

Caring

April 3, 2003

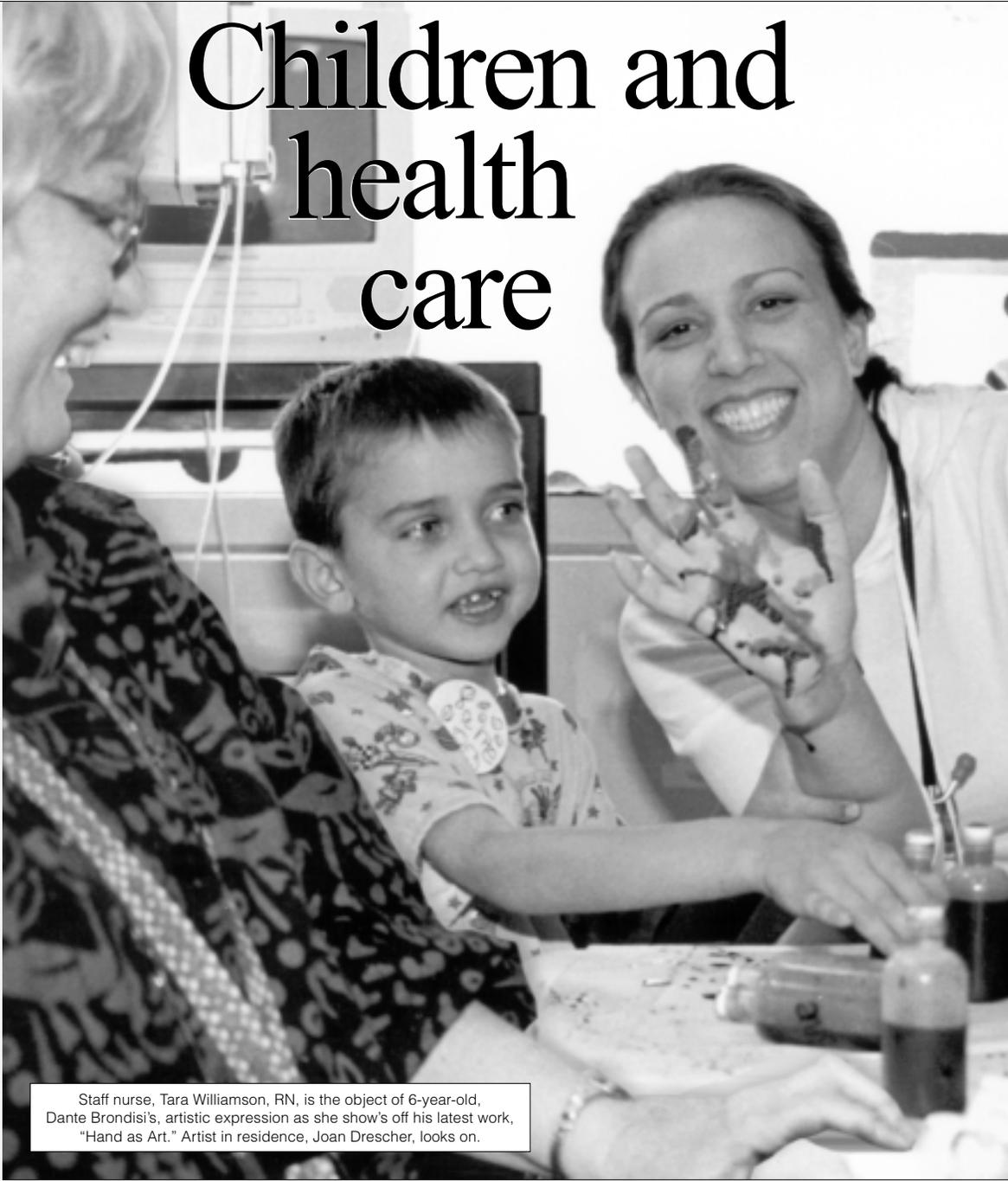
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Children and health care



Staff nurse, Tara Williamson, RN, is the object of 6-year-old, Dante Brondisi's, artistic expression as she shows off his latest work, "Hand as Art." Artist in residence, Joan Drescher, looks on.

MGH Patient Care Services
Working together to shape the future

Meeting the unique and varied needs of children and their families

Many of you had an opportunity to attend the Healing Arts Celebration this past January, commemorating the third anniversary of the inception of MassGeneral Hospital for Children. It's hard to believe this relatively new entity has accomplished so much in such a short time, consistently ranking in the top 1% of pediatric service providers in the country by *U.S. News and World Report* and the *Annual Guide to America's Best Hospitals*.

This special issue of *Caring Headlines*, devoted to Children and Healthcare Week and our pediatric caregivers, gives us a glimpse into the highly collaborative, interdisciplinary practice that keeps MassGeneral Hospital for Children at the top of those ranking charts. Committed to providing the highest quality holistic care to our youngest patients and their families, clinicians and support staff ensure that every child's medical, emotional, and spiritual needs are met, whether it's in the inpa-

tient setting, an outpatient clinic, or those occasions when a child is cared for on an adult unit.

In addition to the day-to-day work of our pediatric caregivers, staff of MassGeneral Hospital for Children respond to the needs of the community in a world that is always changing. Recently, MGHfC joined with Nursing and Child Psychiatry to prepare guidelines for parents on how to talk to children about war and the images they may be seeing on television. Some tips included:

- Don't assume your children understand what they see on TV; ask what their understanding is.
- Arrange to be with your children as much as possible to help allay fears
- When they ask, 'Why?' it's okay to say you don't know why there is a war.
- Listen to your children; let them express their feelings
- Validate their feelings by letting them know you have similar feelings.
- Ask what their concerns are so you can address them directly.



Jeanette Ives Erickson, RN, MS
senior vice president for Patient Care and chief nurse

Whether delivering bedside care, patient education, or responding to the needs of the community, nurses, therapists, child life specialists, social workers, support staff, and many others in the MassGeneral Hospital for Children work tirelessly to meet the unique and varied needs of the infants, children, adolescents, and families we serve.

