

Caring for Our Future

Nursing at The Children's Hospital

Summer 2009



Healthcare Providers Caring for Others: High Risk for Secondary Traumatic Stress

By Kelly Johnson, MSN, RN, CRRN, NEA-BC
Vice President and Chief Nursing Officer

“I was a sophomore in high school and playing right tackle for the varsity football team. It was a warm, beautiful fall day, perfect weather for football. I made an awesome tackle, but went in with my head down, something I had been told at least a hundred times not to do. I knew immediately that I was paralyzed. I was able to flop my arms around, but otherwise was completely unable to move. When I went to the hospital my condition worsened. My level of injury ascended to the brainstem before the night was over, rendering me unable to move any muscle and unable to breathe without the help of a ventilator. I could hear the doctor at my bedside telling my mom it would be best if they just took me off life support and let me pass. I could not blink my eyes, or shake my head, or let them know in any way I was in there and wanted to live. Thank God for Mom, she would not let them remove me from life support. I was in rehab for over six months, and never regained movement or the ability to breathe on my own. I stayed at home with my mom providing 24-hour care for a year, and then she just could not do it any longer. That is how I ended

up living in a nursing home, before I was even old enough to drive, tooling around in my wheelchair with a lap blanket made by the little old ladies from the nursing home where I live...If I could just redo that one second in time.”

So began the first story I heard from an individual with a traumatic spinal cord injury (SCI). Since that time I have listened to and cared for literally thousands of families with similar tragic stories, stories that have changed the course of not only the patients' and families' lives, but my own. This one story started me on this journey of working with individuals with catastrophic, life-changing injuries caused by neurotraumatic events.

I have pondered for some time the impact of working with others' traumatic material. This curiosity has led me on this exploration to understand the experiences of other healthcare workers, and the impact of working every day with patients and families who face unimaginable suffering and pain.

Nurses, and other healthcare providers, face stresses in their everyday work life, which I believe is intensified when working with children and families. There is not a great deal known or written

Cont'd on page 13

Caring For Our Future is a publication written by nurses for nurses. The Children's Hospital is an affirmative action, equal opportunity employer. Copyright 2009, The Children's Hospital Association. All rights reserved.



Editor: Ann Froese-Fretz, MS, RN, CPNP, Nurse Practitioner, (720) 777-6065, froese-fretz.ann@tchden.org

Co-Editors: Denise Abdo, MSN, RN, CPNP Kempe Child Protection Team
Carole Kline, MS, RN, CPNP, Nurse Practitioner, Sleep Medicine Program
Sue Stuller, BSN, RN, Clinical Coordinator of Department Education, SMSC Level 6

Managing Editor: Melissa Combs, Public Relations, (720) 777-8328, combs.melissa@tchden.org

Graphic Design: Angelina Fox, Public Relations, (720) 777-6279, fox.angelina@tchden.org

You can find The Children's Hospital online at www.thechildrenshospital.org

Managing a Traumatic Event at Work

By Pam Baron, CMBA, SPHR
Human Resources Consultant

Over 80% of Americans will be exposed to a traumatic event at some point in time - either directly or indirectly. Healthcare workers have a 50% chance of experiencing a post-secondary stress reaction as a result of exposure to traumatic events at work. While work in healthcare can be traumatizing, from time to time traumatic events are experienced beyond what is expected. These situations may include the violent or unexpected death of a co-worker, a patient death with extenuating circumstances, the unanticipated sudden demise or loss of a patient, or a crisis in the community. Situations such as these can be defined as a critical incident.

When a medical crisis occurs, there is a parallel mental health component. Critical incidents have the potential to create significant human distress and can overwhelm one's ability to cope. Distress related to a critical incident is a psychological crisis: an acute response to a trauma, disaster, or other event. Human-made disasters or traumatic events tend to be more psychologically pathogenic than natural disasters, violating our values and/or expectations of how a person would typically react. In a psychological crisis, significant distress or dysfunction occurs because the individual's emotional and mental balance has been disrupted and their usual coping mechanisms are not sufficient to restore the equilibrium.

