New Knowledge, Innovations, & Improvements
RESEARCH

NK2 - Nurses disseminate the organization’s nursing research findings to internal and external audiences.

Example B: Provide one example, with supporting evidence, of how clinical nurses disseminated to external audiences knowledge obtained through the organization’s nursing research.

Advocate BroMenn Medical Center Clinical Nurse Research: Management of Pediatric Pain during Phlebotomy and Intravenous Cannulation Procedures

One of the research projects Advocate BroMenn Medical Center’s nurses disseminated to external audiences was a study on the management of pediatric pain during phlebotomy and intravenous cannulation procedures. LoriLee Dunahsee, BSN, RN, CPN, Charge Nurse (clinical nurse), Pediatric/Outpatient Infusion unit, was the Primary Investigator (PI). In this study she explored the misperceptions and barriers that may impede optimal pain management in the pediatric population. A full literature review and evaluation of the issue was completed prior to the study being implemented. Twelve registered nurses working on the Pediatric/Outpatient Infusion unit were eligible for participation in this study.

The project was submitted and approved through the Institutional Review Board on October 2, 2012, and the study was completed on December 1, 2012. Two research questions guided the study:

- Is pediatric pain effectively managed in the pediatric department during phlebotomy and intravenous cannulation?
- What are the barriers to effective management of pediatric pain during phlebotomy and intravenous cannulation?

An eight item survey was developed to measure nurses’ feelings of effectiveness in managing pediatric patients’ pain during phlebotomy and intravenous cannulation procedures. Survey items were based on key issues identified during the literature review.

The PI conducted meetings with associates to explain the survey and provide instructions on its use. Pediatric charge nurses were responsible for keeping track of the number of phlebotomy/cannulation procedures and survey tools were placed in a central location when completed.

Twenty data collection forms were completed in the three weeks the study took place. This number was equal to the number of procedures performed in that time frame. One form was omitted due to missing data. Types of procedures were as follows: eight were
phlebotomy only; three were intravenous cannulation only; and eight were a combination of intravenous cannulation with phlebotomy. Age ranges of patients who received phlebotomy and/or intravenous cannulation were seven days to eighteen years of age. A family member was present for seventeen of the nineteen total number of patients.

Results showed that the nurses were comfortable and believed their pain management strategies in this patient population were effective in managing pain for those requiring phlebotomy and intravenous cannulation procedures (Exhibit NK2.B.1 Research Paper).

Knowledge Shared with External Audience

Each year Advocate Health Care (AHC) holds a research symposium that highlights research projects throughout the healthcare system. Attendees include nurses from all across the system. LoriLee presented her research findings at the AHC’s 1st Annual Nursing Research Symposium that was held on Tuesday, April 9, 2013, in Oak Lawn, Illinois, at Advocate Christ Medical Center (Exhibit NK2.B.2 2013 Research Symposium Brochure with Poster Presenters). Research findings were shared via a poster presentation and through dialogue with nursing peers during the poster session (Exhibit NK2.B.3 Copy of Pediatric Pain Poster Presented).

7.27.16 jlm
Barriers to Effective Management of Pediatric Pain During Phlebotomy and Intravenous Cannulation

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BARRIERS TO PEDIATRIC PAIN MANAGEMENT

Abstract

Pain management is essential to quality care of the pediatric patient, as well as to patient satisfaction. However, pediatric pain during phlebotomy and intravenous cannulation continues to be poorly managed. The aim of this study is to identify current misperceptions and barriers to pediatric pain management during phlebotomy and/or intravenous cannulation following a descriptive, quantitative research design. Studying misperceptions and barriers to pain management, and providing nurses with education and strategies to overcome these misperceptions and barriers is necessary for best practice and improved outcomes.
Barriers to Effective Management of Pediatric Pain During Phlebotomy and Intravenous Cannulation

Introduction

Pain management in the pediatric population is essential to quality nursing care and patient satisfaction, but continues to be inadequately controlled. Many pain management strategies have been identified, but are often under-utilized. A study by Dowden, McCarthy, and Chalkiadis (2008) identified barriers to consistent, effective pain management, which include; variability in practice, beliefs and culture, as well as knowledge deficit. Studying the current perceptions of and barriers to effective pain management in the pediatric department, and implementing education and strategies to overcome these barriers is needed to improve pain management, and therefore, increase patient satisfaction.

