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Editorial

Wonderful changes are happening at *Pediatric Intensive Care Nursing!*

by Franco Carnevale

Last year, on our 15th anniversary, we made an important improvement to *Pediatric Intensive Care Nursing* (PICN), as we created a new and open access website for our ejournal. We also created a Twitter handle, to help us promote important developments in pediatric intensive care nursing. This has allowed readers to have much easier access to the wonderful work published in PICN.

This year we are happy to announce some additional important changes. First of all, we are proud to announce that we have added Irene Harth to our PICN editorial team. She is joining us as Associate Editor. Irene brings significant clinical expertise as a prominent nursing leader in pediatric critical care in Germany and internationally. Moreover, she has specialized expertise in the development of electronic media through her longstanding work with the European Society of Pediatric and Neonatal Intensive Care as well as the European Federation of Critical Care Nursing Associations, among other important organizations. Irene has already developed 'a new look' for PICN in this issue, while maintaining our existing distinctive logo. Let us know what you think of our new format. Send me your thoughts as well any suggestions you have for continued improvement to the look as well as the substance of our journal (franco.carnevale@mcgill.ca).

In 2016, the international pediatric intensive care community will be coming together in Toronto in June, for the 8th World Congress on Pediatric Intensive and Critical Care hosted by the World Federation of Pediatric Intensive and Critical Care Societies (<http://www.picc2016.com/>). This is a valuable opportunity for pediatric intensive care nurses to exchange experiences and expertise, while strengthening professional and social relationships and possible collaborations.

This is an event that features an outstanding collection of nursing presentations. We would like to encourage all nursing presenters at this Congress - as well as other conferences - to consider submitting their work for publication in PICN (see our Author Guidelines in this issue). We have a unique and supportive approach to prospective authors, providing support and assistance to help nurses get their work published in our CINAHL-indexed peer-reviewed journal. We hope to receive many of your papers for review for PICN.

Let me end by expressing a strong THANK YOU to Irene Harth for her wonderful work and her commitment to helping us improve PICN!!!

Check out our open access website location for PICN at: www.mcgill.ca/picn

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Improving Parent Satisfaction through Family-Centered Care

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Abstract

Family-centered care is more than unlimited visiting. In fact, family-centered care reinforces that parents are not visitors. A new children's hospital was opened in March 2011 which presented an opportunity for developing family presence guidelines that embrace the philosophy of family-centered care. The goals for the family presence quality improvement initiative were to improve the family's perception of staff attitude toward parents by development of a process that welcomes the family in addition to others who are important in the child's life; and improve the Press Ganey patient satisfaction scores.

Stakeholder input was sought through a survey and based on results the family presence guidelines were developed. The concept of Partners in Care was included in the guidelines. Parents and Partners in Care are encouraged to participate in patient care activities. Since implementation of the family presence guidelines, the patient satisfaction scores related to staff attitude toward visitors has improved and consistently remained about the national benchmark scores.

Pediatric nurses know that family centered care is vital to the optimum care of the child. Family-centered care values, recognizes, and supports the family in the care of their child. The family is ultimately responsible for responding to the child's emotional, social, developmental, physical, and health care needs. Parents may shield the threats of the ICU environment from the child. Parents can influence the child's cognitive consideration of the environment, personnel, and events. The child often watches the reactions of the parent to use as a gauge in understanding events in ways ranging from threatening to beneficial¹. Parents depend on nurses to soften the critical care experience for their child. Parents' perceptions of nurses' caring practices in the pediatric ICU were examined in a recent study. According to the parents, nurses used behaviors that demonstrated affection, caring, watching, and protecting. Parents stated that the most comforting nursing behaviors were those that supplemented the parental role, which preserved family integrity during a time of crisis². Clinical practice guidelines that support the parents of children in pediatric ICUs facilitate family involvement³.

