Evidence-Based Practice NK4

a. Provide one example, with supporting evidence, of how clinical nurses incorporate professional specialty standards or guidelines to implement a practice new to the organization.

Examples may include incorporation of specialty standards from nurse or non-nurse specialty organization (e.g., ANA, APIC, AORN, AWHONN, AACN, ADA, AHA) into practice guidelines or policy.

Clinical Nurses’ Use of Professional Standards/Guidelines
The American Academy of Pediatrics (AAP) Committee on Hospital Care Policy Statement for Family-Centered Care made recommendations regarding parent/family presence:

“This policy statement outlines the core principles of patient- and family-centered care, summarizes some of the recent literature linking patient- and family-centered care to improved health outcomes, and lists various other benefits to be expected when engaging in patient-and family-centered pediatric practice. The statement concludes with specific recommendations for how pediatricians can integrate patient- and family-centered care in hospitals, clinics, and community settings, and in broader systems of care, as well.” (Eichner and Johnson, 2012, p. 394)

Recommendation #4 is that “parents should be offered the option to be present with their child during medical procedures and offered support before, during and after the procedure” (Eichner & Johnson, 2012, p. 399). Yousef, Drudi, SantAnna, and Emil (2018) reported that Parental Presence during Induction (PPI) aligns with the belief in and practice of parental rights. There is evidence that PPI can reduce preoperative anxiety in pediatric patients, improve the quality of induction of anesthesia and increase parental satisfaction (Sadeghi, Tabari, Mahdavi, Salarian, & Razavi, 2016). (Evidence NK4-1, Articles)

Given the AAP Recommendation and the strong evidence in the literature, WakeMed clinical nurses partnered with other health care providers to create a new standard in the organization. According to the American Nurses Credentialing Center (ANCC), “a standard is an agreed upon level of performance that has been developed to characterize, measure, and provide guidance for achieving excellence in practice” (ANCC, p. 160).

At the January 2018 Pediatric Committee meeting, Director of Adult Acute Care Nursing Services Dianna Knight, MSN, RN, NEA-BC led a discussion about the system-wide family presence policy. Education Resource Specialist Kim Laurent, MSN, RN-BC, CCRN-K, CNE and Clinical Nurse Lindsay Robinson, BSN, RN, CPEN reviewed concerns regarding parental presence in the main Operating Room (OR). Parental
presence was allowed in minor procedure areas depending on the provider, but it was not standard practice in the Raleigh campus main OR. The Pediatric Committee includes clinical nurses from the Children's Emergency Department (CED), 4E Pediatrics, Pediatric Intensive Care Unit (PICU) and Pediatric Clinic, along with respiratory therapists, physicians, pharmacists, child life specialists and CRNAs. The committee recommended that a task force review the specialty standard/guideline and evidence to inform the next steps in implementing a new practice change.

In February 2018, the Parental Presence Task Force met to identify opportunities to standardize a systemwide approach to parental presence incorporating the AAP’s recommended standard on Family-Centered Care. The task force consisted of:

- CED Clinical Nurse Lindsay Robinson, BSN, RN, CPEN
- Pediatric Clinic Clinical Nurse Bridget Keller, BSN, RN
- CED Supervisor/Educator Lisa Miller, BSN, RN, CEN
- CED Nurse Manager Jennifer Farmer, BSN, RN, CPEN, SANE-P
- 4E Pediatric Supervisor/Educator Trisha Jones, BSN, RN, CPN
- Day Surgery Supervisor/Educator Carol Warner, BSN, RN-BC
- Post Anesthesia Care Unit Nurse Manager Nancy Groves, MSN, RN, NE-BC
- Pre-op/Post-op Supervisor/Educator Michele Sanders, BSN, RN, HACP
- Child Life Specialist Julie Vanveldhuizen
- Chief Nurse Anesthetist Shelly Schaad, CRNA
- Chief Nurse Anesthetist Jana Pittman, CRNA
- Tim Bukowski, MD
- Bryan Max, MD

The Parental Presence Task Force reviewed current practice, legal implications and educational needs. Their next steps included developing a standardized process and educating anesthesia providers, pre-op and OR clinical nurses and surgical techs, child life specialists, physicians and parents. Clinical Nurse Keller was responsible for creating educational flyers about PPI for clinical nurses and parents. Clinical Nurse Robinson was responsible for obtaining CED clinical nurses’ input into their process for collaborating with child life specialists to help identify the patients, parents and situations that would allow for successful PPI during the implementation phase. (Evidence NK4-2, Parental Presence Meeting Minutes, February 23, 2018)

**Practice New to WakeMed Health & Hospitals – Incorporating the AAP Committee on Hospital Care Policy Statement’s Recommended Standard for Family-Centered Care**

In April 2018, The Parental Presence Task Force turned their focus to identifying families appropriate for PPI and then educating them on it. Keller, Robinson and Jones advocated for nurses to be responsible for identifying the patients, parents and situations that would allow for success in the initial implementation of the new practice to provide guidance for achieving nursing excellence in pediatric patient care. The clinical nurse would identify prospective parents, confirm their interest and assess them for participation in PPI. (Evidence NK4-3, Parental Presence Protocol)
In August 2018, the Parental Presence Task Force developed a workflow process tool to help clinical nurses implement in the Raleigh campus OR the new practice of the recommended standard of the AAP Family-Centered Care Policy to offer parents and guardians the option to be present before and during anesthesia induction. The AAP recommended standard was operationalized through the following process:

- Clinical nurses will assess the parents for appropriateness for implementing PPI and, in consultation with the anesthesia team, will approach the parents to solicit their participation.
- If the assessment indicates they are appropriate for PPI, the parent is educated on the process and provided scrubs, accompanies the child to the OR, and once the child is asleep is escorted out of the OR by a circulating nurse, the pre-op nurse or a child life specialist.

Clinical nurses implemented AAP recommended standard of Family-Centered Care by offering parents the option to be present with their child during the medical procedure, PPI, and then providing guidance on how to create a successful patient and family experience for this new practice. (Evidence NK4-4 Parental Presence at Induction Workflow)

In December 2018, the Marketing and Communications Department partnered with pediatric clinical nurses and anesthesia to create a flyer, “Parental Presence at Induction: Being with Your Child before Surgery,” and a four-minute video for parents to watch before the day of surgery. A link to the new video was added to the electronic medical record (Epic) so the clinical nurse can monitor and reinforce the family’s understanding of PPI.

On January 2, 2019 the PPI pilot was implemented with the pediatric patients of Pediatric Surgeons Duncan Phillips, MD and Tim Bukowski, MD. Based on its success, PPI was expanded to include all pediatric outpatient surgeons effective April 1, 2019 and to all endoscopy and pediatric gastroenterology surgeons on April 3, 2019. As of May 6, 2019, all pediatric inpatients who have a pediatric surgeon are provided the parental presence option. (Evidence NK4-5, Week in Review 4E Peds PICU)

To determine the success of the new practice, parents were given a five-question post-PPI survey. As of March 2019, the results indicated that the practice change was highly successful in meeting parental and pediatric patient needs:

- 17 of 18 surveys were completed, for a response rate of 94%
- All responses were “strongly agree” or “agree” in support of PPI.
- Parents shared comments including: “loved being able to go back with my son, felt it helped keep him calm and gave me comfort seeing where he would be.” “Very grateful for being able to help soothe my baby to sleep and for being able to watch the video beforehand to know exactly what to expect.” “Thank you for allowing me the opportunity to be with my child. It made the transition to the OR much easier.”
References:

