

The Lead in Peds

Transcript: Season 2, Episode 3 – Care Champions: The science, leadership and compassion behind pediatric nursing

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Guests: [Cicely CC Brooks, DNP-ENL, MSN, RN, NE-BC, FAB](#), [Christine Marie Riley, NP, CPNP-AC](#)

Dr. Nathan Kuppermann (00:00):

When people think about innovation in medicine, they often picture physicians or scientists working in labs or deciding new technologies. But many of the most important advances in pediatric care begins somewhere else entirely, at the bedside where nurses spend more time with patients and families than anyone else in the hospital. Nurses are often the first to recognize subtle changes in a patient's condition, identify opportunities to improve care and develop new approaches that can transform outcomes for children.

(00:33):

Today, we're talking about the science, leadership, care coordination, and compassion behind pediatric nursing and the ways nurses are helping shape the future of pediatric medicine. Welcome to The Lead in Peds, the podcast where we highlight the breakthroughs driving pediatric research and clinical care. I'm Dr. Nate Kuppermann, Chief Academic Officer and Chair of Pediatrics at Children's National Hospital.

(00:57):

And today I'm joined by two outstanding leaders in pediatric nursing. Dr. Cice Brooks is Chief Nursing Officer at Children's National and brings more than 25 years of experience in nursing leadership and patient care. Dr. Christine Riley is a nurse scientist whose research focuses on improving outcomes for critically ill infants and understanding how stress and intensive care environments affects development and recovery. Cice, Christine, welcome to the show.

Dr. Cicely (CC) Brooks (01:26):

Thank you for having us.

Dr. Nathan Kuppermann (01:28):

It's great to have you on the podcast. And I imagine that for nurses like other professions, there might've been a moment in your lives that you realize I want to be a nurse. So, let me put it to both of you. Did that happen for either or both of you? Let me start with you, Cice.

Dr. Cicely (CC) Brooks (01:43):

So, no, I didn't necessarily have this epiphany that I wanted to be a nurse when I grew up. Growing up, when you ask kids those questions, it's always they want to be a doctor or a lawyer. And I just didn't know. I think what had the biggest impact, however, was the fact that my own family didn't really have a high healthcare literacy.

(02:06):

And unfortunately, I lost my grandmother at an early age due to health conditions that could have been prevented. And so, understanding where the knowledge gap was from just a family and personal setting, I think really drove me and encouraged me to want to learn more. And the best way to do that was becoming a nurse.

Dr. Nathan Kuppermann (02:27):

That's awesome. How about you, Christine?

Dr. Christine Riley (02:28):

I didn't really have an aha moment either. There wasn't a time where the clouds parted and Florence Nightingale came down and anointed me. I really loved the disease process and actually started out with a genetics degree and spent a lot of time in labs at the NIH and then also in my undergraduate training and realized that it was not enough people for me to spend a life in the lab, but I really loved the disease process. And so, the idea of figuring out where I could combine interest in the disease process with an interest in helping people really is what brought me to nursing.

Dr. Nathan Kuppermann (03:03):

Interesting. By the way, I know this podcast is not about me, it's about you guys, but I didn't have an aha moment either. In fact, I didn't know if I wanted to be a doctor or an actor.

Dr. Cicely (CC) Brooks (03:15):

Oh, wow.

Dr. Nathan Kuppermann (03:15):

So, I took a year off from college and I ended up being a podcaster.

Dr. Cicely (CC) Brooks (03:16):

Yeah. Hey, that's wonderful. There's a lot of similarity there.

Dr. Nathan Kuppermann (03:21):

Yeah. So, anyway, let's talk a little bit about the importance and the power of nursing. And we know the connection between nurses, patients, families, it's really core to nursing care and it's core to patient care in the hospital. And you both know as an emergency physician, I realize the partnership between physicians and nursing is just absolutely fundamental.

(03:44):

But over time, I think people have realized that nursing is not just about patient care, but leadership in hospital, research in hospitals is really also a fundamental part of nursing care. And so, Cice, let me ask you, you oversee a large nursing core at Children's National, and you're a nursing leader and you do lots of different things, but let me get your thoughts about what defines great leadership in nursing.

Dr. Cicely (CC) Brooks (04:14):

I think of nurses as leaders wherever they are in their nursing career. So, whether they have a title or not, nurses are leaders at the bedside. They are, to your point, a very core part of the healthcare team and often is the one that is first in acknowledging that there's some opportunity here, there's something wrong and pulling that team together and providing information based on their clinical assessment. And so, I feel like every nurse is a leader.

