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Critical Thinking: What Would you Do?

By Linda Nylander-Housholder, MSN, ARNP, CCRN

Admitted to your floor is a 3-week-old 3 kg infant with a history of not eating well, only one wet diaper the day before and his parents have found him in his crib not breathing properly.

Your assessment shows a lethargic, pale infant who is mottled and has dusky lips HR 190, R 72, temp 100.5 ax, BP r arm 55/23 BP won't read on left arm or legs, capillary refill 4 seconds, weak brachial pulses and questionable femoral pulses, bilateral crackles and muffled heart tones on auscultation

What should you do?

1) ABCs- open airway position, 100% 02 face mask if no improvement BVM- watch for chest rise and improvement in vital signs
2) Place on monitors (EKG, 02 sat)
3) Start IV draw labs (Glucose, blood gas, CBC, lytes, lactic acid culture) Bolus IV fluids (NS 20 cc/kg)
4) Reassess: Crackles are increased, liver palpated 4 cm below right coastal margin and pulses good only in right brachial and pulses very weak in lower extremities

What should you do now?

Notify MD - (possible coaractation of the aorta-preductal)

What might the MD order if above diagnosis confirmed , why?

Prostaglandin 0.05 - 0.1mcg /kg/ min IV (remember p for profuse - prostaglandin will keep the PDA open, if PDA closes blood flow is increased to lungs resulting in right sided CHF - (did think about the enlarged liver and crackles in the lung)

When would you start CPR?

If HR < 100 and BP and perfusion poor

Did you recognize acute airway distress and decreased level of consciousness - requiring emergency airway management?

Did you consider coaractation of the the aorta when you were unable to read BP on left arm or legs?

Did you consider any other causes besides pulmonary to rule out for this presentation seen in the neonatal period (sepsis, cardiac, hypoglycemia, dehydration, trauma) remember to check those labs and get a good history?

Nikole Sanchez-Rubiera, RN, BSN, MBA

Education:

- Masters of Science in Nursing, University of Phoenix - Anticipated Graduation Date: February 2009
- Masters in Business Administration, University of Miami, Specialization in Healthcare Policy
- Bachelor of Science in Nursing, University of Miami Minor in Business Administration

Career Highlights:

- 1997 -1999 Baptist Health System Patient Care Tech
- 2000 –2001 Pediatric Intensive Care Unit – Registered Nurse
- 2001 – 2002 Respiratory Care Unit (3E) – Nurse Manager
- 2002 –2006 Float/Intensive Care Unit –Registered Nurse
- 2004- 2005 Adjunct Pediatric Clinical Instructor, University of Miami and Miami Dade College
- 2006 – 2007 Senior Financial and Clinical Systems Analyst
- 2008 – Director of Nursing Operations

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In this issue

Nurse Leader

In the Spotlight

Nikole Sanchez-Rubiera, RN, BSN, MBA

Awards:

- 2004 Nurse of the Year (Float Pool) – May 2004
- Miami Children's Hospital Pediatric Clinical Excellence Award – May 1999

Presentations:

- ***Sanchez, N***. Best Practices in Magnet Nursing: Miami's Children's Hospital. Sponsored by American Strategic Management Institute, ASMI Magnet Conference, Arlington, VA, August 21, 2007.
- ***Sanchez, N.*** PACT: Pediatric Analysis & Comparative Tool, Benchmarking for Budget-PACT User Group Conference. Sponsored by Child Health Corporation of America, PACT, Los Angeles, CA., March 20, 2007.
- Gonzalez, J. Rozek, T. & ***Sanchez, N.*** Commitment, Advancement and Impact = Excellence. Advanced Practices, Amazing Outcomes: Improving Care through the Advancement of Nursing - A Florida Best Practice Symposium. Sponsored by the Florida Hospital Association, Florida Nurses Association and Florida Organization of Nurse Executives, Orlando, FL., November 17, 2005

Community Service:

- Greater Miami Chamber of Commerce, Leadership Miami: Executive Committee Leadership in United Way of Miami-Dade County

Hobbies/Family:

- Scrapbooking
- Traveling
- Spending time with Family
- Husband, Vince

From the Desk of Jackie Gonzalez

Dear Nursing Team:

As pediatric nurses, we tend to dwell concurrently in both the present and the future. We immerse ourselves daily in the "here and now," putting the needs of the children in our care before all else. And we steadfastly focus on the future, participating in research and practice enhancement initiatives that will lay the groundwork for care advancements.