Caregivers involved with critical incidents are at risk of post-secondary trauma or other lingering emotional issues because their normal mechanisms for coping with stress can be overwhelmed by such an event. A critical incident generally impacts multiple people, but a single individual could potentially be the only person who is affected. Children's has recognized the need to provide resources to those who suffer critical incidents and has, as a result, developed a small team of

professionals who are certified in Critical Incident Stress Management (CISM). The CISM team is available to facilitate debriefing of an event as well as provide resources to support the return to regular routines.

When a critical incident becomes known, the CISM team works first to identify those who have been impacted by the event, what their level of exposure has been and what their immediate needs might be (e.g., information about the event, relief from the remainder of their shift, recommendations for when they go home, etc.). A formal debriefing follows within a day or two of the incident. Depending on the incident, separate groups of impacted staff may be formed in order to bring people together who have shared a similar level of involvement and experience. The debriefing is structured to include informational updates regarding the incident, discussion of thoughts and reactions, teaching about normal anticipated reactions, resources and self care. The CISM team is also trained to assess the need for additional support and make individual referrals when the assistance of mental health professionals is indicated.

Signs of acute distress can include physical, cognitive, emotional, and behavioral symptoms. The severity and manifestation of symptoms is most extreme during the first 24 hours following the event and vary individually. Physical responses to acute distress can include nausea, headache, anxiety, loss of appetite, difficulty breathing and sleep disturbance. Cognitive symptoms may involve confusion or forgetfulness, blaming others, poor concentration, difficulty making decisions, disorganized thinking, and intrusive images. Emotional responses to a critical incident might include sadness, tearfulness, anxiety, fear, guilt, irritability, anger and loss of emotional control (intense anger or uncontrollable crying). Behavioral

Self Care: Compassion Fatigue/ Compassion Satisfaction

By Terri Woodward, MSN, RN, AHN-BC
Clinical Holistic Nurse Specialist

“When we come to rest in the great heart of compassion, we discover a capacity to bear witness to, suffer with, and hold dear with our own vulnerable heart the sorrow and beauties of the world.”

~ Jack Kornfield(2002, p 103)

Compassion provides opportunities to fully experience life’s paradoxes: pride and shame, emptiness and fulfillment, disillusion and meaning. Those who work in a helping profession are more apt to experience compassion fatigue and compassion satisfaction. Karl D LaRowe, a clinical social worker with expertise in compassion fatigue/satisfaction states in an interview with K. Jackson, “a debilitating weariness brought about by repetitive, empathetic response to pain and suffering, compassion fatigue is a result of absorbing and internalizing the emotions of clients and sometimes co-workers,” (Jackson, 2003, p.21). To transform compassion fatigue, LaRowe promotes three practices: 1) self honesty – the ability to look inward and reflect; 2) personal responsibility – taking ownership of our thoughts, behaviors, and our lives vs. blaming others; and 3) self expression – making our internal world visible in the external world.

In “Compassion Fatigue, Burnout and Compassion Satisfaction” study at the University of Auckland, Huggard and colleagues report resilience, empathy, spirituality and emotional regulation as positive signifiers for compassion satisfaction and protection against compassion fatigue. Compassion satisfaction is the personal and professional sense of fulfillment derived from providing compassionate care along with the belief that one’s work is important and meaningful (Rourke, 2007). Citing a study conducted with child protection workers, Rourke

echoes Huggard’s assertion that compassion satisfaction is protective against experiencing compassion fatigue. Nurses experience and report that caring and compassion deepen the meaning and purpose of their work and that the relational aspects of their practice provide work satisfaction. (Best & Turston 2004; Hudacek, 2008; Rourke, 2007).

Practices that cultivate Compassion Satisfaction include:

Personal strategies:

- Fundamental self-care activities: regular exercise, good nutrition, adequate amounts of sleep
- Daily relaxation practices: meditation, breathing exercises, imagery, prayer, quiet time alone, inspirational reading, journaling, time in nature
- Reflection on positive outcomes, positive feelings and ability to make a difference in one’s work
- Maintain a balance in personal and professional lives
- Attend to spiritual needs and existential understanding to align personal meaning and professional experiences
- Self-development and growth with stress management, time management, communication skills, assertiveness training
- Maintain a sense of humor; find ways to play at work

Work-related coping strategies:

- Find and focus on the positive features of personal and patient experiences
- Take time away from work for vacation, days off, personal development

Cont’d on page 9

Aligning Operational Structure with Our Strategic Plan: 2009

By Kelly Johnson, MSN, RN, CCRN, NEA-BC
Vice President and Chief Nursing Officer

As you are all well aware by now, we have undertaken organizational redesign to align with our strategic plan. I am taking the opportunity in this edition of *Caring for Our Future* to revisit the changes to the organizational structure, with highlights on the division of nursing.