(04:43):

If you're asking specifically about my leadership, I think my role is to really continue to pave the way for those bedside nurses and to have strategies at every level in the organization where nurses can grow and thrive in various areas. So, nursing isn't just about the bedside care, but it's nursing in technology, it's nursing in education, it's nursing in the community. And all of those roles, in my opinion, are of leadership. And so, I think it's very important as growing nurse leaders that we remember that where we started and the impact we had at the bedside and to carry that vision on and make sure we're paving the way for other nurses to become leaders or to stay at the bedside.

Dr. Nathan Kuppermann (05:28):

And let me ask both of you, given the importance of nursing leadership, et cetera, I mean, it really starts with identifying what are the big challenges that nurses face. And I'll start with you, Christine. I know there can't be just one, but maybe a couple of the big challenges facing nurses today. What are your thoughts?

Dr. Christine Riley (05:51):

Yeah. I think there's two major challenges facing nursing today. The first is external, and the second is internal. So, the external challenge I see is that we haven't really been able to capture nursing care and hospital revenue cycles. One of the changes that happened in the 1930s was they changed nursing billing structure to be aligned with the hospitality industry. And that made a lot of sense at the time because there wasn't a lot of variety and needed care. Really, we didn't have very many tools as clinicians. And so, nursing care was rolled into the room charges.

(06:24):

Fast forward almost a century, and that model doesn't fit us anymore. So, we can have a wide variety in nursing care complexity and we're still being reimbursed at the same rate. And I think that's a major challenge in how we can create structures that really elevate nursing to where it is in serving in terms of the healthcare industry, but also the resources that are available to actively retain nursing in roles that maybe can grow with them.

(06:54):

The second barrier I see for nursing is this idea that we can only move up in nursing by moving away from the bedside. I think that's something that's doing as a disservice. It's one of the reasons in my position as a nurse scientist, I've retained a clinical care component and I love my clinical hours. I feel like it inspires my research to care for patients and it inspires my patient care to do research. And having more blended roles like that available to nursing, I think would be a way to really update our nursing care model for these modern times.

Dr. Nathan Kuppermann (07:28):

Cice, let me ask you something that I know given that nurses spend more face time with patients than anyone, emotionally, it's a taxing, very taxing job. So, what's your approach to providing a supporting environment so that nurses can thrive despite those kind of emotional challenges they face?

Dr. Cicely (CC) Brooks (07:49):

I think the healthcare industry in general is difficult, but especially for those direct care providers. And I think it's very important that we create environments that are robust and that really provide protection and guidance for the entire profession and the folks that are in those roles, mind, body, and spirit, for lack of a better word, and making sure that nurses feel safe in how they're delivering care, their environments are safe, because we know that if we invest in them optimally in all of those areas, not just as professionals, but as people as well, our patients are going to get the return on that investment.

(08:30):

And so, even though the work is hard, I think we just need to make sure that we're creating workspaces where nurses can thrive and they feel safe and they have the resources available to do their job, but to do their job well. And I just want to comment really quickly on something Dr. Riley said, because she could have taken the words right out of my mouth and that I think it's important for us to continue to elevate our profession as nurses. I think sometimes it's underestimated. I think through COVID, healthcare was challenged at every level, but especially at the bedside.

(09:04):

And so, remembering that that is key to our profession is that hands-on care and there's a lot of innovative ways how we deliver care. And so, I think keeping nurses at the bedside has definitely been a challenge. It may continue to be a challenge, but I think having hybrid roles such as Dr. Riley's, I think is so important because it maintains that connection in what we do every day.

Dr. Nathan Kuppermann (09:27):

Yeah. It's perfect because the next question I have here is really a continuation of what you're talking about is that we know that nursing is very technical, but it's also very deeply human as well. And now I'm thinking about the other side, that is from the patient side. So, patients are arriving at some of the most stressful points in their lives, and of course, the lives of their parents. So, how about the environment to make sure that patients and their families are feeling safe, comfortable, as much as can be in a very stressful time? What's your approach on that?

Dr. Cicely (CC) Brooks (10:07):

Sure. Yeah. I don't know one family that woke up in the morning and said, "You know what? I want to take my child to the children's hospital." And so, I think it goes back to the overall health and wellbeing of our care team, specifically nursing and making sure that there's that empathetic and personal connection. And again, everyone has things going on in their personal lives. And I think some of us or a lot of us that are parents, we understand that other side.

(10:35):

And one of the things I share with some of our new team members that are coming in is, "If you've ever been on the other side of the coin, remember how that felt. You were very vulnerable, you may have received some catastrophic diagnosis of your child. There's not a lot you can control and how that feels." And so, making sure we're having that empathetic connection with our patients and families. And we're listening.

