

Putting Patient Provider Communication at the Forefront: Overcoming Barriers Through Phases of Pediatric Inpatient Program Development

Tuesday August 9, 2016 8:30 – 10:30
Room Harbour B

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Disclosures:

- John Costello M.A., CCC-SLP has no financial relationships to disclose. He is an employee of Boston Children's Hospital where he receives a salary.
- Tami Altschuler M.A., CCC-SLP has no financial relationships to disclose. She is an employee of NYU Langone Medical Center where she receives a salary.
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- Rachel Santiago, M.S., CCC-SLP has no financial relationships to disclose. She is an employee of Boston Children's Hospital where she receives a salary.

Today's Agenda:

- Communication Vulnerability and Patient Provider Communication
 - What is it? Why is it important?
 - Barriers to Success
 - Background: Pediatric AAC at Bedside
- Establishing a Program: NYU Langone Medical Center
- Maintaining a Program: St. Louis Children's Hospital
- Sustaining a Program: Boston Children's Hospital
- Questions and Discussion

It is not possible to pay too much attention to communication vulnerability in the hospital setting



what i think

what i say

Altered cognition



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What is Communication?



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What is Communication Vulnerability?

- Vision so poor that the patient is unable to read/see, even with corrective lenses*
- Inability to understand loud speech, even with hearing aids*
- Inability to produce speech that is intelligible to the team (occurring as result of disease OR medical intervention) *
- Altered mental status*
- Inability to speak or understand the language of the medical team
- Cultural differences/mismatch
- Limited Health Literacy

—

*Serious communication disabilities in hospitalized patients,
Ebert, D. N Engl J Med. 1998



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Why do we need to pay attention to this?

- Quality of life/quality of care
- The Joint Commission (health care accrediting agency in the US) - changes to hospital standards for accreditation that address communication
- Increased focus nationally and internationally on the impact of communication vulnerability on patient care.

Barriers/challenges

Discussion: *What are the barriers to the use of AAC in the hospital setting?*

Barriers to communicative success according to The Participation Model

(Beukelman and Mirenda 1988)

- | | |
|---|--|
| <ul style="list-style-type: none"> • Access Barriers <ul style="list-style-type: none"> – Physical/motor – Cognitive – Literacy – Visual/auditory | <ul style="list-style-type: none"> • Opportunity Barriers <ul style="list-style-type: none"> – Policy – Practice – Knowledge – Skill – Attitude |
|---|--|

What are some of the current
barriers in many hospital
settings?

Practice barriers

- A person is often in the hospital for life saving or life sustaining measures.
- The clinical priorities of the medical team focus on the urgent medical needs of the patient before communication.
- It is only in rare instances that poor patient communication and the ensuing stress and fear related to that communication vulnerability is recognized as a direct factor in a patient's medical state and recovery.*
- 'We do not welcome staff who are not part of our unit'

Attitudinal barriers

- medical thinking – nurse/doctor knows best
- the medical environment is too scary, new and complicated to expect a novice to be a partner in the process
- It is easier to provide medical care if the patient does not interfere by asking questions, negotiating or challenging decisions.

Knowledge barriers

- Nursing has identified communication as an area of need for more than 20 years.
- Information about resources (tools and professionals) is frequently not available to nurses.
- The practice of AAC for patients who are nonspeaking, is not familiar to nurses as this is not part of nurse training and minimal information in the nursing literature addresses the issue of communication vulnerability.
- The lack of knowledge regarding the assessment process, identification of appropriate tools and strategies and implementation expertise is a significant barrier to patient care (*What can they do for him? They work with speech?*)

Resource barriers

- Resources may be described both in terms of clinical tools and access to clinical experts.
- Tools: While it is not uncommon for an ICU to use marker and paper, a letter board or a dry erase board, even generic communication boards or simple voice output aids are typically not available.
- Clinical expertise in the assessment and implementation process may not be available to the institution
- *Even within field of speech pathology, professional preparedness has not kept up with the growing interest in augmentative communication services especially as it relates to hospital services

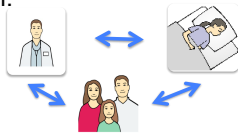
Environmental Barriers

- The hospital environment is dense with medical equipment and supply carts.
- Patient bedspace may have limited room for additional equipment/material
- Due to storage limitations, communication tools and equipment may not be readily available (at a bedspace OR even on the unit).
- Electromagnetic Interference (EMI) considerations may be barrier for some technology
- We can't so that because you can't clean the communication equipment.