Background

Family-centered care is more than unlimited visiting. In fact, family-centered care reinforces that parents are not visitors. Parents are partners with the multidisciplinary team. Most pediatric nurses at a large urban hospital practiced family-centered care; however, the satisfaction scores did not reflect that. The rooms on the Pediatric unit were a source of significant dissatisfaction for families. The rooms were small and the majority of rooms were two patient rooms. The PICU rooms were larger but the majority were also two patient rooms.

A new children's hospital was opened in March 2011 which presented an opportunity: how could the "visitation" policy be revised to embrace the principles of family-centered care? Some nurses went by the "rules", others let patients have as many visitors as they want. How could the culture be changed so that parents were not considered visitors?

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The organization participates in the Press Ganey database for patient satisfaction. Patient satisfaction scores were below the Press Ganey benchmark before the start of the quality improvement initiative.

The goals for the initiative were to

- 1) improve the family's perception of staff attitude toward visitors by development of a process that welcomes the family in addition to others who are important in the child's life
- 2) improve the Press Ganey patient satisfaction scores by development of family presence guidelines that embrace the philosophy of family-centered care.

Methods

A multidisciplinary group was convened and using evidence and a Plan-Do-Study-Act (PDSA) framework, they established the following strategies:

- 1) Transform the current visitation policy to a family presence policy because families are not considered visitors.
- 2) Establish "Partners in Care" – designated people who can visit the child without the parents present.
- 3) Educate the staff about the guidelines and begin the culture change. The staff were committed to fully embracing family-centered care but had questions about visitors outside of the immediate family.

The first step was to obtain stakeholder input.

A survey was developed on Survey Monkey and the link was sent to pediatric and PICU physicians, nurses, and ancillary staff as well as to previous patients and their families.

A total of 61 surveys were completed. The breakdown of roles is shown in Table 1.

Table 1.

Roles of Respondents

• Nurses	27
• Physicians	15
• Families	13
• Others	5

Results

Questions were asked about number of visitors (excluding parents), overnight visitors, "visiting hours", and child visitors (excluding siblings). The number of visitors (not inclusive of parents) that the respondents rated as appropriate ranged from one to no limit.

The majority of respondents felt that two visitors (not inclusive of parents) were appropriate. For visitors other than parents, respondents ranged from eight o'clock am to one o'clock pm for when visiting hours should start and eight o'clock pm until midnight for when visiting hours should end. The respondents were divided almost equally as to whether child visitation (not inclusive of siblings) should be limited to specific times or duration.

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Discussion

Once the survey was completed, the "visitation" policy was revised to family presence guidelines. The purposes of the guidelines are to:

- 1) To promote Family-Centered Care for Pediatric and PICU Families;
- 2) To encourage families to participate in patient care and healthcare decisions;
- 3) To support family's emotional adjustment to the crisis of hospitalization and illness of a child
- 4) To provide treatment and healing in an environment that is safe and secure for patients, families and staff

The key points from the family presence guidelines are:

- 1) Parents and Partners in Care are welcome onto the unit 24hrs a day, with accommodations made for two to sleep at the bedside overnight;
- 2) On admission, Parents or Guardians will be asked to provide a list of adults (Partners in Care) who may be at the bedside when they are not. This information is entered into the admission database. This list is visible to the care team and security staff, and can be updated at any time;
- 3) In general, space limitations permit a maximum of 4 individuals at the bedside. However, exceptions can be made to this at any time at the discretion of a staff member;
- 4) Siblings of all ages and other children older than 4yrs are welcome to visit;
- 5) Parents/Partners in Care are encouraged to participate in patient care activities.

Education was provided to the staff at staff meetings and the guidelines were implemented in April of 2013. Since that time, the scores related to staff attitude toward visitors has consistently stayed above the Press Ganey benchmark of 90.8 %.

The Guidelines support providing treatment and healing in an environment that is safe and secure for patients, families and staff. Patients and families define their families.

The staff of the Children's Hospital guarantee physical comfort, emotional support, and the involvement of family as the patient defines family.