(11:03):

I think one of the things I've learned throughout the last 25 years is a lot of health system has, we have great technology, we've got a lot of shiny toys, we've got new buildings, but if you really ask what resonates with the patient, it's that interaction, it's that touch. It's taking the time to make them feel very important in that moment. That's what they're going to remember the most. And I know it's cliché, but I have to say it, we are the patient's experience. And so, every single interaction with these families count and we have to really put on our thinking caps and trying to understand how to meet the needs of our patients where they are.

Dr. Nathan Kuppermann (11:44):

Before I ask Christina a follow-up, I'm going to share something with you guys and the lead impedes audience that I've never shared. But my wife is also a physician scientist, but very early in our careers, our oldest daughter, who now is a healthy 30-year-old running her business, but she was critically sick in the ICU. And like a year out of our training, we were put on the other end of the experience. And although I wouldn't wish that for anyone, you really learn once you're on that side, what are those special touches that just transform the experience?

(12:20):

And we realized more than ever that it was the nursing care that we were receiving that's really that made us feel at ease and comfortable despite the very stressful circumstances. But I know, Christine, you're a nursing scientist. You do your research work, but you're also a bedside nurse. And I know you work in the ICU and that is perhaps the highest stress place for patients and for nurses to work. You want to highlight some of your experiences with a focus on what has helped patients and their families get through an ICU experience? What's been your experience?*

Dr. Christine Riley (13:01):

Yeah. It's interesting that you shared the story about your daughter. I actually had a similar interaction. I had premature twins and they were in the NICU across the city. Just for seven days, they were actually very good size. People kept telling me they looked just really small to mend I'll never forget that feeling of having no control. And I had all this knowledge and all these skills and I had no control at all. And so, really trying to realign for families a sense of control, helping them understand that you're still this patient's mom.

(13:37):

And I value what you bring to our team as a parent, I think is one of the most empowering things we can do as nurses. And nurses do that every day. So, they can be the one to help mom hold the baby for the first time. They can be the one to help mom do mouth care even if the patient's on a ventilator. And so, really facilitating that connection with your child through the wall of technology in the face of critical illness is one of the things I see our nurses do every day that really elevates the practice to where it is.

Dr. Nathan Kuppermann (14:15):

Yeah, I love that. And actually, I want to continue with that same theme, this issue of nurses helping guide patients and their families through this really intense period of care. Those were some great examples. Other examples of, and this is open for both you, of how nurses can help guide families through the journey.

Dr. Christine Riley (14:40):

I really see nurses as the hub. We're in DC, we have all these traffic circles and they're intentionally designed to create a strategic plan to strategic defense. And nurses are like the traffic circles of the care system. So, you can be centered and be the gatekeeper and also the facilitator for all these different services and systems. And I think that that role in nursing is difficult to capture in our data. But it's something as a clinician I see every day. I don't know if you...

Dr. Cicely (CC) Brooks (15:16):

Yeah, I totally agree. I think nursing is central to how care teams deliver care. And again, I think it goes back to that personal connection, spending that time, being intentional with not just looking at monitors and vital signs and things like that, but also observing the interactions with the families and picking up on the subtle things. And that takes time and a certain skillset to do that. One of the things I say all the time is nurses tend to look at what's not being said. And that's a specialized skillset to be able to observe something that other folks may not readily see. So, I think that's key.

Dr. Nathan Kuppermann (15:56):

I love that because that was a question that I was going to ask later, but I'm going to ask it now because I think I and the listeners might be aware of some obvious things that nurses do that it was just it's core and fundamental to patient care. But as you're saying, Cice, there's some nuances that I know that nurses have because of their training, their caring, and the time that they spend at the bedside. Give some other examples of like something that wouldn't be obvious to a parent or a family that you'd like to share with the listeners here.

Dr. Christine Riley (16:33):

Well, one of my recent studies for my dissertation really talked to expert nurses about when they sensed an infant who was critically ill would be in trouble. And the stories that they came back to me with this qualitative investigation were so interesting that I ended up actually oversampling nurses because I just wanted to keep talking to them, but they described their care as like a dance

or a rhythm that they can sense the rhythm of the infant. And if there's something off with that rhythm, then they knew something was amiss and was worthy of further investigation.

(17:08):

And so, all the nurses that I spoke to in this sample had to have at least 10 years of post-training bedside experience, and they all talked about this innate sensing of how a patient is doing. And that's another thing that's hard to capture. And when we think about resources for nursing, we have to give them the time to have that sensing and to really experience that input and how they're going to respond to that.

(17:33):

And if they're understaffed or we don't have this, the technology is cumbersome, they lose that ability to really connect with the patient into that deep almost spidey sense is how they were describing it to me. And that just takes you back to the idea that a nurse is just as likely to save your life as a physician, just as a physician is just as likely to help you cope as a nurse. And when we work in a team where both disciplines really are challenging each other to those same standards, that is when we get exceptional care.