Magnet Update

I'm pleased to announce that the second and final phase of our journey toward magnet hospital certification—the on-site visit—will occur this spring on Tuesday, June 10th–Thursday, June 12th. Our two magnet appraisers will be Christine Mueller, RN, PhD, CNAA, associate professor at the University of Minnesota School of Nursing in Minneapolis; and Diana Swihart, RN, PhD, nurse educator at James A. Haley Veteran's Hospital in Tampa, Florida.

Now that the dates are known, the Magnet Certification Steering Committee will be providing more concise information about the visit and conducting mock visits to help staff and leadership prepare. I look forward to working with our magnet champions, clinicians, support staff and leadership in demonstrating to our magnet appraisers why "Nursing at MGH is Simply the Best."

Update

It's my pleasure to announce that Diane Carroll, RN, has been appointed chair of the MGH Tuesday Continuing Review Panel of the IRB. Diane is a clinical nurse specialist whose research interests lie in nursing interventions for the cardiac population. She is co-investigator on an NIH-funded study to measure the effectiveness of nursing interventions on improving health outcomes in elders after MI and CABG.

Note schedule change!
Children's art fair and health fair postponed until May

Schedule of Events Children and Healthcare Week

- May 25-30** (all week): Children's Art Fair "Who or What Keeps You Healthy and Safe?" (Main Corridor)
- April 7–11 (all week): Entertainment during the day and in the evening (on pediatric inpatient units)
- Monday, April 7th: 1:30–2:30pm; Family-Centered Care Awards (Ellison 18 Playroom)
- Tuesday, April 8th: 12:00–1:00pm; Grand Rounds: "Caring for the Caregiver: Coping with Stress in the Workplace," (Wellman Conference Room; lunch will be provided)
- Wednesday, April 9th: "Hurt Alert Day" (all day on inpatient pediatric units)
- Thursday, **May 30th**: 9am–3pm; Children's Health Fair "Jump Aboard for Good Health" (Bullfinch Tent)

Providing children with personalized, state-of-the-art, family-centered care

—by Mary Lou Kelleher, RN, MS,
pediatric clinical nurse specialist

All children and families are not alike. They come in different shapes, sizes, colors, and traditions, all of which make them unique and special. At the MassGeneral Hospital for Children, we respect and value this diversity because it enables us to provide the best possible care we can. When a child is admitted to our hospital or comes for a clinic visit, we know that child is part of a family—and that brings special benefits and challenges to the healthcare setting.

One of the major

components of family-centered theory states that, “What affects one member of the family unit affects the whole.” At MassGeneral Hospital for Children, all members of the healthcare team understand this principle and incorporate it into their daily care.

Over the past year, we have been busy making our ‘hospital within a hospital’ the best place it can be for children and their families. Our Continuous Practice Management (CPM) Committee continues to meet

weekly to discuss and problem-solve around issues of systems and practice.

Our patient satisfaction surveys continue to improve with an overall satisfaction rating of 92% in 2002. This year the work of the CPM will include a formalized and standardized pediatric pain program to maximize the comfort of children in all areas of the hospital. We will use the most recent pharmacologies available to prevent and alleviate pain, and we will incor-



Mary Lou Kelleher, RN,
pediatric clinical nurse specialist

porate complementary therapies into our standard practices.

If you’ve visited the pediatric area of the Same Day Surgical Unit recently, you’ve already seen our ‘new look.’ This was the first area to be transformed using our ‘Under the Sea’ theme.

Realizing that the stress of illness and the complexity of health care contribute to anxiety, fear, and discomfort for children and families, we undertook a project three years ago to find out what children and families wanted the hospital environment to look like. Our goal was to create an environment that would comfort children and families and surround them with soothing, healthy energy. We held focus groups with children and families from inpatient and

outpatient areas asking them to tell us what they wanted. The overwhelming favorite was the wonderful world of under the sea. Now, in the pediatric area of the Same Day Surgical Unit, you see parents and children pointing to whales, turtles and blow fish, happily interacting with their environment as they await surgery.

We plan to carry this theme throughout all areas of the hospital where children are cared for at MGH.

In keeping with the philosophy of healing children through their environment as well as medicine, we are proud to announce the establishment of the MassGeneral Hospital for Children Healing Arts Committee. This group of creative and energetic people is working to bridge the gap between caregiver and patient through art. The committee, a collaborative group of nurses, residents, ther-

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Ellison 17 staff nurse, Kim Waugh, RN (right),
with 2-month-old patient and her mom.
(Being a baby can be *exhausting!*)

Pediatric Therapy Team offers comprehensive, interdisciplinary evaluation

The Pediatric Therapy Team is an interdisciplinary care team comprised of Karen Rocco, OTR/L, occupational therapist, Sue Riley, PT, physical therapist, and Katie Castano, SLP, speech-language pathologist. The team performs comprehensive evaluations on children who warrant assessment by any two or all three of these disciplines. Children referred to the program include those with no known medical or developmental etiology having functional difficulty in school or at home,

and children with documented medical or developmental diagnoses. Parents bring children for initial recommendations or for a second opinion on the services the child may already be receiving.

The Pediatric Therapy Team was conceived in an attempt to streamline the evaluation process for parents and their children. On the day of the evaluation, the child and parent(s) spend the entire day at MGH. On the morning of the evalu-

ation, the team meets to review a team intake form and any other paperwork the parents have brought from previous evaluations. We use the time to determine specifically what the parents' goals are for the day.

Following this session, the child meets with each clinician individually for a couple of hours at a time with breaks for snacks, lunch, and moving around. This may seem like a lot, but the process mimics the length and types of activities a



(L-r): Katie Castano, MS-CCC, SLP; Karen Rocco, OTR/L, SIPT/C; and Sue Riley, PT, MS, DPT, PCS,

child would have in a normal school day. This enables team members to see how the child functions, not only when rested, but also at the end of a school day after several demanding tasks.

At the end of the pediatric therapy team evaluation, team members meet to summarize find-

ings and collaborate on recommendations. Parents join in a discussion of the preliminary findings and answer any questions the therapists may have. This gives parents another opportunity to provide input and help 'fine-tune' the care plan. This is followed in a few weeks by an integrated report, which summarizes the team's findings and recommendations.