In the midst of our busy, forward-moving lives, it's important that we also preserve a sense of history. At Miami Children's Hospital we share a proud tradition of nursing leadership. A desire to preserve and celebrate our collective past led to the creation of "Great Hearts Great Minds and a Love of Children," a book capturing the history of nursing at Miami Children's from 1950 to 2008.

This beautiful book was written by Christine Ardalan, an English-educated nurse with a master's degree in American history who has spent the last decade researching and chronicling the history of nursing in South Florida.

I hope each and every one of you takes the time to read the wonderful story of nursing at Miami Children's Hospital. For many of our long-serving nurses, it will be an opportunity to relive the past and celebrate accomplishments. For our newer team members, it is a chance to reflect on what it means to be a Miami Children's Hospital nurse, sharing in a long tradition of excellence and commitment to children.

To those who sacrificed and paved the way to excellence, I extend heartfelt thanks. And to those who continue to support our tireless efforts to enhance the lives of children and families, I look forward to our continued collaboration in 2009 and beyond. Together, we will continue to "write" the inspiring story of nursing excellence at Miami Children's Hospital.

Jackie Gonzalez

Jackie Gonzalez, ARNP, MSN, CNAA, BC, FAAN
Senior Vice President / Chief Nursing Officer



Collaborative Problem Solving

By Shirley Kendzora MSN, ARNP, RN-BC

For many years the Department of Psychiatry at Miami Children's Hospital has utilized a behavior modification approach of rewards and consequences in the treatment of children and adolescents. In an attempt to be more effective with clients who are explosive and inflexible, the department will be adopting a new psychosocial approach called collaborative problem solving (CPS), developed by Ross Greene, PhD., author of The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children (2005).

Dr. Greene is an Associate Professor in the Department of Psychiatry at Harvard Medical School and founding Director of the Collaborative Problem Solving Institute in the Department of Psychiatry at the Massachusetts General Hospital. **He will be presenting an all-day seminar at MCH on February 6, 2009 to aid in the implementation of the program.**

Dr. Greene bases his CPS model on the belief that explosive children do not choose to be so, and that they do well given the proper tools. Explosive behavior reflects a developmental delay in the areas of cognitive flexibility and frustration tolerance. Dr. Greene's "explosive child" presents with deficits in the specific thinking pathways of executive skills, language processing skills, emotion regulation skills, cognitive flexibility skills, and social skills.

Executive skills involve the ability to efficiently shift from one mind-set to another, ability to organize and plan, and the capacity to separate or detach self from emotions caused by frustration.

Language processing skills allow for categorizing and expressing emotions, identifying and articulating needs, and solving problems. Emotion regulation skills increase rational thought with the decrease of irritability, anxiety, agitation, obsessive-compulsive behavior, and ritualizing. Cognitive flexibility skills are needed to cope with the different experiences encountered when living in an unpredictable and ambiguous world.

Social skills require an ability to pick up social cues and also to connect those cues to past experiences. There is also a need to know how social interactions should ensue and to know a range of appropriate responses to use. Social interactions require flexibility, complex thinking, and rapid processing.

Dr. Greene (2005) identifies three plans that can be used to handle problems with the explosive child. Plan A, which imposes adult will, Plan B which engages the child in a discussion in which the problem or unmet expectation is resolved in a mutually satisfactory manner, and Plan C in which the expectation is dropped completely. With CPS, Plan B can be either emergency or proactive Plan B, but it is the plan of choice when dealing with the explosive child and includes the steps of providing empathy and reassurance, defining the problem, and inviting both the child and adult to brainstorm the potential solutions to the problem. In order for a child to participate in Plan B they need to be able to identify and articulate concerns, consider a range of possible solutions, and reflect on the feasibility and likely outcomes of solutions and the degree to which they are mutually satisfactory to themselves and the adult.

Behavior modification is based on the belief that behavior that is rewarded will be repeated. In the inpatient setting, the desired behavior that is rewarded is largely determined by the treatment team and the program structure, essentially an imposition of adult will over the child. CPS will increase the child's participation by sharing responsibility for their behavioral changes. In the same way that behavior modification has been the treatment modality applied to all patients in the psychiatric unit; CPS will be the new approach for all patients too, because all children need to learn critical development skills.

Whether it is leading therapeutic groups and activities focusing on the specific thinking skills to be learned, identifying the situations/events or triggers that precipitate explosive outbursts, guiding the child successfully through the Plan B process, or educating parents in the CPS method, the implementation of this approach will also require flexibility, frustration tolerance, and a shift in mind-set by the mental health professionals involved. We are excited about this challenge and look forward to discussing CPS with Dr. Greene.