Problem and Purpose

Pain in the pediatric population is often underestimated and undertreated. Children’s perception of pain is influenced by previous painful experiences and affects future responses to painful procedures (Page & Blanchette, 2009, p. 124). Negative results of inadequate pain management in children include long-term behavioral changes, pain-perception impairment, and pain-tolerance reduction (Kline, et al, 2010, p. 25). A variety of pharmacological and non pharmacological interventions are available to decrease pain during painful procedures. Interventions are aimed at improving a patient’s level of comfort, therefore, improving the patient’s experience (Kolcaba, Tilton, & Drouin, 2006). Nurses are instrumental in effective pain management; however, nurses’ limited or inaccurate knowledge, experiences and attitudes regarding pain in children can affect nursing judgment regarding adequate pain management interventions (Gimbler-Berglund, Ljusegren, & Enskär, 2008, p. 21; Rieman & Gordon, 2007, p.
307). In a regional medical center in the Midwest, the prevention of pain during pediatric procedures such as phlebotomy and intravenous cannulation is inconsistently managed. This leads to increased anxiety for the patient during procedures, increased anxiety for the patient for future procedures, and decreased patient and family satisfaction. The purpose of this study is to identify current misperceptions of and barriers to pediatric pain management during these procedures. The results of this study will then be utilized for the development of nursing education and strategies for successful pain management, with a goal of improved pain management as well as patient and family satisfaction. The intended population for the purpose of this study is the pediatric registered nurse (RN) in the pediatric department of a regional medical center in the Midwest who performs phlebotomy and/or intravenous cannulation. A descriptive quantitative research design will be followed.

**Review of Literature**

Reviewing literature in preparation for this research study revealed many articles addressing pediatric pain management and implementation of pain management strategies. It was difficult to find very many studies regarding barriers to effective management of pediatric pain. Seven research articles from within the past five years which addressed both pain management strategy implementation and the issue of barriers to effective management of pediatric pain were evaluated. Five research articles from within the past five years which addressed the implementation of pain management strategies were evaluated. The following is a review of each of these articles.

In the first study, Johnston, et al. (2007) felt pediatric pain was undertreated. They utilized a clustered randomized trial in six Canadian pediatric hospitals to determine if individual coaching sessions would improve pain management practices, including changing attitudes and
knowledge, in the pediatric population. Greipp’s model of ethical decision making, individualized audit and feedback, and a Socrates-based clinical reasoning model for intervention were the conceptual frameworks utilized. 141 nurses (30%) from six university-affiliated pediatric hospitals in Canada were grouped and assigned to coaches. The hospitals were paired with one hospital the control and one the experimental. Chart audits were performed, and based on the audit results, the nurses were coached through a think aloud process of clinical reasoning every two weeks for at least ten sessions. Each nurses responded to the Pediatric nurses’ Knowledge and Attitudes Survey Regarding Pain. Data was analyzed by SPSS version 14. Nurses who received coaching increased their rate of documented pain assessments, but did not increase use of prescribed analgesics. Knowledge increased in two of the three coaching hospitals. The authors found that although individual coaching sessions increased knowledge, site-specific factors and cultures affected the implementation of this knowledge. They determined that targeting the individual is not sufficient to improve management of pediatric pain, that the hospital as a whole needs to be targeted.

Rieman and Gordon (2007) also utilized the Pediatric Nurses’ Knowledge and Attitude Survey (PNKAS) with the purpose of evaluating knowledge in pain management and assessment. They felt this knowledge affects how patients are cared for. They surveyed 295 nurses from eight pediatric hospitals. The data was analyzed using SAS® (SAS Institute, Cary, NC) and entered into EXCEL® spreadsheets. The results suggested that the nurses lacked in education about pain, and did not consistently apply pain management guidelines. The authors determined that utilizing the PNKAS survey can be useful for hospitals to determine knowledge and practice gaps in pediatric pain management. They feel this is essential in order for these pain management practices to change.
The under treatment of pediatric pain was the basis for the Ellis, et al. (2007) study. A comprehensive pain management program (CPMP) was designed by a nursing pain management committee to improve nursing pain management practices in a hospital. The Ottawa Model of Research Use was the framework for implementing and evaluating this program. Each unit had a pain resource nurse, and all nurses were given the opportunity to participate in a pain workshop. 366 nurses were evaluated through four questionnaires (demographics, perception of current pain management practices, assessment and management of pain in hospitalized children, and beliefs and perceptions about children in pain). Charts were audited pre and post implementation of CPMP. The results of the study showed that the CPMP improved pain assessment and valuing pain management. Some of the strengths identified were the implementation of a pain committee and pain resource nurses. Also identified were remaining barriers to effective pain management that needed further focus.

