Robert “Bob” Bonar Jr., president and chief executive officer of Dell Children’s Medical Center of Central Texas, reminds me of this quote as we talk about the building of the hospital. He’s making the point that what happens there isn’t the result of luck or divine intervention. It’s the result of a whole community of people who decided to do the right thing.

“One of the reasons Austin is a great place to live is people deciding to lean in and say, ‘This is a difficult thing to do but it would be good for the community so we better figure it out,’” he says. “It couldn’t have happened without the philanthropy, without the city cooperation, without the dedication of the pediatricians and without the leadership from Seton.”

On June 30, 2007, the Dell Children’s Medical Center opened on land that was once part of the old Mueller Airport. That same day, the Children’s Hospital of Austin, located on the campus of the University Medical Center at Brackenridge, closed. Other publications have covered the opening extensively, so I won’t tread that ground again in this article. Nor will I give you much in the way of statistics, beyond the number of beds (currently one hundred forty, but with room to open more as needed); the fact that the building won the highest level of achievement, Platinum, from the US Green Building Council; and that it has a phenomenal amount of art (eight hundred works, many of which are interactive). If you want to know about all the services the hospital offers, check the web site.
Instead of facts and numbers you can find elsewhere, I’ll tell you four stories. Each was chosen to show why this medical center matters to Austin families, how the Austin community worked together over three decades to make it happen, and why its nursing care is special.

Story One is the tale of a tragedy averted, and the heroes who saved a life. Story Two is about a family who was ripped apart by tragedy, and how the hospital is helping them come together again. Story Three is the tale of a community that kept doing what was right, and ended up with a world-class hospital for its efforts. Story Four will show you why, in the midst of a nationwide nursing shortage, the hospital has no trouble filling its nursing positions. These are not stories of miracles, they are stories of what happens when people decide to do the right thing.

First, I need to offer a piece of background information on myself. From 1990 to 1993, I was director of marketing at Brackenridge and Children’s Hospital of Austin, during the time when it was managed by the City of Austin. I also did some freelance writing for the Seton Good Health magazine in the late nineteen-nineties. Neither of those experiences inclined me to feel especially positive or negative about the Dell Children’s Medical Center or the management of the Seton Family of Hospitals. I approached this story with curiosity, knowing that the hospital I was to write about was a completely different place from the one I had known fifteen years ago.

Tragedy Averted

On February 8, 2008, Jonah Frost, age six, was playing with his cousins in the backyard of his aunt’s house, while his mom and aunt talked inside. It was Jonah’s scream that brought his mother running outside.

“I heard this horrible scream. Jonah was bleeding. There was blood all over his hands and all over his crotch. At first I thought the dog had bitten him. But he kept telling me to get the stick out,” says Jennifer Frost. She then realized that Jonah had jumped off a fence and landed on a clump of recently trimmed bamboo. A spear of bamboo had gone through Jonah’s leg and into his abdomen, slicing through the femoral artery in his groin. The bamboo had broken off near the skin. It was a life-threatening emergency; a severed femoral artery can quickly lead to massive blood loss and death.

Frost screamed to her sister-in-law, who dialed 911. When paramedics arrived, they administered the止血剂 and rushed Jonah to the Topfer Emergency Center at the Dell Children’s Medical Center (DCMC), the only pediatric trauma center in the region.

“The doctors were ready to receive him when we got there,” says Frost. “When we arrived, there were like fourteen people standing at attention waiting for us to get there.”

As the medical team moved Jonah into a trauma room, two social workers walked Frost a few feet away so that she could still talk to Jonah but was out of the way of the medical staff.

“There was no chaos. There was such a sense of organization, and everyone there knew what they were supposed to do,” she says. “That helped me stay calm, so I could smile and be calm for Jonah. He never cried. He was very serious, very brave.”

Pediatric emergency specialist Todd Maxson, MD, director of the Children’s Trauma Center, says that sense of organization and quiet calm is deliberate. Trauma center staff train extensively in handling life-threatening injuries, and each member of the trauma team has a specific role.

Unlike television ERs, real life trauma teams don’t yell and rush about; while they work quickly to save lives, they also adopt a relaxed demeanor that helps keep the patient calm and relieves the family’s anxiety. Maxson says that is one of the things that attracted him to the field, that sense of quiet, well-choreographed teamwork.