Since the program's inception in May, 2002, the team has evaluated 20 children. We have seen the value and importance of timely and close collaboration. Through this intensive, interdisciplinary interaction we're able to identify findings that otherwise could have been lost in the weeks or months it might have taken to coordinate separate evaluation sessions. We'd like to share one case that is particularly noteworthy.

Mary was referred to the Pediatric Therapy Team by her pediatrician and parents. They were

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Riley and Rocco work with 4-year-old, Emma Meglan, who is suspended from a ceiling swing for this fun therapy session.

Pediatric Therapy Team

continued from previous page

concerned because Mary had received all failing grades on her last report card. She'd been having difficulty in school for two years. Though having undergone a CORE evaluation in her local school system, no special services were recommended. Mary's mother turned to the Pediatric Therapy Team for an independent evaluation. Her comment was, "I don't know how she got promoted to the grade she's in."

Mary's school difficulties were listed as poor organization, unable to find her homework in her bag, forgetting books, poor memory, and not doing home-

work. Her mother also noted that she had been diagnosed with a 'sleep disorder,' often sleeping only a couple of hours each night. Mary had been having angry outbursts, pulling her hair out, especially around homework time. While the organizational issues, and other academic concerns are fairly typical of children we evaluate, Mary's symptoms seemed more far-reaching.

With the information we had, we proceeded through the day-long evaluation with Mary. While at times becoming frustrated with some of the demands placed on her, she completed all three evaluations with

good cooperation and effort. In all three disciplines, Mary's scores ranged from superior to solidly within the average range. There were very few areas in which she scored below average, and we felt fatigue could have been a contributing factor to those scores.

As we do after every evaluation, the three of us met to discuss our findings. The more we talked, the clearer it became that there didn't seem to be any gross-motor, fine-motor, or speech-language reasons that would account for the degree of difficulty Mary was having in school. As we reviewed the previous reports provided by her mother, one sentence leaped off the page. It referred to an

event that had happened two years earlier when Mary had come home from school upset. When her mother asked her why she was upset, Mary alluded to an event where she may have witnessed sexual abuse. Following a brief period of silence, we knew our primary recommendation to her mother would be a referral to a mental health specialist.

When we met with Mary's mother to review our findings and recommendations, we presented a relatively normal developmental profile. We then raised our concerns.

With tears in her eyes, Mary's mom said, "I always thought there was something going on, I was afraid to find out what it was."

She agreed to take Mary to a mental health provider, but seemed to be struggling. We had concerns regarding this mother's ability to follow through given what we perceived as her own feelings of fear and guilt. Mom left that evening knowing she'd be provided with the appropriate contacts to get the help we thought her daughter needed.

Over the next two days we sought the help of the Child Protection Team here at MGH to get the information we needed for Mary's mother. We gave Mary's mother the telephone numbers of mental health specialists in her area who specialized in sexual abuse. At that time, Mary's mother reported that as a result of our meeting, she too, had begun to see a mental health provider to help her deal with what might emerge as a result of Mary's intervention.

While we don't yet know the final outcome, we're confident that Mary is on her way to getting the help she potentially needs. We have talked about this child as a team many times. She had a profound impact on all of us. We believe that had it not been for the team members coming together in the same room, and each of us saying, "The problem is not rooted in my discipline," Mary's emotional issues might never have come to light. Our collective belief was that something else was at the root of her problems.

The supportive environment of our team approach gave us the forum we needed to identify the problem and take the collective risk to talk to Mary's mother.

"The strength of the wolf is the pack;
The strength of the pack is the wolf."

—Rudyard Kipling,
The Jungle



Pediatric Therapy Team members, Riley, Rocco, and Castano, use play to assess pediatric patients during interdisciplinary evaluation sessions.

Children and Grief

—by Elyse Levin-Russman, LICSW,
pediatric clinical social worker

Life is often filled with opportunities for hope and celebration, and we cherish those occasions. But it is impossible to experience life without also knowing loss. Whether dealing with the death of a beloved family member, the critical illness of a close friend, or the devastating loss of many lives in a tragic accident, loss is all around us. As adults, it's often difficult to manage our feelings of grief and sadness. These challenges are just as real and just as overwhelming for children.

As clinical social workers, we're often called upon to assist parents in coping with their own emotions around loss as well as their children's. A family may be dealing with the serious illness or injury of one of their children. Parents may be in crisis, struggling with the impending death of a child. Siblings have their own emotional pain. They, too, are anticipating the loss of a loved one. Ideally, parents are sensitive to the needs of all their children. But in situations of crisis, they may be too overwhelmed to do anything more than the daunting task of supporting their critically ill child.

As caregivers, we can support parents and provide assistance in attending to the emotional

needs of all their children. We do this when the patient is a child, a parent, or someone else who is significant in a child's life.

There was a time when it was believed children didn't grieve. They were described as 'resilient' and therefore unaffected by loss in the family and community. Fortunately, we have come to appreciate the special ways in which children respond to loss so that we, as parents and caregivers, are better equipped to help them cope with their feelings. Children who experience loss, whether they're old enough to articulate their feelings or not, feel helpless and sad following the death of a family member. Even if they're too young to understand the permanence of death, they are able to grieve.

It is important to have a developmental perspective in understanding children's responses to loss. For example, a 7-year-old will react differently to a grandparent's death than a 12-year-old. While understanding the finality of death, the 7-year-old may also feel guilty or responsible that his thoughts or actions somehow contributed to his grandfather's death. The 7-year-old may be more forthcoming about his feelings than a 12-year-old. The pre-adolescent

may have a more sophisticated understanding of death and its impact on his family. He may also try to deny his own emotions and be reluctant to share his thoughts. He may insist he's fine but act out his emotions in other ways.

Just as no two adults grieve in the same way, so too there is variation in children's responses. There are many factors that affect the way a child responds to loss. Her relationship with the person who died; the way in which the loved one died (sudden or anticipated loss); the child's previous experience with loss or death; and the family's ability to talk with the child, all play a part in shaping how a child copes with death. How the adults in a child's life handle their grief also serves as a model for how children are expected to respond. Parents and adults who share their feelings provide permission for a child to openly express her emotions. This is healthy and can be therapeutic for all family members.