The next research study by Megens, Van Der Werff and Knape (2008) was implemented out of a desire to develop hospital-wide practice standards for acute pain management that would lead to improved care. The authors created a project team that worked together for one year with a post anesthetic care unit (PACU) and a surgical ward in a children’s hospital to implement a pain policy and pain assessment tools. Pain assessment was performed utilizing the Visual Analogue Scale (VAS) and the COMFORT scale. Both preemptive and post-operative pain control through analgesics was utilized. The plan was implemented utilizing the Nolan model for improvement. Goals were for pain scores to be documented, and for severity of pain to be “no or mild” in 95% of cases. 402 patients were included in the study that lasted 30 weeks. The goals were not met and the authors determined that implementing a pain management policy is a
difficult task. They determined that the acknowledgement by staff of the importance of pain management needs improvement.

Once again, the concept of the under management of pediatric pain was the basis for the study by Dowden, McCarthy, and Chalkiadis (2008). They utilized qualitative research methodology to study current pain management practices, staff pain management perspectives, and to identify potential barriers and areas in need of change. 454 staff members from an Australian pediatric hospital were interviewed utilizing a semi structured and guided interview approach with open ended questions. “A detailed document was produced outlining the current status of pain management and recommendations for future service delivery” (Dowden, McCarthy, and Chalkiadis, 2008, p. 322). Results identified areas needing improvement included procedural and chronic pain management. Barriers identified were variability in practice, beliefs and culture, as well as knowledge deficit. The authors planned to use these results to guide improvement in pain management.

Similarly, Gimbler-Berglund, Ljusegen, and Enskär (2008) sought to identify nursing factors that impact pediatric pain management. They had also identified that pain management in the pediatric population was lacking. A qualitative design through semi-structured interviews was utilized. 20 nurses from a pediatric ward in a Swedish hospital with at least one year nursing experience were interviewed. The data was analyzed through the process of content analysis. Cooperation from physicians, parents, and children; the child’s behavior, diagnosis, and age; organizational routines or lack of; and nurses’ experience, knowledge, and attitudes were all factors identified by the data. The authors determined pediatric pain management could improve with increased physician, parent, and nurse cooperation. Also, education and planning good routines could also lead to improvement in pain management.
A qualitative study by Namnabati, Abazari, and Talakoub (2012) purposed to identify barriers to pain management in Iranian children. The data was collected through interviews of sixteen pediatric nurses from an Iranian hospital. This data was analyzed utilizing the Colaizzi method. The results revealed themes of barriers that included organizational limitations, limitations related to the characteristic of the child, and factors resulting from the nature of the disease and its treatments. The authors stated that developing pain management guidelines would be useful in the efforts to overcome the identified barriers to pain management in children.

The Soft on Sticks project by Jeffs, et al. (2011) evaluated the effectiveness of implementing pharmacological and non-pharmacological pain management strategies for needlestick procedural pain management in children. Child, parent, and nurse data was collected pre- and post-implementation of the project. Data about needlestick procedural pain management was collected from the children utilizing the Wong-Baker FACES Pain Rating Scale. The parents completed a questionnaire which helped them to evaluate how effective the nurses managed their child’s needlestick procedural pain. The nursing staff completed a survey which evaluated their practices and perceptions. The post-implementation data was utilized in the development of follow up education. The results included improved nurse empowerment and quality of care.

Similarly, a study by Habich, et al. (2012) evaluated the effectiveness of implementing an evidence based pain assessment and management guideline. It also utilized a pre-post design. The sample for the study included pediatric nurse surveys, pediatric patient chart reviews, and pediatric patient/parent satisfaction scores. The model of relationship-based care was utilized to guide the development of pediatric pain assessment and management guidelines. Descriptive statistics were used along with Pediatric Nurses’ Knowledge and Attitudes Survey Regarding
Pain (PNKAS) data. A one-way analysis of variance (ANOVA) was calculated on the survey scores. Strengths and weaknesses were identified from the results. The results indicated no difference in nurses’ knowledge and attitude regarding pain. Increases in pain assessment and reassessment, as well as the use of pain assessment tools were noted. There were no differences in patient/parent satisfaction scores.

