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Pediatric Intensive Care Nursing is indexed in CINAHL: Cumulative Index to Nursing and Allied Health Literature.
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Editorial

Getting the word out: *Pediatric Intensive Care Nursing* is now indexed!

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We are proud to announce that this publication – *Pediatric Intensive Care Nursing* – is now indexed in CINAHL: *Cumulative Index to Nursing and Allied Health Literature*. This is extraordinary news!

CINAHL is the leading automated database for nursing literature. This means that whenever a nurse – anywhere in the world – is doing a computer search on a pediatric intensive care nursing problem, our articles will be listed. Therefore, the ideas and work that we publish will not only be useful to our usual readers (mainly members of the PICU-Nurse-International egroup), but they can also become known to the broader international nursing community. In fact, non-nurses will be able to learn about our work as well, because some other professionals frequently consult CINAHL.

This achievement is also important because it will help us continue to attract good articles to publish. Authors will frequently choose to publish in a journal that will make their work the most widely distributed – indexed journals are particularly appealing to prospective authors.

This complements our preceding achievements in building a truly representative International Editorial Advisory Board. Within a very short amount of time (2 years!), we have become a formal professional publication.

I would like to take this opportunity to personally invite all our readers to consider submitting your work to us for publication. You may have projects that you have conducted or talks that you have presented at a conference that could make fine articles with only a bit of work. This publication can only be as strong as the material that is submitted to us by our pediatric intensive care nursing community!!

Annie's Story: The Synergy Model in Pediatric Critical Care Nursing Practice

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Abstract

The Synergy Model describes a nurse-patient relationship that optimizes patient and family outcomes.[1] All patients, regardless of age, have similar needs that they experience across a continuum of health to illness. The dimensions of the nurse competencies are driven by the needs of patients and families. When there is synergy between the patient/family needs and the nurse competencies, optimal patient outcomes occur.

Annie's Story

Annie was a seven-year old girl who was diagnosed with rhabdomyosarcoma. She was well known to the nursing staff of the pediatric and pediatric critical care units. She developed complications during the course of her treatment that required critical care monitoring. After seven months of treatment, her deterioration occurred in a rapid manner. The nursing staff realized that care would need to shift from obtaining cancer remission to orchestrating death.

Her last admission was for the development of neurological symptoms. Her CT scan revealed metastasis into her brain. Shortly thereafter, she could no longer see because the tumor was encroaching on her optic nerve. This was a very difficult development for the child who often entertained staff by pretending she was a doctor and answering the phone at the nurse's station. She became very demanding, constantly pushing the call button and asking for every little thing. We realized that she wanted someone to be with her because she was frightened.

The nurses surrounded Annie with as much love and attention as possible. We told her constantly that we loved her. We always responded to her call bell even when we knew that her father was at her bedside. She always told us that she wanted only her "nurse" to give her ice chips or a back rub. Many of us would rub her back for hours even though our arms were often hurting from rubbing; we would not stop until someone could relieve us. We heated her lotion so her back rubs would be warm and relaxing. We always made sure that we soaked her feet in warm water since she told us how good that made her feel. When she was agitated or scared, one of us would sit next to her and whisper in her ear to imagine herself on a beach and to listen to ocean waves hit the shore. We took turns reading her books, taking her outside and throughout the hospital on her stretcher and just sitting next to her bed, holding her hand. Sometimes, if we were too busy to sit with her, we moved her stretcher out by the nurse's station so she would not be alone.

One day, Annie was especially depressed because she could not see. I made up a game to get her mind off of being ill. She described what a nurse looked like and I had to guess who she was describing. Then I described what a nurse did or said and she would guess the person. We laughed – most importantly, she laughed.

She had her tumor debulked a short time before she died. Fortunately, she regained her sight. She made the most of her last days. She wanted us to sing to her

and then she recorded herself singing and played it for everyone. One of her recordings was played at her funeral. She also loved to eat tunafish sandwiches and potato chips at 1:30 am – we always made sure she had her favorite snack then.

During her last few days, she constantly wanted her nurse with her. Even though she did not require 1:1 care, with our manager's approval, we made her a 1:1 assignment. Nurses worked extra shifts so the nurse caring for Annie did not have to take any other patients. I was able to hold her for 4 hours on the day before she died. After she died all of the staff were comforted by knowing that we were able to "orchestrate" her death, supporting both Annie and her parents through the worst thing in the world anyone could ever experience.

Patient Characteristics

The Synergy Model describes characteristics, which are unique to every patient and care situation. Annie was minimally stable because she could not maintain a steady state equilibrium as she continued to deteriorate. She was complex because her emotional needs were very high and her family could not be there often to support her. She relied upon the nurses to support and comfort her. She was extremely vulnerable because of the psychological stressors; the adverse outcome for her could be a lonely and painful death. She was minimally resilient since her restorative capacity was no longer functioning. She did not have many resources available to her, however she participated somewhat in her care by identifying her needs to the nursing staff. Her trajectory of illness was predictable; getting better was no longer an option for her.

Nurse Characteristics

Nurse competencies also span a continuum that are based on patient needs. There are 8 competencies described by the Synergy Model, which are essential for contemporary nursing practice. Even though all eight competencies are critical, each competency assumes a higher or lower degree of priority for each patient, depending on the patient's characteristics.[1] The competencies that were of highest priority for Annie were caring practices, advocacy/moral agency, and systems thinking.

Caring practices are a constellation of nursing activities that are responsive to the uniqueness of the patient and the patient's family and create a compassionate and therapeutic environment with the aim of promoting comfort and preventing suffering. Caring behaviors include, but are not limited to, vigilance, engagement, and responsiveness.[1] The nursing staff were extremely responsive to Annie's unique and changing needs. Our care created the compassionate environment, which ensured her safety while providing her comfort. Vigilance was required in this situation, especially since Annie went through a period of time when she could not see. Our actions prevented suffering brought on by loneliness, pain, and fear.

Advocacy and moral agency is defined as working on another's behalf and representing the concerns of the patient, patient's family and the community. Moral agency requires "knowing the patient" which creates trust inherent in the nurse-patient relationship.[2] When a cure is no longer possible, nurses take a leadership role in ensuring that death occurs with comfort and dignity. Orchestrating death is described as nursing's "most profound contribution to humankind."[2] The nursing staff provided Annie with support and comfort throughout her process of dying. We also supported the parents. Even though they could not always be there, we provided them with whatever they needed to comfort Annie. Her parents wanted all of Annie's nurses to be at her funeral. We made sure that we were all there.

Systems thinking is appreciating the care environment from a perspective that recognizes the holistic interrelationships that exist within and across healthcare systems.[1] We needed to make the system work for Annie so that we could provide her with safe passage. Her needs required us to examine the system of care. We needed to rearrange assignments so that she was her nurse's only patient. We worked with other departments to ensure that her snacks were available at any time. We also ensured that

she could travel outside the unit, regardless of any medical equipment that was required.

Nurse-Patient Outcomes

The best outcome for Annie was a death with dignity, love, and comfort. Annie experienced this. Her death came peacefully and her parents and nurses knew that everything possible had been done to accomplish this ending. Even though safe passage often refers to the prevention of complications, providing Annie with a good death was an optimal outcome.

Conclusion

The Synergy Model describes how synergy between patient characteristics and nurse competencies result in optimal patient outcomes. The Synergy Model is applicable across the lifespan and in all types of patient situations. Pediatric patients have special needs that mandate certain competencies take priority. Prioritization of competencies is also driven by the patient situation. When cure is not an option, providing compassionate end of life care results in the best outcome for a particular patient and family.

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We would like to thank the Pediatric and Pediatric Critical Care nursing staff who gave their hearts and souls to caring for Annie. They are shining examples of the Synergy Model in action.
DR
PMH

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Perspectives on parental presence during resuscitation: A literature review

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Abstract

This paper presents a synthesis of research and review articles discussing parental presence during resuscitation. The incidence of resuscitation in paediatrics is relatively low and not many studies are available. The articles related to paediatric resuscitation and parental presence are mainly professional-oriented and small in population. Therefore more multi-centre studies are needed to foster a greater understanding of the impact of witnessed resuscitation on parents and professionals. There is however a growing acceptance by health care professionals of allowing parents to be present at the resuscitation of their children.

Introduction

Practice in the paediatric and neonatal intensive care is changing rapidly. Ten years ago parental presence during resuscitation was not allowed or possible. Today it is a growing practice across most European countries.
Interest in this topic began in the Accident and Emergency (A&E) departments and has began to spread to critical care areas (Doyle et al. 1987, Albarran and Stafford 1999). Only a few years ago, Jarvis (1998) published a study about the attitudes of professional towards parental presence during resuscitation. The findings became widely discussed within many paediatric intensive care settings. Meanwhile more studies and review articles have become available to support and develop this practice. However, there are still many questions that do not have sufficient founded answers.

This short paper is an abstract of reviews of the work presented at several (international) congresses of the past 2 years.

The parents' perspective

Studies related to family and parents participation during resuscitation have been mainly conducted in the A&E and adult intensive care area. Surprisingly, most studies show that during the past decade the expectation of family members being present at resuscitation does not change (Barrat and Wallis 1998, Boie et al. 1999, Doyle et al. 1987, Eichhorn et al. 1996). Doyle (1987) interviewed 70 family members of 30 patients (age between 3-90 years) who attended resuscitation in the A&E department. The number of respondents was 47. Most family members reported the presence of the resuscitation to be beneficial for their bereavement. The majority of the family members thought that their presence was valuable for the patient and they would attend resuscitation again. The results of Doyle (1987) are reflected in other studies.
In a controlled study, Robinson (1998) demonstrated no long-term adverse psychological effects among relatives who witnessed resuscitation. However, the study is unclear if there were parents of young children involved. If the psychological impact of parents who witnessed resuscitation differentiates from adult resuscitation has never been studied. Further research on this topic in paediatric critical care area is needed and of importance to practice.
The positive benefit to family members during the resuscitation and on the long-term in the bereavement period is similar in most study outcomes. However, caution must be taken to interpret the results of the

studies. Most studies have a very limited number of participants. The social and cultural differences within Europe are diverse and may influence the perspective of family and parents to witness resuscitation. Reports by parents and professional of the experiences of witnessed resuscitation are still valuable to receive insight in today's practice (MacDonald 2001, Mossel 2001).

The professionals' perspective

Among professionals there is still controversies on family or parents being present at resuscitation of their beloved ones. Arguments against the presence range from traumatic experience of family/parents to disturbance of professional performance (Redley and Hood 1996, Osuagwu 1991, Zoltie et al. 1994). But the past few years there is a tendency to give the family members or parents the choice to stay at the bedside (Bloomfield 1994, Jarvis 1998, Mitchell and Lynch 1997, Robinson et al. 1998, Walker 1997, Whitlock 1994). Most articles conclude with the words 'allow, support, promote, encourage, give the opportunity' to present the view on whether parents or family should be allowed to stay during resuscitation. It is the impact of the used words to express ones vision and it is the cultural environment of a department, which influence practice. Guidelines are therefore necessary to state the department's vision and practice (Jarvis 1998).

Although many professional may be concerned about the increase of stress during witnessed resuscitation, Boyd and White (2000) demonstrated among 114 professionals no significant increase in stress during witnessed resuscitation among adult patients. Whether the study outcomes can be compared to stress levels among nurses and doctors during paediatric resuscitation is not clear. More studies in the paediatric population are needed to understand the nature of professional performance during resuscitation.

Concerns are noticed about the moral, ethical and legal aspects. Walker (1997) concludes that the right of parents or family to witness resuscitation is dependent upon professionals' willingness to promote the principle of respect for autonomy. Decisions to stop resuscitation are discussed in several papers and it appears that the final decision should be the responsibility of the resuscitation team-leader (Albarran and Stafford 1999, Jarvis 1998, Rosenczweig 1998).

Perspectives from professional organisations

Only a few professional organisations have stated their vision on the presence of family members during resuscitation. The Resuscitation Council UK (1996) published a report with general guidelines and guidelines for specific areas and situations. The statement of the Resuscitation Council UK is 'We believe that relatives should be given the opportunity to be with their loved ones ate this time and proper provision must be made for those who indicate that they may wish to stay'. Although given the freedom of choice, this statement provides clearly that the family presence has to be organised under certain conditions.

