Building a Toolbox for Work with Pediatric Patients and Their Families

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The goal for this talk is to address the basic principals of pediatric practice by using case examples and unit examples to illustrate important elements of our work with children and families, and then to offer tools for use in our daily practice.
OUTLINE

INTRODUCTION: Roles and Settings

AREAS OF PRACTICE
• Assessment
• Adjustment to Illness
• Growth & Development
• Education
• Child Abuse/Neglect
• Transitioning

TOOLBOX
• Resources
• Referrals
• Tools
• Programs
• Games and Activities
• Consultations

SHARING OF INNOVATIVE PROGRAMS
Finding a *balance* between task (tools/interventions) and relationship (trust and rapport), *recognizing readiness for change*, as noted by Prochaska and DiClemente, and most importantly *working where the client/consumer* (in its broadest definition) *is at in their stage of change*, is imperative to behavioral health practice in social work.
AREA OF PRACTICE: Assessment

CASE EXAMPLE: Navidad
Assessment

Basic Social Work Skills

- Culturally Appropriate
- Developmentally Appropriate
- Medically Appropriate
- Assessment of Home Environment
- Assessment of Neglect
- Mental Health
Assessment includes:

**household composition:** who is in the home? Multiple homes?

**family history:** prior losses? Medically savvy? MH/CAN/drugs?

adjustment to and understanding of illness

mental health status of parent, child: V axis diagnosis

child abuse and neglect risk factors

developmental status of parent and child

strengths and supports

stressors and barriers

learning styles and delays of parent and child
Assessment

• Direct Assessment and Observation
  – Initial assessment
  – Transplant assessment
  – Home visit assessment

• Use of Consultation
  – Cultural and Spiritual
  – Ethics
  – Palliative Care
  – Mental health
  – Child Life

• Validated Assessment Tools
  – Quality of Life Surveys
  – Depression Scales

• Time
  – Annual Review
Systems Theory

Systems theory focuses on organization and interdependence of relationships. A **system** is composed of regularly interacting or interdependent groups of activities/parts the emergent relationship(s) of which form the whole. Problems are treated by changing the way the system works rather than trying to "fix" a specific part. Proposed by Ludwig von Bertalanffy 1945.
Family Systems Theory

“The family systems theory is a theory introduced by Dr. Murray Bowen that suggests that individuals cannot be understood in isolation from one another, but rather as a part of their family, as the family is an emotional unit. Families are systems of interconnected and interdependent individuals, none of whom can be understood in isolation from the system.”
Assessment

There are few absolutes and situations are rarely black and white. As social workers, one of our best tools is our own problem solving skills.

I have worked with a schizophrenic patient who is not taking any antipsychotic medications. But he is successfully maintaining a kidney transplant with good medication compliance. Our team decided as long as his medical adherence was good it wasn’t our place to dictate management of his own psychotic symptoms.

I have worked with one monolingual Spanish-speaking mom who was for a brief time successfully maintaining twin 12-year olds on PD while living in a modified garage. Mom knew how to keep her kids clean and safe in a way that a homeless shelter or foster care couldn’t have provided.
Home Visit Assessment
Assessment

• Home Visit Assessment
  – Setting (urban vs. rural)
  – Household composition (people, animals)
  – Structural integrity
  – Amenities (power, water, garbage)
  – Storage (indoor/outdoor)
  – Cleanliness (messy vs. unhygienic)
  – Emergency preparedness (smoke detectors, evacuation plans)
  – Family safety (violence, weapons, drugs)

People will say things in their own living room that they would never say in a clinic exam room.

Kids like to show off their room.

Parents appreciate having medical staff come to them.

Social Workers have assessment skills that allow the home visit assessment to go deeper than a technical review.
Navidad was a newborn approaching ESRD and communication with mom was challenging. Spanish interpreters used. Body language suggested anger, unresponsiveness was read as lack of cognition. Mom lived with two kids and her brother in rural Eastern WA.

