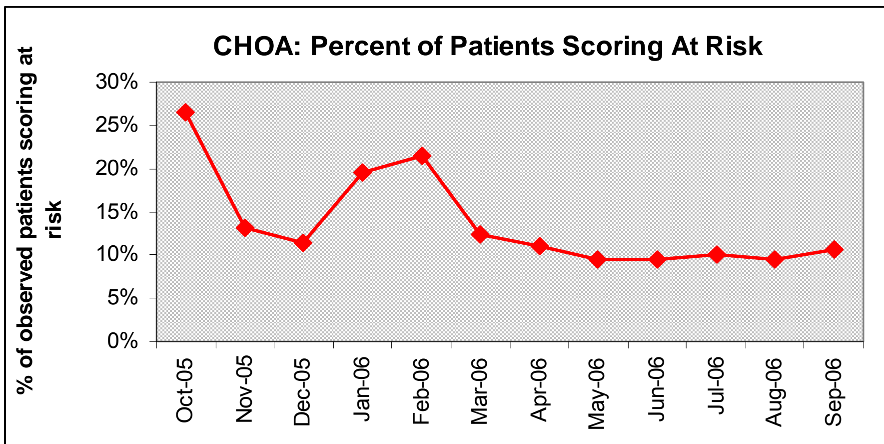
Results – Egleston Prevalence (ICD-9)



Results – Scottish Rite Prevalence (ICD-9)



Results – Patients Scoring at Risk in High Risk Setting



Results Summary

- **Pressure Ulcer Incidence** decreased by **59%** from October 2005 to September 2006.
- Self reported hospital acquired pressure ulcers increased by **650%** from 2004 to 2005.
- **Braden Q** with CHOA General Interventions successfully implemented in all high-risk areas (excluding NICU)
- **NSRAS** with CHOA General Interventions successfully implemented in both NICUs

Sustaining Results

- Decision Pathway
  - PICU, TICU, CICU, CIRU completes Braden Q risk assessment scale every 12 hours
  - NICU completes NSRAS every 12 hours
  - Braden Q score 7-16 generates use of CHOA Braden Q General Interventions
  - NSRAS score ≥ 13 generates use of CHOA NSRAS General Interventions
  - Patients admitted with pre-existing pressure ulcers generate WOC Nurse consult
  - Patients developing hospital acquired pressure ulcers generate WOC Nurse consult
  - Patients developing hospital acquired pressure ulcers have completion of ONS report

Spreading Improvements

- Initiate system-wide pressure ulcer prevention/care awareness
  - TEACH presentation
  - Mandatory education inservicing poster launch
  - WOC Nurse inservicing
  - Careforce Chronicle articles

Spreading Improvements

THESE PATIENTS ARE NOT AT RISK FOR DEVELOPING HOSPITAL-ACQURIED PRESSURE WOUNDS.

RIGHT?

The fact is acutely ill infants and children are at risk for pressure ulcers. We tend to use our intuition and experience in determining who might need special intervention, instead of a set of standards, based on best practice evidence.

The Wound Prevention Team, consisting of a multi-disciplinary team of nurses, respiratory therapists, and physical therapists from multiple areas of practice at CHOA, is addressing this need. Our ultimate goal is to prevent hospital-acquired pressure wounds. We want to educate you on proper pressure wound assessment and staging. We also want to shine the light on the misconceptions and myths we have about pediatric pressure wounds. Lastly, we want to update, standardize, and educate you on the products we have available to use to prevent and treat pressure wounds. When a patient does present with a pressure wound, we have provided direction on the proper reporting and consultation processes.

The need is evident. The desire to act is present. So, let's get started!

Fact or Fiction?

Many of our practices regarding wound prevention and care are based on our intuition, past experiences and influences from colleagues. As a result, each of us has our own unproven and frequently unsuccessful method of preventing pressure wounds. Look at the following statements regarding your everyday practice and wound prevention. Examine if you have been following the crowd or following the evidence.

- **There are some patients that simply cannot be turned under any circumstances.**

This is false. Essentially all patients can be repositioned with incremental movements as small as 15 degrees, which have been shown to be an effective prevention tool. Patients should be repositioned every 2 hours up to increments of every 4 hours to avoid skin damage.