Dr. Nathan Kuppermann (18:08):

It's super interesting. I want to have a thought about that. So, my research is really how to identify children who don't look necessarily overtly ill, but they might be harboring something. And one of the classic things is pediatric sepsis. Some kids present with obvious sepsis, nurses, doctors, we recognize it. But now we have new models using technology to screen for sepsis, but you know what? They do not work well alone. They work well in conjunction with what you're describing in this sense and from the nurses, the physicians, from the team. In fact, when there's a trigger, there's a team huddle. It's the nurse, it's the physician, because what you're describing, I think is very powerful.

Dr. Cicely (CC) Brooks (18:58):

Yeah. As an OB nurse, I was always taught, "You're not treating the monitor, you're treating the patient." And in OB, we have two patients, one you can see and the one you can't see. And so, often we would rely heavily on, yes, what are the dynamics and the data points telling us? But it was also being in tune with that mom and that family. And I think one of the things from a nursing perspective is we're not just treating a patient, we're treating an entire family or unit.

(19:30):

And so, just treating the patient is not always enough. And so, recognizing that that mom or that caregiver in the corner is slightly more quiet than they have been, or they're looking a little bit

more stressed or they're not visiting as much. Those are subtle things that have to be addressed if we want to provide the best high-quality outcomes for our patients.

(19:52):

And so, often it's the nurse that is first to recognize that something's different here. And the good news is that our care team listens to us when we say, "Hey, there's something going on here. I'm not quite sure what it is, but what do you think?" And pulling other people into the scenario and situation, whether it's social work or case management or physician colleagues, just always remembering we're not just treating that kiddo in the bed and all the monitors and bells and whistles, but that entire family unit.

Dr. Nathan Kuppermann (20:25):

I love both you guys talking about this because I think there's probably a perception, a lot of it pushed by television and whatnot, that the nurse is just there and doing routine care. But in fact, what you guys are describing are the critical, important clinical nuances. And I will tell you, and I'm not just saying this because I'm podcasting with two nursing leaders, but I'm a pediatric emergency physician and okay, residents out there, no disrespect to you all, I love training residents, but in the emergency department, the nurses, they are the last wall to save patients' lives because partly in an academic center, we have great physicians, great nurses, but of course we have trainees, both physicians and nurses.

(21:15):

And we count on the expert nurses to help us at training centers because we need the experience along with the people that we're training. And I cannot tell you how many times the nurse has saved my life as the attending physician in the emergency department.

Dr. Cicely (CC) Brooks (21:36):

Well, I love that because it's about teamwork. And we all started somewhere. So, I remember as a brand-new nurse, I didn't know anything either. And I'll never forget the person that really was most influential the first year or two in my nursing career was actually our unit secretary and her name was Tammy and god rest her soul, she ended up dying during COVID. But I will never forget the impact that this person who may have just had a high school diploma, but was sitting at that front desk, knew how to get in touch with everyone. She like ran Grand Central Station, but I learned just as much from her as I did my physician colleagues and my preceptors.

(22:20):

And so, even though nursing is pretty core to that healthcare team, it's still a team. And we all have to remind ourselves, we're at various places in our careers and never forget, you were that

bright, shiny, new person that just had no clue what you were doing and you relied on others to help get you through.

Dr. Nathan Kuppermann (22:42):

Yeah. Absolutely.

Dr. Christine Riley (22:43):

Yeah. I think you really speak to the importance of having like a flattened hierarchy in our health system and really this idea that everyone is learning from everyone regardless of title or position on the team.

Dr. Nathan Kuppermann (22:54):

Absolutely.

Dr. Christine Riley (22:56):

And we try to promote that definitely.

Dr. Nathan Kuppermann (22:58):

Yes. Let's talk a little bit about science and research. I don't think that's an area that people know that much about that, that nurses are deeply involved with science and research. Christine, you have a PhD and Cice, you have a doctor in nursing practice, they're both doctorate degrees. Do you want to explain the difference between the two and how do they work hand in hand or not, or how does that work?

Dr. Cicely (CC) Brooks (23:23):

I think it speaks to, again, just the wide vast knowledge and expertise we have in the nursing profession. And so, my doctoral degree is in executive nurse leadership and my focus was actually on professional development and executive succession planning, because I think it's super important.

(23:42):

And one of the things in my program is most of my mentors were actually not nurses. They were CFOs and COOs and CEOs because I wanted to bring a slightly different perspective to nursing from a leadership perspective. And I think it goes hand in hand with some of the other doctoral and PhD trained nursing systems that we have in place. But again, I just think it speaks volumes to the vast variety of types of nursing excellence that can be achieved.