Children are NOT small Adults

Why is pediatric acute and intensive care different from adult services?

- The bedside assessment and intervention involves a triad of interaction including the child who may be developmentally quite young, the parent(s) and siblings and the clinician.



We propose basic tenets (A-B-C-D-E-F) for successfully engaging a child at bedside.

- Assure
- Bring
- Control
- Direct
- Emotion and Personality
- Fun

Costello and Santiago, manuscript in review

A-B-C-D-E-F

- **Assure** – In a hospital setting, a child is constantly on guard for the clinician who will invade their personal space and introduce an unwanted procedure
- **Bring materials and tools** with you to the first visit. For many children, 'seeing is understanding'
- **Control**. Children need to feel a sense of control in the hospital.

Costello and Santiago, manuscript in review



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A-B-C-D-E-F

- **Direct attention to the child**. While your behavior will ultimately be directed by the child's behavior, your attention should always be to the child first
- **Emotion and personality** - hospitalization is a very emotional experience. Loneliness, isolation, separation, anxiety, sorrow, etc. The reflection of personality is essential and is key to successful development and implementation of communication strategies.
- **Fun**. Children understand their world and cope through play. Despite potentially life threatening medical circumstances, you must be ready to focus on fun
- Costello and Santiago, manuscript in review



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Regardless of point of care

A patient should be able to:

- ◆ Access nurse call
- ◆ Gain attention of loved ones/others in the room
- ◆ Participate in own care at level medical and cognitive status allow with appropriate language/representations
- ◆ Have his/her methods of communication documented for all providers to understand/expect
- ◆ Have access to the most appropriate communication tool ranging from quick access/no tech strategies to high tech integrated systems



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Profile/Phases of Communication Vulnerable Patient

Phase 1: Emerging from Sedation

Phase 2: Increased wakefulness

Phase 3: Need for Broad and diverse
communication access

(Costello, Patak, and Pritchard, 2010)



Phase 1 Emerging from Sedation

- Yes - no - I don't know
- Call for nurse/modified nurse call
- Gain attention of loved ones/staff with simple voice output

Also – developmentally young/emergent communicators and 'control'



Phase 2 Increased wakefulness

- Require all of phase 1 strategies
- Require more relevant vocabulary
- Picture boards – needs, body/comfort, personal interests
- Alphabet boards
 - ABC
 - QWERTY
- Multi-message voice output devices with digital or synthetic messages
- Voice amplification



Phase 3

Broad and Diverse Communication Access

- All options from phase 1 and 2
- Generative communication with alphabet and sophisticated page sets
- Word and grammar prediction
- Encoding strategies
- Music and video files
- Internet access
- telephone





NYU Langone Medical Center

- Hassenfeld Children's Hospital is housed within several locations throughout NYC - not a centralized building.
- PICU has 13 beds.
- General Pediatric Unit has 30 beds.
- Dedicated children's hospital is currently being built and with an anticipated opening date of 2017.
- Outpatient OT who specializes in Assistive Technology is an AAC provider for adults.
- Outpatient pediatric AAC evaluations are provided at another campus.
- Inpatient services have been limited.