Meanwhile in 1998 the Emergency Nurses Association has up-dated their statement from their previous statement in 1993 regarding family presence during resuscitation. The associations' position statement supports the option of family presence during invasive procedures and/or resuscitation efforts (ENA 1998).

The Dutch Society of Paediatric Nurses (Hoed van den-Heerschop and Groeneveld 2000) formulated a statement where the parents have the right to be present during resuscitation. Meanwhile the statement is focussed on the right of the child to have good medical and nursing care. The statement therefore follows that parents have to leave the resuscitation site whenever they impede the resuscitation negatively.

Considerations

Resuscitation is often unexpected and parents may not always be present or on site. It is crucial to inform parents about the critical situation and on arrival explanations of the resuscitation process are important (Albarran and Stafford 1999, Connors 1996, Latour 2000, Williams 1994).

Guidelines are necessary and recommendations are given to write them to

settings where professionals work (Jarvis 1998, Resuscitation Council UK 1996).
Surprisingly not much attention is given about parental presence during resuscitation at respectable life support training courses. The PALS, APLS, ALS, ATLS and other resuscitation training courses should include in their curriculum the management of stress observed at parents, family members and professionals (Jarvis 1998, Mitchell and Lynch 1997). But meanwhile increasing the frequency of resuscitation training is another important factor to increase competency. Resuscitation skills decline rapidly when not frequently practised (Berden et al. 1993, Maibach et al. 1996). This may influence the stress level and competence of the professional when suddenly parents are watching the resuscitation. As Goetting (1994, p 1150) suggested 'practice makes perfect, and poor CPR produces poor outcome', the outcome in paediatric resuscitation is also related to the wellbeing of the parents.

Conclusion

Although many studies originate from A&E departments and outside of Europe, the outcomes are valuable for further research and guidelines in paediatric resuscitation.
The incidence of resuscitation in paediatrics is relatively low and not many studies are available. The articles related to paediatric resuscitation and parental presence are mainly professional oriented and small in population. Therefore more multi-centre studies are needed to have more understanding of the impact of witnessed resuscitation on parents and professionals. But so far, there is a growing acceptance by health care professionals of allowing parents to be present at resuscitation of their children.

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Searching for a Logo: Calling for Imaginative Ideas

The International Editorial Advisory Board is searching for a Logo for this publication. We are now 2 years old and have established an identity of our own. We would like to complete this by creating our own distinctive logo.

We therefore call on all our readers, and friends of our readers, to submit any original designs that you wish to propose - set your imaginations free!

The Board will select one such logo among the proposals that we receive. Please send your proposal to the Editor (Franco Carnevale): frank.carnevale@muhc.mcgill.ca

The Preservation of Core Values in Times of Chaos and Conflict

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Abstract

The healthcare environment, as other industries, is in a perpetual mode of change, chaos, paradigm shifts, adaptation and uncertainty. Thus, people in leadership positions are challenged to even a higher level to maintain stability and the core values and principles that are the interest of all and, most certainly, them. The strongest alliance a leader has is the wholesome principles and core values based upon stewardship, service, people and commitment. This article provides the tools, skills and priorities for a professional when they are faced with such a personal or leadership challenge.

Preamble

Hospitals and health care will continue to face enormous challenges and transitions with the shortage of staff in many specialties coupled with the high costs and increased regulatory requirements. No one in the field can escape this and many of which will affect each one of us directly or indirectly. This article provides the tools, skills and priorities for a professional when they are faced with such a personal or leadership challenge. While just a few examples are used, there are numerous situations that could be applied to the content of this article. But, for simplicity, the author has kept the examples narrow and focused.

Introduction

As a pilot is faced with immediate and occasionally life-threatening decisions that must be made in a split second, so too is the individual functioning at all levels in a healthcare leadership position. They have received honest and continued feedback that departments, programs or demonstrated ability is positive, effective and quality service and employee empowerment is the profiled focus. But, that can change in a split second as can a decision for a pilot flying a plane.