Dr. Christine Riley (24:16):

Yeah. I think of the two degrees and there's like a lot of misconceptions about both. So, I just want to clear the record. There's not one that is better than the other. There's two different paths. And when I was trying to decide for myself which path I was going to go down, I spent a lot of time looking at programs side by side and trying to figure out which was going to be my path. And what I came down to is the DNP is, do you have how questions? And the PhD is, do you have why questions? Because you need the why questions to get new knowledge and you need the how questions to get that knowledge into practice.

(24:53):

And so, together, the DNP and PhD can create what is really a really powerful translational model where I'm able to generate new findings and my DNP colleagues help me get those findings into practice. And we've actually added to that sort of a triad model where we have a PhD partnered with a DNP, partnered with a clinical nurse.

(25:13):

So, we have the whole spectrum from research to implementation in one research team. And what we're trying to do is decrease that implementation time where it takes 17 years to get findings into practice. We're trying to make that two years because we don't really have 17 years to wait around on some of these findings. And so, there's no better or worse. They're just how questions and why questions and really the degrees together are really powerful to get findings generated and then into practice.

Dr. Nathan Kuppermann (25:44):

Christine, let me ask a little bit about your research in particular. So, I know you study infants in the ICU and the stress response. Why don't you tell us a little bit about your work and also, I'm going to just give you the follow-up question and how do we decrease that stress burden on infants and children in the ICU?

Dr. Christine Riley (26:06):

So, my research actually started from quality, which was inspired by a patient. So, I had a patient who I was very close to suffer a postoperative cardiac arrest and have basically the perfect resuscitation, like textbook. And he still had a devastating neurological injury and we had to redirect care. And so, losing that patient really changed for me the paradigm on the focus of resuscitation versus can we go a little bit more upstream and start to really prevent cardiac arrest.

(26:38):

And so, I started with a QI algorithm that really did decrease our cardiac arrest rates, but was finding that even with over 60% decrease in cardiac arrests, we were still having high risk neonates arresting. And so, that started to lead me back to my why questions. And I started to look at this idea of stress as a modifiable risk factor for cardiac arrest, which is something I see clinically. The patient looks okay and then they get a chest x-ray and have a cardiac arrest or they get an endotracheal tube suctioning or a veni puncture. Something tips them over.

(27:11):

And so, connecting that clinical phenomenon with a very old stress theory, general adaptation syndrome, which came about in the 1930s really has me on this path of exploring this hypothesis that is stress exposure in the ICU environment, a modifiable risk factor for cardiac arrest in these high-risk infants. And exploring that, I've really learned a lot about stress and that it's from all different sources. So, stressors come from the environment, they come from the care team, they come from the disease itself. And really what these infants are dealing with is a compounded exposure to stress response.

(27:47):

We know that from the NICU literature, hospitalized infants may encounter up to 75 stressful experiences per day of hospitalization that has never been replicated in the cardiac ICU where infants are having open heart surgery. So, I imagine it's even higher and that's part of what our team is working to sort of tease apart and start to quantify.

Dr. Nathan Kuppermann (28:08):

That's awesome. So, Cice, let me ask you. So, Christine is just one example of a nurse scientist doing a really important work that changed the way that we think about patient care and deliver patient care. So, you as a nursing leader, the nursing leader at Children's National, how do you nurture an environment that allows nurses to pursue that research and then get it translated to the care?

Dr. Cicely (CC) Brooks (28:34):

I mean, that work is so important. And I always talk about how innovative nurses can be. You give us tape and some scissors, we're going to figure out how to do things differently. And so, I think continuing to elevate this amazing work that's happening every day at the bedside, providing a platform where nurses can share ideas and ask those whys. And how can I help my partners in the C-suite understand how important it is to invest in this work?

(29:05):

We are creating future therapies alongside our physician partners. We are changing the way healthcare is delivered in the future, just like our predecessors before us. So, I think it's even more important to continue that work and to invest in this and give nurses just that platform to be able to have the opportunity to share ideas and new knowledge and undergird and support them with the resources they need to carry that forward.

(29:32):

Here at Children's National, we do an amazing job and there's more to be done. We've got some great leaders in nursing research that are so passionate about this work that are locally known and nationally known and, in the future, soon internationally known. And that is really the goal to, again, to elevate our profession and say, "Hey, we have more to offer here." And so, as the nurse leader, it's my responsibility to be an advocate and a cheerleader for this work. And to encourage new ideas and again, invest in our team to be able to move healthcare forward.