Reference:

Greene, R. (2005). *The Explosive Child: A New Approach for Understanding and Parenting Easily Frustrated, Chronically Inflexible Children (2005)*. New York: Harper.



Tiny Graduate Returns to NICU

By Miriam Prado, RN

Standards of neonatal care for premature babies have increased dramatically over the past two decades and many of these babies are surviving at lower gestational ages today, without any signs of long-term deficits.

Pre-term survival is improving now because of interventions we have in pregnancy and neonatal care. Research data reveals that premature babies who would have died 20 years ago are surviving and going on to have a good quality of life, including having children of their own. It is also noted that women who were born pre-term are at increased risk of having premature offspring. Recently, the MCH NICU had the opportunity to experience this phenomenon firsthand. One of our NICU preemie graduates gave birth to a 27-week preemie girl. Our graduate is now on the other side of the preemie experience.

Sarah (not her real name) was herself a 25-week preemie, weighing 1½ pounds at birth in 1987. Sarah spent almost six months in our NICU and was discharge home with an apnea monitor, on oxygen, with home nursing support for a few months. After leaving MCH, she saw many specialists. She eventually graduated from high school and began working in the family business. Sarah is spunky, full of spirit, and determined to be a great mom. Now 21 years old, she got married a year ago and says that "seeing my baby for the first time was very overwhelming and scary." She states she has a lot of faith in the doctors and nurses in the NICU.

There is good news. Most premature babies survive, and their chances for survival into adulthood improve the longer they live. The number of babies born prematurely has risen by 30 percent in the past 25 years and they make increased demands on health and educational services. Premature babies are at risk for developmental delays. The Early Intervention Program can help those babies to reach their potential by providing them with special services as early as possible in their lives. The program helps children in the areas of cognitive development, communication, social and emotional development. All children should have developmental screening periodically throughout childhood.

Preemies can have cognitive or emotional delays and problems communicating, according to a study published in the Journal of the American Medical Association. These "micro preemies "also often need special help in classrooms, are delayed academically and have trouble interacting socially with their peers as they begin to mature. Many experts hoped the therapies would also reduce the rate of disabilities or other long-term problems for these babies. But that hasn't happened. Early intervention is important because a child's capacity for learning certain parts of language, which are regulated by brain maturation, is fixed by age 3. The first three years are a peak period of development during which the child's brain has twice as many synapse as an adult's. As a child's brain is stimulated, the synapses are strengthened; if a synapse is used repeatedly in the early years, it becomes permanent. If it's used rarely or not at all, it's unlikely to survive. These reasons are why children need consistent emotional, physical, cognitive, and language simulation starting from birth. The smaller the baby, the greater the likelihood that he or she will encounter at least some type of developmental or learning disability.

Remarkably, there are many babies that come out of prematurity untouched and whole. It takes a team to grow a preemie. It takes a lot of people, a lot of technology- and millions of dollars- to keep one tiny baby alive.

Wake Up and Smell the Caffeine in NICU

By Elena Ortega, MSN, ARNP, CCRN

So many of us wake up every morning looking forward to our "cortadito" (Cuban coffee), because we need our daily caffeine to function. I bet you probably did not know that many of our premature babies in NICU also receive their daily caffeine. Although it is not the same delicious caffeine boost we imbibe to keep us awake, it does function in quite the same fashion. Premature babies are at higher risk of having apneic episodes. Apnea of prematurity, also known as primary apnea, is described as episodes in which the infant stops breathing for at least 20 seconds. It is one of the most frequent respiratory issues seen in premature babies.

Caffeine citrate is given to these small infants in order to increase breathing frequency and decrease the episodes of apnea. Caffeine works as a cardiac, respiratory and central nervous system stimulant and as a muscle relaxer. The peripheral chemoreceptors are stimulated, thus initiating normal breathing and preventing apnea. Infants who receive this caffeine tend to wean off the mechanical ventilators sooner and tend to decrease the chances of needing to be placed on the mechanical ventilators again. So next time you go down to get your cortadito, think of all those premature babies who are also receiving caffeine to help them survive.



To Eat or Not to Eat Eating Disorder: An Overview

By Kelli-Ann McIntosh, RN

In today's society, teens admire the physiques of models and Hollywood stars who grace magazine covers. Some start dieting in an effort to attain physical perfection. A few take dieting to an extreme, eventually developing eating disorders as a means to perfection or to gain control of an aspect of their lives.