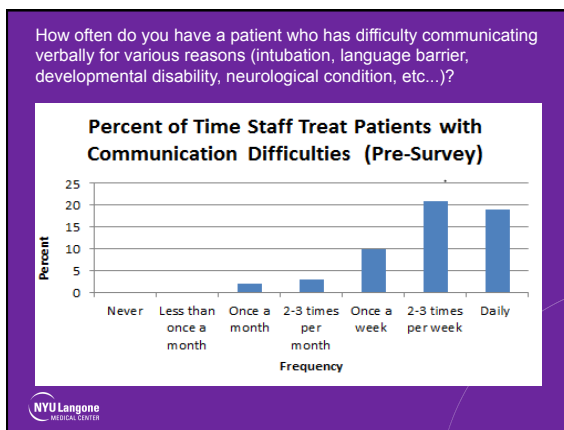


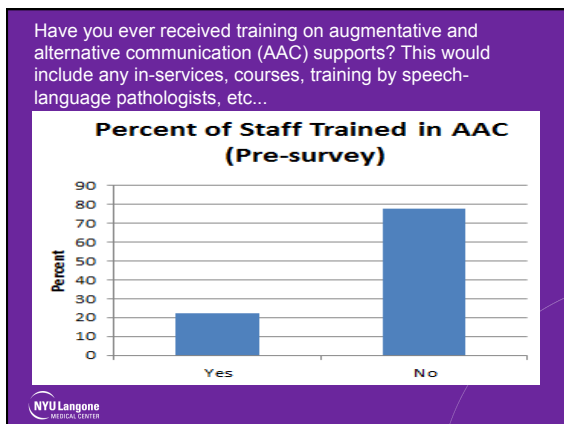
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Program Development

- Identified the need for communication supports in the PICU.
- Long-term plan is to implement a program hospital-wide, however the PICU is an ideal place to start.
- Strengths are administrative support and funding.
- Awarded a grant for funding to develop an AAC toolkit (low-tech to high-tech supports on the unit).
- Multi-disciplinary support: designating "Nurse Champions" and "Child Life Specialist Champions".
- Survey dispersed to better understand current perceptions by medical staff.







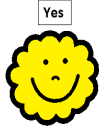
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Program Development

- Trained staff on communication strategies and supports for children with communication vulnerabilities (early March 2016).
- Participating in PICU rounds to flag patients with risks for communication difficulties.
- Co-treating with PT and OT when they are addressing early mobility.
- Created a parent handout in multiple languages which is included in admission packets.



Communication Toolkit


ALWAYS REFER THE PATIENT FOR A SPEECH/LANGUAGE EVALUATION

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Focus On:

- Attitude
- Resource
- Knowledge



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Attitude

Historically, hospital culture is that speech therapy services prioritize feeding/swallowing over communication as it is considered to be the more medical concern.

Challenges:

- This has been a departmental culture as well.
- Medical and rehab staff have been noted to feel that communication needs can be addressed by “dropping off a communication board.”
- Therapists have decreased confidence in their skills and resources.



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Attitude

Solutions:

- Encouraging SLPs to observe AAC evaluations and treatment.
- Co-treatments with SLPs to demonstrate how to incorporate AAC into evaluation and treatment of feeding/swallowing.
- Demonstration of how provision of communication supports can improve outcomes for feeding/swallowing.
- Review of education and currently available resources, tools, materials within the department.



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Resource

Productivity demands limit time allotted to address communication needs.

Challenges:

- Pressure to increase billable time versus the unbillable time needed to develop AAC systems/communication supports.
- Therapists have limited time available to observe AAC sessions.
- Demands of patient care supercede clinical development in this area.



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Resource

Solutions:

- Ongoing education regarding shift of culture that communication is a medical priority.
- Short-term pain for long-term gain.
- Streamlining AAC needs/referrals to one SLP mostly.
- Development of protocols/materials to ease burden of care from other therapists.



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Knowledge

There is a need further understanding of how speech therapy services can be utilized to address communication needs of critically ill patients.

Challenges:

- Efforts to increase presence of therapies in ICUs often exclude communication assessments/interventions. Focus is on patient mobility.
- Admission order set is for PT/OT/ST. Speech is often automatically “unclicked” when a patient is intubated.
- Staff turnover: residents/attending physicians rotate each month.