Jonah’s mom remembers a spiky-haired young MRI technician named Robbie Sanders who talked calmly and matter-of-factly to her son. “He was so laid back he helped Jonah relax and stay calm. Jonah asked for him right after he got out of recovery.” She also remembers two social workers who helped her stay calm. “They were wonderful. I was so scared and they were so emotionally available to me,” she says.

Despite the calm surface, the trauma team was moving swiftly to get Jonah to the operating room. The MRI revealed the bamboo stick bisecting Jonah’s artery, and they knew they had to act quickly to repair the artery, stop the bleeding and restore blood flow to his leg.

“We got him straight to the operating room and took a vein out of the leg to reconstruct the artery,” says Maxson. “He went home in two days. The parents were kind of obsessing over a little fluid buildup in his leg, and I was glad they got to obsess over that. If all the right things had not been in place, he could have ended up dying or being a six-year-old amputee,” says Maxson.

Frost says that a month after the injury, Jonah was back to running around and riding his bike.

Jonah’s story is a dramatic example of the difference a trauma center can make, Maxson says.

The difference between a regular emergency center and an advanced trauma center, he says, is the readiness to deal with the most extreme injuries. Texas uses standards from the American College of Surgeons to designate trauma centers as Level One (highest level of care, plus research and teaching capabilities), Level Two (same level of care as Level One, but without the research and teaching aspects), and levels Three and Four (basic services to maintain life and transport the patient to more advanced care).

Until 2002, Texas exempted children’s hospitals from trauma center requirements and, in fact, barred them from certification as trauma centers. That changed when the Children’s Medical Center of Dallas sought to earn a Level One designation, and hired Maxson to help them do it.

He and the hospital administrators worked with the Texas Department of State Health Services to rewrite the regulations to not only allow designation of children’s trauma centers, but also to provide specific requirements and oversight that matched the standard to which adult trauma centers are held.

Before 2002, he says, even major children’s medical centers did not
offer the same level of care to pediatric patients as adult patients got at trauma centers.

“In Dallas, after hours, if a pediatric patient needed emergency surgery, you’d have to call around to find an anesthesiologist to put the kid to sleep. We called around and hoped we could get them in and hoped we could get them in time,” says Maxson. In Jonah Frost’s case, that kind of delay could have cost him his life or his limb.

Now, pediatric trauma centers in Texas must meet the same standards as adult centers, with the added requirement that trauma staff be specifically trained in caring for children.

While the trauma center at DCMC has not yet received its designation (a center must be open and operating for about eighteen months before accreditation can be earned), it is currently offering care comparable to a Level Two center, and is building its ability to offer the research and teaching capabilities that will earn it a Level One designation. That means it must have the following people and facilities available in house—not just on call—twenty-four hours a day, seven days a week:

- Qualified trauma surgeon, radiologist, emergency physician and anesthesiologist.
- CT (computerized tomography) scanning. (Dell also has an MRI, magnetic resonance imaging, in the Trauma Center.)
- Equipped and staffed operating suite, with a backup surgical suite.
- Trauma intensive care unit.
- Trained trauma team.
- At least two trained trauma nurses.
- Dedicated resuscitation suites that can manage two patients simultaneously.
- Staffed laboratory facilities.
- Helicopter landing pad.

In addition, a Level One or Two center must have both a trauma director (usually the trauma surgeon) and an emergency medicine director (usually the physician who handles non-trauma medical emergencies); must work closely with its local EMS; and must have an injury prevention program. In all, the American College of Surgeons lists nine pages of requirements, detailing diagnostic and treatment capabilities, training requirements, administrative oversight and research and teaching criteria.

Maxson and a handful of core staff members were hired away from the Children’s Medical Center of Dallas in 2006, shortly after the decision was made to create a trauma center at the new children’s hospital that was scheduled to open in June 2007.

According to CEO Bonar, the original plan was for children’s trauma services to remain with the adult trauma service at the University Medical Center at Brackenridge when the new hospital opened. Duplicating the resources needed for a trauma center at the new children’s hospital was seen as too expensive. But Brackenridge emergency medicine director Patrick Crocker, DO, (who is now the emergency medicine director for DCMC) convinced the Seton board of directors that the investment should be made, that children would get better care if the trauma service was located in the pediatric hospital.

“He told the board, ‘Come on guys, it’s the right thing to do,’” says Bonar. The board was convinced.