Dr. Christine Riley (30:07):

Yeah. I think one of the things we don't realize sometimes, and maybe you've seen this too, is that scholarship is an anecdote to the healthcare heartbreak. We see this heartbreak every day. And if you can connect to something beyond your shift to something bigger, it really is an anecdote to that heartbreak we interact with every day. And so, my research was born out of what was heartbreaking.

(30:33):

And so, it's one of the things I think I see as a coping strategy for our nurses, if we can connect them to want to change something, to see a problem they want to fix, really that carries your why beyond your shift and makes the burden of the job a little bit less.

Dr. Nathan Kuppermann (30:50):

It's interesting. There's a lot of things that physicians and nurses share in common. I mean, we're all care providers and we can lead, we can investigate. And I think a common theme, and one of the great things about at an academic children's hospital, obviously the most important thing that we all do is we care for patients. Caring for children is our why.

Dr. Christine Riley (31:13):

That's first. Right.

Dr. Nathan Kuppermann (31:14):

That comes first, always. But there's so many other things, again, to both address broader issues or issues that we come up with in the care of patients, whether it's developing great leadership

models to help nurses become leaders or discover new data, new evidence that directly translate to patient care. It's one of the great benefits of working at an academic center, both for nurses and physicians. We really get this. It's really, it's a blessing that we get to do all these different things that ultimately go to improve the care of patients.

(31:52):

Christine, just in follow-up to Cice's comment about the importance of leaders like Cice creating the environment to nurture research, from your end as a researcher, what do you look for in leaders to help fertilize the soil for research for nurses?

Dr. Christine Riley (32:09):

Yeah. So, I think about innovation as being the marriage between leadership and research. So, research drives the data, leadership drives the implementation. And to really innovate, you have to have both things. And so, I really look to our leaders to be open to changing practice based on new ideas, to be curious about how we can do things better, and to really give us the time to start to answer some of those questions and the understanding that there's a twofold ROI when we invest in nursing scholarship.

(32:46):

We are saving money usually because their questions have some cost savings because they want to know how to do things better that usually translates into doing things more efficiently. But it also retains our nurses because they feel connected back to the organization in a way that's really meaningful. And so, that's that second return on investment. So, I think it's really important to have both to think of innovation as research plus leadership and capitalize on the support we have from both the research and the leadership fields at Children's.

Dr. Cicely (CC) Brooks (33:20):

Nurses are notorious for workarounds. If there's a way to do something easier or more efficiently, we're going to do it. And so, one of the things I encourage our frontline team members is, "Hey, if there's a better way to do something, share it. If you see something, say something, speak up about it. If there's something in your care delivery model that's annoying or you feel like it's two or three more extra steps and there's a better way to do it, let's create an environment that allows you to raise that issue. There probably is a better way to do it. If there's a cost savings initiative, we're using too much of the wrong supply or not enough of the right supplies."

(33:59):

Those are things I think we as nurses sometimes take for granted, but that's innovation in its most purest form that people are asking the question, "Well, why? Does it take 15 steps to do this one thing? Is there a better way to do it?" And so, anytime I find that nurses are creating their own way to do the same type of work, I like to dig into that a little bit to say, "Well, let's look at this from a bigger picture." Because if this is an inefficient way to provide care in this area, it could be inefficient in other areas.

(34:30):

And unless we have a platform where we can pull all of that information together and make meaning of it and move things forward, I think we just find ourselves stuck. And so, again, we can get very creative in the nursing realm. And so, I think having a very robust shared governance model and research platform to share those ideas are fundamental.

Dr. Nathan Kuppermann (34:55):

I want to go to that innovation word since it's the word of the day right now. And this is to both you, and I'll have you each speak about it. What do you see right now as the, like today, the most important innovations that are happening in nursing? Just maybe one or two. And let me start with you, Christine, and then I'll go to you Cice.

Dr. Christine Riley (35:17):

Well, I think there's a lot of hype about AI. Everyone's so excited about AI. And I think there is a place for AI in healthcare. I don't think it is to replace the clinician. I think it's to allow the clinician to do the work that only a clinician can do. And so, that's one of the things I think is exciting about innovation in nursing.

(35:35):

What I'm hoping someday we have the charting just happens. Free them from those computers. I feel like our nurses are saddled with this computer charting and there's so much information in there, but as someone who started on paper and still secretly misses it, I think one of the things that I'm really looking forward to is this idea that we could have AI do our nursing charting. So, nurses can just care for patients and it's recorded by AI.

(36:03):

And I know we've been piloting those models in some of the outpatient settings for physician notes, but wow, the power of that, if we could free our nurses from the computers and just let them do care, I think that would be something that would really be a game changer in how we care for patients.