Also similarly, Cregin, et al. (2008) studied data from before and after the implementation of a topical analgesia protocol for pain management for pediatric patients undergoing nonurgent painful procedures. Pediatric patients in the inpatient unit as well as in the ambulatory care clinics of a community medical center were targeted. Adherence to use of the protocol was tracked. The results showed a two percent increase in the use of the pain management protocol. These results indicated a multidisciplinary approach to protocol development and implementation increased compliance with the protocol.

A study reviewing published research through a computerized literature search to provide insight into factors impacting the management of pain in pediatric patients was conducted by Twycross (2010). Search terms for pain were used. Themes from literature published in the last 15 years were identified. Conclusions from the study included the need for a multifactor approach (education, organizational support, and change leaders) for improving pain management. The author determined that even though the evidence shows the importance of pediatric pain management strategies, children continue to experience pain. Nurses need support in making decisions regarding the management of pain in the pediatric population.

Finally, in a study by MacLaren, Cohen, Larkin, and Shelton (2008) 58 nursing students were divided into two groups, training and control, to evaluate the effectiveness of an evidence based training program about cognitive-behavioral pain management strategies. The aim was to
determine if this training would influence nurses’ attitudes about pediatric pain management, knowledge of pain management strategies, and ability to implement pain management strategies. The nursing students were given the Knowledge and Attitudes of Pain Management Questionnaire (KAPMQ) pre-training and post-training to assess knowledge and attitudes toward pediatric pain management. The results of the study showed that pain management training programs improved knowledge of strategies, as well as improved ability to implement these strategies. However, the training program had no impact on nurses’ attitudes of pediatric pain management.

Evaluation

In evaluating these articles, barriers were a common theme identified in preventing adequate pain management for the pediatric population. Consistently, pediatric pain management is recognized as necessary, but as challenging to achieve due to knowledge deficit, attitudinal, cultural, and institutional differences. In reading these studies, it is evident that the barriers in the pediatric department will need to be identified before pain management will be consistently effective.

Gap Analysis

Most of the studies sited poor participation in the studies as a challenge. Also, lack of interest or lack of deeming this topic as important was also noted by many of the studies. Pediatric pain management is a broad concept, which makes it difficult to study effectively. The importance of pediatric pain management needs to be communicated and realized. Recommendations for further research noted in these studies include: assessing nurses for adequate knowledge about pediatric pain management and how to apply that knowledge;
exploration of variables that impact analgesic practices; impact of time and routines on pain
management; and follow up measures of implemented pain management strategies.

Theoretical Framework

Katharine Kolcaba’s comfort theory was utilized to guide this project. Katharine
Kolcaba’s comfort theory is a mid-range theory for nursing practice. Comfort is a complex term
with several meanings. In this theory, “comfort is a noun or an adjective, and an outcome of
intentional, patient/family focused, quality care” (Parker & Smith, 2010, p.390). The three types
of comfort Kolcaba identifies are relief, ease, and transcendence. Relief is the state of having
specific comfort needs met. Ease is the state of calm or contentment. Transcendence is the state
in which one can rise above problems or pain. (Kolcaba, Tilton, & Drouin, 2006). Interventions
are aimed at improving a patient’s level of comfort, therefore, improving the patient’s
experience. “Comfort theory guides nurses to detect comfort needs of patients and families that
are not being addressed and to develop interventions to meet those needs” (Parker & Smith,
2010, p.394). Increased comfort is an immediate desired outcome. Pharmacological and non
pharmacological interventions can be implemented to meet Kolcaba’s three types of comfort
(relief, ease, and transcendence). Educating the pediatric staff about the influences on and the
need for comfort for the pediatric patient and his family will lead to greater understanding of
pain management.

Research Questions

After reviewing the literature, two research questions were developed. They are as
follows:

1. Is pediatric pain effectively managed in the pediatric department during phlebotomy and
   intravenous cannulation?
2. What are the barriers to effective management of pediatric pain during phlebotomy and intravenous cannulation?

Methodology

The intended population for the purpose of this study was the pediatric RN in the pediatric department of a regional medical center in the Midwest who performs phlebotomy and/or intravenous cannulation. At the time of the data collection, there were 12 RNs eligible for this study. A special department staff meeting was utilized to inform the pediatric RN staff about the study, including a summary of the study and the method for data collection. In addition, notes from the meeting were e-mailed to every RN working on the pediatric unit at the regional medical center.