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Knowledge

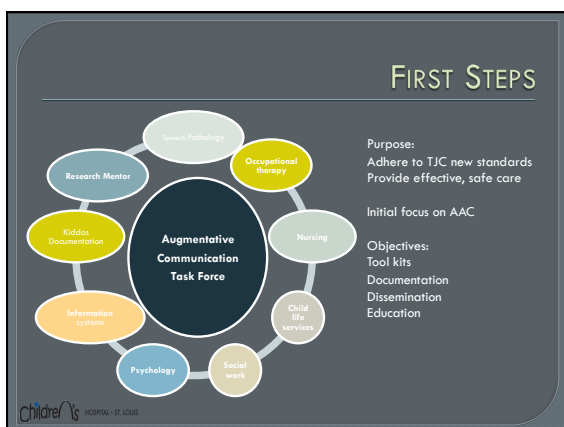
Solutions:

- Early Mobility Project is being used as a vehicle to introduce AAC in the PICU.
- Communication needs are being identified by SLPs evaluating feeding/swallowing. “I saw a patient for swallowing and I think they need your help with communication.”
- Flagging patients with risks for communication difficulties during PICU rounds.









PRELIMINARY SURVEY

- Evidence gathered by the study team indicated that approximately **200 opportunities were identified over one month** when a PICU patient could benefit from augmentative communication.

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DYNAMIC LOW-TECH COMMUNICATION BOARD

- Low-technology design with a combination of symbolic & overlay categories that include:
 - Text based core words used in medical setting
 - Dry erase section for handwriting
 - Alphabet board with repair strategies
 - Pain overlay

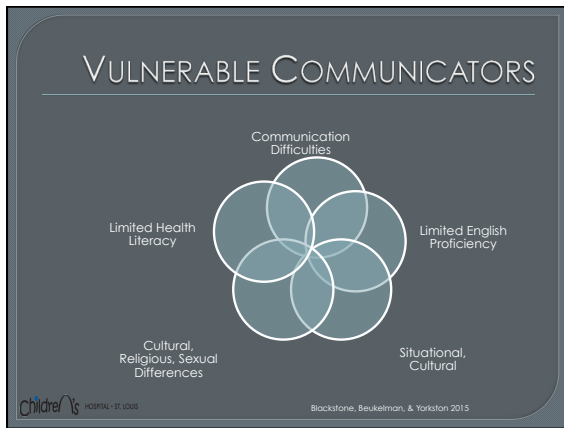


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PROPERTIES OF COMMUNICATION BOARD

- Layout accounts for rapidly **changing capabilities of patients** in the critical care setting.
- **Technical capabilities** of facilitators
- **Communication first**, no competition for multi-use tools
- **Inexpensive**/ Ease of funding
- 50 communication boards : one for each PICU bed

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WHAT ARE WE DOING NOW? WHAT'S WORKING?

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DURING AND AFTER VIDEOS ©

KNOWLEDGE AND EDUCATION

- Monthly new hire orientation -phase 2 written curriculum
- AAC Labs within the PICU and on the units
- Unit-based joint practice council
- Rounding of patients on the floors to help care providers identify appropriate patients
- Presence at psycho-social rounds within the PICU to assist in identification of appropriate patient referrals
- Participation in the EMP group and delirium rounds
- Inpatient time to build rapport and identify more appropriate referrals
- B.U.N.T.
- Physician education regarding new order format
- Continued education hospital wide to include the Ambulatory Procedure Center, Same Day Surgery, Emergency Department, and other inpatient units

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COMMUNICATION EFFORTS

- Weekly happenings
- Children's Chat
- Testimonial and education collection
- Increase visibility of AAC/PPC (screen savers, table tents, flyers, etc.)
- BUNT cards and bookmarks distributed at new hire orientation and placed on workspace computers

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DOCUMENTATION EFFORTS

- Interdisciplinary adaptive care plan
- New order format

Children's HOSPITAL - ST. LOUIS Attitude and Practice, Referral Process, Staff Support

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COMMUNICATION SUPPORT COHORT