Whether caregivers or caring adults, it's helpful to keep in mind the many ways we can support grieving children:

- **Speak honestly**
Let children know, in language they can understand, the truth about their loved one's



Elyse Levin-Russman, LICSW,
pediatric clinical social worker

illness or death. Giving children the opportunity to ask questions and receive information is often reassuring.

- **Listen carefully**
Take your lead from the child and talk about what *they* want to talk about. Children need only a certain amount of information and may become overwhelmed with more than they want to know.
- **Encourage parents to include children in family rituals**
Just as for adults, wakes and funerals give children, *if they want*, the opportunity to say good-bye to a loved one and get support from others. Providing information about what will occur prior to attending a wake or funeral is also helpful.
- **Honor children's grief**
At the time of a family crisis, it's easy to overlook a child's

pain, particularly if the child has no overt signs of distress.

Remember, a child's expression of grief may come when you least expect it. Support their feelings and encourage communication.

- **Involve children in decisions wherever possible**
Children can feel a special connection to their loved one if they are allowed to participate in decisions, however small. For example, allowing a child to choose which tree to plant in memory of their parent can be a great source of comfort.
- **Facilitate a system of support for grieving children**
At the time of loss in a family, parents may not be able to provide for all their children's emotional needs. Enlisting other family members or friends to offer special time with

The spiritual life of children

—by Reverend Ann G. Haywood,
pediatric chaplain

As a pediatric chaplain, I offer and coordinate spiritual care for pediatric patients, family members, and hospital staff. I have the privilege of journeying with people through some of life's most challenging and sacred times.

When I first met 16-year-old, 'Victoria,' in the Pediatric Intensive Care Unit (PICU), she was intubated and sedated. She was surrounded by lines, tubes, pumps and monitors, and I could tell just by looking at her she was in critical condition.

"She's very sick. We weren't sure she was going to make it when we admitted her," said one physician.

As I began the process of assessing the spiritual care needs of Victoria and her family,

the nurse and social worker offered helpful information, letting me know which family members were visiting and when.

After speaking with members of the care team, I stood beside Victoria, not knowing what this day or the coming days would hold for her and her loved ones. I wondered if she would live or die, and my heart ached as I considered some of the possible outcomes. I drew upon my own faith as I leaned close to her and gently said, "Good morning, Victoria. My name is Ann Haywood. I am a friend to children here in the hospital. I want you to remember that you are very loved, and I look forward to talking with you when you're feeling better."

I later met Victoria's family, and they told me about her personality and interests. They shared their faith in God and their sense of peace that Victoria was going to recover fully.

One of her parents said, "Chaplain, the doctors told me she is slowly improving. It's going to take a long time, but I am a patient person. She is going to get better. Please keep us in your prayers."

The next few weeks were simultaneously encouraging and frustrating. Victoria was now awake, but she was sometimes confused and anxious. She attempted to silently mouth words to her family and caregivers but it was almost impossible to understand what she was saying. Each day seemed to bring a mixture of progress and setbacks. I sat at her bedside and saw a frail, scared teenager. I asked her if I could hold her hand. She nodded yes and tightly grasped my hand. She looked deeply into my eyes, and I tried to imagine what it must be like for her at this moment. I wondered how long this hospital stay would last and where this journey would lead us.

Victoria was transferred out of the ICU and, with the help of her physical therapist, began taking her first steps. I

visited a few times a week and witnessed the struggles and joys of her recovery. For me, one of the most exciting moments was when I heard Victoria's voice for the first time.

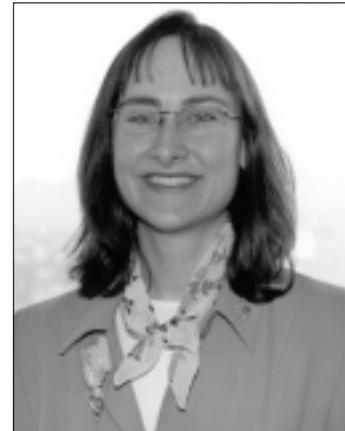
Sometimes as we sat and talked, Victoria spoke of fears, joys, frustrations, or hopes for the future. Other times, we talked about favorite movies, family, friends, and the beauty of the sky at sunset. From my pastoral care toolbox, I offered the ministry of presence, non-judgmental listening, humor, and personal prayers. My hope was that no matter what, Victoria would know that she was loved by God, family, friends, and caregivers.

During one of my visits, Victoria spoke of her regrets about poor life choices that had contributed to her hospitalization. As she tried to make meaning of her current situation, she said, "Did you think I was going to die? I wasn't supposed to live, you

know. I'm a walking miracle."

She told me about a good friend who had died tragically a few years before; she showed me his picture. She believed that somehow this friend and some good doctors and nurses had worked together to give her a second chance at life.

The day finally came when Victoria was transferred to a rehabilitation facility where she prepared to return home. When I reflect on my interactions with Victoria, her family, and her caregivers, I see that the journey was long and often difficult, with unexpected moments of grace and joy along the way. I celebrate the possibilities of life that await Victoria. I recognize the courageous patience of her family. I applaud the hospital staff on a job well done. And I continue to hold Victoria and all who love her in my heart and in my prayers.



Reverend Ann G. Haywood,
pediatric chaplain

Children and Grief

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children can be a valuable gift. Professional support for grieving children, whether individually or in a group, may also be useful.

In Rabbi Earl Grollman's book, *Straight Talk about Death for Teenagers*, he reminds us that grief is not a disorder or a sign of weak-

ness. Rather, it is an emotional, physical, and spiritual necessity. The only cure for grief is to grieve. In the darkness of a family crisis, we should remember that the support we provide to the children we care for will comfort them in one of life's necessary journeys.

SDSU nurse helps make surgery a child-friendly experience

My name is Pam Wrigley, and I have been a nurse at MGH for 25 years; for the last 7 years I have been the pediatric team leader in the Same Day Surgical Unit (SDSU).

In the SDSU pediatric area we assess all pediatric patients before surgery and see them through post-operative recovery. We see patients who will be going home from the SDSU, Radiology, general anesthesia cases, and some patients who may be admitted to the hospital after surgery. Admission to the SDSU can be rushed (if patients arrive late) or leisurely depending on our case load. But in either case, our goal is the same: to provide high quality family-centered care to all our patients and their families.