As leaders, they must adjust priorities, demonstrate effectiveness and influence over individuals worked with that continues to build a solid base for progress and achievements. But, one incident can enter their perceived solid sphere and put them in a position of immediate, unexpected action, or re-action that one may not be prepared to deal with due to the very nature of the unexpected. Loosing a job, making a health threatening patient care decision or a 'significant personal injustice' from the throwback of the chaotic healthcare environment can be devastating. This can very easily be considered a pivotal point in ones professional career as "the ultimate test of ones leadership ability, fortitude and principles". Of critical importance is their ability to maintain composure, maturity, integrity, and honest command of the situation for successful recovery. This 'recovery' can be paralleled to "climbing the tallest tree, surveying the entire situation, and yelling out, "Wrong Jungle!"" (Covey).

The First 60 Seconds

The most critical period during this unexpected and unprepared for situation is theoretically and emotionally the first several minutes after the incident. How one reacts defines the true professional; what they're learned, practiced and demonstrated in principles and core values. Reaction is everything. The professional must not let the

feeling of injustice or undefined nature of the situation enter into their communication or reaction. It is the professional who listens intently to the unexpected and maintains composure.

After the incident is over, it is a time for pause and reflection in an environment of personal safety. A grieving period can be a reaction that many will go through, however, it is more productive for the professional as well as the organization, and system or patient if this can be avoided. The growth that a professional has acquired up to this point determines if this can be accomplished.

The feeling of injustice, lack of credibility felt for the system or organization or person can not help but enter the leaders mind and affect ones being. Moving past this strong emotion, and not reacting verbally or emotionally, determines the place of credible leadership for the victim. The effective and influential leader is wise to the fact that there are many things that occur in life, both personally and professionally. They are also wise to the fact they have no control over this, but must embrace and maintain their core values and principles during this difficult and challenging time.

The true leader does not give any time or effort to the negative, demoralizing, and destructive motivations that are communicated to them even if done so in a destructive and unfound manner.

Re-establishing Self Worth

Human goodness and focus become a critical factor for the professional as they begin to re-establish their "known and demonstrated competence" and self-worth as not only a person but also one who has meaningful purpose, value and significant contributions. It is all too easy to pity oneself and move into a state of defensiveness and an "eyes-shut" safeguard. Every individual, leader or not, has a contribution to be made not only in their profession but also to the community and people at large. The leader must maintain patience; trust and faith in oneself, knowing that only they can "rescue" themselves from the turmoil, and perhaps unclear devastation or event and move forward with the outcome focus as positive.

It is the rare leader who has the courage to commit and hold strong to ones principles and core values during chaos based on the emphasis to the actualization in order to enrich the world around them often not seen by others. Through this action, always aware and practiced consistently, the move back to the feeling and knowing ones worth evolves.

From the words of Laurens Van Der Post, " Every person must be their own leader. They now know enough not to follow other people [during chaos]. They must follow the light [core values] that's within themselves, and through this light they will create a new and [enriched self and sense of] community."

Lessons Learned

Listening brings growth.

Through any adversity or negative situation experienced, listening to what is said, how it is said and finding the true message is heightened growth for the professional. Reflection on specifics, truths or untruths, wrongs or rights, is a step that must be taken. Study every person and situation for its opposite and in order to bring closure and, most importantly, growth to the event this must be accomplished single and soulfully. Insight and new learned knowledge about people and environment reactions open the leader to the purposeful learning contained in the unexpected, unintended or unjust experience.

The leader puts them back on focus. The results begin to re-establish self-confidence, self-preservation and worth. They have "picked up the pieces", put them back in perspective and embraced the new opportunity facing them for growth, priorities and goals that have evolved from this experience.

This is probably the most difficult but the most significant exercise a leader must go through for continued success and contribution.

The leader knows they have a meaningful purpose and value because they have gone through this devastating process holding true to their principles while still opening themselves up for learning and listening, hurt and injustice or truth and awakening.