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The Transition of Medical Care dependent Adolescents

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Abstract

With advances in paediatric cardiology and paediatric cardiac surgery, the population of adults with congenital heart disease (CHD) has increased in the last decade not only in Europe. It is a fact, that a high rate of these patients is now reaching adulthood. Additionally, we can state that nowadays there are more adults with CHD (ACHD) than children.

This patient group of ACHD has many special issues and needs and is at increased risk for developing serious co-morbidities. Unfortunately the development of appropriate services within the adult health care domain in Europe often does not match the complex clinical needs of these patients.

Thus, late adolescents with their specific requirements are sort of 'in between' the health services – they are too old for paediatrics and too young for adult hospitals.

And the sad thing is: some of them are falling into this gap, they get lost in transition, so to speak – and this can have a significant impact on their health condition.

There is some evidence that transition programs and specialised centres for the care of ACHD patients result in better disease control and improved patient outcome.

Key words: transition, adult congenital heart disease, adolescence, chronic conditions, developmental needs, transition programs, adolescent friendly services, specialised referral centres

Background

Most children born with a chronic health condition, e.g. cystic fibrosis, a rare metabolic disorder or congenital heart disease, have had a poor prognosis in the past but are now expected to live more than 20 years; they are now entering the adult world:

- 85 - 90% of all CHD patients will reach the age of 18
- In Germany we estimate around 300,000 patients of all ages with a congenital heart disease^[1], in the USA there are 1 million ACHD patients, increasing each year by 20,000^[2]
- the postnatal incidence to get a baby with a heart lesion is 7.5 to 1000 live births^[3].

The population of adults with congenital heart disease (CHD) has increased significantly in the recent decades; today there are more adults with CHD than children.

These patients are at increased risk of developing serious co-morbidities, e.g. several forms of heart failure, pulmonary hypertension, valvular dysfunction, thromboemboli, complex arrhythmias and sudden death. Besides the complications due to their cardiac disease, ACHD patients are also at increased risk for other diseases. A Canadian study found that compared to the general population these patients had a significantly higher need for primary care: 68% had visited emergency rooms, 51% had been admitted to hospitals and 16% had had the need for intensive care^[4].

These patients had a more or less long career in paediatric hospitals and when they are beyond the age of 18 they should move to adult health care.

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Unfortunately the development of appropriate services within the adult health care domain in Europe often does not match the complex clinical needs of this patient group.

Thus, late adolescents with their specific requirements are sort of in between the health services: they are too old for paediatrics and too young for adult hospitals.

And the sad thing is that some of them are falling into this gap; they get lost in transition, so to speak, and this can have a significant impact on their health condition.



Fotos: dpa (2), Sascha Kopp - VBM

Barriers in the transition process

Impediments to a successful transition process are multiple and they can arise from all parties: the adolescents themselves or their parents might not be 'compliant' and the transferring as well as the receiving system can be part of the problem.

The WHO defines adolescence as the time span between 10 and 19 years of age ^[5].

This is the time when young people have to define themselves and to find their place in the world by developing new social roles and exploring independence from their parents. It is a challenging time with many transitions on different levels: physically, psychologically and environmentally when children finish school, i.e. leave their parents' home.

For many patients with chronic conditions this time is even harder as they have to deal with the physiological as well as the psychological consequences of their condition and the limitations, maybe even disabilities this brings for them. They are much more emotionally vulnerable compared to their healthy peers. Furthermore they may realize for the first time the ongoing need for a long term medical treatment, repeated hospitalizations and with this the dependency on multiple medical staff.

Nevertheless, most of them are going through the same phase with the same symptoms: difficult behaviour, dangerous life style, sometimes in combination with an overestimation of their own abilities. This can have a tremendous negative impact on their health condition ^[6].

Different Care Philosophies

The adult health care system is a total different world for adolescent patients. They will certainly experience different professional languages, styles, expectations and cultures: they will be confronted with a totally different care philosophy.