So Maxson and his team were hired. “We came a year before the two hospitals were separated so we could drill and train and work with EMS,” he says. “On the day of the move, I wanted to be able to look the community in the eye and say, ‘You’ll get the same level of care as you would at Brackenridge.’ We worked really, really hard for a year to be ready on day one.”

The trauma center at DCMC is now working to earn a Level One designation. The staff has begun gathering data for research and DCMC is seeking approval from the American Board of Surgery to begin a pediatric surgery residency program. “We’re checking off all the requirements for Level One designation in hopes that we’ll get the residency program.”

Currently, the Trauma Center at Dell Children’s Medical Center is the only pediatric trauma center in Central Texas.

A family gets a chance to stay together

On May 12, 1999, Dalton Ayers was five years old. He was at the home of family friends in Lockhart, playing with another child and the
family dog in the backyard. Either the dog made a break for it, or perhaps the children let the dog out of the gate, no one is sure. As the dog raced to the front yard, Dalton and his friend raced after him, afraid that they would get in trouble for letting the dog out.

In the front yard, the other child’s father was mowing the lawn. In the blink of an eye, the children ran in the path of the mower, and Dalton tripped and fell. His left arm slid under the mower, and he was partially pulled under the whirling blades. His arm was so mangled that it was later amputated, and much of the right side of his face was destroyed.

He was taken by STARFlight helicopter to the Brackenridge Trauma Center, but it did not have the capability to deal with a child as badly injured as Dalton. Along with a medical team to keep him alive en route, Dalton was flown to the University of Texas Medical Branch Hospital in Galveston. His mother and father, Genia and Dana Ayers, drove the four-hour route to Galveston, not knowing if their son would be alive when they got there.

For the next three months, through Dalton’s multiple surgeries, Genia Ayers lived in Galveston while her husband worked and cared for their other two children, Quinton, age two at the time of the accident, and baby Weston, just four months old. She missed her two younger kids, and felt bad that she hadn’t had a chance to say good-bye before the long separation.

Even when Dalton and his mother returned to Lockhart to resume family life, the two of them would travel as many as five or six times a month to Galveston for doctor appointments or more surgeries.

“Sometimes we’d go down there for a doctor’s appointment, but have to be there for two or three days,” says Ayers. Because Dalton’s siblings were so young, they didn’t always comprehend what was happening; they just knew that mommy was gone a lot, and didn’t always return when expected.

In Galveston, Ayers was on her own, because her main support people, her husband and mother, were needed in Lockhart to care for the younger children. If the doctors gave her bad news about Dalton—an infection, the need for more surgery, a complication—she had to deal with it on her own.

“God gives you the strength to deal with what you have to deal with,” she says.

The long separations took their toll on the family, leaving the younger boys with “huge separation anxiety,” says Ayers. “It affects them today. They always want to know where I am. If we’re at home and they don’t see me, they’ll start calling for me. ‘Mom, mom, where are you?’ If I’m gone for a day, they ask, ‘Are you coming back tonight? What time will you be back? Are you sure you’ll be home?’ Weston is nine now and I can’t go anywhere without him. I’m trying to get him to trust that I’ll come back. That’s the toll that Galveston had on them.”

In February 2006, they realized that Dalton was again going to need surgery. Dalton has had numerous surgeries to reconstruct his skull, but his body has repeatedly either outgrown or rejected the prostheses that were implanted. The current implant was being rejected, so the family prepared for another hospital stay. This time, though, Ayers and Dalton wouldn’t have to go to Galveston. They learned that the Children’s Hospital of Austin finally had recruited a pediatric craniofacial reconstructive surgeon, a subspecialist who is expert at reshaping or repairing the bones and tissues of the head. In 2005, with the promise of a new world-class pediatric medical center in the works, the Austin facility was able to recruit Patrick Kelly, MD, to help found a craniofacial surgery program in Austin.

Ayers is very grateful that Kelly is here and that the trips to Galveston won’t be needed anymore.

“It was so much easier to be here in Austin. My mother could come up to the hospital after work and give me a break, and my husband would stay overnight so I could come home and spend time with Quinton and Weston,” says Ayers. “It’s been easier for them, because they know that if they need to see me, someone can take them up to the hospital. They don’t have to be away from me so long.”

In the 2006 surgery, Kelly created a new skull bone from Dalton’s ribs. So far, the implant is doing well.