- Leaders of communication support programs at SLCH working together to acknowledge each specialty and interest, but also to educate and promote one another.
- Present as a united front for patient-provider communication throughout the organization
- Helping advocate for training and documentation
- Authored a resource list for the hospital

 Attitude and Practice, Education, Staff Support

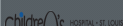
RESOURCE LIST

- Speech Pathology: Available for communication consult
Inpatient Communication Board
Customized communication supports and varied access methods are available as well
- Language Services (Formerly Interpreter Services)
Call center (Phone or in-person interpreter services)
Print transcriptions available, including Braille
Video Remote Interpreter (iPad)
- Occupational Therapy
Vision, Sensory, Motor support
- Audiology
Place hearing test orders through KIDDOOS
Hearing aid support and minor troubleshooting
Cochlear implant support and minor trouble shooting
- ADAPTED ORAL BUTTONS
Bio Med
Occupational Therapy Consult
- ABOUT ME SIGNS - HOSPITAL WIDE
Facilitated through admission packets
- ADAPTED TOY PROGRAM
Available for children with sensory and motor delays
Child Life Services
- Passy Multi-Speaking Valve (PMVSV)
Must have medical clearance to be trialed
Majority of acute patients do not qualify for PMSV due to increased respiratory need
If on a vent with a cuff inflated, not medically stable for a valve
Consider augmentative communication supports

 Attitude and Practice, Education and Staff Support

CASE STUDY

PRESENTING:	INITIAL CONSULT:
• 19 y.o. female with developmental delay and Cockayne Syndrome • Non-native English speaker, not documented in EMR • Hearing loss • Vision impairment	• Increased sedation as a result of agitation • Posey bed/restraints • Decreased compliance and participation in therapies and medical care



CASE STUDY-CONTINUED

- Hearing aides were fixed and placed
- Communication supports were customized with tactile feedback to accommodate for visual impairments
- Supports customized in both Mandarin and English
- Upon a follow up speech consult, it was observed that the patient was independently producing individual manual signs for *more*, *open*, *all done* and *mine*.
- A sign inventory was created, presented to nursing, and hung in her room.

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CASE STUDY-CONTINUED

- Staff reported a *completely different child* once her hearing aides were fixed and placed
- Decreased sedation and restraints
- Increased participation in therapies
- Increased "playfulness" and overall positive affect
- Staff also reported feeling better about the care they were providing
- *Communication Cohort members utilized: Speech Pathology, Audiology, Language Services, Child Life*

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COMMUNICATION SUPPORTS COHORT: DOCUMENTATION

- Interdisciplinary team is working to develop a standardized adaptive care plan that will become a part of the EMR and will follow a child across admissions
 - Communication needs
 - Preferred language of patient and caregiver
 - Sensory needs
 - Behavior plan
 - Adaptive equipment
 - Calming strategies
 - Etc.
- Working with Epic to ensure that communication supports are documented at intake, streamline the order process, and make communication supports an easily accessible piece of information in the patient's chart

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ADAPTIVE CARE PLAN

- We are proposing BJC/SLCH adopt the following:
- a **comprehensive** adapted screening tool
- Information derived from this screening tool would then become **transparent** within the EMR, making essential information identified in the header/banner, FYIs and Summary portion of Epic.
- Identification of certain information or needs would be built into the **operation** to trigger alerts to nursing and identify referral need.
- **Continuity:** This information needs to remain transparent in the EMR across HSO, departments, and lifespan.
- **Accountability** for completing the adapted screening tool. All parts would be mandated to complete.
- A **collaborative, dynamic** approach to filling out the screening tool.