Adult care has another approach; it expects the patient's self-responsibility for their medical condition and that they are able to care and to decide for themselves independently.

Additionally they rarely include the parents in the same way as is done in paediatrics.

This might be quite challenging for the young adult who was used to the protective and parental-style relationship of paediatric services.

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The transfer to an adult service into an environment with many older patients that offers less social support, which does not match their developmental needs and where clinical practice may be focused on the older patients: not a great motivation for the young adult to continue with this service.

There is a lack of appropriate adult services for young people with chronic heart disease. Unfortunately there is still little knowledge of CHD patients and their treatments in adulthood. Only a few clinicians have acquired the respective expertise.

As an example: in US 50% of ACHD patients (500,000 Americans) need specialist's follow up ^[7]. In 2010 only 100 US cardiologists have had the expertise to care for those patients ^[8]. On the other hand 5000 paediatric cardiologists were available for the care of 800,000 US children with CHD ^[9]

At paediatric facilities cardiologists and paediatric staff are familiar with the anatomy and medical consequences of CHD, but they are not well-experienced in how to care for these patients as grown-ups and their accompanying co-morbidities.

In adult facilities staff may have knowledge of co-morbidities and adult care, but they might not be familiar with the extremely complex conditions of ACHD with many different defects and their treatments. ACHD patients need the expertise in both.

In this regard, the German Heart Foundation is aware of the fact that a high percentage of young adults are lost to their medical follow up when they reach the age of 18. The negative impact on their health condition is well documented ^[6].

Same picture in the United States: Yeung and colleagues demonstrated in a recent study the link between lapses in medical care and adverse outcomes in ACHD patients. 63% of these patients failed to keep their follow ups as recommended and as a result 60% of them received a new diagnosis of hemodynamic significance ^[10].

What to do to improve this situation?

There is some evidence that transition programs can result in better disease control and lead to improved patient outcome. Transition is not only an administrative event but should be a guided educational process over a certain period of time.

The British National Framework for Children – which is a standard for Hospital services, suggests that every paediatric hospital should have a policy on transition to adult services ^[11].

In their view a transition program should cover:

- *A policy on timing of transfer*

Although it may be useful to set a target age, there is no 'right' time for transition. A flexible approach that takes the developmental readiness of the patient into account would be best, and it should be linked to other social transitions such as leaving school. Physical and emotional maturity is the first requirement for the transfer process.

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- *A preparation period and education program*

During this time the young person will be helped to find out what is needed for his personal health care management in order to achieve a proper transition to the adult clinic. A time schedule for the transition should be set up. This formal process can already start in the teen age. It should be individualized on the basis of the patient's maturity level and it depends of course on the stability of the disease and patients psychosocial status, as well.

- *A coordinated transfer process*

A coordinator should be identified. He will be responsible for arranging all issues across health and social care, besides others.

- *An interested and capable adult clinical service*

- which has close contacts with the children's service
- which has an understanding of the developmental needs of young adults
- which participates actively in the transition process
- specialist disciplines should be provided specifically for the needs of these young people.

- *Administrative support*

- to ensure the smooth transfer of medical and social care and all other relevant records
- the provision of summaries including one for the patient's own use
- efficiently organized appointments

Furthermore specialised care for ACHD patients provided in referral centres with experienced and trained personnel can have a significant impact on morbidity and mortality of this patient group ^[12].

Conclusion

Adolescent healthcare is an issue which will need increased recognition in the future. All care givers should know more about the developmental requirements of teenagers, especially those with chronic conditions, and they should be prepared to provide professional care for these young people.

The transfer of patients with complex disorders into adult care settings should be a gradual approach and can be started in the early teenage to enable the adolescent patient to cope with mastering the challenges of their chronic condition.

Additionally appropriate transition programs need to be established in order to provide a planned movement of adolescents and young adults with chronic conditions from a child-centred to an adult-oriented health care service. This implies adolescent-friendly services which are based on the patients' complex medical as well as social care needs.