A one-page data collection form was developed based on evidence based approaches to managing pain and anxiety in children during procedures as well as information in the literature about common barriers to effective pain/anxiety management. The RNs were instructed to fill out one data collection form after every phlebotomy and/or intravenous cannulation they performed on pediatric patients during a three week time period. The data collection forms were turned in to the shift charge nurse at the end of each shift. The charge nurses logged the number of phlebotomy and intravenous cannulation procedures done each shift. This log was matched with the number of data collection forms received, discrepancies were to be identified, and RNs were reminded to complete the data collection form if not yet done. After tallying the number of data collection forms completed, the shift charge nurse placed the data collection forms in a sealed envelope provided in the pediatric department report room and turned them in to the manager’s office.

Moral and Ethical Issues
Moral and ethical issues were not present, as no varying or withholding of treatment occurred. Discomfort or risk to the participant was minimal. Identified risks and discomforts for participants in this study included; exploring feelings related to performing a painful procedure on a child, and taking time to reflect and complete a data collection form after performing pediatric phlebotomy and/or intravenous cannulation.

Informed consent was obtained prior to the RN participating in the study data collection. All participant information was held in the strictest confidence. The study received prior approval by the institutional review board (IRB) in a hospital and university with which the author is affiliated.

Results

Twenty data collection forms were completed by the pediatric nursing staff during the three week time frame. These twenty forms matched the twenty occurrences of pediatric intravenous cannulation and/or phlebotomy recorded by the charge nurses during the data collection period. One form was omitted from the study for incomplete data. The breakdown of the types of procedures performed included: eight procedures were phlebotomy only; three procedures were intravenous cannulation only; and eight procedures were a combination of intravenous cannulation with phlebotomy (see figure 1).

The data was compiled and analyzed and frequencies counted from the remaining nineteen forms. The age of the patient who received phlebotomy and/or intravenous cannulation ranged from seven days old to 18 years old. Five of the patients were less than one year of age. Six of the patients were age’s one to four. Three of the patients were age’s five to nine. Five of the patients were age’s ten to eighteen. A family member was present with their child during the procedure for seventeen of the nineteen patients.
The data collection form questions were designed to extract descriptive, quantitative data about current RN strategies being implemented to manage pediatric pain and anxiety during phlebotomy and intravenous cannulation as well as identified barriers to these strategies. The questions also provided an opportunity for the RNs to rate how well they perceived the procedure went for the child. The following is a summary of the descriptive data.

**Pain/anxiety strategies used with patient.**

The RNs were asked to record all of the strategies used to manage the child’s pain and anxiety related to the procedure (see Figure 2). The RNs utilized no strategies zero times. The RNs utilized lidocaine twelve times. The RNs utilized oral pain medications zero times. The RNs utilized describing the procedure to the child six times. The RNs utilized distraction techniques thirteen times. The RNs utilized relaxation techniques five times. The RNs utilized sucrose solution with a pacifier one time. The RNs utilized having a family member assist the child eleven times.

**Barriers which prevented managing the patient’s pain/anxiety.**

The RNs were asked to record all barriers that prevented managing the child’s pain and anxiety related to the procedure. The RNs recorded no barriers were experienced eighteen times. The RNs recorded the child’s age was a barrier one time. No RNs recorded the following as barriers to managing the child’s pain: not able to obtain a physician order; equipment not available; family wishes; RN comfort in using methods to manage pain/anxiety; RN knowledge of methods to manage pain/anxiety.

**Rate your perception of the overall experience for the patient.**

The RNs rated their perception of the overall experience for the patient during the procedure (see figure 3). The RNs rated the patient’s experience “very positive” five times. The
RNs rated the patient’s experience “positive” eight times. The RNs rated the patient’s experience “somewhat positive” five times. The RNs rated the patient’s experience “somewhat negative” one time. The RNs rated the patient’s experience “very negative” zero times. In total, eighteen of the nineteen pediatric patients who received intravenous cannulation and/or phlebotomy were perceived to have a “somewhat positive” experience or better.

*Evaluate your effectiveness in managing the patient’s pain/anxiety during the procedure.*

The RNs evaluated their effectiveness in managing the patient’s pain and anxiety during the procedure (see figure 4). The RNs rated their effectiveness “very effective” six times. The RNs rated their effectiveness “effective” nine times. The RNs rated their effectiveness “somewhat effective” four times. The RNs rated their effectiveness “somewhat ineffective” zero times. The RNs rated their effectiveness “very ineffective” zero times. In summary, all of the attempts to manage pediatric pain during intravenous cannulation and/or phlebotomy were perceived to be effective to some degree.

**Type of Procedure Performed**

![Pie chart showing the distribution of procedures performed](image)

- Intravenous Cannulation
- Phlebotomy
- Combination of Intravenous Cannulation with Phlebotomy

*Figure 1*
Pain Management Strategies Utilized During Intravenous Cannulation and Phlebotomy

Figure 2

Perception of Overall Experience

Effectiveness Managing Patient's Pain/Anxiety

Figure 3

Figure 4
Discussion

Pain management is an essential component of quality pediatric nursing care. Managing pain during procedures such as intravenous cannulations and phlebotomy is important for positive patient outcomes as well as patient and family satisfaction. Analyzing quantitative data regarding the utilization and effectiveness of pharmacological and non-pharmacological pain management strategies during these procedures provides an opportunity to determine what strategies are working well and what barriers exist.

Figure 2 shows a graph of the different types of pharmacological and non-pharmacological strategies utilized for managing pediatric pain and anxiety during intravenous cannulations and phlebotomy. The results indicate that the RNs are utilizing several different types of strategies, and utilizing more than one per procedure. This could be an indication that the RNs understand the importance and use of pain management strategies.

Out of all nineteen procedures performed, an RN only reported one time that a barrier to utilizing pain management strategies was encountered. This data, and the high frequency in utilization of pain management strategies, could be an indicator that the RNs are comfortable using these strategies.

Evaluating the data from the study provides answers to the research questions posed. The RNs rated their perception of the patient’s overall experience during intravenous cannulation and/or phlebotomy as “somewhat positive” or better in all but one of the occurrences, with the majority “positive” or “very positive”. The RNs evaluated their effectiveness in managing the patient’s pain “effective” to some degree in all of the occurrences. These results indicate that pediatric pain is being effectively managed in the pediatric department during phlebotomy and intravenous cannulation. The frequent use of pain management strategies and the minimal report
of barriers to utilizing pain management strategies indicates that the RNs are not experiencing barriers to effective management of pediatric pain during phlebotomy and intravenous cannulation.

The answers to the research questions indicate for the most part, the RNs in the pediatric department are comfortable with and effective in managing pediatric pain during intravenous cannulations and phlebotomy. The results from this study will be utilized to applaud the RNs in their efforts, to encourage them to continue in these efforts, and to support continued education in strategies for managing pediatric pain.

Implications

Pediatric pain management needs to have a more prominent place in the focus of pediatric care throughout the organization. Further work needs to occur in the management of pediatric pain management in the other departments and areas that care for these patients. Studies could be conducted utilizing the data collection form in the departments that perform painful procedures on the pediatric patient. The data could then be used to provide focused education in skills centered on managing pain for this patient population with a goal of improved health care practices. As pediatric pain is managed across the continuum of care, the pediatric patient will have improved health outcomes as well as an improved patient and family satisfaction.
References


Advocate Health Care Presents

1st Annual Nursing Research Symposium

Collaborating to Advance the Profession

Tuesday, April 9, 2013
8 am – 5 pm
Auditorium Conference Center
Advocate Christ Medical Center
4440 W. 95th Street
Oak Lawn, IL
1st Annual Nursing Research Symposium
Collaborating to Advance the Profession

Program Schedule

8:00 am Auditorium  Registration & Complimentary Breakfast
8:15 am Auditorium  Welcome
8:30 am Auditorium  Transforming Care Delivery through Nursing
Carol Boston Fleischhauer, RN, MSN, JD
10:00 am Break
10:30 am Auditorium  Translational Research: Using Evidence and Theory to Enhance Quality, Safety and Patient Outcomes
Shelia Haas, PhD, RN
12:00 pm Foyers, Dining Room  Lunch and Networking
12:30 pm – 2:00 pm 0629AB  Poster Presentations
2:00 pm CONCURRENT SESSIONS
Auditorium  Strengthening Interdisciplinary Collaboration: Best Practices for Advancing Professional Partnerships in Care Delivery
Carol Boston Fleischhauer, RN, MSN, JD
0636AB  Effective EBP & Research Mentorship: What does it take?
Shelly Malin, PhD, RN, Advocate BroMenn Medical Center, Illinois State University
Keyser Room  Research & Practice: Podium Presentations Highlighted
Cheryl Meyer, RN, PHCNS, BC, Advocate at Home
3:00 pm Dining Room, 0629AB  Break, Dessert Bar
3:15 pm CONCURRENT SESSIONS
Auditorium  Using Technology to Enhance Tracking of the Impact of Translational Research
Shelia Hass, PhD, RN
0636AB  Using an Evidence Based Practice Model: Putting the Flow in the Flowchart
Ann Gagliardi, BSN, RN, CCRN, TNS, Cheryl Lefaiver, PhD, RN, CCRP, Kate Murczek, RN, BSN, MS, CEN, Advocate Christ Medical Center
Keyser Room  Research & Practice: Poster Discussion Forum
Linda Plewniak, RN, MSN, MHA, Advocate Trinity Hospital
4:15 pm Evaluation Time
**Program Purpose:** This conference will explore best practices based in science and innovations that contribute to positive patient outcomes and enhance the professional practice environment.