Our reorganization touches each of our six strategic goal areas: operational and service excellence; clinical program growth; innovation, discovery and research; mother and baby program; faculty alignment; and community provider alignment.

Understanding the Restructure

- Building a successful organizational structure for our future, the strategic plan is our compass. The strategic plan makes a significant investment in leadership. Our organization's ultimate success is only as strong as our vision and investment in our people and leadership to chart and stay the course.
- Rethinking the way we do our work to achieve our mission more effectively. We are addressing the increased size and complexity of our organization. Our strategic plan is focused on creating integrated care delivery, and we must develop the supporting processes.
- Building upon the successes we experienced in 2008 and continuing to challenge ourselves to sustain high-level performance in 2009 and beyond. We are tapping into existing talent by facilitating professional development opportunities, and maximizing opportunities to grow leadership capabilities and expand capacity of all levels across the organization. The intent of the restructure is to enhance communication and decision making, clarify roles and responsibilities, and establish more focused accountability with shared responsibility and reduction of silos.

The restructure is not about the economic plan of action we addressed in the first quarter, or is it about downsizing. In fact, we added positions that are critical to execution of the strategic plan.

The Process

The process we used to design the restructure encompassed months of teamwork and a lot of communication. We were very methodical and thoughtful about considering all alternatives. We made decision by consensus, after thoroughly considering all the options. Individuals who were affected by the restructure were informed prior to the broader announcements. We began communications at the individual level and broadened to the department and then division levels.

Overview of Changes Outside of the Division of Nursing

Clinical program growth includes creation of new service lines. Service line leadership teams consisting of nursing leadership, physician leadership and business leadership are being established. Currently, Children's is recruiting for directors/executive directors, which will then be followed by an effort to hire service line nursing leadership.

Operational and service excellence is being supported with realignment of current departments and creation of new departments. A department of process improvement is being established. This department will report to Jena Hausmann, chief operating officer, who will work closely with the quality and patient safety department, and Dan Hyman, MD, chief quality officer. A Department of Service Excellence will also be established and will incorporate customer service, volunteers, patient representatives, the creative play center, front desk representatives, valet services and PBX operators.

The Environment of Care was reorganized into two areas: facilities management will report to Jerrod Milton, vice president, operations; property and planning management will report to Beth Gaffney, vice president, clinical/support services. The Network of Care was reorganized to broaden the scope of work for directors and establish enhanced clinical manager roles at each of the sites. Additionally, the Strategy and External Affairs Division has been aligned into three key areas: strategic marketing and communications, business development, and physician relations. The Medical Staff Office will also hire a new leader. And, Children's is in the process of recruiting leadership for the new Division of Innovation, Discovery and Research.

Reorganization in the Division of Nursing

There were four goals contemplated during the reorganization in the division of nursing: 1) to align with the global organizational structure; 2) to design the infrastructure in the division of nursing to align with the hospital's strategic plan; 3) to support strategic alignment of positions in our current organizational structure that will support nursing at all levels of decision making; and 4) to promote effective and efficient communication and decision making in the division of nursing. The strategy was to build on the strengths in the division, and provide strength in areas that were not aligned with either the

organizational structure or the strategic plan.

The first decision was to flatten the structure to allow the chief nursing officer (CNO) to work closer with direct patient care. The senior leadership, vice president roles will no longer exist. The vice president talents will be re-directed to areas where we need work to be accomplished: director, advanced practice nursing, and director, special projects.

The director roles will possess a broader scope of responsibility, accountability and authority, as will the unit manager roles. The directors in the division of nursing will report directly to the CNO. Additionally, the director roles have been structured to align with service line development, and will include director of peri-operative services; director of emergency services; director of critical care nursing; and director of medical-surgical nursing. New roles include director of innovation and outcomes; and director of professional development.