On this particular Tuesday, at 6:30am, the day was just beginning. JJ was a 4-year-old girl who had come to the SDSU for major maxillo-facial surgery and potentially a tracheotomy. She was going to be admitted to the Pediatric Intensive Care Unit (PICU) for observation after surgery. JJ was sitting in the waiting room with her parents, her baby brother and her grandparents. I noticed right away that JJ was a typically shy 4-year-old.

She clutched a stuffed animal and sat snugly between her mother and father. Her grandparents were close by keeping an eye on JJ's brother who was asleep in his stroller. As I approached JJ and her family, she curled up, scooted closer to her mother, and looked to her for reassurance, perhaps hoping I would disappear.

Since there was no one else in the waiting area, I decided to take advantage of the opportunity. Instead of moving JJ to another unfamiliar area, I sat down and discussed the pre-operative process with her parents right there. I asked questions about her admission assessment. As I talked with her parents I occasionally looked over at JJ and talked to her. Due to her congenital anomaly it was difficult for her to speak, but I made a point to begin a non-threatening connection with her. JJ began to relax during the discussion; she even smiled. I suggested she change her clothes and we could see how big she was (weight and height) and then we could go to another area where I would check her vital signs. JJ walked down the long hallway toward the changing room with her parents and was less apprehensive.

In the holding area after she changed, I explained to JJ that I would put a little sticker light on her finger (to check her oxygen saturation), give her arm a hug with the blood pressure cuff, and she could decorate her name bracelets with little stickers to make it prettier. JJ was relaxed now and comfortable with my presence. When we were done with the pre-op phase, JJ was transported to the operating room with her parents.

When her parents returned to the SDSU, I showed them where they could wait to speak with the surgeon after surgery, and I explained that JJ would be taken to the PICU for recovery. While we were talking, JJ's mother brought up another concern. AJ, her 9-month-old son, seemed sick. They had flown in from out of state and since their arrival in Boston he had been wheezing off and on and had a slight cough at night and in the morning. She wondered if there was a way he could be seen by a pediatrician here at the hospital. I asked them to bring AJ back to the holding area, where I assessed that he was not in any distress, his lungs were clear and he didn't have a fever. Since it was only 8:00am and the pediatric clinic wasn't

open yet, I suggested they go get something to eat and when they came back I would call and see if AJ could be seen in the clinic. I didn't feel that sending them to the Emergency Room would be appropriate since they were very anxious about JJ's surgery and afraid the surgeon wouldn't be able to find them. And AJ was doing fine. Sitting in the EW would only add to their stress.

When they returned to the SDSU, we talked about their insurance, and I called the pediatric clinic. The clinic said that pending additional insurance information they would be able to make an appointment to see AJ. The family was relieved. Mr. J. called the insurance company and got the information. I called the clinic and an appointment was made for the end of the day. I gave them a map and directions to the Gray Family Waiting Area where they would be kept up-to-date on the progress of JJ's surgery, and I told them the surgeon would talk with them after the operation. I told them I'd try to stop by and see them during the day.

When I finished work at about 3:20, I checked the computer and saw that JJ had been taken to the PICU. I walked over to the PICU to see her and her parents. She was in a room by herself and had not had a tracheotomy. Her parents were at her side. I chatted with JJ's mom. She was so

relieved and happy to see me. She thanked me for my help and for arranging AJ's appointment. I showed them how to get to the clinic so they wouldn't get lost. I talked with JJ's parents for a little while. They were very appreciative for the help I had given them, not just with JJ, but the whole family.

The next day before I left work, JJ was up on the unit. I got a card and went up to see her. She was sleeping but her mom was there at her side. She said AJ (her son) was fine; he was given a nebulizer treatment in the clinic, had slept through the night, and was much better. She said I'd have to come back when JJ was awake because I was "the first nurse she had smiled for."

I did return later and JJ did smile, as much as she could. Her eyes lit up when I talked with her. Her grandparents were thankful that AJ had been seen by a pediatrician and was doing well.

JJ came to see us before she went home. She had to return to the SDSU for a small procedure a few months later, and when she came in she was much more comfortable in the hospital setting. Her parents and grandparents remembered the wonderful care they had received from everyone during their stay. Mrs. J shared how hard it was to be away from home with your children and not

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Exemplar

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have your usual support systems. I was happy I had helped make the experience easier for all of them.

Comments by Jeanette Ives Erickson, RN, MS, senior vice president for Patient Care and chief nurse

Pam is a skilled and experienced pediatric caregiver. Her interactions

with JJ and her family show the depth of her understanding of the special needs of children. She was sensitive to JJ's fear and anxiety. She used language and concepts that JJ could easily understand. She made a point of putting JJ at ease with non-threatening communication and reassuring smiles. Pam let JJ participate in her hospital experience in a positive way through developmentally appropriate activities like decorating her ID band.

When JJ's sibling became ill, despite a busy case load, Pam helped the family navigate the system to ensure that AJ was seen in a timely manner in the pediatric clinic. Pam maintained her presence with this family long after JJ had left her care.

It's no wonder JJ smiled for Pam. She felt safe and cared for under Pam's skilled, knowledgeable and watchful eye.

Thank-you, Pam.

Celebrate National Women's Health Week

5 Simple Ways to Stay Healthy

Help celebrate National Women's Health Week with the Women's Health Coordinating Council. Learn simpler ways to enjoy a healthier life, such as:

- eating better
- moving around
- not smoking
- getting regular medical exams and screenings
- being safe

**Wednesday, May 14, 2003
9:00am–4:00pm
Main Corridor**



Pediatric team leader, Pam Wrigley, RN, applies a numbing cream to IV insertion site for 12-year-old patient in the Same Day Surgery Unit. The colorful, new 'undersea' decor is visible in the background.

“Where does it hurt?”

an update from the MGH Pediatric Pain Task Force

Most of us know that pain is a subjective and individual experience. That's why it's important that a patient's description of pain be accepted and used as a basis for treatment. For those of us responsible for the assessment of pain, difficulty sometimes arises when patients are unable to clearly articulate the nature of their pain. As a result, pain can go unrecognized and/or undertreated, possibly throughout a person's whole life.

