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Treating the Patient and Their Families

For this special issue of ICU Management, Professor Saïd Hachimi-Idrissi, Head of the Paediatric Intensive Care Unit at the University Hospital of Brussels (UZ Brussels) took Managing Editor Sherry Scharff on a tour of the unit and sat down to talk about the challenges of managing paediatric patients, maintaining staff levels and avoiding burnout.

Could You Take Me Through a Standard Day?

I start at 8 am and go directly to the ICU, consulting in all the units, but mainly in the paediatric wing. As a professor, I generally teach in the afternoon and evening, some days until 10 pm. Most of the courses are in intensive care medicine, and paediatric critical care and emergency medicine.

We have five ICU departments; in each department, we have six beds. One of these units is dedicated to paediatrics; one for trauma, another for cardiac care; a separate unit for cardiac surgery and a general ICU. There is an additional ICU, which we call the haematological unit that is used for burns and transplantations. Within these units, the physicians move fluidly, supervising cases based on their specific areas of expertise. We have surgeons who come to work with us from across Belgium, and in trauma and cerebral resuscitation we are doing work, which is very well respected. Another area of strength within our units is our work with ventilation techniques. In fact we were the first to work with the NAVA system in children. In the future I hope we will expand and improve further in the areas of abdominal surgery and also orthopaedic surgery.

What are the Main Differences in Treating Critically Ill Children vs. Adults?

The approach in treating the same disease in a child is completely different than in an adult. From the very basics; that means communicating with children, withdrawing information from them... the approach must be different. Moreover, sometimes we are lucky that we have the additional information provided by the mother and father or family accompanying the child; but often this requires yet more effort on behalf of the physician, as we must approach the parents differently as well, often needing to ease anxieties in addition to retrieving information. True, we must reassure the kids, but reassure the adults that come with them as well. In fact, I would venture to say that 50 percent of the treatment that we provide in the paediatric ICU is directed at the family - from parents to grandparents, sometimes two sets even; one from each side of the family... We have to treat them all! Needless to say, it can get a bit crazy.

The second thing that is quite important for treating children, that means in contrast with adults- is that we often think they are more resilient than they indeed are. Frequently we are working with very little information about the condition from the children, and
we must rely primarily on observation. The symptoms for so many conditions are the same: fever, feeling of being unwell, vomiting, diarrhoea, etc., however, sometimes there are additional symptoms, but they are misunderstood by the physician and these can be fatal. So while children can be very strong and resilient, if we are not able to make the diagnosis very quickly and indeed very accurately, we can lose the kids in less than one hour. With children especially, we have to anticipate and prevent all the most common complications that may occur, and if those complications occur, we are behind and we might lose the patient. We must always be thinking in terms of preventative treatment; working three steps ahead.

Do You have to Deal with Cultural Differences in Treating Patients?

Brussels is a cosmopolitan city. There are different backgrounds, religions, colours, languages and so on. When I was a student, we had no training on how to manage patients from different cultures, but now we have training programmes and there are lessons in the first year of medicine.The root of this is the knowledge that communication is very important in medicine and sadly this is often where we fail. We have to make sure we are attempting to communicate, and have the best approach for each patient/family. The second part related to cultural

differences, is that we must be aware of the important cultural issues, so that we can take advantage of this knowledge, and offer the most suitable treatments and/or explain to patients the treatments in a way that helps them accept the course of action. For example, there is a predominant belief in most faiths that God will ultimately decide fate. My approach is often in the manner of “I am here, as a tool, with my treatments to help God” to cure their child. In most cases, the family can see and appreciate this way of thinking and accept the treatment; but we must respect the differing cultural feelings and approach them individually. We must use every tool at our disposal, integrate every member of the team in the process of treating our patients and families- and key to this is the nurses. Without them we can do nothing!

Staff.What are Your Greatest Challenges in Managing Staff?

In the paediatric unit, we are lacking nurses. We need more, but unfortunately finding nurses who are specialised in working in a paediatric ICU is difficult. Most nurses find it an emotionally draining and often frustrating area to work in.This can be due in part to the fact that many nurses are of the age where they themselves have young children, and they are mindful that they too could be treated in the ICU. Some nurses have an understandable problem coping with that. The other real concern with working in an emotional and stressful department such as the PICU, is that the average rate of burnout is six or seven years.

We try to target that threat of burnout by keeping staff informed, well-educated... we encourage empathy for the patients, dedication to helping them recover but also acknowledgement of the difficulties of their tasks. Keeping staff attuned to professional development is also key in keeping them committed to remaining in their roles, and maintaining respect for the work they do.

At the moment, we have the equivalent of 16 full time people working in the unit. Some of these are half time workers- so for one full time staff member, we may have two people working 50 percent of the hours. Of course, it is preferred that we have staff who are working at least 80 percent, and this works well for our nurses who are over 50 years old, and can take one or two days off additionally a month, to recuperate. We do this in order to keep them. In addition to the 16 full time staff, there is a resident and a physiotherapist as well as a part time psychologist and part time social nurse.

Do You Favour Long or Shorter Shifts in Your Unit?

We have three main shifts: before 7 am – 3pm;2pm–8pm;7pm–7am.

Of course, there is some overlap for handover between shifts, but it is always preferred that the shifts remain long (twelve hours) to keep consistent care in the unit. Unfortunately, this does not suit most nurses, who are usually of the age of having young children at home and keeping them from 8 am until 8 pm causes them a lot of frustration and subsequently, creates a problem in the ICU.

In terms of availability, we look to nurses in their 50’s and 60’s, who no longer have young children at home to work these twelve hour shifts... of course, many are not keen to work such long shifts for a number of years. As a manager, it is important that you respect the sacrifices that workers make in order to be dedicated to their position, and you try to provide a good example. Often, this means you must sacrifice your own “free time” for the greater good before you can ask others to do the same. I think all the staff are doing a very good job. Sure, we struggle with balancing everyone’s private issues with the needs of the department, but in the end, I think most people are happy and the unit runs efficiently and effectively as a result. What more can you ask for?

Did You Have Some Training in Management?

No, I rely on my own instincts when it comes to working with people. There are a number of managers working within the hospital these days—but how can I say this diplomatically? Forget diplomacy... Hospital managers are focused on results, as we are, of patients and staff. However, their focus is with regards to how many minutes we should spend with each patient, the cost of each treatment and the amount of time staff should have off in relation to how long they have worked.There is a real element of empathy missing here, which is crucial on both sides for an important department like an ICU to run smoothly.The ICU is not a factory: We do not produce X number of bottles of water, for example, per hour with Y number of workers for such a cost.There are too many outside variables. While it is true that medicine has a business aspect to it, i.e., we must be mindful of the costs of treatments, equipment and staff and indeed, make sure we have the funds to cover it all; we are not manufacturing a product, we are providing an important social service and have a public impact: Our mission is to care andcure.
This is considerably quit different from the owners, managers and workers of a manufacturing company.

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