Dr. Cicely (CC) Brooks (36:19):

I couldn't agree more. It adds to our efficiency and how we deliver that model of care. And so, too, starting on paper, very simplistic, you charted what you needed. Now, for all kinds of reasons, be it regulatory, safety, our need to document our care has quadrupled over the years. And so, if there's a way to do that more efficiently, that also allows the patient and the family to be more incorporated in that delivery care model, even from a documentation standpoint, I think is something that we'll continue to work on.

(36:56):

My dream, and I've shared this with every chief informatics officer I can, is I would love to see the day. And I do think this type of technology does exist, but needs to become more robust. I want to be able to have our nurses walk into the room, engage their patients, have a conversation with them, and that information gets documented organically in its proper places.

(37:23):

And so, we know physicians have been documenting via voice where it's Dragon or transcript for years, and it's how your documentation goes into the medical record. Whereas for nurses, we operate from a different methodology, whether it's flow sheets or in the MAR and those areas. So, our documentation tends to be a little bit more decentralized, for lack of a better word.

(37:48):

And I know AI and Ambient Listening is something that's right there on the cusp. But what I think is very important is that all of these tech companies and AI companies and EHR companies need to have nurses at the beginning of that process. And I think what happens is we have companies that present us with AI options, but they've not included us in the build. And so, then it's like, "Well, that's great technology. However, it doesn't work very well for us. This is how we'd like to see that technology work." And so, again, it's going back to the why does it work this way, and including nursing from the very beginning on how we deliver care.

Dr. Christine Riley (38:27):

Yeah. And I actually think, I mean, this is going to go back to one of the first points about the billing, is that we view physicians as the revenue generators of a health system when in reality,

the purpose of a hospital is skilled nursing care. If you didn't need skilled nursing care, you could have your surgery and go recover at home.

(38:44):

And so, we build these technology systems around the biller, which is the physician, which is viewed as a revenue generator, and then we forget all of those work hours that our nurses are doing behind the computer. And so, I think part of it is really getting to the table sooner and realizing that nurses are not only essential, but they're an equal partner in the outcome and the revenue of our institution.

Dr. Nathan Kuppermann (39:11):

What do you think pediatric nursing looks like 10 years from now?

Dr. Cicely (CC) Brooks (39:17):

Wow.

Dr. Nathan Kuppermann (39:17):

So, I know that's a long way. Maybe we could say five to 10 years from now, okay? Make it a little bit easier.

Dr. Cicely (CC) Brooks (39:21):

Well, I'm sure you have appreciation. I grew up watching the Jetsons. And so, I was watching something on TV and they did like a Jetson look back and like a lot of the technology that was on Jetsons, what we're doing now. And so, I think about some of what I see, not just on TV, but I'm like, "Wow, that's going to be great in five or 10 years." But I think from a pediatric nursing perspective, because I feel like nurses are super smart, it's going to be mind blowing.

(39:49):

I think we have to figure out a way to deliver care more efficiently, more effectively, lesser cost model because healthcare is very expensive that still produces the same, if not better outcomes. And again, whatever the future of pediatric nursing looks like, we've got to be in the forefront through continued research support and innovation.

(40:16):

But I'm actually super excited about the future. We've got some really smart nurses that are coming out of school these days, and I'm excited. Healthcare for nursing and education and training has evolved a lot over the years, and it will continue to evolve. But again, we have to

maintain that connection through that research and innovation to make sure we're continuing to evolve with healthcare.

Dr. Nathan Kuppermann (40:42):

Yeah. There's a lot of great research happening now, and it's hard to imagine stuff in the future, but looking five to 10 years from now, something like that, where do you see pediatric nursing research and also not only with the evidence generation, but getting it to the bedside to change pediatric care? What are your thoughts on that?

Dr. Christine Riley (40:59):

Yeah. Well, nursing research has been around a long time. I don't think people realize that, but the reason we have clean hospital rooms is Florence Nightingale's original research. The reason we wash our hands is nursing research. The reason we have bili lights for premature babies, that's nursing research. So, nursing research has a long history of success and I think we'll continue to move forward.

(41:23):

One of the things I think will change or that I'm hoping to change at least is to move a little bit more towards an individualized care model. So, we went from one-to-one nursing, okay, that wasn't that efficient or effective. We went to protocolized care. There's a lot of benefits to protocols, but I'd like to really see our nurses using their judgment as expert clinicians to decide, "Does this baby need cares now?" Instead of, it's been four hours, time for cares. Really to start to see if we can decrease the need for so much intrusion in the healing process by letting nurses have a little bit more freedom about when they provide care.