I am very excited about this new direction, and anxious to get our team in the division of nursing established so we can move forward with the organization in execution of the strategic plan. We have great talent at Children's, and I look forward to continued development of front-line leaders and future leaders at this hospital. Please contact me if I can answer any questions. ●

Cont'd from page 7

- Engage in self-assertive behaviors, setting limits, taking breaks and saying no/yes to meet your personal needs
- Choose/cultivate a work environment congruent with personal philosophy
- Debrief both formally and informally on stressful days and following adverse events/incidences
- Develop meaningful rituals for situations dealing with loss, grief, prolonged suffering, and death

To assess your compassion fatigue/compassion satisfaction go to:
<http://mailer.fsu.edu/~cfigley/satfat.htm>.

References

- Best, M.F. & Thurston, N. E. (2004). Measuring nurse job satisfaction. *Journal of Nursing Administration*, 34 (6), 283-290.
- Einstein, A. (5/20/209). <http://www.wisdomquotes.com/000762.html>.
- Figley, C.R. (1995). *Compassion fatigue: Coping with secondary traumatic stress disorder in those who treat the traumatized*. New York: Brunner-Mazel.
- Hudacek, S.S. (2008). Dimensions of caring: A qualitative analysis of nurse's stories. *Journal of Nursing Education*, 47, (3),124-129.
- Jackson,K. (2003). Compassion fatigue: The heavy heart. *Social Work Today*, March 24, 2003.
- Kornfield, J. (2002). *The art of forgiveness, loving kindness and peace*. New York: Bantam.
- Rourke, M. T. (2007). Compassion fatigue in pediatric palliative care providers. *Pediatric Clinics of North America*, 54, 631-644. ●

TCH Allstars

Podium Presentations

Society of Pediatric Nurses Annual Conference –

Atlanta, GA (March, 2009)

“Predicting outcomes of traumatic brain injury in the PICU”

Jen McCurdy, BSN, RN

Molly Wenger, MS, RN

“Evidence-based education: Innovative teaching tools for children.”

Karen LeDuc, MS, RN, CNE

“Reducing hospital acquired infections: Two successful initiatives at a children’s hospital.”

Elise Benefield, BSN, RN

Roberta Smith, MSPH, RN

8th Annual NICHQ Forum for Improving Children’s Healthcare – Grapevine, TX (March 2009)

“Development of a pediatric rapid response team with family activation.”

Beth Wathen, MSN, RN

Emily Dobyms, MD

“I’m SAFE: Development of a fall prevention program to enhance quality and patient safety”

Mike Rannie, MS, RN

Jenae Neiman, MS, RN

Sigma Theta Tau Research Symposium – Denver, CO (March 2009)

“Evidence-based education: Innovative teaching tools for children”

Karen LeDuc, MS, RN, CNE

20th Annual Rocky Mountain Regional Multidisciplinary Research & Evidence-based Practice Symposium – Denver (March 2009)

“Evidence-based education: Innovative teaching tools for children”

Karen LeDuc, MS, RN, CNE

“I’m SAFE: Development of a fall prevention program to enhance quality and patient safety.”

Jodi Thrasher, MS, RN, CFNP

Karen Terry, MS, RN

“Acknowledging praxis: Recognizing caring in reflective narratives of pediatric nurses.”

Jennifer Hagedorn, BSN, RN

“Evaluation of evidence-based nursing practice at a children’s hospital.”

Anne Marie Kotzer, PhD, RN, CPN, FAAN

Multiple other authors

“Does measles, mumps, and rubella (MMR) vaccine influence the diagnosis of autism in patients who have received immunizations?”

Shellie R. Mason, BSN, RN

NACHRI Creating Connections – Nashville, TN (March 2009)

“A centralized hospital data request and review process”

Mike Rannie, MS, RN

International Traffic Medicine Association – The Hague, Netherlands (April, 2009)

“Head injury in infants involved in motor vehicle crashes.”

