

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

*Nicole Kirouac BN, RN, Shayne Taback MD, FRCPC, Kathy Miller BSc, OT, Arlene Stocki PT, Gina Rempel MD, FRCPC, FAAP, Joanna Gies RD, Pat Ozechowsky RD, CNSC, Leslie Galloway BN, MSc, Paige McCullough OT, Courtney Wuskynyk RN, BN
Winnipeg Children's Hospital, Winnipeg, Manitoba, Canada*

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, inpatient 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

*Dawn Hagerty BSN, RN, CDE, Linda Cohen RN, MPH, MSN, CDE, Sandy Hirsch RN, MS, CDE, Maria Yomtov RN, MSN, CDE
SUNY Downstate Medical Center, Brooklyn, NY*

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

- d. Representation on hospital wide clinical committees
 - e. Research activities
 - f. Implementing new policies/procedures
 - g. Evaluating new policies/procedures
3. The process of utilizing CDEs
- A CDEs involvement in:
 - a. Community activities
 - b. Patient clubs
 - c. Regulatory affairs
 - d. Nursing education
 - e. Physician education
 - f. Medical resident/physician education in-servicing
 - g. Preceptorship of nurses

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Mentorship Program for Regional Endocrine Nurses

Mabel Tan BSN, RN

British Columbia Children's Hospital, Vancouver, British Columbia, Canada

British Columbia is a vast province consisting of a population that spans five regional health authorities and one provincial health authority. General care can be accessed within these health authorities; however, pediatric subspecialty care is mainly provided at our hospital located in Vancouver. This requires many families to travel long distances to receive subspecialty care.

The limited local access to subspecialty care and the burden of making visits to Vancouver impact the health outcomes of children living with chronic conditions outside of metropolitan Vancouver. Families face financial strain because of the cost of time off work, transportation, accommodations, child care, and food. From a safety standpoint, families also risk traveling in poor weather in the winter to maintain regular follow-up. This may cause families to postpone travel or decrease the number of visits to our hospital. A number of studies (Vierhout et al., 1995; Tyrer, 1990; Williams, 1989, as cited in Gruen et al., 2009) show that clinical outcomes are poorer when patients are not seen in follow-up regularly.

Current literature suggests that outreach clinics are beneficial in improving access to specialty care (Gruen et al., 2006), reducing costs of accessing care (O'Brien et al., 2001), and improving the proportion of patients living in rural or remote communities receiving guideline consistent care (Howe et al., 1992).

It is obviously challenging within a regional system of care to provide specialty level services, but with capacity building and increased support from our hospital within these communities, I believe that children and families throughout BC can receive standardized nursing care and experience improved health outcomes such as prevention of severe illness episodes and stability of condition.

At our hospital, we have developed a mentorship program to enhance the capacity of regional clinic nurses working with pediatric endocrine patients and families. In addition, we have made efforts to improve accessibility of hospital resources, standardize care by creating an online guide, and increase support to nurses in regional clinics by providing telehealth and in person in-services and telephone or telehealth consultations.

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A Multicenter, Observational Study of Girls with Central Precocious Puberty Treated With Histrelin Subcutaneous Implant

Paul Thornton MB BCH, MRCPI

Cook Children's Medical Center, Fort Worth, TX

Background: Gonadotropin-releasing hormone agonists (GnRHa) are the standard of care for treating patients with central precocious puberty (CPP). However, there is a paucity of long-term, posttreatment follow-up data for patients previously treated with GnRHa.

Aims: The aim of this study was to provide long-term data documenting the reactivation of the hypothalamic–pituitary–ovarian (HPO) axis in girls with CPP who have been treated with histrelin subcutaneous implants (Supprelin LA).

Methods: This is an ongoing multicenter, observational patient registry. Girls diagnosed with CPP by 8 years of age, who started histrelin implant therapy by 8.5 years of age, and who are either currently on or have completed histrelin implant therapy are eligible. For this registry, CPP diagnostic criteria include breasts at Tanner stage 2 or higher and at least one of the following: random luteinizing hormone (LH) ≥ 0.3 IU/L and estradiol ≥ 20 pg/mL; GnRHa-stimulated LH ≥ 4 IU/L; or GnRHa-stimulated estradiol ≥ 20 pg/mL. Patients are treated by the investigators according to locally accepted clinical practices. Height and data related to puberty including Tanner stages, menarche or resumption of menses, puberty hormone levels (including LH, follicle-stimulating hormone, and estradiol), and bone age are extracted from charts or recorded during routine visits. Predicted adult height is calculated using the Bailey–Pinneau method. Primary end point is time to menarche or resumption of menses after discontinuing histrelin therapy. Patients will be followed for up to 3 years from the time of last implant removal.

Results: Up to 150 girls are expected to be included in the registry. To date, 17 sites are participating, and 2 patients (age 7 and 9 years) have been enrolled. At baseline, both patients had a normal body mass index, and a Tanner staging breast score of 3. On-therapy data from the first set of patients in the registry will be presented. Any adverse drug reactions will also be discussed.

Conclusions: This is the first patient registry to assess the recovery of the HPO axis after discontinuing histrelin for the treatment of girls with CPP.

Clinical Implications: Data from this ongoing registry will help determine the effect of long-term continuous gonadotropin suppression in girls with CPP in regard to the timing of HPO axis recovery.

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Long-Term Efficacy of Growth Hormone in Short Japanese Children Born Small for Gestational Age

Charles DiPaula PharmD^a, Toshiaki Tanaka MD^b, Susumu Yokoya MD^c, Anne-Marie Kappelgaard MD^d

^aNovo Nordisk Inc., Princeton, NJ, USA

^bTanaka Growth Clinic, Tokyo, Japan

^cDepartment of Medical Subspecialties, National Center for Child Health and Development, Tokyo, Japan

^dGrowth Hormone Scientific Marketing, Novo Nordisk A/S, Virum, Denmark

Background: Approximately 5% of all newborns are born small for gestational age (SGA), below 2 standard deviation scores (SDS) for height and/or weight. Beneficial effects of long-term