(42:03):

And can we make the model look a little different where we have the nursing parent dyad running or driving the care team and the team in the back and allowing nursing and the mother to maybe decide we need an echo today and mom can be here to do it or we do want to check labs and we want to do it at this time. Instead of having the care team, I think our patients are on the care team clock. I'd like to see it the other way around, have the care team on the patient's clock.

Dr. Nathan Kuppermann (42:35):

No, it really, it is the direction that we're going in medicine in general that is precision medicine. And what you're describing really is a form of precision medicine. We do have protocols for reasons because we generate evidence, but we generate evidence around populations of patients with X condition or whatever, but then there's the individualized care, whether it's genetic based

or based on the circumstance or the nuance that nurses detect, we do need more personalized healthcare. And I can really appreciate that.

(43:11):

So, my last question I'm going to ask of both of you as we wrap up here is just tell me what excites you the most about the next generation of nurses? We didn't even talk about the training of a new nurse. We alluded to it, like we're talking about the training of new doctors, but what excites you about the next generation of nurses coming up?

Dr. Cicely (CC) Brooks (43:31):

Again, I think it's how we deliver care. I think COVID taught us a lot in who we are and can be as a profession. And we had to get very creative talking about personalized care, a lot of the protocols remained in place, but how we delivered care had to be very different during that time. And so, it challenged us to really think out of the box on how that care was delivered when and where. And so, I'm excited that we're going to continue to build on that. I'm always a stickler to don't let a good crisis go to waste.

(44:06):

And so, I think now is the time. I think I'm excited that our academic partners are starting to look at their own curriculums because there's a lot of things in nursing school I didn't learn. And so, the business component necessarily, and some of the other things that really compliment how we deliver care has not historically been a part of the educational system for nurses.

(44:30):

And so, I've had the pleasure to see a lot of those curriculums evolve over time. And it goes back to research, innovation, and partnerships with our academic partners to say, "Hey, we're noticing a trend that nursing students don't have this particular skillset," whether it's having a difficult conversation, picking up on those social cues, how to learn de-escalation when families are in a stressful period and mood. And so, I think having that continuous re-evaluation evolution of education, research and innovation is exciting and I'm just glad to be a part of it. But I think I know, especially at Children's National, our future is bright.

Dr. Nathan Kuppermann (45:18):

Great. Christine, how about you?

Dr. Christine Riley (45:20):

One of the things I think is so exciting about this next generation is just their fearlessness. They really are not afraid. They're not hindered by the dogma, which I think is really refreshing. For a

long time in nursing, a lot of times the answer would be, "Well, because we've always done it that way," which I think is one of the most dangerous phrases in healthcare. And they're not saying that and they don't accept that as an answer. And so, I think this fearlessness is really exciting.

(45:47):

We just started a program this year to really engage bedside nurses in research. It's funded by the Dunn family, and we just got another foundational donation from the Van Metre companies to really create a nursing excellence academy, one of which will have a research track. And so, our nurses join our research team and they participate in primary data collection.

(46:11):

And just the first three hours with them, we had a list of study ideas. They just have the best ideas, they have the best questions, and they have this fearlessness this, "Why not me," approach to life, which I think is something I want to see more of as we're turning the channel on what's next for nursing and for nursing at Children's National.

Dr. Nathan Kuppermann (46:35):

Outstanding. So, Cice, Christine, thank you both, first of all, for what you do. It's just so fundamental to the care of children. And thank you for joining me today on The Lead in Peds.

Dr. Cicely (CC) Brooks (46:47):

Thank you. It's a pleasure.

Dr. Christine Riley (46:47):

Thank you.

Dr. Cicely (CC) Brooks (46:47):

Thank you for having us.

Dr. Nathan Kuppermann (46:48):

Having spent so many years working alongside pediatric nurses in the emergency department, I can say without a doubt that they are the heartbeat of the hospital and critical to the efficient and safe delivery of care to children. Nurses aren't just the glue holding everything together. They are heroes in medicine, saving lives and making a tangible difference every single day.

(47:11):

Their expertise, quick thinking and compassion transform care for children and families, often in ways that go unseen but are absolutely vital. Without them, hospitals simply wouldn't function and their dedication truly drives the success of pediatric medicine.

(47:29):

Today, we talked about the leadership, science, and compassion that define pediatric nursing from supporting families during some of the most difficult moments of their lives to advancing research that improves care for infants in intensive care, nurses play a critical role in shaping the future of pediatric medicine.

(47:49):

I want to thank Dr. Cice Brooks and Dr. Christine Riley for joining us and for the work they do every day for patients and families at [Children's National](#). And thank you for listening to The Lead in Peds. [Be sure to subscribe wherever you get your podcasts](#) so you don't miss future conversations about the people and ideas shaping the future of pediatric medicine.