**Target Audience:** This symposium is designed for nurses, advanced practice nurses, nurse educators, administrators, health care professionals and nursing students who want to learn more about applying nursing knowledge and research at the bedside.

**Conflict of Interest Disclosure:** This educational activity’s planners and presenters have indicated that they have no bias or conflict of interest.

**Off-Label Use:** NA

**Accreditation Statements:** Advocate Health Care (OH-368,10/1/2014) is an approved provider of continuing nursing education by the Ohio Nurses Association (OBN-001-91), an accredited approver by the American Nurses Credentialing Center’s Commission on Accreditation. Learners have the opportunity to earn from 5-6.5 contact hours during this educational activity. Criteria for successful completion include completion of the evaluation form. Partial credit may be awarded, with attendance at 80% of event. Approval of the continuing education activity does not imply endorsement by the provider, ANCC, or ONA of any commercial products displayed in the conjunction with this activity.

**Registration opens:** February 1, 2013

**Registration deadline:** April 1, 2013

**Web registration is preferred:** (payment by credit card only) at advocatehealth.com/seminars, or call 1.800.3.ADVOCATE (1.800.323.8622), Monday – Friday, 8 am – 6 pm

**Conference fee:** Advocate associates, $50; Non-Advocate attendees and faculty, $75; Students – must present ID, $25

**Go Green:** A link to handouts for the keynote and concurrent sessions will be sent to all participants following registration.

**Special Needs:** We welcome all registrants to this symposium. If you have a disability or need an accommodation to participate in this event, advance notification will help to serve you better.

**Directions:**

**From the south:** Take either Harlem Avenue, Cicero Avenue or Pulaski Road to 95th Street. From Harlem or Cicero proceed east on 95th to Kilbourn Ave. From Pulaski, travel west to Kilbourn Ave.

**From the west:** Take the Tri-State Tollway I-294 north or south and exit east onto 95th Street. Follow 95th to Kilbourn Avenue.

**From downtown Chicago:** Take the Dan Ryan Expressway I-94 south to the 95th Street exit and go west. Or, take the Stevenson Expressway I-55 to Cicero Avenue. Go south on Cicero to 95th Street, then east on 95th to Kilbourn Avenue.

**From the north:** Take the Kennedy Expressway I-90 downtown to the Dan Ryan Expressway I-94. Follow the Dan Ryan south to 95th Street exit and go west on 95th Street. Follow 95th Street west to Kilbourn Avenue.

**From the northwest suburbs or O’Hare Airport:** Take the Tri-State Tollway I-294 south and exit east on 95th Street. Follow 95th Street to Kilbourn Avenue.

**From Hammond, Indiana or Michigan:** Take I-80/94 west to I-294 north. Take I-294 to Cicero Avenue and exit north. Take Cicero north to 95th Street then go east on 95th to Kilbourn Avenue.

Conference Center is located at northwest corner of the campus on Kilbourn Avenue at 93rd Street.

**Parking:** Free Valet Parking is located at Imaging Center Circle Drive on Kilbourn Avenue south of 93rd Street.
Speakers

Carol Boston Fleischhauer, RN, MSN, JD is a Managing Director in Educational Services for The Advisory Board Company. In this capacity, she serves as a national spokesperson for the firm’s research to key membership constituencies, including nursing, human resources, quality, and medical leadership. She is also responsible for presenting this research to member organizations throughout the United States and abroad.