Kelly says he was just completing his fellowship in craniofacial surgery when he was asked to head up the program at Children’s. “It was a pretty risky endeavor on all sides to start a program fresh out of a fellowship,” he says. Usually, a surgeon joins an established team before making the leap to creating a department. To mitigate that risk, Kelly and Children’s recruited an experienced pediatric neurosurgeon to work with him.

“A craniofacial surgeon can’t function without a good neurosurgeon and a good craniofacial orthodontist,” says Kelly. Timothy George, MD, FAAP, who was associate professor of neurosurgery, pediatrics and neurobiol- ogy at Duke University and had fifteen years of surgical practice, proved to be a good fit for Kelly. Orthodontist Adriana Da Silveira, DDS, rounds out the craniofacial surgical team.

“Yesterday a girl fell off her bike and crashed her head. Dr. George operated on her brain. Her eye socket was crushed up, too, and I reconstructed it while he was in there. So she only had to go through one operation,” says Kelly. That kind of team work is common, he says. “It’s a hard thing for a neurosurgeon to be interested in the bones. Their interest is in the brain. The bones and up is that stuff that just slows them down.” That other stuff, he says, is his job.

In a surgical team like theirs, “You have to jibe as people, to understand and respect each other.” He says the team also relies heavily on Mary Breen, RN, CNS, an advanced prac-tice nurse who coordinates the surgeries and helps families through the process. She worked fifteen years in the craniofacial program at Dallas Children’s Medical Center before coming to Dell Children’s Medical Center.

Much of the work of the Craniofacial and Reconstructive Plastic Surgery Center involves repairing a wide variety of congenital deformities, everything from cleft lips and palates to head tumors that are present at birth. “About five or ten percent of our work is trauma. The rest is congenital defects,” says Breen.

Kelly notes that while any one type of congenital defect may be rare, there are a lot of different types of defects, and in aggregate, they are fairly common. During medical school and residency at the Baylor College of Medicine in Houston, Kelly says he saw a lot of kids from Austin. Now, they can get the care they need close to home and family.

For the Ayers family, being able to stay together while they get the best medical care for Dalton means that they can begin to heal the emotional wounds created by those past separations.

To learn more about Dell Children’s Medical Center and the services it offers, call 512-324-0000 or visit www.dellchildrens.net.

To learn more about the Magnet Program, visit the American Nurses Credentialing Center web site at www.nursecredentialing.org.

To learn more about the Versant RN Residency Program, visit www.versant.org.

For information on trauma center requirements, a PDF version of the criteria is available at www.ncems.org/pdf/Trauma/ACS 1999 Trauma Facilities Criteria.pdf.

—Karen Branz Leach

To learn more about the Magnet Program, visit the American Nurses Credentialing Center web site at www.nursecredentialing.org.

To learn more about Dell Children’s Medical Center and the services it offers, call 512-324-0000 or visit www.dellchildrens.net.

To learn more about the Magnet Program, visit the American Nurses Credentialing Center web site at www.nursecredentialing.org.

To learn more about the Versant RN Residency Program, visit www.versant.org.

For information on trauma center requirements, a PDF version of the criteria is available at www.ncems.org/pdf/Trauma/ACS 1999 Trauma Facilities Criteria.pdf.

—Karen Branz Leach

The story of Dell Children’s Medical Center begins back in 1972, when Brackenridge Hospital hired a young pediatrician named Karen Teel, MD, as director of its pediatric residency program. At the time, there was no residency program, just a month-long rotating internship, and there was no children’s hospital. Pediatrics consisted of ten beds on the fourth floor at Brackenridge.

“So many of the interns were actually interested in pediatrics, but some were just doing their required rotation,” she says. “I was working as a pediatrician in a civil service position out at Berg-
Teel and Talbot created a variety of committees to plan the hospital, being careful to include a physician from each pediatric group in town on each committee. “That was key. That way, we were all on the same page.”

They also initiated Brackenridge’s first fund-raising effort, using staff from the community relations department. When a city department head eliminated the community relations department, the pediatricians had no one to do the fund-raising. Concerned that support for the project was dying, Teel and Talbot designed a survey for pediatricians asking if they thought the city needed a children’s hospital, and if so, where it should be located.

“A hundred to a hundred and fifty of the surveys were returned, and to a person they all said they wanted a children’s hospital. And almost to a person they said it should be at Brack.”