As the renowned and planetary guru of management and leadership Peter Drucker said in his 1976 legionary book *Management: Tasks, Responsibilities, Practices,* there are four temperaments needed for top leadership to succeed and their lack of them is a major reason why business, healthcare or not, fail to grow. To thrive as a leader they must have each component in their daily, demonstrated practice: the thought person, the action person, the people person, and the front person. And, the front person is the integrity, honesty and fairness that are exemplified.

Contemporary thinkers from Ralph Waldo Emerson to Abraham Maslow to Warren Bennis to Stephen Covey have all carried on the tradition on the qualities of leadership. Emerson wrote, "The purpose of life seems to be to acquaint man with himself." Bennis writes: "Letting the self emerge is the essential task of leaders." Covey says, "It is futile to put personality ahead of character, to try to improve relationships with others before improving ourselves." Thus, the leader must consciously and definably recognize, learn and apply the learned lessons from an event of chaos or conflict. (Cashman, 1999)

The Nice Finish First

The truly superior and learned leader always finishes first.

They are looked upon by their colleagues as a person who is not afraid to make difficult decisions, one who can balance the organization/principle confronted them and still maintain a balanced focus for people-oriented and concern for their well being. But the greatest difference between average and superior leaders is their emotional style as documented in numerous studies. The most effective leaders are positive and outgoing, more emotionally expressive and dramatic; warmer and more sociable (including smiling more), friendlier and more democratic, more cooperative, more likeable and "fun to be with," more trustful, honest and appreciative, and even gentler than those who are merely average. (Goleman, 1997)

Change and Purpose Mastery

In Cashman's, *Leadership From The Inside Out, Becoming a Leader for Life* (1999*)*, he talks of change mastery and purpose mastery as a way of growth toward wholeness as a leader. In change mastery, one must embrace the purposeful learning contained in the unending, disruptive, chaotic and creative flow of life. And, in purpose mastery, one must maintain an ongoing discovery of how they express their gifts to add life-enriching value to the world [and work environment]. The leader must always be able to differentiate between their 'character' and 'persona' and this is what lies between leading from the "inside" versus the "outside".

Image and persona are not qualities that are high focus for the leader. They are only relevant in the positive, proactive and empowering frame of demonstration through their work as a "final touch" to their overall effectiveness. The leaders character, or leading from the inside, is what core values and principles are all about. They live, work, prophesize this daily. They are trusted, open, and honest and demonstrate peaceful, meaningful purpose and merit.

Summary

It is not "earthshaking" news that the healthcare environment, as other industries, is in a perpetual mode of change, chaos, paradigm shifts, adaptation and uncertainty. Thus, people in leadership positions are challenged to even a higher level to maintain stability and the core values and principles that are the interest of all and, most certainly, them. The strongest alliance a leader has is the wholesome principles and core values based upon stewardship, service, people and commitment.

The leader at all levels and in all environments will be challenged daily with unexpected experiences or compromising situations. This will be the true test of the

leader and how it is approached and reacted to will be the deciding factor for future personal and professional success and growth.

"It's not differences that divide us.
It's our judgments about each other that do."

-
Margaret Wheatly, 2002

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Information For Authors

Pediatric Intensive Care Nursing welcomes paper submissions for upcoming issues of this publication. Papers may focus on any clinical or professional topic relevant to nursing the critically ill child and pertinent to an international nursing readership. Submissions should be 2-4 double-spaced pages in length.

Send your proposed papers directly to Franco Carnevale (Editor):
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PICU International : E-Group Provides Ideas, Support

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Freelance writer, based in Boca Raton, USA

Abstract

This paper describes the creation of an international egroup for nurses with an interest in critically ill children. A variety of clinical as well as organizational problems are presented, for which members have been able to seek advice or information from experts and peers around the world. Information on how to join the egroup is also presented.

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Franco A. Carnevale, RN, PhD, head nurse of the pediatric intensive care unit at Montreal Children's Hospital, doesn't feel isolated in his job. In fact, every time he has a question about a patient, he can post it to about 325 PICU nurses from around the world who participate in an Internet-based information sharing forum and are more than happy to relate their experiences to one another.