Rachel Woolley, MSN, RN, CFNP

Multiple other authors

Craniofacial and Cleft Palate Association Meeting – Scottsdale, AZ (April 2009)

“Surgical nostril retainers: Take ‘em or leave ‘em”

Maureen Smith, MS, RN

“Cleft Camp sharing circle”

Jamie Idelberg, RDH

“Cleft palate information binder for families”

Sondra Valdez, BSN, RN

AACN National Teaching Institute and Critical Care Exposition – New Orleans, LA (May 2009)

“Pediatric oncologic emergencies”

Beth Wathen, MSN, RN

CHCA Annual Forum – New Orleans, LA (May 2009)

“Key uses of PHIS at The Children’s Hospital in 2008”

Mike Rannie, MS, RN

Meghan Birkholz

NACHRI Facilities Design Conference – Austin, TX (May 2009)

“Evidence-based design: The New Children’s’ Hospital pre/post occupancy evaluation.”

Anne Marie Kotzer, PhD, RN, CPN, FAAN

Multiple other authors

Awards

Society of Pediatric Nurses Annual Conference Best Poster Presentation:

“The institution of a daily goals checklist in the pediatric critical care unit”

Christine Peyton, MS, RN, CPNP-AC

Jonathan Kaufman, MD

20th Annual Rocky Mountain Regional Research and Evidence-based Practice Symposium Blue Ribbon for “Best Quality Improvement” poster:

“The creation and use of a pediatric catheterization database to improve efficiency of patient flow”

Heather Shockley, BSN, RN

C. Denise Kaufholz, MSN, RN, CPNP

1st TCH Patient Safety Award – PICU and 8th Floor Medical Unit

For work in the CHCA “eliminating codes collaborative”.

TCH Allstars

Publications

“The dangers of glass fireplace doors from a pediatric perspective” (2009, March). Burn and Fire Prevention Newsletter.

Desiree Jimenez, EMT-B

Angela Montgomery, BSN, RN

“Language used by Korean and Korean American children to describe emotional reactions to illness and hospitalization.” (2009). Journal of Transcultural Nursing.

J. H. Park

Roxie Foster, PhD, RN, FAAN

S. Cheng

Interviewed for articles “Emotional Effects” and “Tragic Circumstances,” both in Advance, www.advanceweb.com posted April 8, 2009, regarding their study, “Parent recall of experiences with a child with refractory or relapsed cancer when enrolled in an early phase (phase 1/phase 2) clinical trial”

Molly Hemenway, ND, RN, CPNP-AC

Debra Schissel, BSN, RN

DAISY Awards

Roberta Pawlowski, BSN, RN – PICU

Deb Southworth, BSN, RN – CCBD

Ann Doner, RN – Child Health Clinic

New Clinical Nurse IVs

Kathleen Miller-Reed, Cardiology

Tobin Benham, Perioperative Services

Marilyn Willis, NICU

Christine Reed, CTIC Scatter Bed Unit

Patricia Modreck, ENT Ambulatory

Joleen Farina, NICU

Amy Hnetinka, NICU

New Clinical Resource RNs

Elise Peterson

Robin Gjellstad Thomas

Kara Schuler

Michelle Chiodini

Cont'd from page 1

about the experience or effects of secondary traumatic stress (STS) on the nursing workforce. Pediatric nurses may not be well equipped to manage the effects of repeated exposure to STS. Awareness of and strategies to manage STS are generally not included in the curriculum in schools of nursing, nor in the cadre of employee health services provided for staff.

STS follows indirect exposure to another's trauma. The inability to recognize and employ strategies to manage STS may lead to STS reactions (STSR) or potentially STS disorder (STSD) (Figley, 1995). In the words of Stamm, STS leads us to “depart from believing in the illusion that we are protected from others' pain by scientific postures and our white coats” (1999, p. xv). Nurses and other healthcare providers are not immune to STS. The challenge is for nurses and other healthcare providers, and those who employ them, to understand STS can be an occupational hazard. It is important to know how to recognize it and have strategies to manage stress before it becomes a disorder, effects job performance or negatively impacts the desire to continue in the healthcare professions, readily available to clinical staff.

