SIG is a forum in which nurses involved in the care of patients within a specific specialty area have the opportunity to collaborate to further nursing practice, exchange ideas, and discuss standards of care to provide a consistent patient and family care experience.
SIGs enable the registered nurse to promote care within the specialty, bridging the challenges of ensuring standardized outpatient nursing care in an organization with multiple ambulatory sites. Patients and families receive a more integrated and uniform experience regardless of geographical location through the integration of evidence-based practice and the collaboration with peers. The primary objectives of the SIG include the following:

- Develop a professional network within the SIG specialty areas to promote clinical efficiency and expertise in care delivery.
- Investigate, create, and apply evidenced-based practice to elevate the standard of care.
- Collaborate with members of the interdisciplinary team to provide the highest quality patient care experience.
- Advocate for the needs of patients and families.
- Standardize the care provided to patients and families across the ambulatory setting.

The outcomes and results were the establishment of an algorithm starting with the prescriber's orders and the prescribed medication to the actual process of medication shipment; informational packets for the patient prescribed Lupron and/or Testosterone, starting with what it is and ending with where more information about the condition would be found; discharge packets for the patient prescribed Lupron and/or Testosterone, starting with what to expect after getting medication and ending with how to reach us; and revised prescriber order forms to be filled out by the prescriber and processed by the nurse.

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Childhood Osteoporosis: Screening, Prevention, Treatment, and Safe Handling Practices in a Tertiary Care Pediatric Hospital

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Osteoporosis is a challenge facing children of all ages with multiple different health conditions and physical abilities. The reality of this challenge stemmed the development of the child health program's interdisciplinary bone health project team in a tertiary care, in-patient pediatric hospital. The committee's goal was to develop protocols and tools to help identify at-risk children and ultimately prevent fragility fractures in these children. An evidence-based screening tool was developed to allow primary caregivers to quickly recognize the child who is most at risk for osteoporosis and determine the next step to take related to bone health. The use of standardized evidence-based diagnosis, treatment, and prevention protocols empowers all care providers to make bone health a priority for their patients. A "handle with care" protocol, along with identifiable signage, gives caregivers and others who may handle the child the ability to do so safely, with adequate knowledge of fracture prevention strategies. A resource for families and caregivers, which includes the definition of pediatric osteoporosis, diagnostic criteria, and prevention strategies, has been developed. Nutrition and lifestyle recommendations, including activities of daily living, safe handling practices, and tips to prevent injury, are also included. All children admitted to the children's hospital are screened during their admission using a standard nursing database with a specific bone health screen added. The process from screening to initial workup, diagnosis, and treatment or prevention arm will be described in detail. Any child identified as high risk or having pediatric osteoporosis will be automatically entered in the "fragile: handle with care" protocol. This multidisciplinary approach to bone health and fracture prevention is the key to successful outcomes for all children at risk for osteoporosis. Roll-out and sustainability of this project have depended greatly on networking and collaboration with many stakeholders from initiation through to maintenance of this practice change. A working component is to expand screening and fracture prevention methods by identifying children with osteoporosis in the community through education of professionals and families.

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Diabetes Nurse Leadership Group: A Forum for Improving Diabetes Care

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Four certified diabetic educators (CDEs) with varying roles at our hospital work together to meet the challenges we face in providing care for our pediatric patients. We meet weekly to address diabetes improvement initiatives both at the hospital and community at large. The CDEs working at the university created a forum to meet on a regular basis to join forces to facilitate providing optimal diabetes care and education for the members of the hospital, academic, and communities of Brooklyn.
Learning objectives were as follows:

1. To identify the opportunities where CDEs can have an impact on the education, management, and prevention in and out of the hospital and academic setting.
2. To illustrate the use of CDEs in an urban academic medical center to optimize the education of nurses, patients, and the community in diabetes management and prevention.
3. To describe the process of using CDEs in diabetes improvement initiatives and education in an academic urban hospital and in the Brooklyn community.

Content Outline

1. CDE opportunities in an urban academic medical center
   a. Inpatient
   b. Outpatient
   c. Education of staff
   d. Education of students
   e. Community health forums
   f. Research
2. Utilizing CDEs in an urban academic medical center
   a. In-servicing staff
   b. Precepting students
   c. Conducting workshops