This phenomenon is especially true in the pediatric population— younger patients may not have the language skills or vocabulary to accurately

describe their pain; and, of course, infants aren't yet able to verbalize their needs. In an attempt to address this issue, MassGeneral Hospital for Children has developed a Pediatric Pain Task Force to establish and implement best-practice guidelines for pediatric pain management throughout the hospital.

In September, 2002, a multi-disciplinary team of clinicians from MGH/C attended the International Forum on Pediatric Pain in Nova Scotia. The four-day conference covered the genetics of pain and analgesia, the early pain experience, cogni-

tive and social development, and the effects of chronic illness. It explored family issues around pain as well as social, cultural, and ethnic influences. The conference gave the MGH/C team an opportunity to network with pain experts from around the world.

Upon their return, conference attendees joined with other MGH staff to begin work on a pediatric pain initiative. A proposal was drafted that included a mission statement, standards of care, and practice competencies. Appropriate pain-assessment tools were identified to coincide with the level of

Pain Relief Champions: Removing Barriers to Pain Relief

Are you serious about providing the best possible care for your patients?
Do you want to work collaboratively with colleagues from all disciplines?
Are you willing to work on projects that address pain?

If you are, Pain Relief Champions: Removing Barriers to Pain Relief was designed for you. All clinicians are invited to attend.

April 14–15, 2003
Holiday Inn Select – Government Center
Boston, Massachusetts

The course is free to MGH employees. Partners HealthCare employees pay \$60. Non-Partners participants pay \$120. Continental breakfast and lunch are included. CE/CMEs will be available.

Pain Relief Champions is supported in part by a grant from the Mayday Fund and other sponsors. Applications are available on-line.

For more information, call Tom Quinn at 617-726-0746 or go to: painrelief@partners.org

development for reporting pain. Currently four different scales are in place throughout the hospital: NPASS (neonate-1 year old), FLACC (birth-3 years old; non-verbal), Wong-Baker FACES (3-10 years old), Verbal 0-10 (verbal with understanding of number progressions).

The Pediatric Pain Task Force is in the process of educating pediatric staff on use of the various pain scales as well as revising documentation standards and forms. Members of the task force have been leading unit-based in-service training,

developing new *Did You Know...?* posters, and constructing parent-child educational posters to explain procedural pain to children. Julie Goldman, RN, clinical educator, in The Center for Clinical & Professional Development, is conducting a pain knowledge and attitude survey among pediatric nurses to help identify staff's educational needs.

As clinicians we have a professional and moral responsibility to recognize and treat pain to the best of our ability. It is the hope of the Pediatric Pain Task Force that our work will help provide nurses and staff with the background and resources to provide optimal pain relief and management to our pediatric patients.



(Photo provided by group)

Attendees of the International Forum on Pediatric Pain in Nova Scotia are (front row, l-r): Patty Maloney, Mary Lou Kelleher, and Susan Warchal. (Middle row): Tracie Grant, Kathleen Pease, Cathleen Durham, Tracee Cook, and Mary Smith. (Back row): Kathleen Conley and Bob Young.

Behind the scenes

—by Judy Sacco,
operations coordinator

At a Broadway play when the curtain goes up, the action begins, actors deliver their lines, and the audience enjoys a magical theater experience. But there's an entire crew at work behind the scenes who play an integral part in the seamless, coordinated production of that stage play.

The same is true of the care provided at MassGeneral Hospital for Children. There's a whole team of support staff and personnel who work tirelessly behind the scenes to ensure a smooth and efficient work environment for

clinical staff and seamless care for our patients. Operations associates, unit service associates, Materials Management personnel, Dietary staff, Environmental Services, and Building & Grounds employees, all contribute to the delivery of high-quality, family-centered care on our pediatric units. The distinct work of the pediatric service is delivering care that honors the child's world at every stage of his or her development.

Operations associates are often the first people to greet families when they arrive on a unit. Their customer-service

skills and welcoming attitude are critical in helping parents feel secure and confident in our ability to care for their child. Operations associates juggle many tasks at once, always with the goal of ensuring the highest quality care for each child.

In the Nurse Partners Triage Program, operations associates answer incoming phone calls from anxious parents with sick children. They record important intake information in preparation for the nurse. Speaking with distraught parents after hours requires a skilled and compas-

sionate listener who can put them at ease and help reduce their anxiety.

Operations associates establish an early rapport with parents that is essential to the success of the program.

Unit service associates, or USAs, are an integral part of the pediatric team. Every day, USAs go into patient rooms and clean up for patients and family members who have stayed overnight with their sick child. Often, USAs are drawn into conversations with families, sometimes discovering that the native language of the family is the same as their own. The comfort level that results from these cordial interactions is invaluable.

On pediatric units, USAs' responsibilities are a little different than on adult units. For instance, they never leave water buckets unattended; they watch out for objects that may be dangerous for toddlers; and they understand the need for cleaning toys and furniture to keep our infection rate to a minimum. USAs on the pediatric units enjoy their work, and contribute much to the mission of the MassGeneral Hospital for Children.

Unlike the adult setting, children on pediatric units can eat whatever they like, whenever they like, if they're able. You can imagine what it takes to meet the many and varied requests of children and their appetites. Food service

coordinators go to great lengths to ensure children eat well so they can recover quickly. Time and again they leave the unit in search of pizza, spaghetti, chicken tenders, ice cream, flavored milk, or even pancakes for lunch if that's what the child feels like eating. For our littlest patients, no request is too small, too strange, or too difficult.

Materials Management, Police & Security, Buildings & Grounds, and Environmental Services respond quickly and enthusiastically to all our requests for help. At last year's Children's Health Fair all departments lent their energy and skill, taking care of everything from parking busses to bringing electricity to unwired areas, connecting computers, hauling supplies, lending equipment, and keeping the tent and surrounding areas safe for children!

When 24 'taxis' for toddlers were donated by Jordan's Furniture and delivered unassembled in large cartons, we called the metal shop. Gary Butler and his men took the cartons to the shop, assembled all the taxis, and had them back on the unit in less than three hours. What a great gift for the children, their families, and all of us

These are just a few examples of the 'behind-the-scenes' work that goes into making MassGeneral Hospital for Children the wonderful, caring, family-centered hospital it is today.