- **Pressure wounds occur after a patient has been hospitalized for more than a week.**

Actually, the great majority of pressure wounds is inflicted in the first 12-24 hours of admission in compromised patients and occurs deep within the tissue. We simply see the evidence of those wounds after several days as it surfaces to skin level. Prevention of pressure wounds for our high risk patients needs to happen on admission.

- **If a patient is placed on a specialty bed that turns, I do not have to manually reposition them.**

Just because a patient is on a self-rotating bed does not mean they do not need to be manually repositioned. The assessment skills of a healthcare provider can never be replaced by technology. It is during repositioning that a caregiver can physically assess their patient for signs of skin breakdown. This is a cornerstone of care and an essential component of wound prevention.

- **Massaging a reddened area with lotion increases tissue perfusion and prevents progression of a pressure wound.**

Again, not true. If an area that is suspect for an evolving pressure wound (nonblanching erythema, pain, induration), massaging only increases the damage already done. Stage I wounds should never be massaged under any circumstances.

- **Duoderm is the treatment of choice for most pressure wounds.**

Actually, it's just the opposite. There are many wonderful products available to us to prevent and treat wounds. Duoderm is usually not the treatment of choice, since it holds moisture against the skin, becomes soggy and falls off.

- **Foam Donuts help reduce pressure to areas at risk for breakdown, especially on the head.**

False. Donuts redistribute pressure around the area and can either cause a wound or make an existing wound larger and more extensive.

Spreading Improvements

- Inclusion of Pressure Ulcer Prevention Education for New Nurses
  - Pressure ulcer prevention education incorporated into new nurse orientation
  - WOC Nurse presentation at Nurse Resident Orientation: "Three Cheers for Pediatric Wound, Ostomy & Continence Nursing"
  - WOC Nurse presentation at ICU Orientation: "The Wild World of Pediatric Wound, Ostomy & Continence Nursing"
  - WOC Nurse precepting/shadowing experiences for new PCA nurses & nurse externs

Parent/Family Involvement

- Target chronic high risk groups
  - Spina bifida
  - Cerebral palsy
  - Paraplegia & Quadraplegia
  - Brain injuries

Parent/Family Involvement

- Creation of skin/wound teaching materials for Patient & Family Education
- Topic outlines designate general points check-off for nurse to teach & provide to patient/family prior to discharge
- Teaching sheets or booklets provide more in-depth information for patient/family in conjunction with care or prior to discharge (i.e. 'Skin Care for Child with Limited Mobility')

Skin Care Teaching Sheet

Skin Care for a Child with Limited Mobility

Education INFORMATION FOR PATIENTS AND FAMILIES

Why is skin care important?
If your child is immobilized (unable to move freely) for any reason, pressure sores can occur. Too much pressure on the skin for too long a period of time causes pressure sores. Pressure causes a loss of blood flow to the area, which can cause part of the skin to die. Proper skin care and pressure relief (weight shifts) can help prevent pressure sores.

Where do pressure sores occur?
Pressure sores can occur in any area of the body, but bony areas are more likely than others to have problems. These include the:
- Skull and ears
- Shoulders and shoulder blades
- Elbows
- Hips
- Lower back and tailbone
- Knees
- Shins, ankles and heels

*Full Teaching Sheet will be posted on the Affinity Node (AAP, CHCA, NACHRI, NICHQ) websites

Diaper Rash Teaching Sheet

Diaper Rash
(Diaper Dermatitis, Candida Dermatitis)

Education INFORMATION FOR PATIENTS AND FAMILIES

What is diaper rash?
Diaper rash is a skin irritation in the diaper area. Diaper dermatitis is skin irritation from urine or bowel movements or a reaction to the diaper itself. Candida dermatitis (yeast diaper rash) is a diaper area infection caused by the yeast *Candida albicans*. Conditions that increase your child's risk of getting a yeast infection include:

- Antibiotic therapy
- Frequent stools
- Thrush
- Other forms of skin irritation

What are the possible symptoms?
Your child may have one or more of the following symptoms:

- Skin redness and rawness
- Diaper area blisters
- Fussiness and discomfort when the diaper is wet or soiled
- Diaper rash surrounded by red dots (yeast diaper rash)

* **Full Teaching Sheet will be posted on the Affinity Node (AAP, CHCA, NACHRI, NICHQ) websites**

Lessons Learned

- A multidisciplinary team is crucial for success.
- Evaluate current data to improve consistency with reporting and tracking methodologies.
- The WOC Nurse role has proven instrumental in assessment, evaluation, education, and implementation of care practices.
- The Braden Q scale is not suitable for the NICU population.