Additionally, specialised centres established within adult care settings, ideally in relation to paediatric centres, could be established as in many cases the management of adolescents with chronic conditions requires the integration of experts from various disciplines.

The formation of multidisciplinary teams in these centres could be a means to meet these needs.

The Transition of Medical Care dependent Adolescents

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How to Create an Effective Poster for a Professional Meeting: A literature review

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Abstract

Background: Poster presentations are an essential component of a career in research, and can facilitate discussion of new findings among health care professionals.

Methodology: Three peer-reviewed articles were analyzed in order to develop a step-by-step guide to effective and professional poster creation, evaluation, and presentation.

Results: A five-step plan was created. The steps include plan, create/organize, review, prepare, and present.

Conclusions: Posters should serve as a tool to guide discussion, rather than summarize conclusions. This paper provides directions to effectively create and present a poster for a professional meeting.

Background

Poster presentations are a crucial method of disseminating new knowledge and facilitating discussion of current and future projects. Learning how to present a professional and effective poster is a key aspect of nursing study as well as nursing practice. Poster presentations allow nurses to convey their information in an interactive way, network with other colleagues, and create working relationships for future projects. Nurses can use poster presentations to ask and answer evidence-based practice questions, advocate for the practice of nursing, share ongoing research, and disseminate results of projects, among other goals ⁽¹⁾. The purpose of this literature review was to determine the key elements of a professional and successful nursing research poster presentation.

Methods

The literature review included 3 articles. A search of PubMed including the terms "posters", "nurses", "successful", "professional" was run. Abstracts and related references were scanned for relevance. Inclusion criteria included publication within the last 5 years, and within a peer-reviewed nursing research journal. The reviewed articles were "Poster presentation - a visual medium for Academic and Scientific meetings", published in *Paediatric Respiratory Reviews* in 2011; "Creating Effective Scholarly posters: a guide for DNP Students", published in the *Journal of the American Association of Nurse Practitioners* in 2013; and "Developing a professional poster: four "Ps" for Advanced Practice Nurses to Consider", published in *AACN Advanced Critical Care* in 2013.

Results

A specific plan to develop an effective and professional research poster presentation was developed based on the information contained in the articles. Five steps: plan, create/organize, review, prepare, and present, are outlined as follows.

How to Create an Effective Poster for a Professional Meeting: A literature review

- Plan

The first step of any poster presentation should include submission of an abstract to the organization holding the event. The abstract should coincide with the overall purpose of the poster, and clearly outline what will be included.

The criteria for the presentation, as outlined by the sponsoring organization, should be reviewed and noted prior to creating the poster.

Criteria include:

- the size and method of displaying the poster (easel, wall-mount, etc.),
- the location of the presentation (event hall, lobby, etc.),
- the number of attendees,
- the length and schedule of the event, and
- the overarching theme of the event ⁽²⁾.

Poster authors should also determine the materials they will need for presentation, such as mounting board, easel, tacks, and mounting materials. The final step of the plan is to determine the team who will work on the poster. At a minimum, this should include the primary author, one consultant, and one or more outside reviewers ⁽¹⁾.

- Create/Organize

The process of creating the physical poster should begin with determining the primary focus of the poster as it relates to the submitted abstract. This is especially crucial, as poster presentation attendees typically spend less than 5 minutes viewing a poster ⁽²⁾.

Next, the presenter should develop a template, which may be adjusted as necessary to emphasize the most important elements of the poster. According to Christenbery et al., the five primary elements of a research poster are the title/banner, background/problem/objectives, methods, outcomes/results, and conclusions.

The title should be brief and informative, and the banner should also include the authors and associated logos (such as university or organization). In the background section, the project's relevance should be explained. It may be necessary to include two or three relevant studies as well.

The problem statement should be defined, as well as 2-3 key objectives.

The methods section should include a brief description of the most important elements of the projects, including the sample, selection method, inclusion/exclusion criteria, implementation, and results.