Family-Centered Care

continued from page 3

apists, children, and families hosted a Healing Celebration in January, 2003, that showcased the artistic talents of patients and staff both individually and collaboratively. The event was a great success and helped raise money to support The Healing Arts Program in the day-to-day delivery of care, using art as medicine.

Through the years as we have responded to the needs of children in a changing world, staff of MGH/C have become well versed in how to talk to children about matters of unrest around

the world. Using the basics of developmental theory, staff help parents and teachers talk to children about terrorism, prejudice, war, and other grown-up concepts they hear about. They explore ways to help children, in simple, non-threatening terms, decrease their anxiety. Nurses have visited classrooms from kindergarten to high school, helping children and adolescents explore their feelings, responding to questions, and listening to what children have to say.

This year's celebration of Children and HealthCare Week will

once again showcase the outstanding work of clinicians, support staff, and so many others in caring for children at MGH/C. We have much to be proud of. We continuously implement new pediatric programs in specialty areas such as Cardiology, Transplant, and Neurology. We give and promote the best in children's health care, and we do it in a personalized, state-of-the-art, family-centered way. We continue to meet the challenges that confront us and respond to the needs of children and families in our care and in our community.

The healing arts: bridging communities through art and medicine

—by Somava Stout, MD

Art work, performances, local authors, craft tables, quilts, more than 30 local businesses and community artists—what do these things have in common? They all came together on January 15, 2003, for the first annual Healing Arts Celebration at MassGeneral Hospital for Children.

A motivated group of children, families, and caregivers came together in July, 2002, to create the Healing Arts Team. Its mission: “To use the healing power of art to

draw attention to the needs of our patients and communities; to enhance the healing process of children by bridging the burden of illness with the rewards of fantasy and art.” The team believed that while nourishing the creativity of the community, we could provide children and caregivers an artistic outlet to face their challenges with dignity and optimism. We hoped to unite members of the community within and outside the hospital with a common vision based

on creative expression.

The Healing Arts Team began by sponsoring a child-caregiver art show to raise funds and awareness about the program. They sponsored a series of quilting bees on pediatric units for children, families, and caregivers. Shannon Scott-Vernaglia, MD, assembled all the swatches to create the Healing Arts Quilt, which was the centerpiece of the Healing Arts Celebration.

News of the celebration spread through the hospital and the com-



The Healing Arts Celebration

community. Financial support came in from many departments and organizations. In a letter to MGH president, Dr. Peter Slavin, nurse manager, Judy Newell, RN, wrote, “To see those who are usually engaged in conversations about disease, plans of care, disposition, and discharge talking about their unique, artistic offerings showed another side of their personalities. What a joyful way to get to know the people we work with every day.”

As word of the Healing Arts Celebration spread, there was an outpouring of art and artistic donations from all over: paintings, clothing, books, crafts, sculpture, works of fiction and nonfiction about hospital experiences.

Some children asked their friends and family to make artistic donations instead of giving them birthday presents. More than thirty local businesses contributed gift certificates and gifts to raise funds for the silent auction. An elderly African-American woman from Attalusha, Alabama, heard about the celebration and sent a beautiful handmade quilt that was created especially to support the event. The magical part of the celebration was that it left no one out, and inspired everyone.

The Healing Arts Celebration took place on January 15th in commemoration of MassGeneral Hospital for Children’s third anniversary. Fueled by contribu-

continued on next page

Healing Arts

continued from previous page

tions of love and caring, a warm and festive time was had by all. Said Soma Stout, MD, coordinator of the Healing Arts Team, "Whether you were wearing a hospital johnny, scrubs, or black tie; whether you were two or ninety-two; whether you had contributed a stick figure drawing or an expensive piece of art, you were deeply valued and welcome, and people felt it."

Dr. Alan Ezekowitz, Chief of Pediatric Services, said, "This event epitomizes the spirit of family-centered care and the dedication of those who take care of children and their families. It was an uplifting experience for everyone."

The Healing Arts Celebration raised more than \$8,000 in less than two hours with its silent auction. The team has already begun implementing a

The Employee Assistance Program Work-Life Lunchtime Seminar Series presents "Home Buying"

Presented by Bob Gray, senior mortgage originator, Harvard Credit Union

Buying a house or condominium for the first time can be an overwhelming experience. This seminar will give you an overview of the financial aspects of the purchasing process, including an explanation of the steps necessary to secure a mortgage and obtain pre-qualification status.

**Thursday, April 10, 2003
12:00–1:00pm; Wellman Conference Room**

For more information, call 726-6976.

number of initiatives to benefit the children of MassGeneral Hospital for Children. Some projects include:

- creation of a patient-caregiver tile wall in the Ellison 17 and 18 family rooms
- a Healing Arts Creativity Night on pediatric units
- a musical instrument library for hospitalized children
- CD and book libraries
- an innovative program called, Pockets Full of Playful Fun,

to help improve child-care-giver communication and decrease waiting-room anxiety through the use of art.

The Healing Arts Team was recently awarded an Excellence in Action award for its work in bridging communities and enhancing the hospital experience for children through art.

For more information about the Healing Arts Program, please contact Somava Stout at [sstout@partners.org](mailto:ssout@partners.org).



And games!

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April 17, 2003



Registered dietitians: an integral part of the pediatric care team

—by Patrick Baldassaro, senior manager, Patient Food Services, and Martha Lynch, senior manager, Clinical Nutrition Services

The department of Nutrition & Food Services takes great pride in the role it plays in the care of children at MassGeneral Hospital for Children. This role encompasses clinical care and food-service activities. Each pediatric unit has a primary registered dietitian (RD) accountable for ensuring that pediatric patients receive the highest level of care. RDs are active participants in the multi-disciplinary care team on all units.

RDs provide guidelines and support to the medical team around nutrition (delivered by IV, feeding tubes, or by mouth) special metabolic diets, and planning for all disease and drug-related food interactions.

RDs work closely with patients who have cystic fibrosis, diabetes mellitus, Crohn's disease, eating disorders, and metabolic diseases. Their work includes detailed assessments, teaching survival skills, educating patients and families, and reassuring patients about how they will be able to live with disease restrictions.