What is mom’s ability to understand the medical needs of her child? What kind of support and resources does she have in her own community? Will mom open up and let us know what is bothering her?
• Bilingual Social Worker
• Home Visit Assessment
• Birth to Three Services
• Community Resources

Bilingual Social Worker found that what looked like anger was fear and grief. Community workers were telling her she couldn’t care for child. Home visit found the home unsafe for PD with an infant, but uncle helped mom complete all repairs on our checklist. Birth to Three services gave mom some sense of normalcy with her child. PHN was both a set of eyes in the home and an ally for mom.
Assessment Tools

• Depression scales
• Quality of life surveys
• Expert consultations

• Multidisciplinary team
• Interpreters
• Providers in alternate settings (school, counselor, PHN)
AREA OF PRACTICE: Adjustment to Illness

CASE EXAMPLE: Patrick
Adjustment to Illness

• Anticipatory Grief
• Treatment Choices
• Adherence to Medical Plan
• Impact on Lifestyles
• Impact on Relationships
Anticipatory Grief

- Cycles of Grief
- Parent’s loss of expectations: will my child be able to live to adulthood, graduate from college, get married, have children, get a job?
- Child’s loss of expectations: will I be able to play soccer, go to the prom, eat pizza, go to college, live to adulthood?
- The role of faith and other supportive forces
Adjustment to Illness

Treatment Choices

- **Peritoneal Dialysis:** at home, overnight, easier on little bodies, caretaker responsibilities, flexibility, less restrictive diet, home safety, better school attendance, peritonitis risks.

- **Hemodialysis:** in-center, sometimes at home, 3-6 times per week, more restrictive diet, nightlife possible, staff responsible for care, rigid schedule, school interference, line infection risks.

- **Transplant:** success is closest to “normal life,” rigidity of adherence, suppressed immune system.
Treatment Choices

- When do parents have the option to choose no treatment?
- Pediatric dialysis patients often do not have choices about where to obtain care (CHRMC is the only pediatric dialysis center in AK, WA, ID, MT).
- What happens when the treatment team doesn’t agree with the treatment choice a parent makes?
Adjustment to Illness

Non-Adherence To Medical Plan

- Neglect
- Lack of Understanding
- Lack of Appropriate Tools and Resources
- Self-Harm Suicidality Feeling of Hopelessness
- Adolescent Invincibility
Adjustment to Illness

Impact on Lifestyles

- Travel
- Home life
- Work life
- Childcare
- Camp
- College
Adjustment to Illness

Impact on Relationships

- Marriage
- Dating
- Siblings
- Sleepovers
- Peers
- Extended family
Adjustment to Illness

Quotes from patients, parents, and staff:

Parent upon hearing the diagnosis: “But we’re good people. We don’t drink or smoke or anything. Why is this happening to our son?”

5-yr old on why he didn’t want a transplant: “I don’t want to pee, that’s gross.”

12-yr old during txp eval: “Is it okay if I’m not ready yet? I just want my body to get used to this PD stuff first.”

Mom whose infant daughter needed to start PD: “Could we just not do this today – I’m not ready.”

Mom of girl waiting for transplant over 5 years: “We’re just waiting to see what happens with that stabbing victim…”

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Patrick

- Patrick was a serious athlete when he had to start PD. He competed at a nationally competitive level. Out of fear that his coaches would side-line him, Patrick and his parents decided to keep it a secret. Mom began to have significant anxiety about neighbors or teammates finding out. She went to great lengths to hide supplies at home and keep the equipment in a locked closet.

How can we help this family get support when they won’t tell anyone about the diagnosis? While patient privacy is something we all covet, does this behavior represent problematic adjustment to illness?
Patrick and his parents were offered numerous support services over the years with little impact. For a long time there remained a real disconnect between disease and person. Patrick was adherent with his GH and EPO, non-adherent with binders and diet. After about 4 years on PD, his membrane failed and he had to switch to HD. He started to make friends with other patients in the unit and mentored younger patients interested in playing soccer. Mom made connections with other parents as well.
Adjustment to Illness Tools

Support Groups
Parent to Parent connections
Starbright
Online Support Network
Wish Granting
Renal Prom
Sibling Support Programs

HD Unit Programs
Dialysis Camp
Adherence Support Programs
Counseling Services
Child Life Specialist
AREA OF PRACTICE:
Growth and Development

CASE EXAMPLE:
Christian
Growth and Development

- Pediatric dialysis patients are not small adults
- The major difference between pediatric and adult patients is the need for children to grow and develop
- Examine the impact of the disease upon growth and development
- Examine the impact of growth and development upon the disease.
### Growth and Development

**Know the stages (Piaget, Erikson, etc.)**

<table>
<thead>
<tr>
<th>Stage</th>
<th>Conflict</th>
<th>Focus Area</th>
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<td>Infant</td>
<td>Trust vs. Mistrust</td>
<td>Maximize comfort</td>
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<tr>
<td>Toddler</td>
<td>Autonomy vs. Shame</td>
<td>Mastering physical environment</td>
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<td>Pre-School</td>
<td>Initiative vs. Guilt</td>
<td>Initiate rather than mimic</td>
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<td>School Age</td>
<td>Industry vs. Inferiority</td>
<td>Self-worth, refining skills</td>
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<td>Adolescent</td>
<td>Identity vs. Role Confusion</td>
<td>Self image under peer pressure</td>
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<tr>
<td>Young Adult</td>
<td>Intimacy vs. Isolation</td>
<td>Personal commitment</td>
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Growth and Development

Know the milestones:
Object Permanence
Walking
Cause/Effect
Potty Training
Talking
Etc.
Know the impact of Kidney Disease:

Bone disease, anemia, hypertension, poor growth, short stature, rigid nutritional guidelines, and other symptoms of chronic kidney disease affect the growing child’s ability to attend school regularly, make critical developmental milestones, maintain successful peer relationships, etc.
Christian

Christian is a 5-year old boy with ESRD secondary to renal dysplasia. He lives on a remote island in AK with parents and 3 brothers. The oldest brother has a transplant. He has something on the autistic spectrum not yet diagnosed. It takes both parents to hold him down for lab draws, plane rides, and other interventions.

What tools do we need to help this family make appropriate treatment choices and to make those choices work within their family?
After his PD catheter was placed, Christian was sent home for about 6 weeks with a teddy bear that had been fitted with a PD catheter and could be connected to the dialysis machine at night. Christian was able to do dialysis on the bear at home and get familiar with the sights and sounds of PD. He was then admitted to a med/psych bed for PD teaching and initiation. He received a definitive diagnosis of autism, got started on some new medications, and the family got assistance from psychiatry and child life in strategies for addressing behavior and anxiety around medical procedures.
Growth and Development Tools

Birth to Three Services
Head Start
Division of Developmental Disabilities
Division of Vocational Rehabilitation
Children with Special Health Care Needs
Public School Districts
AREA OF PRACTICE: Education

CASE EXAMPLE: Luis
School is the primary activity and mark of functional status for children.
Education

- Post-transplant adolescents do better academically than adolescents with CRI or those on dialysis. (Lawry et al., 1994).

- Healthy school-age siblings have better academic achievement in spelling, arithmetic, and reading than their sisters and brothers on dialysis or with a transplant. (Brouhard et al., 2000).

- Children with CKD show lower IQ scores compared with the general population (Lawry et al., 1994; Hulstijn-Dirkmatt et al., 1995; Mendley and Zelko, 1999; Warady et al., 1999).
Education

• How long has kidney disease been affecting the child?
  – Did the child have healthy time in school prior to diagnosis?
  – Has the child been sick for a long time without diagnosis?

• Cognitive impacts of the disease and the treatment
  – BUN, Anemia, Bone Disease

• Time out of school for medical appointments and illness
  – Hemodialysis schedule, transplant recovery and follow-up schedule, clinic visits, lab draws, hospitalizations, illnesses

• Impact of poor peer relationship on interest in attendance
  – Short stature, tubing and scarring, treatment schedule prevents social life, delayed maturity
Education

• Health Plan: Individualized plan to meet the specific health needs of the student
  – Examples: Medication, fluid, or BP monitoring

• 504 Accommodation: Individualized plan to accommodate the student’s medical (or mental health) condition for learning purposes
  – Examples: Bathroom pass for polyuric student, water bottle for transplant patient, tutor for HD student missing class on a regular basis

• Individual Education Plan: Individualized plan for students meeting special education criteria used to address specific learning disabilities or delays
  – Examples: Pull-out time for reading or math assistance
Luis is a 13-year old patient living in rural Eastern WA. Home situation is not suitable for PD and he is too small and with other medical complications to get HD in an adult setting. Luis and his family are living temporarily in Seattle until we can assess transplant readiness and grow Luis enough to feel safe about an adult HD unit.

Luis is looking at 9 months in Seattle. What are we going to do for school?
• Hospital Tutor
• 504 Accommodation
• Alternative School Program: Hutch School

Luis was referred to the hospital education department for tutoring assistance during each weekday HD run. He tried attending a local public middle school with a 504 Accommodation, but the urban setting was rather shocking for this young man. We were able to get him enrolled in an alternative school program through the Fred Hutchinson Cancer Research Center.
Education Tools

Home Hospital Instruction
Individual Education Plan
Health Plan
504 Accommodations
School Nurse
School Counselor

Create packets or presentations that can be sent to school when a student is newly diagnosed or first starts dialysis.

Attend school conferences by phone
AREA OF PRACTICE: Child Abuse and Neglect

CASE EXAMPLE: Destiney
Symptoms of Abuse vs. Symptoms of CKD

- Bruising
- Broken Bones
- Frequent School Absences
- Lack of Social Connections with Peers

With medical explanations for these symptoms, our patients are both at risk for false allegations of abuse as well as oversight of actual abuse and neglect.
Chronic Neglect

At what point do you recognize and call it neglect?

At what point do you make a referral to child protective services?

How do you recognize recovery?

When do patients and parents have choices about treatment and when does saying no equal neglect?

Is the parent neglectful when the teenager is non-adherent?

How do we respect cultural and religious practices in the setting of mainstream America?

“‘Negligent treatment or maltreatment’ means an act or a failure to act, or the cumulative effects of a pattern of conduct, behavior, or inaction, that evidences a serious disregard of consequences of such magnitude as to constitute a clear and present danger to a child’s health, welfare, or safety” Revised Code of Washington 26.44.020
Child Abuse and Neglect

• Chronicity breeds chronicity.
• Chronic illness can lead to chronic underemployment which can lead to chronic poverty which can lead to chronic mental health issues and chronic neglect.
• Living with chronic illness is a stressful lifestyle and can interfere with relationships.
• It can be hard for some parents to separate the child from the situations the child’s condition creates.
Destiney was an 8-year old girl with Caucasian and Native American heritage, living in Great Falls, MT with her mother, two siblings, and mom’s abusive boyfriend. She was airlifted to CHRMC in ESRD without prior knowledge of her disease. After 3 months in Seattle on HD, she returned home on PD. Severe neglect was identified within 4-5 months at home. Missed appointments, missed medications, cancelled home visits led to an assessment that ultimately found mom to be connecting Destiney to PD, then leaving her alone at home to go to the local bar.

How do you make neglect assessments from afar? What assistance do you provide to a family to prevent chronic neglect? At what point do you refer to protective services?
Destiney was admitted to the hospital and CPS referral was made. She was placed at Ashley House for 8 months while mom moved to Seattle and addressed her own mental health, addiction, and DV issues. Mom made the most dramatic 180 degree turn around that I have witnessed in my career. Destiney was switched to HD prior to returning to her mom’s care, but mom eventually proved to be one of the most adherent parents on my caseload. Destiney was transplanted several years ago and remains at home with no further CPS referrals.
Child Abuse and Neglect Tools

Child Protective Services
Child Welfare Services
Family Preservation Programs
Public Health Nurse
Children with Special Health Care Needs
Medical Foster Care

Ashley House
Medic Alert
AREA OF PRACTICE: Transition to Adult Care

CASE EXAMPLE: “It’s All About Me”
Transition to Adult Health Care

The goal for all young people is to optimize their ability to assume adult roles and functioning.
What Youth Want Their Health Care Providers to Know:

“It’s All About ME!”

The challenge:
To move from taking care of our patients to helping them take care of themselves......... Health care self management
Pediatric and Adult Specialties Really Are Different

**Pediatrics**
- Family-centered
- Developmental focus
- Nurturing
- Interdisciplinary

**Adult Medicine**
- Individual autonomy
- Disease focus
- Intellectual
- Multidisciplinary
Background Information

• Consensus Statement developed by
  – American Academy of Pediatrics
  – American Academy of Family Physicians
  – American College of Physicians
  – American Society of Internal Medicine
  – Also endorsed by the Society for Adolescent Medicine

• The transition process should begin at age 14

• Outlines critical steps needed for successful transitions.
Creating an Independent Teen

- The process of going from a child to an adult is complex (what an understatement!)
  - Body changes
  - Emotional maturation
  - Hormonal surges
  - New types of interactions with parents and other adults—increasing independence, more choices
What Happens When There’s a Medical Condition to Consider, Too?

- Teens need education in health care self management
  - They need to learn how to manage their OWN symptoms, treatment, physical and psychosocial needs
  - These are all inherent to living with a chronic condition
- They need to start the transition process
Transition? What is it?

- Transition is the deliberate, coordinated provision of developmentally appropriate and culturally competent health assessments, counseling, and referrals.
- Transitions are part of normal development and occur across the life span.
- Transition ensures that as a young adult, the teen will be successful in:
  - Adult health care systems
  - Work
  - Independence
  - Inclusion in community life
Habilitation

Creating and developing **skills that prepare a person for life’s challenges**

- Educational needs
- Medical Needs
- Social Needs
- Spiritual Needs
- Vocational Needs
A transition program refers to the variety of information, education, and services used to prepare the young adult to move from pediatric into adult care.
The transfer process refers the actual steps to facilitate your move from pediatric to an adult-centered program.

- Selection of facility & doctor
- Creation of timetable
- Transfer of records
- Graduation Party
What Do We Need to Know?

- Children and youth with special health care needs (YSHCN) comprise 13% of US children.
- 90% of YSHCN reach their 21st birthday.
- 45% of YSHCN lack access to a physician who is familiar with their health condition.
- 30% of 18 to 24-year-olds lack a payment source for health care.
What Teens Want Us to Know:

• 90% want to live and work independently
• Many feel they are “treated like a child”
• Many feel a loss of control
• They feel they are not seen as unique individual, separate from their condition
• Health care providers defer to parent(s) in interactions and for decisions
The provider’s prime responsibility is the medical management of the young person’s disease, but the outcome of this medical intervention is irrelevant unless the young person acquires the required skills to manage their own condition and their lives.

So What?
Unsuccessful Transition Results in:

- Lower self esteem
- Lack of proper health care
- Increased patient risk
- Crisis management mode
- Reduced quality of life
- Likely increased health cost over the patient’s lifetime
Our Challenge: Health Care Self Management

• Educate and engage our patients
• Educate and engage our whole health care team
• Be open to new approaches and ideas
• Provide health care that is planned cooperatively with the patient
• Recognize patient behavior impacts successful outcomes more any than clinical care received.
Transitioning to Adult Care

• Start EARLY
• From birth, you can teach children skills they will need to be adults with chronic illness
• Work with parents as well as youth
• Help your medical team understand the importance
• Know your time frame
Transitioning to Adult Care

• As teens approach 18, pay attention to:
  – Consent for care
  – Consent to speak with parents
  – Advanced directives
  – Insurance coverage
  – SSI eligibility
A Successful Transition Process Means:

- **Your Team** has adequately prepared you
- **Parent(s)/caregivers** are less anxious to transfer
- **Young adults** are ready to transfer
- **Adult program** is well-informed about your needs
Transitioning Tools

1. Health History Notebook
2. Education & Training for young adults, parent(s) and caregivers
3. Team Planning
4. Transfer Clinic & Celebration
5. Follow-up
6. Teaching Record
7. Referral to community agencies and services
8. Visit with patient to transfer clinic
9. Transfer of other specialty services
Department of Pediatrics identified “Transition of Patients to Adult Healthcare Providers” as a priority.

Several groups have worked since 2003 on the following areas:

- **Patient Education** — to develop teaching tools for patients, families and providers in education about self-care responsibilities
- **Resources** — to assist patients, families and providers in successfully interfacing with health related resources needed for continuing medical care
- **Medical Home** — to outline patient, family and provider responsibilities in transition of care to adult provider health systems
The Results: It’s All About Me”

- Tool was developed and revised aimed at teen and family use.
- Follow AAP guidelines that state that preparation for transition to adult care starts at age 14.
- Can be customized by department or by the patients themselves.
- Consider patient’s condition and developmental abilities.
How Do We Get Started?

- Clinics will order All About Me notebooks from distribution
- Identify appropriate patients
- Ask youth/families about their needs, concerns and priorities
- Follow the recommended provider/patient interactions appropriate for age and abilities.
- Make sure that parents understand their ever shrinking part of their child’s care.
- Follow transition check list to make sure all aspects of transition are addressed
- Give patients all pertinent medical information
How to Introduce “All About Me”

• Tell the teen that “This is a tool to help you take charge of your own medical care”
  – Helps you to stay organized—medications, appointments, therapies
  – Keep track of your medical records
  – Helps you and your provider to stay on track
  – Not miss taking care of those things that are important to you

• Bring your book with you to all your appointments, and wherever you travel

• Share the letter written by one of our very own teens (found in the front of each book)

• Tell the parent that they need to support this process.
  – Make them step out of the room for part of each clinic visit.
What Happens When the Patient is Ready to Transfer Care?

- Provider should dictate a transfer summary for new provider. This also lets other departments know when transfer has occurred.
- Have new provider sent reply back when patient seen.
- Release Of Information Form now has a section to mark for Transfer of Care
  - Medical Records will generate packet of pertinent health information
Community Outreach

- Patients and families feel connected to CMHC for support as well as medical care.
- Variety of ways for them to connect with others in the community that are dealing with the same challenges.
- Getting patients involved in these outreach programs makes the prospect of leaving CMHC a little less overwhelming.
Compassion and Self-Care

Courage and Wisdom

Integrity and Boundaries

Organization

“Social workers often describe it as their Achilles’ heel: getting—and staying—organized. But in data-driven, do-it-now work environments, expert organizational skills can be instrumental to the success of the social worker, agency, and client alike” (Robb, 2004, p24).
While all 7 habits are imperative, organization is highlighted because we just reviewed several areas of practice and presented individual case examples.

In addition to assessing the needs of the individual and families we serve, we are also involved in doing ongoing assessments of the climate of our units, hospitals, etc. and meeting their needs. This requires even more organization!
AREA OF PRACTICE: Assessment

EXAMPLE:
Unit within a Hospital Setting
Systems Theory

“A system is an aggregate of interrelated and interconnected elements and activities that forms an identifiable whole. A system has a hierarchic, multilevel structure and displays a particular pattern of behavior. General systems theory seeks to describe the principles by which systems function, grow, develop and interact with other systems. These principles are used to predict the behavior of biological and social systems and to formulate strategies for changing a system. Systems theory has been attractive to social workers because it provides terminology and metaphors for describing client systems (e.g., individuals, families, organizations) and the process of change” (Sheafor, et al, 2000, p89).
Assessment

Things to keep in mind with regards to assessment:

• People and situations change.
• Change is difficult, not just for individuals and families, but also within our respective settings.
• It is imperative to continually assess over time and place.

Common changes within our respective settings:

• Change in management
• Staff turnover
• New policies and procedures, guidelines, etc
• New facilities
Assessment

When the new tower of the Children’s Hospital was built, the Dialysis Unit was moved from the third floor to the first floor. It now appears that staff feel isolated and detached from the other Units.

As the Social Worker on the Unit, what can you do to recognize/acknowledge the strengths of the individuals on the Unit? What can you do to inform others in the hospital about Unit accomplishments? What kind of support and resources do you have to work with within your setting?
TOOLS

• Appreciation Cards & Comment Box
• Unit/Clinic/Hospital Recognition Programs:
  – PRIDE Points
  – Courtesy Las Vegas
  – Friday Message
• ESRD Network 15 Newsletter

Children and their families are invited to complete an appreciation card or make comments/suggestions and place them in our comment box.

On a monthly basis, take appreciation cards and complete PRIDE Recognition forms for everyone who is acknowledged by photocopying the comments onto PRIDE Recognition forms (PRIDE Standards: Professional, Respectful, Innovative, Dedicated, Enthusiastic).
Recognition Forms are submitted to the Unit Manager, then staff members are presented with the Recognition Form and Pride Point, which may be redeemed for $1.00 off any item in the cafeteria or six Pride Points may redeemed for a movie ticket. This is usually done during staff meetings to balance task and relationship or after a difficult situation on the Unit.

If the appreciation card notes individual staff member’s names vs. “staff,” in addition to the Pride Recognition forms, a Courtesy Las Vegas form is completed and submitted to Human Resources. Recognition is given by The Las Vegas Chamber of Commerce.

A thoughtful comment from the parent of a patient was submitted to our CEO and was included in her Friday Message which is sent by e-mail hospital wide.

Articles about the Unit in the ESRD Network 15 Newsletter are forwarded to Unit Managers, Employee Health Nurse, and CEO, and Pride Recognition Forms are completed for all staff members.

Imperative not to reinvent the wheel and utilize existing programs within your setting.
AREAS OF PRACTICE: Education (Patient)

EXAMPLE: Bulletin Board
Patient Education

Earlier in this presentation Education was addressed with regards to the school setting.

Another form of education we as social workers provide is initial education about new diagnosis, modalities of dialysis, transplant, etc.

Another important part of our role and other members of the interdisciplinary team is the ongoing education we provide to our patients and their families……reinforcement.
You have reviewed educational information with children and their parents on numerous occasions. The same themes come up in your individual discussions and during interdisciplinary rounds.

What can you do to normalize patient education? How can you balance the task of ongoing education with building relationships between pediatric patients and staff?
TOOLS

Educational/Informational Resources:
• Starlight Starbright Children’s Foundation  “Living with Kidney Disease”
• National Kidney Foundation  “Hope Street”
• American Kidney Fund
• Kidney School
• Life Options
**Strengths Perspective**
This approach “presumes that all individuals and groups have overlooked untapped reserves of ability, energy, courage, knowledge, experience, fortitude, good will, integrity, and other assets. If these strengths are recognized and used in the helping process, they elevate the client’s motivation and the possibility for positive change” (Sheafor, et al, 2000, p93).