In recognition of this gap in knowledge and support for our nurses and other providers at The Children's Hospital, a work group has been convened to evaluate

the need to provide STS prevention services. There has been a good deal of work undertaken by individuals in our organization, but ideas, data and best practice have not been shared extensively throughout the organization. This work group is charged with the task to combine efforts and define a comprehensive strategy to address STS prevention. The work group includes representation from nursing (ED, PICU, management and supervisors), medicine, psychology, child protection team, psychiatry/behavioral health, human resources, employee health and administration.

We are committed to creating a supportive environment and a prevention program to deal with the work stresses our staff manages daily. If you have stories or suggestions you would like to share with the work group, please send them to Brenda Washington, washington.brenda@tchden.org, in administration.

References

- Figley, C.R. (1995). *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized*. New York: Brunner-Routledge.
- Stamm, B.H. (1999). *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators*. Baltimore, MD: Sidran Press. ●



The Children's Hospital

Continuing Education Calendar

July

Nursing Grand Rounds

July 22 • Aurora, CO

“Forensic nurses’ experiences of receiving child abuse disclosure” (CNE credit)

Cris Finn, PhD, RN, FNP, FNE

August

27th Annual Pediatric Infectious Diseases Conference

August 2-7 • Vail, CO

Examines topics of interest to general pediatrics and infectious diseases. (CME credit)

Sports Medicine Symposium

August 21 • Aurora, CO

Topics address a variety of pediatric and young adult orthopaedic sports disorders. (CME credit)

Nursing Grand Rounds

August 26 • Aurora, CO

Sleep-disordered breathing in children: Evidence for early diagnosis and management. (CNE credit)

Carole Kline, MS, RN, CPNP

Ann C. Halbower, MD

September

5th Annual Cardiac Kids Parent Conference: Growing Up with Congenital Heart Disease

September 12 • Aurora, CO

Discusses issues and problems in the care of adults with congenital heart disease. (CNE credit)

18th Annual O’Neil Pediatric Clinical Update

September 17-18 • Aurora, CO

Focuses on common pediatric conditions and current child health issues. (CNE credit)

Nursing Grand Rounds

September 23 • Aurora, CO

CHCA Collaborative: Eliminating codes and utilization of a pediatric early warning signs tool. (CNE credit)

Jodi Thrasher, MS, RN, CFNP

Beth Wathen, MS, RN, CCRN

16th Annual Abby Stoddard Lectureship

September 24-25 • Aurora, CO

Two-day lecture series with case discussions and presentations in pediatric neurology.

October

32nd Annual L. Joseph Butterfield Perinatal Conference

October 15 (evening)-16 • Laramie, WY

Forum addresses issues pertinent to antenatal, intrapartum, neonatal and follow-up care. (CNE credit)

Nursing Grand Rounds

October 28 • Aurora, CO

Care coordination across the continuum: Pilot project to evaluate a tertiary/primary care partnership model. (CNE credit)

Mary Navin, MS, RN, NEA-BC,

Leslie Anderson, BSN, RN, FNP

Darla J. Van Essen, MS, RN, NEA-BC

November

Pediatric Orthopaedics for the Primary Care Provider

November 6 • Aurora, CO

Focuses on the acute management of orthopaedic conditions and current clinical issues. (CME credit)

Nursing Grand Rounds

November 18 • Aurora, CO

We’re here for you! Facilitating nursing research through the CTRC. (CNE credit) Panel Presentation Clinical Translational Research Center (CTRC)

Other CNE Opportunities

Emergency Nursing Pediatric Course (ENPC)

(CNE credit from ENA)

Sept. 23-24 Dec. 14-15

Neonatal Resuscitation Program (NRP)

Provider Courses (no credit)

Sept. 11 Oct. 23 Nov. 13

Renewal Courses (no credit)

Sept. 10 Oct. 22 Nov. 12

Pediatric Advanced Life Support (PALS)

Provider Courses (CME credit)

Sept. 14-15 Nov. 9-10 Dec. 1-2

Renewal Courses (no CE credit)

Aug. 13 Oct. 21 Nov. 16

Trauma Nursing Core Curriculum (TNCC)

(CNE credit from ENA)

Oct. 5-6

Brochure Request: Contact The Children’s Hospital Education Services department at (720) 777-6160.