The reason, says Teel, is that the pediatricians wanted one pediatrics program and one residency program, so that all children’s care would be in one place. That way, resources would be concentrated and all children, rich and poor alike, could get the same level of care.

“We were concerned that if Seton or St. David’s built a children’s hospital, they might not want to treat the unfunded patients. That would split children’s care. We didn’t want that,” she says.

By 1985, as they were about to break ground, Tom Young was hired as administrator at Brackenridge. “He saw that we got what we needed.”

That same year, the Junior League of Austin took on Brackenridge and Children’s Hospital as a fund-raising project. “They had some women who were very active in the community, like Mary Herman and Bitsy Henderson and Libby Malone. We really had the woman power to do it,” says Teel.

They organized the first Children’s Miracle Network Telethon in Austin, and raised about four hundred thousand dollars. “The Telethon was also a great way to promote Children’s Hospital in the community,” Teel says.

Children’s Hospital of Austin, fondly known as CHOA to staff and physicians, opened on February 12, 1988. Despite the lack of physician office space or a parking garage—families had to park in the Brackenridge garage a block away—it quickly became exactly what the pediatricians had envisioned, the hospital of choice for children in Central Texas. All children were accepted without regard to their family’s ability to pay.

By 1995, CHOA was full to overflowing, and Seton had taken over management of Brackenridge and CHOA. An expansion of CHOA in 1996 added a physician office building and the long-overdue parking garage, along with more surgery suites and other diagnostic and treatment facilities.

The addition of the office space made recruitment of pediatric subspecialists, such as pulmonologists, nephrologists, and specialty surgeons, more viable. Austin’s population was growing, and the newcomers tended to be young couples with children, increasing the need for more pediatric specialty care.

As CHOA’s business boomed, a yearly problem arose: during the winter, when children’s respiratory illnesses skyrocket, beds were in short supply. CHOA also encroached on Brackenridge space, taking over the fourth floor again for pediatric surgery. Pediatric patients also slowed the flow in the Brackenridge MRI lab, because children can’t be rushed through the process. They often need sedation to allow them to stay still during a scan, and the prep time for sedation meant that fewer patients could be seen. By 2002, it was obvious to everyone in the pediatric community (and many at Brackenridge) that another expansion of CHOA would soon be needed.

“My own personal moment of truth was a call to the pediatric ER,” says Teel. “I had a four month old who had vomiting and diarrhea, and he was dehydrated. He needed intravenous fluids right away. They said, ‘Send him down, your patient will be number twelve or thirteen waiting in the ER to be admitted.’” Though the ER could treat him, they didn’t have a hospital bed available.

“He would have to stay a day or two in the ER before they would have a bed to admit him to,” says Teel.
Teel mobilized The Pediatric Physician Alliance of Central Texas (PPACT), which she had helped to form in 1995. Teel was its first president, followed in 1999 by Daniel Terrazas and in 2002 by Maile Killian. Samuel Mirrop is the current leader.

The group “very systematically went around to all the hospitals in the area, to see if they could help with the overcrowding,” says Teel. “Some said they could help with ten beds, but that was not at all what we needed. You can’t do pediatrics with just ten beds,” says Teel. What was needed, the group realized, was either a massive expansion of CHOA or a new hospital.

“The turning point was a meeting with pediatricians and Seton administrators. Everyone was mad as heck because they were working in a situation that was unworkable,” says Teel. Seton administrators got the message and began exploring ways to enlarge CHOA.

The biggest obstacle was land. CHOA was landlocked, with Brackenridge to the west, the physician office building to the south, I-35 to the east and Fifteenth Street and the Erwin Center on the north. Seton did a feasibility study, looking for a way to add floor space for new beds at CHOA and concluded that it couldn’t be done without serious disruption of patient care. Though CHOA had been built with the idea that a fourth and fifth floor could be added when more patient beds were needed, building those floors would mean shutting down the third floor during construction. And that was where all the patient care beds were.

Seton’s solution was to build a brand new children’s medical center that Seton, not the city, would own. Seton purchased land in far north Austin at Parmer and I-35, near the Dell campus, for the new hospital, but the pediatric community wasn’t enthusiastic.

“It was too far from the center of the city. Patients from East Austin would have a hard time getting there. How about a doctor on call who lives in West Lake? It might meet Seton’s needs, but not the community’s needs,” says Teel.