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OUTCOMES AND NEXT STEPS:

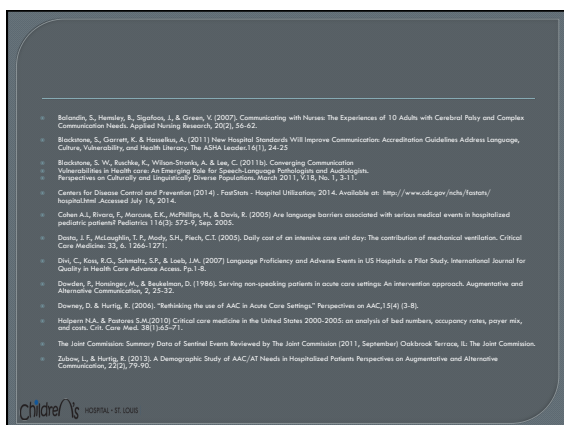
- All of this work has led to an **emerging culture** shift toward valued PPC

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RESOURCES

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Background and Overview of Efforts

- BCH:
 - 400 beds
 - 4 ICUs
 - Ongoing plans for expansion & increased # of beds
- Service provision for 25+ years
- Formal inpatient position for ~10 years
- Current positions
 - 2x 1.0 FTE, 2 SLPs
 - Established outpatient clinic (formerly on main campus)
 - Position stems from Augmentative Communication Program
 - Focus on AAC implementation through the continuum of care
 - Equipment closet with a variety of AAC tools and materials
 - Average caseload: variable; ~30 patients on a given day and rising!

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History of Success: Acceptance, Understanding, and Hospital Culture

- Years of service delivery = staff-wide awareness
- Outpatient presence → Inpatient presence
- Culture of care
 - Inclusive
 - Total care of child
 - Strong psychosocial teams
 - Supportive administration
- Collaborative atmosphere

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Still...

Barriers to service delivery always exist!

Overcoming these barriers is ongoing and may require a shift in focus over time.



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Focus On:

1. Attitude and Practice
2. Referral Process
3. Education (staff and family)
4. Resources
5. Key Considerations for Established Programs



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Attitude and Practice

- Strong departmental support
- Early history of acceptance and inclusion from ICU admin.

Challenges:

- Frequent staff turnover
- New hires associate "Speech Pathologist" with dysphagia
- Low familiarity of AAC and PPC (staff and families) and benefits
- BCH = *highly* complex medical needs; communication as a contributor to quality care may be overlooked.



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Attitude and Practice

Solutions:

- Ongoing in-services to educate staff (yearly!)
- Psychosocial team members advocate for communication enhancement.
 - Closely work with patients and families
 - Are educated on risks/benefits of communication access
 - Interdisciplinary rounds for multiple units and departments → increased staff awareness
- Signage and handouts for staff in RN lounges, front desks, computer stations

Visibility → Awareness → Understanding → Change in Attitudes and Way of Practice



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Attitude and Practice

Solutions:

- Now with 2 FTE SLPs:
 - Culture of staff → advocated for 2nd SLP need
 - Stemming from a long history of staff appreciation, acceptance, and understanding of service provision and AAC implementation!
 - Administration understands:
 - Staffing and coverage needs
 - Demands
- Increased presence in unit rounds
- Increased presence on floors
- Increased ability to provide consistent and ongoing education to staff and families
- More frequent follow up with patients



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Referral Process

- Consult orders placed as "Augmentative Communication"
- Utilized well since conception of position but room to address quality improvement

Challenges:

- Confusion among staff re: referral keywords
- Information gathered through Nursing Admission Assessment is limited
- Late referrals
- Providers verbally request consult but do not formally refer consults.



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Referral Process

Solutions:

- Ongoing in-services to educate staff
- Teamed with CHAMPS
 - modified referral order search terms
 - modified NAA and automatic screening referrals
- RN teaching video re: placing referrals
- Streamlined documentation for evals and follow-up visits
- Ongoing:
 - Interdisciplinary rounds
 - Presence on units
 - Collaboration with nursing, physicians, and psychosocial providers




NURSING ADMISSION ASSESSMENT

Interpreter Needed - Patient? ☐ Yes ☐ No

Interpreter Needed - Parent/ Guardian? ☐ Yes ☐ No

Interpreter Contact:

For inpatient, answering yes will place an automatic referral to the Interpreter Services.

Does the Patient Have Any Communication Challenges?

☐ Yes ☐ No ☐ Unable to assess

Does the Patient Have Any Existing or Anticipated Communication Vulnerabilities?