Carol has over 30 years of progressive health care experience in patient care practice, operations, management, education and consultation in academic medical centers, community hospitals and clinics, multi-hospital organizations, and integrated health care systems throughout the United States and abroad. Carol’s areas of expertise include operations and care model redesign, quality improvement, information management, human resources, and strategic planning.

Carol holds a clinical assistant professor appointment at the University of Washington School of Nursing, with curricular responsibilities for graduate-level nursing and allied health care students. She is active in various professional and community-based organizations.

Carol holds bachelors and masters degrees in nursing from Northern Illinois University and a JD from John Marshall Law School. She has advanced education and development in quality improvement methods and theories through Intermountain Health Care and the Institute for Healthcare Improvement.

Sheila A. Haas, PhD, RN, FAAN, is a Professor and former Dean of the Marcella Niehoff School of Nursing at Loyola University Chicago. Dr. Haas holds a MSN from Loyola University Chicago and a doctorate from the University of Illinois at Chicago where the focus of her research was productivity, clinical ladder systems, and patient acuity systems. Dr. Haas developed the Nursing Administration major and the dual degree MSN/MBA at Loyola University. She also holds a joint appointment to the Loyola University Chicago Graduate School of Business.

She currently teaches in the graduate program in nursing (MSN, DNP and PhD), as well as the MBA program. She does research, publication and consulting in the areas of clinical ladders, work redesign and evaluation, differentiated practice evidence-based practice and nursing intensity systems. She has facilitated development of prototypical intensity systems in several healthcare organizations. Dr. Haas’ research, done with Loyola colleagues, on the role of the nurse professional in ambulatory care has been used to delineate competencies and to help conceptualize the American Academy of Ambulatory Care Nursing (AAACN) conceptual framework and core curriculum. She is currently working on defining the dimensions of ambulatory nursing intensity.

Dr. Haas has served on the Research Committees of AAACN and the American Organization of Nurse Executives (AONE). She also served as an AAACN Board member and President. She is also past President of the National Federation of Specialty Nursing Organizations where she has worked with the Board of the Nursing Organization Liaison Forum of ANA to design an innovative organization to represent the common goals and needs of specialty nursing. In 2009, Dr. Haas was recognized as the Illinois Outstanding Nurse Leader. Currently, Dr. Haas serves on the American Nurses Credentialing Center (ANCC) Board of Directors, the Nursing Spectrum Regional Board, and the Nursing Economics Editorial Board.
## Breakout Session: 2:00pm
### Research & Practice: Podium Presentations Highlighted

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<td>Ready, Set, Go! Innovation and Peer Support Launch our Patients to a Successful Discharge</td>
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<td>Gordana Dermody, MSN, RN, CNL</td>
<td>OSF Saint Anthony Medical Center</td>
<td>The Implementation of an Integrative Approach to Reducing Falls in a Magnet Designated Medical Center: The Implications of Clinical Microsystems to Decrease Fragmentation</td>
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<td>Nannette Jones, RN, BSN</td>
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## Breakout Session: 3:15pm
### Research & Practice: Poster Discussion Forum

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<td>Donna Ellis, MS, APN</td>
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<td>Frances Flynn, APRN, BC-CNS</td>
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<td>Camille Rogell, MSN, ACNS-BC, CHFN</td>
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<td>Use of Cold and Vibration During IV Insertion in Pediatric Patients</td>
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Introduction

Pain management is essential to quality care of the pediatric patient and patient satisfaction. Pain during phlebotomy and intravenous cannulation continues to be poorly managed. The purpose of this study was to identify current misperceptions and barriers to pediatric pain management during phlebotomy and intravenous cannulation.

Methods

Nurses on an inpatient pediatric unit completed a Best Practice Derived Data Collection Form (DCF) immediately following a procedure with a patient between the ages of 0 - 18 during a 3-week time period. Descriptive analysis was used to create a snapshot of current practice and nurses perceptions of their effectiveness in managing pain, as well as perceptions of the overall experience.

Results

Nurses:
- Used a variety of pain management strategies.
- Believed they were effective in managing the pain associated with these procedures.
- Believed the experience was positive for the patient.

Implications for Practice

- Collecting data concurrently is a useful method of assessing practice.
- Nursing education and strategies for successful pain management were developed based on the results of the study.
- Pediatric pain management must have a more prominent place in the focus of care throughout a hospital.
- As pediatric pain is managed across the continuum of care patient outcomes and satisfaction will improve.

References