The outcomes section, often the most important, should include the results of the project, how they were measured, and a visual representation, such as a graph, chart, or table. It is also possible to include patient or sample quotes in this section if indicated.

Lastly, the fifth section includes important conclusions, implications for practice, and a brief summary. It is also important to note that any or all of these sections may be altered or removed based on the characteristics of the project.

Additionally, the presenter may include a section for important acknowledgements if necessary.

How to Create an Effective Poster for a Professional Meeting: A literature review

Other important considerations for the organization and creation of a poster include font sizes, colors, and overall flow of the sections. The ideal poster contains 300-500 words, and about 50 words per each of the elements⁽²⁾. Most viewers respond well to less text, so only key points should be outlined and bulleted. Text should be replaced with visual representations whenever possible⁽³⁾. The poster should serve as a guide for discussion, not a summary of results. The text should be readable from 3-4 feet away, and the font should be no less than 24⁽¹⁾. A simple, easily readable font, such as Arial or Helvetica, should be used. Each section of the poster should be clearly outlined and titled, and the sequence from one section to the next should be logical. Styles vary and should match the norm, for example, organized from left to right or from top to bottom. The poster should also be proportional and balanced with images and text. Colors can often be used to attract viewers, but should not detract from the overall purpose of the poster. Posters should not have more than two or three colors as part of their theme⁽¹⁾.

- Review

Reviewing and revising the poster is a critical component of creating an effective and professional research presentation. Following creation of the first draft, each person who has a name in the title banner should view the poster, and create modifications as necessary. The second draft should be proof read by the authors, as well as one outside neutral party⁽²⁾. It may also be useful for presenters to evaluate their posters, using a tool such as the poster presentation evaluation tool presented by Christenbery, et al.

- Prepare

Preparation prior to the actual presentation event is absolutely imperative to leading a professional discussion about the research poster. Presenters should be able to give a one-minute summary of their project that includes the most pertinent information, such as the problem, its relevance, the key steps of the project's implementation, and important results. The presenter should also be able to expand upon key elements, and answer questions as they arise. As a rule of thumb, the poster should facilitate a discussion about the research project as a whole. Another important factor to consider is the target audience, as this will determine the type of questions that arise. The presenter should determine the target audience, and what aspect of the project they will consider most important as a part of preparing for presentation. For example, a group of researchers may be most interested in the implementation of the project while a group of student nurses may consider the topic and results more significant⁽¹⁾. Presenters should also prepare contact information, such as business cards, to have available at the event. Alternatively, include your email address on the poster so participants can photo your address

- Present

The final step in poster presentation is the event itself. Presenters should dress in professional attire, and stay with their posters at all times. It is important that any member of the team who is attending the event is also prepared to answer questions and remain with the poster if necessary. The author should also know the schedule and general environment of the event in order to adequately prepare⁽¹⁾. The presenter should also have contact information available in order to foster follow-up questions and relationships.

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Conclusion

Poster presentations are an excellent environment to foster information dissemination and fruitful discussion of research. The poster itself should clearly and concisely display a project and its results. It should attract attendees with its appearance while guiding a conversation about a research project. The process outlined in this article can help guide nurse researchers to develop and present professional and effective posters. The collaborative nature of a poster presentation event fosters the development of working relationships in order to facilitate the progression of nursing research.

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Format

Manuscripts must be written in English; either American or British spelling may be used but must be consistent throughout. Manuscripts should be typed double-spaced, using Arial or Times New Roman font in at least 11-point, with margins of at least 2 cm or 1 inch. Number pages consecutively beginning with the title page. The preferred length for research, clinical and review papers is 1000-2500 words, excluding references. Submissions to Spotlight on PICU should not exceed 1500 words. The sections of the manuscript should be in the following order.

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- Title should be concise and informative, and typed in bold capitals.
- Names (first name, initial(s) and family names) of authors in the order in which they are to appear.
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