Premature babies can weigh as little as 500 grams. RDs need to assess their nutritional needs, their ability to digest and absorb nutrients, and take into consideration any medical or surgical issues in order

to formulate a nutrition care plan. The tolerance, weight-gain and ever-changing metabolic picture of premature babies require constant monitoring. Families need reassurance, education, and support as the growth and development of their child depend on optimizing their baby's nutritional intake. From a nutritional standpoint, babies can be discharged as soon as they're gaining weight consistently and taking all nutrition via bottle and/or breastfeeding.

Educating other members of the healthcare team is part of every pediatric dietitian's job. This occurs during daily rounds, inservices, one-on-one, or in group educational sessions.

In addition to RDs, patient food service managers, supervisors, and nutrition service coordinators work diligently to meet the needs of pediatric patients, and try to bring them a little happiness in the process. A key factor is knowing each patient's food and nutrition preferences.

Staff has developed a special pediatric menu designed to be child-friendly; it includes many of their food and snack favorites from home. Staff is always ready to help when children with cancer, whose

tastes are changing, want or can only tolerate, certain foods.

One of the newer patient populations benefiting from the combined talents of the clinical and food service staff are ketogenic diet patients. This diet is very restricted with 90% of calories coming from fat and very little carbohydrate. It took a team of Nutrition & Food Services staff to develop a suitable menu

that includes butter and lettuce tacos and buildings made of butter blocks to look appealing to a child. Every item must be gram weighed, and trays need to be checked repeatedly to ensure 100% accuracy.

Families also require a great deal of education to deal with the rigors of this diet. The response of patients and families has been overwhelmingly positive as children reduce their number of seizures and start to live safer lives.

'Special Days' give the team a chance to do special things like pizza parties, Red Sox Open-

ing Day parties, or ice cream sundaes on the unit. A wonderful tradition at MGH is Family Thanksgiving when the whole family comes in for a traditional Thanksgiving meal complete with turkey and all the fixings. Birthdays are another special occasion that call for special cakes from our bakery along with festive party trays, mats, and napkins.

Working closely with the nursing staff, Nutrition and Food Services offers individualized care and attention to our pediatric patients and their families. It's the little things that make a hospital feel like home.



(L-r): Karylen Headley, food service supervisor; Susan Steere, clinical dietitian; Melanie Maletta, clinical dietitian; and Tessie Doctor, nutrition service coordinator

Educational Offerings

April 3, 2003

When/Where	Description	Contact Hours
April 15 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
April 16 1:30–2:30pm	USA Educational Series Bigelow 4 Amphitheater	---
April 17 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
April 23 8:00am–2:30pm	New Graduate Nurse Development Seminar II Training Department, Charles River Plaza	5.4 (for mentors only)
April 24 7:00am–12:00pm	CVVH Core Program VBK 601	6.3
April 24 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
April 24 1:00–2:30pm	Conflict Management for OAs and PCAs VBK 601	---
April 25 8:00am–4:30pm	Preceptor Development Program Training Department, Charles River Plaza	7
April 28 and May 1, 5, 6, 12, 15 7:30am–4:30pm	ICU Consortium Critical Care in the New Millennium: Core Program Wellman Conference Room (except May 5th: Walcott Conference Room)	45.1 for completing all six days
April 28: 7:30am–4:30pm April 29: 7:30am–4:30pm	Intra-Aortic Balloon Pump Workshop Day 1: SEMC. Day 2: (VBK607)	14.4 for completing both days
April 29 8:00am–2:00pm	BLS Certification for Healthcare Providers VBK601	---
May 1 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
May 1 1:30–2:30pm	Nursing Grand Rounds O’Keeffe Auditorium	1.2
May 1 1:00–2:30pm	The Joint Commission Satellite Network presents: “Patient Safety: Standard, Goals, Reducing Risk through FMEA.” Haber Conference Room	---
May 2 8:00am–4:30pm	Introduction to Culturally Competent Care: Understanding Our Patients, Ourselves and Each Other Training Department, Charles River Plaza	7.2
May 8 8:00am–12:00pm (Adult) 10:00am–2:00pm (Pediatric)	CPR—Age-Specific Mannequin Demonstration of BLS Skills VBK 401 (No BLS card given)	---
May 9 and 19 8:00am–5:00pm	Advanced Cardiac Life Support (ACLS)—Provider Course Day 1: O’Keeffe Auditorium. Day 2: Wellman Conference Room	16.8 for completing both days
May 12 7:30–11:00am, 12:00–3:30pm	CPR—American Heart Association BLS Re-Certification VBK 401	---
May 12 8:00am–4:30pm	Heart Failure: Management Strategies in the New Millennium O’Keeffe Auditorium	TBA

For detailed information about educational offerings, visit our web calendar at <http://pcs.mgh.harvard.edu>. To register, call (617)726-3111.
For information about Risk Management Foundation programs, check the Internet at <http://www.hrm.harvard.edu>.

Nursing Career Expo

Human Resources invites you to learn more about nursing at MGH, including opportunities for staff nurses (experienced and new graduates), clinical nurse specialists, patient care associates, and surgical technologists.

Sunday April 6, 2003

12:00–4:00pm

North and East Garden Dining Rooms

The Center for Clinical & Professional Development will provide a one-hour continuing education session to participants of the Expo. The session is free, and 1.2 contact hours will be awarded.

“Accelerating Wound Healing”

1:00–2:00pm

Haber Conference Room

For more information, contact: Megan Brown
(mcbrown@partners.org) at 726-5593
or fax: 726-6866.

First annual Robert W. Carey Lectureship

At the time of his retirement, Robert W. Carey, MD, established a fund to recognize the contribution of nursing in the ambulatory infusion setting and acknowledge the spirit of collaborative practice. To honor his generosity, the nursing staff of the Infusion Unit has established the Robert W. Carey Lectureship to promote professional education and celebrate the value of collaborative practice and research in the Cancer Center among all disciplines.

Please attend the first annual Robert W. Carey Lecture

presented by

Ned Cassem, MD.

April 14, 2003

O’Keefe Auditorium

Reception: 6:00–6:45pm

Lecture: 7:00–8:00pm

For more information call Waveny Cole at 617-724-4424 or e-mail: wcole1@partners.org



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