A perfect example: Carnevale said that Montreal Children's Hospital has a 2-year-old boy from Germany on a mechanical heart, waiting for transplantation. The situation is the first of its kind in Canada and the patient is the youngest in North America on the device. "We don't have experience with this and don't know how sedated or awake we should keep the patient: we don't want to keep him in a coma needlessly …," Carnevale said. "So I put out our predicament to the group. Several members shared their helpful experience, and one of our German members hooked me up directly with a German physician that has worked a great deal with this device and has given us additional advice on other matters."

Carnevale, who is associate professor in the School of Nursing, associate professor of the Faculty of Medicine (Pediatrics) and adjunct professor in the department of Counseling Psychology at McGill University, founded the PICU International e-group after attending the June 2000 3rd Congress on Pediatric Intensive Care in Montreal. He chaired the nursing program at the meeting and wanted to continue the dialogue initiated at the conference.

The PICU e-group formed July 4, 2000, and has surpassed Carnevale's expectations. With more than 300 members from over 20 countries and every continent except Antarctica, the e-group regularly raises important issues in PICU nursing. Carnevale, who volunteers his time to the group, also edits a newsletter, which he hopes one day will become a "formal" online journal.

E-group member Lourdes Castaneda-Jacobs, BSN, RN, patient center care manager for pediatrics and pediatric intensive care at Baptist Children's Hospital, Miami, said, "After using it [the PICU e-group], I found it is a way to stay globally connected. Personally, I found that it has made the world a much smaller place. We are able to communicate with nurses from all over the world and see how our practice is different from theirs."

The group makes getting good information easier, according to Eve Butler, MSN, RN, CCRN, clinical nurse specialist for Baptist Children's Hospital. "One of the challenges that we face with pediatric intensive care, in particular, is that there is not the research and organization that there is in the adult population," Butler said. "So it has been a great tool to validate what we think is right as well as learn things that we haven't tried before."

Nurses who post questions often have answers within hours, if not immediately, according to Butler, who spends about 20 minutes daily reading the postings and might send out a question once a week.

Butler has implemented pain management ideas from the group. Baptist, she says, has incorporated the Face, Legs, Activity, Cry and Consolability (FLACC) pain assessment tool into the children's hospital's protocol based on feedback from PICU nurses in other countries.

Though Butler and Jacobs have yet to meet any of the nurses they correspond with, they said they feel they know some of them. Butler finds comfort in knowing that the stresses that she experiences on the job are not hers, alone. "The bottom line is that we're basically the same in the care that we want to provide and the standards. We might use different equipment to achieve that … but as nurses we all have the same concerns and want the same for our patients."

While Maria C. Liatsos, BSN, RN, staff nurse at the Jackson Memorial Hospital, Miami PICU, didn't know about the PICU e-group, she said it's a great concept. "Most hospital pediatric ICUs have specialties, whether it's cardiac or transplant – some sort of specialty where they really excel. We specialize in multi-visceral organ transplants. So sharing our ideas about how we handle transplants and rejections and different problems can arise from transplants could benefit other hospitals that do single-organ transplants. And pediatric hospitals that might specialize in trauma, could share their ideas with us," she said.

Liatsos said the emotional support offered by the group would be an asset to PICU nurses. "People who work in that environment are the only ones who truly understand how all that works. Sharing feelings about losing children and the process of chronic illnesses and seeing children suffer is a hard thing to see every day. The only people who really understand are people who do the same thing elsewhere," she said.

"The PICU International Group is particularly helpful when looking at specific practices within the Pedi-ICU environment. An example would be endotracheal tube suctioning practices, including such issues as instillation of saline and Ballard catheter usage," said Bonnie A. Rice, MSN, ARNP, CCRN, CCNS, clinical nurse specialist at All Children's Hospital, St. Petersburg, Fla.

Joining the e-group is easy and does not cost anything. Interested nurses simply need to send Carnevale a message at frank.carnevale@muhc.mcgill.ca saying that they are interested in joining PICU-Nurse-International. Nurses should provide their full names and places of employment when they apply.