**Narrative Therapy**
“Rather than acquiring the facts about the client’s life (taking a psychosocial history), the therapist listens to the client’s stories” (Cooper, 2005, p163).
TOOLS, CONTINUED

• Strengths Perspective
• Narrative Therapy

A bulletin board was used to normalize the task of ongoing patient education by taking from various educational/informational resources and having a monthly theme “Heart Month, “Nutrition Month,” “Transplant,” etc. This task was balanced by having a “Spotlight of the Month.” Each month we drew the name of one patient and staff member and they each completed a brief questionnaire (What I want/wanted to be when I grow/grew up, Things I enjoy to do in my spare time, etc). Their picture was placed in a star frame on the board with their “Getting to Know You” information posted underneath. Sharing of stories helped build relationships between pediatric patients and staff, and also among staff on the Unit.
AREA OF PRACTICE: Education (Staff)

EXAMPLE: Decreasing Dialysis Patient-Provider Conflict (DPC)
"The social worker is frequently in the position of trying to help clients resolve conflicts (e.g. between parent and teenager, husband and wife, etc) and sometimes in the position of trying to help two professionals resolve their conflict. An important first step in helping others resolve a conflict is to realize that the dynamics of the conflict may be complex and that the conflict is often about issues that no one is mentioning.” (Sheafor, et al, 2000, p 475)

What can you do to support staff in recognizing the causes of conflict and how to effectively resolve conflict? What kind of support and resources do you have to work with within your setting?
TOOLS

• Decreasing Dialysis Patient – Provider Conflict Project (DPC)
  ▪ Create a Calm Environment
  ▪ Open Yourself to Understanding Others
  ▪ Need a Nonjudgmental Approach
  ▪ Focus on the Issue
  ▪ Look for Solutions
  ▪ Implement Agreement
  ▪ Continue to Communicate
  ▪ Take Another Look

• Nursing CEU’s

Met with Nurse Manager and Charge Nurse to obtain their support and develop a plan for implementation in the Unit. Completed and submitted a packet for Nursing CEU’s to the Education Department. Trainings were held first thing in the morning and nurses received 6 Nursing CEU’s upon completion of ALL 8 modules. Positive feedback received for all sessions!
DPC Goals:

• Safe Dialysis Facilities
• Increase awareness of conflict and improve skills to decrease conflict
• Improved Staff/ Patient relationships
• Create common language to describe conflict

www.esrdnetworks.org/dpcIntroductiontotheDPCProject.ppt
Why Is DPC Important?

• Foster an improved patient-staff working relationship
• Prevent escalation of conflict to maintain a safe workplace
• Provide you with skills to intervene successfully in a conflict
• Improve employee morale
• Increase employee and patient satisfaction with the dialysis experience

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TOOLBOX

- Quality of Life survey
- Assessments
- Home visits
- Counseling
- PHN
- 504 Accommodations
- CLS
- MedicAlert
- Make A Wish
- Camp
- Transition Panel
- Phos Bingo
- Transplant Jeopardy

- Monopoly game
- Ethics
- Palliative Care
- CPT
- Cultural competence
- Food, lodging, transportation
- Med/psych beds
- Dialysis bear/doll
- Independent living skills
- Medication cards
- Military resources
- School supports
• Time Management “working more efficiently and effectively”
• Applying for CEU’s (Social Work, Nursing)
• Unit/Clinic/Hospital Recognition Programs
• Unit/Clinic/Hospital Newsletters, Weekly E-mails
• AT&T Language Line
• Boundaries
• Balance between task (interventions) and relationship (trust & rapport)
• Medicare Rights Center
• Thinking “out of the box”
• EACH OTHER!

As social workers we tend to do things based on instinct/intuition, it’s important to be able to identify what we are doing on a professional level…
• Advocacy
• Strengths Perspective
• Resiliency
• Narrative Therapy
• Person Centered Therapy, Carl Rogers, “everyone has the ability to actualize their strengths”
• Solution Focused Therapy
• Cognitive Behavioral Therapy
• Recognizing readiness for change, as noted by Prochaska & DiClemente
"Successful is the person who has lived well, laughed often and loved much, who has gained the respect of children, who leaves the world better than they found it, who has never lacked appreciation for the earth’s beauty, who never fails to look for the best in others or give the best of themselves."
Citations

- CMS Proposed Conditions of Coverage
- Revised Code of WA
- www.esrdnetworks.org/dpcintroductiontotheDPCProject.ppt
Thank You!

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