As a nurse on 3NE, providing care for an individual with an eating disorder is not uncommon. Eating disorders are grouped into three categories: anorexia nervosa, bulimia nervosa and binge-eating disorder.

Anorexia nervosa (AN) is when an individual deliberately starves him or herself to prevent weight gain. AN is characterized by abnormally low body weight, amenorrhea (absence of menses for three consecutive months in women), and fear of weight gain in which the person is preoccupied with weight and body shape. Most anorexics are perfectionists and high achievers.

Bulimia nervosa (BN) is when an individual has uncontrolled bouts of binge eating, followed by purging and excessive exercising. Some of these individuals also engage in other self destructive behaviors such as promiscuity and self mutilation just to name a few. Bulimics rarely exhibit low weight.

Binge eating is similar to that of BN. However these individuals consume large amounts of food but do not engage in purging. Binge eaters eat large amounts of food regardless of whether they are hungry. They tend to eat by themselves because of the embarrassment of the amount of food consumed. Binge eaters tend to feel powerless and out of control.

For each individual admitted with an eating disorder to 3NE the treatment is individualized to that specific person. However, there is a protocol implemented on the floor which each ED individual has to follow. This protocol includes 1:1 supervision especially during meals, daily blind weight. Orthostatic BP, specific gravity, strict I/O, and time frame allot for food consumption.

Some care providers become overwhelmed and upset when caring for these patients, a response that may result from the provider's misunderstanding of the diagnosis. It is important to remember individuals diagnosed with an eating disorder are not just dieting to lose weight but for many it is their only means of control. Caring for individuals with an eating disorder takes a lot of patience. It is therefore important to be both emotionally and psychologically supportive of these patients.

Back Over Accidents and Children

By David Aguero, OR RN, and Agustin Peralta, OR RN

As the size of vehicles has gotten larger, so has the risk of back over accidents. Tragically, advocacy groups report that two children die every week in back over accidents in the U.S. Many of today's biggest vehicles have enormous blind spots. A test by Consumer Reports found that these blind spots extend out as far as 50 feet behind the largest SUVs. Only a few cars today have sensors that sound an alarm when the vehicle is backing dangerously close to something, or offer a TV camera to illuminate the blind spot.

Kids and Cars organization gathered children to film a public service ad aimed at increasing awareness of the problem of back over accidents. Even so, there is no federal standard for automobile visibility, a mandate that at least one auto owner's group opposes. Congress is now considering insisting on a visibility standard, which advocates say could be met by the use of new technology.

Back over accidents underscore the importance of parents knowing where their children are at all times. Young children often slip out the door without their parents being aware. This occurrence is known as the "bye-bye syndrome," said Janette Fennell, founder and president of Kids and Cars. This year children all over United States have been run over and killed by parents.

The National Highway Traffic Safety Administration envisions a "Safe Community in Every Community in America." Such a community would promote injury prevention activities at the local level to solve local highway, traffic safety and other injury problems. It uses a bottom up approach involving its citizens in addressing key injury problems. A safe community program uses an integrated and comprehensive injury control system with prevention, acute care, and rehabilitation partners as active and essential participants in addressing community injury problems. The safe community has a coalition task force that is comprehensive and community based with representations from citizens, law enforcement, public health, medical, injury prevention, education, business, civic and service groups, public work offices, and a traffic safety advocates that provide program input, direction, and involvement in the safe community program.

References: *MSNBC.com 2008; NHTSA.gov; SFGATE.com*

Influenza Facts

By Barbara Simmonds, Director of Infection Control

- Influenza symptoms include: fever, muscle aches, headache, exhaustion, cough, congestion, and chest discomfort.
- Incubation period, or time from exposure to first symptoms, is 1-3 days.
- Virus can be passed on to other people for about 5-7 days after first symptoms.
- Health care workers are at high risk of developing Influenza and transmitting the virus to patients, even without showing symptoms themselves.
- Virus is spread through the air, probably only within 3-feet of an infected person. Flu is also transmitted by touching a virus-contaminated environmental surface, then touching eyes, nose, mouth.
- Vaccine is the best protection against the "flu".
- The intramuscular vaccine CANNOT give you the flu. (It is a killed virus!)
- Only three viruses are included in the vaccine each year.
- A new "flu shot" is needed EVERY year due to mutation of the viruses and waning immunity.
- The vaccine is free to MCH employees. Call Employee Health at Ext. 2636
- Anti-viral medication can be given to lessen symptoms in those not vaccinated.
- Rapid Flu test should be performed on symptomatic patients during flu season.
- Antibiotics are not effective against viruses and should only be used for secondary bacterial infections.

24th Annual Pediatric Nursing Conference

By Monica H Brown, MSN, RN, CPN & Orah Meyer, RN

The 24th Annual Pediatric Nursing Conference was held in Las Vegas, Nevada, June 26-28 and, thanks to the availability of funds from the Frida Hill Beck fund, Orah Meyer, RN, and I were given permission to attend after completing the application process. Amid a city backdrop of spinning roulette wheels, chiming slot machines and rolling dice, one could hear a pin drop in the conference room during the Opening Session, so rapt was the audience.

This being Orah's first foray into the world of national conference attendance and my umpteenth, I felt somewhat responsible for her well being in terms of navigating the various sessions. My agenda differed somewhat from that of Orah's. I was focused on some of the more esoteric topics for presentation and sought to satiate my auditory and visual senses with what other pediatric hospitals were doing as far as best practice is concerned. I also answered the call for volunteers to moderate some of the sessions and was thrilled to be selected to introduce the speaker for one of the first sessions entitled: Description of "Private Parts" by Child Victims of Sexual Assault.

This rather delicate topic was handled expertly by Juana Cantu-Cabrera, DNP, RN, a lecturer at The University of Texas-Pan American Department of Nursing who is often called upon to give expert forensic testimony in child sexual abuse and family violence cases in her native South Texas. After moderating this session, I wondered whether we were utilizing our full listening skills or could be missing important information when obtaining our admission histories.

Orah reported being especially moved by "Nickel Mines: The Story of Forgiveness" by Jeanne J. Venella, MS, RN, CEN. This haunting and riveting recollection of the massacre of the Amish schoolchildren in October, 2006, highlighted the importance of disaster preparedness in the emergency department and system-wide communication at The Children's Hospital of Philadelphia. What started as an ordinary day in this community and at this facility became a tragic chapter in the region's history.

Sessions on leadership, body decoration, pediatric laboratory interpretation skills, pediatric trauma, the how to's of evidence-based practice, helping families understand autism and family presence in pediatric trauma resuscitation were all very compelling. Alas, it was not possible to attend each and every session so time management skills were very important.

The editorial board of Pediatric Nursing Journal was available to encourage the audience to participate in nursing research, and to start writing our stories as we as nurses have much to say that can positively impact our profession. "Writing with Influence: Leading with the Pen," by Veronica Feeg, PhD, RN, FAAN was particularly interesting, especially to those of us who enjoy writing and aspire to be writers.

The next Pediatric Nursing Conference is scheduled to be held in Orlando at the end of June 2009, so, what can we say to the enthusiastic nurse who is vaguely interested in the idea of attending but who is teetering on the brink of action? Visit the website at:www.pediatricnursing.net and plan to complete the Frida Hill Beck application process.

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New Minor Surgery Suites Open

By David Aguero OR RN and Jennife Gamad, Preop ARNP

Recently the minor procedures suites were inaugurated on the second floor, Variety Wing of the hospital. Their main use is for GI procedures. Deanne Johnson is the manager of the minor procedure suites. The new facility has six pre-op spots, three PACU I spots, five PACU II spots and four procedure suites. The Doctors performing GI are: Dr. Ruben Gonzalez-Vallina, Dr. William Muiños, Dr. Jesse Reeves-Garcia and Dr. Oscar Loret de Mola. They utilize high definition scopes and latest-generation equipment.

Cases are currently performed on Tuesdays, Wednesdays and Fridays, with additional days planned soon. The average case load per day is six to 10.

2008 Recommended Immunization Schedule

By Teresa Mackenzie, RN, CPN, CCM

The recommended pediatric vaccines include those to prevent diphtheria, tetanus, pertussis, poliovirus, pneumococcal, haemophilus influenza type B, hepatitis B, hepatitis A, measles, mumps, rubella, varicella, influenza and rotavirus. Children born in the U.S. begin the primary series at birth and should be up to date by 18 months of age. Children of migrant families or who are delayed in receiving vaccines will require the recommended vaccines in order to enter daycare.

Many combinations of vaccines are manufactured and pediatricians are encouraged to follow the "Recommended Immunization Schedule" developed by the Department of Health and Human Services, Centers for Disease Control and Prevention and accepted by the American Academy of Pediatrics.

A second series (boosters) including diptheria, tetanus, polio, measles, mumps, rubella and varicella are due at the age of four to six years and prior to entry to Kindergarten.

At 11 to 12 years of age, adolescents are required to have the Tdap (tetanus, diphtheria and pertussis) vaccine to enter the 7th grade. Also recommended but not required for this age group is the meningococcal vaccine.

All females are encouraged to receive three doses of the human papillomavirus vaccine between the ages of 9 and 26 years of age.

It is highly recommended that adolescents planning to attend college receive the meningococcal vaccine if they have not previously received this vaccine and especially if they plan to live in a dormitory setting.

The MCH Pediatric Care Center (PCC) administers approximately 5,000 vaccines each year and has scored an "Excellent" Rating from the Department of Health, Vaccines for Children Program for the past three years for compliance to the recommended schedule.

Please contact the PCC at 305-669-6505 or ext. 2779 if you would like a copy of the Recommended Vaccine Schedule or if you would like to make an appointment for your child.

JCAHO Issues Sentinel Event Alert Regarding Bullying

By Carol Ann Hoehn, BSN, RN

Bullying is no longer a problem found only on the schoolyard. It has now garnered the attention of the Joint Commission. JCAHO has posted an alert in its July 9, 2008 Issue 40 titled "Behaviors that Undermine a Culture of Safety." The alert states: "Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care is dependent on teamwork, communications, and a collaborative work environment. To assure quality and to promote a culture of safety, healthcare organizations must address the problem of behaviors that threaten the performance of the healthcare team." Existing Joint Commission requirements will be effective January 1, 2009 for all accreditation programs.

The Task Force on the Prevention of Workplace Bullying defines intimidating and disruptive behaviors as "bullying." "Bullying is an offensive abusive, intimidating, malicious or insulting behavior, or abuse of power conducted by an individual or group against others, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress. Bullying is behavior which is generally persistent, systematic and on going." (Task Force on the Prevention of Workplace Bullying, 2001, p. 10)

Bullying behaviors include:
- Intimidation
- Excessive micro-management
- Condescending or patronizing behaviors
- Withholding information or depriving responsibility
- Assigning tasks above or below competence level
- Arbitrarily changing tasks
- Punitive, severe or irrational punishment
- Social isolation or "outcasting"
- Silent treatment
- Spreading rumors or gossiping
- Public humiliation or belittling of opinions
- Attacking the victim's beliefs, lifestyle or private life
- Excessive criticism
- Failure to give credit

Workplace bullying can occur within any department, between any employees and can also be exhibited by patients and family members who seek special privileges by threatening the healthcare organization employees.

Bullies are often people who:
- Simply find negativity acceptable
- Are unable to articulate their anger and, therefore, use aggression instead
- Have learned to act like a bully from someone else (such as their parents, preceptors, co-workers or even other managers in the organization)
- Have learned that bullying is an okay behavior by watching others within the organization become rewarded for it, with promotions and/o bonuses
- Have low self-esteem
- Are narcissists
- Are motivated by the excitement of gaining power
- Are stressed out
- Are problem solvers who uses bullying tactics to ensure activities to occur in the way they want them
- Are actors manipulating their world to keep it the way they want it

The longer bullying goes on, the more severe and harsh the behaviors become and the more they undermine a culture of safety in a healthcare environment. Catherine Mattice on the website www.noworkplacebullies.com, states that "53% to 71% of bullies are in management positions. Therefore, 29% and 47% of cases represent peers bullying peers, or subordinates bullying their superiors. Approximately 81% of victims report being bullied as a group by a single individual, meaning the organization's members have essentially 'allowed' the bully to rise to the top. When one individual is bullying a group, the behaviors tend to last longer than when a group is bullying a single individual." Powerlessness infects the lower status healthcare workers who are made to feel they have failed if they seek help in dealing with unrealistic demands. JCAHO's alert states that "intimidating and disruptive behaviors are often manifested by healthcare professionals in positions of power."

The Joint Commission alert addresses the "root causes and contributing factors" of intimidating and disruptive behaviors. "Intimidating and disruptive behavior stems from both individual and systemic factors. The bullies "can lack interpersonal, coping or conflict management skills. Systemic factors stem from the unique health care cultural environment, which is marked by pressures that include increased productivity demands, cost containment requirements, embedded hierarchies, and fear of or stress from litigation. These pressures can be further exacerbated by changes to or differences in the authority, autonomy, empowerment, and roles or values of professional on the health care team, as well as by the continual flux of daily changes in shifts, rotations, and interdepartmental support staff. This dynamic creates challenges for inter-professional communications and for the development of trust among team members."

The alert includes 11 points of suggested actions including: 1) educating the team members – both physicians and non-physician staff. 2) Holding all team members accountable. 3) Developing and implementing a reporting/surveillance system. 4) Encouraging inter-professional dialogues as a proactive way of addressing ongoing conflicts to name a few.

The Joint Commission alert states, "The presence of intimidating and disruptive behaviors in an organization, however, erodes professional behavior and creates an unhealthy or even hostile work

environment – one that is readily recognized by patients and their families. Health care organizations that ignore these behaviors also expose themselves to litigation from both employees and patients."

It is now time for healthcare organizations across the country to take the advice we have been offering to our school-aged children and stop the culture of bullying. It's time this industry takes a new approach to how we all communicate with each other and to set up a culture that will not tolerate management by bullying. As Ann Landers said, "The true measure of an individual is how he/she treats a person."

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MCH Way

The new MCH Way celebrates some of the cultural enrichment strategies being embraced by the MCH family.
"Be Here Now"

By Marie Severe, Director of Early Steps

Have you ever found yourself working on an important assignment, when a co-worker comes into your office and demands your attention? She "needs" your help—RIGHT NOW?! You want to shout, "I'm busy!" Instead, you stop what you are doing to listen to her. The entire time she is talking to you, your mind is on your assignment and tonight's dinner, but you stare blankly at her, as though you were "listening" to every word. Later, when you go home, your spouse sits at the table while you are making dinner. You start talking about the co-worker interrupting you, your boss ignoring you, and the car's engine making noise. You turn to your spouse and notice that he is sifting through the mail. You ask: "Are you listening to me?" He looks up and says: "Were you saying something?"

These are times when the concept of "Be Here Now" becomes your best friend. "Be Here Now" means being fully present and aware at the moment, without being distracted. It gives you the greatest opportunity for maximizing effectiveness and life fulfillment according to the Senn Delaney Workshops.

To "Be Here Now," you have to stop thinking about the past and the future, and give your attention to the present. You have to make sure that you are fully aware and responsive to the moment by focusing on the situation or person before you, being empathetic, and clearing your mind of any distracting thoughts that you cannot control right then. You have to listen for understanding.

As we embark on the MCH Way, engage your co-workers, shift your energy when necessary, and ask others to "Be Here Now" for you, as you will be for them! So the next time the eager co-worker rushes into your office when you are in the middle of a critical deadline - assess the situation. Can you spare five minutes? If so, then really "Be Here Now." Move away from the computer. Face you co-worker, and begin listening. If not, simply say: "I want to 'Be Here Now' for you when we talk. Can we do lunch?" What about the inattentive spouse. Just turn to him, smile, and say: "Honey, are you "here now"?

Miami Flavors Cookbook to Raise Money for Emergency Department

The volunteers of MCH Foundation Community Council have created a cookbook like no other! ***Miami Flavors*** contains recipes from many of Miami's finest chefs as well as Miami's own movers and shakers, all contributing to Miami's unique and diverse culture. This beautifully produced book was generously underwritten by Cargill International and so 100 percent of the proceeds benefit MCHF and will be used to help refurbish the Emergency Department.

At $21.35 (including tax) it is a real bargain and will make wonderful gifts. For more information please contact Ann Lyons at ext.1830, or Joanne Bogdon-Diaz at ext.1821.



NURSING NEWS

CERTIFICATIONS

The following PICU nurses passed the CCRN exam:
Renee Butts, RN, BSN, CCRN
Kristina Miranda, RN, BSN, CCRN
Aurora Barrios, RN, BSN, CCRN

The following nurses passed the Neonatal CCRN exam:
Elizabeth Espinosa, Karen Jacobs, Mariam Teruel, Elena Ortega, Annalyn Velasquez Marissa Subido and Flor Tena, Gail O'Donnell, Sandra Frank (Life Flight) Joem De Los Reyes, Carol Cupido-Hylton and Lisa Wright.

Jane Larew, RN passed the Neonatal RNC exam

NICU currently has 26 certified nurses.

Liza Paggadu , RN, CPN (CICU) passed the Pediatric Certification Exam

Solfia Torre, RN, BSN (Dialysis Unit) passed the National Nephrology Nurse Certification exam

ANNOUNCEMENTS

Maria Fernandez, MSN, ARNP, Director of LifeFlight, has been appointed by State Surgeon General Ana Viamonte Ros, MD, to serve a four-year term on the Emergency Medical Review Committee representing the air medical industry.