At the same time, some community activists objected to Seton building its own children’s hospital and closing the city-owned hospital. Many worried that Brackenridge would become the stepchild, that Seton would dump Brack when its lease ended.

To allay those fears, Seton agreed to a fifty-year extension of the Brackenridge lease, says CEO Bonar. “When Seton was willing to do that, it diminished those concerns,” he says.

Then, says Teel, real estate developer Dick Rathgaber suggested to Seton President Charles Barnett and Seton Executive Vice President Pat Hayes that the old Mueller airport might make a great site for the new hospital. There was plenty of land for the hospital, for a physician office building, the Ronald McDonald House and anything else that might be needed. And it was close to the center of the city, just three miles north of Brackenridge. When the pediatricians heard of the plan, they were encouraged, and got on board.

The next concern was convincing the city to sell the land to Seton, and do it quickly.

“A lot of pediatricians went to the City Council meetings to convince the city to sell the land,” says PPACT President Sam Mirrop, MD.

As Bonar says, they had to get the city to move “with a reasonable degree of speed.” Because of the yearly winter crisis, with kids stacking up in the ER waiting for a bed, “We had an aversion to waiting two or three years to begin building,” says Bonar.

They were successful. The city manager’s office and other city staff all agreed to expedite the process, and the deal was made. By 2005, Seton was able to break ground at the new site with plans for a two-hundred-million-dollar, world-class children’s medical center.

Ascension Health, which is the parent corporation that operates the Seton Family of Hospitals, pledged one hundred and twenty-five million dollars. The remaining seventy-five million was raised by the Children’s Medical Center Foundation of Central Texas. Susan Dell, who is a member of the Foundation board, and her husband, Michael Dell, gave twenty-five million dollars through their own foundation, and their name was given to the new medical center. The Dells have also given money for a pediatric research center through the University of Texas that will be housed next door to the Children’s Hospital; it is currently under construction.

“The very first gift for the hospital was from the Topfer family, who gave three-point-two million dollars,” says Maureen “Missy” Wood, executive director of the foundation and a vice president of the Seton Fami-
ly of Hospitals. The emergency center is named for the Topfer family. By the time construction was complete, the Foundation had raised eighty-seven million dollars, twelve million more than the goal. The extra money allowed the hospital to purchase additional technology and to pay for the addition of the trauma center, which was not in the original budget.

Not all the gifts were from wealthy people, says Wood. “We had lots of gifts of five dollars or twenty-five dollars. It all adds up.”

The Foundation will continue raising funds, with a goal of fifty million dollars over the next five years. Half of that will fund programs, while the other half will fund an endowment to support the hospital in the future.

On June 30, 2007, the Dell Children’s Medical Center opened. In the first seven months of operation, the number of children treated as patients at the hospital has been twenty-three percent higher than projected, while outpatient volume has been sixteen percent higher than expected, says Doug Waite, chief financial officer for the Seton Family of Hospitals. Clearly, the community has embraced the hospital.

Like the old Children’s Hospital of Austin, all children are welcome at Dell Children’s Medical Center, regardless of whether they have insurance. Despite that open door policy, the hospital is expected to operate in the black, says Waite. “We don’t have to rely on philanthropy for day-to-day operations,” he says. “Donations support new equipment and services and will pay for replacement of equipment down the road.”

That financial stability is due to two factors. First, virtually every child in Central Texas who has insurance and needs hospital care will go to DCNE. The insured patients, and the revenue they bring, are not scattered throughout the various hospitals in the region, but concentrated in one facility. The second factor is that most uninsured children are eligible for some kind of medical funding, either through Medicaid or the State Children’s Health Insurance Program. The billing staff at Dell Children’s hospital is adept at helping families apply for assistance, which means that very few of the children are completely unfunded. While Medicaid doesn’t always pay the full cost of care, what it does contribute helps pay the overhead and keep the hospital solvent.

By insisting that the community concentrate all its pediatric resources in one hospital, Austin pediatricians have ensured that the hospital will be financially healthy and able to grow into a world-class medical center.

As pediatric surgeon Robert Schlechter, MD, says, “In 1984, when we first started talking about a children’s hospital, I never envisioned what we have now. I was excited when we opened CHOA and excited when we expanded it in 1996. I never expected what we have now. I think it was a matter of a conscious decision by the pediatricians that they wanted to resist calls to provide care for children in multiple places. And Seton was clear that we needed to look after the needs of children, not the needs of the hospital or the insurance companies.”