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Pediatric Intensive Care Links

Come visit many interesting website links to various international nursing societies as well other important resources:

Go to our website: http://groups.yahoo.com/group/PICU-Nurse-International and click on 'Bookmarks'

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Newsletter of the International Pediatric Intensive Care Nursing Network
Volume 2, Number 2, November 2001

If you have missed this past issue, as well as any other issue, you can access them at our website: http://groups.yahoo.com/group/PICU-Nurse-International (just click on 'Files')

4th World Congress on Pediatric Intensive Care

New Dates and Venue

Hynes Convention Center
Boston, Massachusetts, USA
June 8 – 12, 2003
www.pic2003.com

Dear Nursing Colleagues,

As many of you are aware, there has been concern for some time now about the unfortunate economic events in Argentina and the potential impact on the 4th World Congress on Pediatric Intensive Care. After much thought and deliberation by many, including the Board of Directors of the World Federation of Pediatric Intensive and Critical Care Societies, the difficult decision has been made to relocate the Congress. The new venue is the Hynes Convention Center in Boston, Massachusetts, USA. The new dates are Sunday, June 8 to Thursday, June 12, 2003. The Congress Hotel is the Westin Hotel, Copley Square in Boston.

Martha Curley is still the co-chair of the Scientific Committee and the program will continue to uphold the excellent standard that has been planned all along. Martha, along with other members of the Scientific Committee, are reviewing the program to determine any changes necessary because of change of venue.

Our Latin American colleagues worked very hard to welcome us to Argentina and we are sorry that the current situation dictates that we will not be able to meet there. However, we hope to meet them in Boston.

We look forward to a stellar 4th World Congress in Boston and we look forward to seeing you all there. If there are any questions, please do not hesitate to contact one of us or Martha Curley.

Franco Carnevale, RN, Member
Wil DeGroot, RN, Vice-President
Pat Moloney-Harmon, RN, Member
Board of Directors,
World Federation of Pediatric Intensive and Critical Care Societies (WFPICCS)

Upcoming Conferences

12th Congress Western Pacific Association of Critical Care Medicine
22-25 August 2002, Bali, Indonesia
Language: English
Info: www.WPACCM.com

Austrian International Congress 2002 Anaesthesia & Intensive Care: Art or Science?
11-13 September 2002, Vienna, Austria
Info: www.oegari.at
Language: German & English

8th Symposium of The European Society of Paediatric and Neonatal Intensive Care (ESPNIC) Nursing
13-14 September, 2002, Göteborg, Sweden
Info: www.espnic.org

15th annual congress European Society of Intensive Care Medicine
29 September - 2 October 2002
Barcelona, Spain
Info: www.esicm.org
Language: English (and Spanish translation)

Australian and New Zealand Intensive Care Meeting
October 2002, Perth, West Australia
The one day paediatric and neonatal conference will be run concurrently on Friday 18th with the main (adult 3 day) intensive care meeting and there will be paediatric and neonatal sessions included on the Saturday. The theme is cardiac.
Invited confirmed speakers are:
Dr Ian Adatia, Cardiologist, Critical Care Unit, Hospital for Sick Children, Toronto
Dr Lisa Hornberger, Cardiologist (Fetal echocardiography) Hospital for Sick Children, Toronto.
Dr Jenny Sokol, Neonatal Intensive Care Specialist, Princess Margaret & King Edward Hospitals, West Australia.
Jos Latour, Nurse manager PICU and NICU, Vu Hospital, Amsterdam.

XXI Congress of the Société Française des Infirmiers en Soins Intensifs
Adult and Pediatric Intensive Care
Themes: Cardiovascular arrest, Burns, Enteral nutrition, Ethics.
January, 2003, Paris, France
Language: French
Info: www.sfisi.assoc.fr or info@sfisi.asso.fr

10th European Burns Association Congress
10-13 September 2003, Bergen, Norway
info: eba2003@congrex.no
Website to be announced
Main topics:
Burns in developing countries
Reconstructive surgery
Quality of life
Burn related research

What are your comments?

The Editorial Board would appreciate your comments on this publication. This can include any thoughts that you have regarding the structure as well as the content of the Newsletter. We would particularly appreciate your suggestions on topics or issues that you would like to read about in future editions.

Forward your ideas to Franco Carnevale (Editor) :
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