Debbie Del Favero, MSN/ED, CPN, CNA-BC was nominated for the Nurse Leadership Award by South Florida Organization of Nurse Executives (SFONE).

Bing Wood received the Luminare Award, Support Services Practitioner of the Year by Life Alliance and Recovery Agency (LAORA)

ECMO Program received the Life Support Excellence Award

GRADUATION/BOARDS

Lisa Sosa, Manager CICU, received her MSN, ARNP
Diana Lopez, RN, CICU, received her - MSN, ARNP
Sherry l. Persia, RN, CICU, received her MSN
Joleen Eligon, CA, CICU, received her Bachelor's in Psychology
Mechy Cabeza, WS, CICU, received her Bachelor's in Exercise Physiology
Dyana Castro, WS, CV Floor, received her Bachelor's in health sciences

NEW HIRES

New Employees in LifeFlight®:
David Magrisso, EMT
Bryan Smith, EMT
Anthony Toledo, EMT-P
Anthony Oro, EMT-P
Liosdan Diaz, EMT
Nelson Gonzalez, EMT
Carmen Marando, EMT-P

New Hires in the 3-North:
Stephanie Bernardo, RN

New Hires in the NICU:
Kimberly Daniels, RN
Maria Lacayo, RN
Sherry Langstaff, RN

New Hires in the PICU:
Emily Stauffer, RN
Juliet Tamez, RN
Vanessa Gonzalez, RN
Kristin Aloi, RN
Bouzo, Elizabeth, RN
Isabel Perez, RN
David Pastor, RN
Adreana Bedoya, RN

New Hires in the CV Floor:
Alice Latorre, RN
Jacqueline Rodriguez, RN
Emma Thompson, RN

New Hires in the CICU:
Venice Davis, CA
Najir Rojas, RN
Jeri Brown, RN
Paola Garcia-Herreros, GN

MIAMI CHILDREN'S HOSPITAL®
We're here for the children

ANCC MAGNET RECOGNITION

DAISY Award Celebration

MCH nurses who received the DAISY Award for Extraordinary Nurses in 2008 were recognized at a special event in November. The event was sponsored by The DAISY Foundation, an organization dedicated to recognizing excellence in nursing nationwide, and UnitedHealthcare, which is partnering with the DAISY Foundation to further its mission.

Food For The Soul

Food for the Soul is a regular feature of the Pursuit of Excellence newsletter. MCH nurses share favorite recipes such as this one by Linda Nylander-Housholder, MSN, ARNP, CCRN.

SWEDISH PANCAKES

Makes about 12 large pancakes

Ingredients:

4 Tbs Sugar
1/2 tsp Salt
1 1/2 cups Flour
3 Eggs
2 cups Milk
2 Tbs Melted Butter

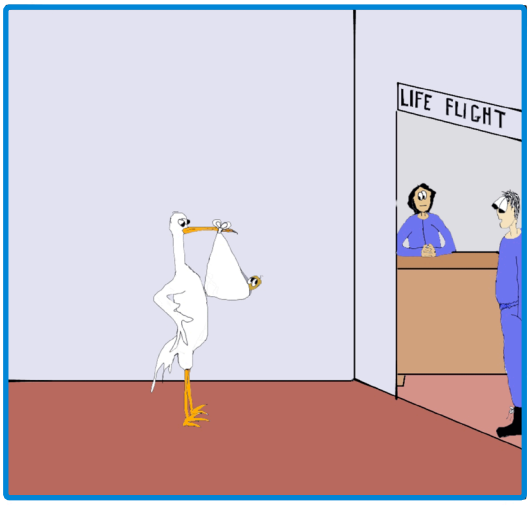
Directions:

Mix sugar, salt and flour and set aside. Beat eggs until thick and light in color, add milk and butter. Add dry ingredients and mix until well blended.

If you have a cast iron frying pan this makes the best pancakes if not use any frying pan. Heat pan medium on high until a few drops of water dropped in pan dance. When pan is hot -pour small amount of batter in pan rotating pan so entire bottom is covered with a thin layer of batter.

Using butter knife, release edges from sides of pan, once golden brown then slide knife under middle of pancake and flip.

Serving suggestions:
Top pancakes with...
- Butter and syrup
- Powdered sugar
- Butter and sugar
- Strawberry jam



"There's someone here to see you about the position. He says he has extensive experience with neonatal transport."

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