A magnet for pediatric nurses

When Melissa Kessler, RN, was hired to work as a nurse in the emergency department of the new Dell Children’s Medical Center, she didn’t get straight to work. Instead, Seton enrolled her in the Versant RN Residency Program, a twenty-two-week program at DCNE designed to ensure that she will have all the skills and knowledge she needs to make a successful transition into her new career. The Versant program was started at the Children’s Hospital of Los Angeles in 1999 as a way to help retain newly hired nurses. According to the Versant web site, about thirty-five to sixty percent of new nurses fail out in the first two years after graduation. One reason was the lack of support during the first few weeks and months of nursing, when the new grads were overwhelmed by work they didn’t feel prepared to handle.

The program, which has been adopted by twenty-five hospitals across the country, combines classroom study, hands-on training, one-on-one mentoring with an experienced nurse preceptor, and extensive evaluation of each nurse’s skill. The orientation, more than five months long, gives new nurses a chance to feel confident in their skills before they have to care for patients solo.

“I’m paired with a preceptor any time I’m on a nursing unit,” says Kessler. “I’m getting a lot more support than friends I graduated with who chose to work at different hospitals.”

Gayla Maddern, RN, CPN, who is a supervising nurse at DCNE and a preceptor in the Versant program, says the program starts with a thorough evaluation of each incoming nurse. “In the past as a preceptor, I didn’t know what level of experience the new hires had. And the standards were vague.”

Now, she has written standards and a way to precisely evaluate and document each new nurse’s skills, and can tailor her teaching to each nurse’s needs. To be allowed to work without direct supervision by a preceptor, new nurses must prove their proficiency on each of the standards.

This careful orientation is especially important in pediatric nursing, says Robert Walsh, RN, MSN, CPN, CNAA, senior director of nursing for DCNE. “Pediatric nursing is different. It scares many nurses because there isn’t much room for error. With adults, a little too much or too little medication may not have much effect. In pediatrics, it can have disastrous results,” he says.

The Versant program was introduced as part of the hospital’s efforts to earn Nurse Magnet Certification from the American Nurses Credentialing Center. DCNE earned that designation in March 2008 (Seton Medical Center, University Medical Center at Brackenridge and Seton Northwest Hospital also were awarded this certification in March). The program emphasizes high standards in patient care and involvement of nurses in decision-making.

The Magnet credential is important because it signifies a radical change from old-style management, in which decisions came down from administrators and nurses had little say in how the hospital was run. In a magnet hospital, nurses are involved in all decision-making that affects patient care.

When DCNE was still in the planning stages, says Walsh, nurses were part of the planning committee that designed the patient care units.

The result was a unique design for the twenty-four bed units. Instead of a central nursing desk with rooms along a hallway, the group designed each unit to have three pods that consist of a nursing desk surrounded by eight beds. Nurses at the desk can see each patient’s room and, because the work area is split into three sections, there is less noise at each desk. This improves the ability of nurses to keep track of what’s happening with each patient, and also adds a sense of peace and privacy.

When the building was ready for move-in, nurses on each unit decided how the unit would be arranged. “Nurses have complete authority to make changes on their units to make the work flow easier,” says Walsh.

DCNE also encourages staff nurses to earn national certification in pediatric nursing. In January, sixty-two nurses from the medical center sat for the rigorous exam and fifty-five (eighty-seven percent) passed, beating the national pass rate by four percentage points, says Walsh.

This attention to the needs of nurses is paying off. Despite a national shortage of nurses, DCNE routinely has multiple applicants for each nursing job. The only area where recruitment is difficult, says Walsh, is in the critical care areas, which require specialized training and experience.

Maddern and Kessler both say that, while pediatric nursing can be demanding, they are satisfied with the work.

“Kids rebound so quickly. They may be upset because you have to poke them for a shot or an IV, but then they turn around and draw you a picture,” says Maddern.

“I was a computer programmer for four years,” says Kessler. “It wasn’t fulfilling, so I left.” She gave up a high-paying job to go back to school and spend another three years earning her nursing credential. “There is no question that was the right decision for me. Kids are so resilient. I love working in the ER because I get that almost instant gratification of seeing a kid go from being really sick to almost a hundred percent. It makes me feel that my job is worth something.”