☐ Patient cannot speak
☐ Tracheostomy in place
☐ Patient uses Sign Language
☐ Due to intubation
☐ Patient uses communication system
☐ Patient is unable to use standard call light
☐ Other:

Cognitive/Perceptual Pattern

Any Speech Issues? (Required)

☐ Yes ☐ No ☐ Unable to assess

Please Describe Speech Issue(s)

☐ Developmental delayed ☐ Vocal cord paralysis
☐ Articulation difficulties ☐ Non-speaking
☐ School therapy ☐ Other:

Does Your Child Have Difficulty Hearing? (Required)

☐ Yes ☐ No ☐ Unable to assess

Please Describe Hearing Issue(s)

☐ Cochlear implant, left ☐ Ear plug, right ☐ Hearing loss, left
☐ Cochlear implant, right ☐ Ear tube, left ☐ Hearing loss, right
☐ Deaf, left ☐ Ear tube, right ☐ Other:
☐ Deaf, right ☐ Hearing aid, left
☐ Ear plug, left ☐ Hearing aid, right

For inpatient, consult Center for Communication Enhancement.




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Education

Challenges:

- Ongoing in-services and effects on productivity

- Presence and involvement in patient and team meetings yields increased education

Negatively affects productivity

Unbillable hours

- Frequent staff turnover (MDs and RNs)
- Individualized education re: multitude of bedside communication strategies




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Education

Solutions:

- Ongoing in-services
- 1:1 Bedside education to patient, staff, and caregivers
- Bedside signage
- Follow up throughout continuum of care → ongoing monitoring and modification of needs
- Committees:
 - Developmental Care Implementation Committee
 - Autism Spectrum Center
 - Child Life Services – Adapted Play Initiative (Spectrum Kits), Bilingual Topic Boards
 - Tracheostomy Care Team
 - Communicating with Non-English Speaking Families

Utilization of interpreter services - increased # of international patients and PPC support for Non-English speakers



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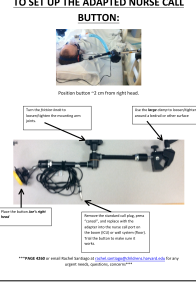
BEDSIDE SIGNAGE & EDUCATION

“I can understand what you are saying. Please speak directly to me.”

“I blink *once* for YES and *twice* for NO”

“Please write when speaking with me. Use the dry erase board or typewriter”

TO SET UP THE ADAPTED NURSE CALL BUTTON:



***PLEASE NOTE: In small hospital for steps to <http://www.bostonchildrens.org/PPC/PPC%20Resources%20for%20the%20NICU%20and%20NICU%20Nurses> for the NICU and NICU Nurses, please contact the NICU and NICU Nurses.



Boston Children's Hospital
Until every child is well



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

BOSTON CHILDREN'S CHILDREN'S HOSPITAL

Resources

Challenges:

- Equipment management
- Staffing (less challenging now w/ 2.0 FTE)



Boston Children's Hospital
Until every child is well



HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL

BOSTON CHILDREN'S CHILDREN'S HOSPITAL

Resources

- Solutions:
 - Departmental support!
 - Close partnership with Child Life Services
 - Established equipment return protocols
 - unit specific
 - Standard communication boards in ICUs
 - On-call coverage
 - Well educated, experienced staff!



BOSTON CHILDREN'S CHILDREN'S HOSPITAL

What We've Learned:

Key Considerations for Established Programs

- Quality Improvement DOES NOT END with a good work flow
- Advances in strategies, tools, and technology means ongoing professional development and education
- Education for staff, families, *and* patients MUST be ongoing throughout the continuum of care.
- Productivity will inevitably increase with:
 - Increased presence and visibility on units
 - Increased presence in rounds
 - Increased presence at the bedside
 - Ongoing in-service education for staff
 - Increased collaboration with providers (medical *and* psycho-social team members)
 - Ongoing communication with bedside nurses re: changing patient status
 - History of successful outcomes at the bedside!



THANK YOU!

Questions?