Tips and Advice for Other Hospitals – Do!

1. Create multidisciplinary team.
2. Identify high risk settings and groups to target prevention efforts to minimize risk.
3. Implement use of neonatal/infant vs. pediatric skin risk assessment tool in identified high risk setting.
4. Develop and implement use of appropriate strategies to attain and maintain intact skin.
5. Be creative when designing pressure ulcer prevention education, including staff and families.

Tips and Advice for Other Hospitals – Don't!

1. Don't ignore! Pressure ulcers do occur in the neonatal and pediatric population.
2. Adult skin risk assessment scales are not appropriate for use in the pediatric population.
3. Donuts are not effective at proper pressure redistribution. Evaluate & initiate evidence-based pressure redistribution products pertinent to the age & size population.
4. Don't wait until it's too late to identify patients at risk! The great majority of pressure wounds are inflicted in the first 12-24 hours of admission in compromised patients.
5. Don't exclude parents from involvement. They are your eyes and ears.

Questions & Discussion

Press *1 to ask a question

If your question has been asked, or to remove yourself from the queue, press #

Speakers' Bio & Contact Info

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Marie Oren-Sosebee, RN, BSN, CWOCN currently serves as the pediatric Wound, Ostomy & Continence Nurse (WOC Nurse) Coordinator for Children's Healthcare of Atlanta. As a certified WOC Nurse, Marie is responsible for the 2002 initial development and implementation of the comprehensive inpatient WOC Nurse role and department with the eventual expansion of inpatient services and development of the WOC Nurse Coordinator role. She functions as a clinical resource, liaison, and consultant to other health care professionals for the care of children ages birth to 21 years with skin, wound, ostomy, and/or continence disorders and diagnoses. Marie is a member of the national WOCN Society Pediatric Sub-Committee and has participated in numerous local and national speaking opportunities.

Speakers' Bio & Contact Info

Doris Hanna, RN, CPNP, ScD

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Doris Hanna, RN, CPNP, ScD has been with NICHQ since October 2005. She has served as the lead director on Project Access: Improving Care for Children with Epilepsy and on Reducing Delays and Loss to Follow-up in the Newborn Hearing Screening Program by Working Through the Medical Home. She serves as the lead on NICHQ's work on the Pediatric Affinity Group dedicated to purging harm from pediatric health care and recently assumed the position of Project Executive for the Childhood Obesity Action Network.

Dr. Hanna as held numerous faculty positions in schools of nursing specializing in pediatric nursing with clinical practica at Children's Hospital Boston. She worked as a consultant to the Massachusetts Coalition for the Prevention of Medical Error leading the project on Communicating Critical Test Results and collaborating on the Reconciling Medications initiative. The Coalition used the learning collaborative model to facilitate the implementation of these two patient safety initiatives in Massachusetts. She has two recent publications in the Joint Commission Journal on Quality and Patient Safety based on her work on these projects.

Dr. Hanna was a member of the Reconciling Medications implementation team and a quality improvement specialist at Children's Hospital Boston. After earning her doctoral degree from the Harvard School of Public Health she pursued certification as a Pediatric Nurse Practitioner and maintains clinical practice in the urgent care clinic at a local HMO.

Resources

Visit www.aap.org, www.chca.com, www.childrenshospitals.net, www.nichq.org or www.ihi.org for copies of today's:

- Webcast Recording
- Presentation
- How-to Guides
- Pediatric Supplements
- Speaker Biography

To learn more about The Kids' Campaign and the 2007 Pediatric Webcast Series including information on upcoming topics and how you can share your success stories contact:

deborah.boetig@chca.com.

2007 Pediatric Webcast Series

- *July 11 - Preventing Harm from High-Alert Meds*
- *July 25 - Reducing MRSA Infections*
- *August 8 - Getting Boards on Board*
- *August 22 - Reducing Surgical Complications/Surgical Site Infections*
- *September 5 - Preventing Pressure Ulcers*
- *September 26 - Deploy Rapid Response Teams*
- *October 3 - Prevent Adverse Drug Events*
- *October 17 - Prevent Ventilator-Associated Pneumonia*
- *October 31 - Prevent Central Line Infections*

All calls are scheduled at noon eastern; 11am central; 10am mountain; 9am pacific