Vision
To be a great children’s hospital

Values

Unity – we work together to achieve our goals
Passion – we are committed to improving children’s health and caring for sick children
Integrity – we act with honesty in all we do
Excellence – we seek unsurpassed quality in every aspect of our work
Respect – for everyone in our care and for each other
The Royal Children’s Hospital Melbourne is Victoria’s major paediatric hospital, a centre of clinical excellence specialising in neonatal, child and adolescent health. With our partners the University of Melbourne and the Murdoch Childrens Research Institute we are recognised internationally as a leading teaching and research centre.

In parkland beside the site we have occupied for almost 50 years, the new Royal Children’s Hospital is taking shape. This new $1 billion RCH will open its doors to Victoria’s children in 2011. The new hospital will combine world class facilities with the specialist skills and commitment of our dedicated staff.

Meanwhile the clinical work of our hospital continues around the clock, every day of the year. As staff handover to the next shift, patients are admitted and discharged, families visit and often stay, out-patients come and go and children arrive at emergency.

On one such day in August 2008 our photographers and a writer recorded 24 hours in the life of our hospital. A day like any other, filled with many ordinary moments, as well as many life saving, life changing moments for our patients and their families.

We invite you to share this day with us and reflect upon what makes Melbourne’s Royal Children’s Hospital great for children, their families, our staff and our friends. It is passion for children’s health that sets our hospital apart, it’s the strength and the courage of our patients and their families that give reason for that passion.

We thank our patients and their families for letting us share in their lives during that day in August. These are their stories.

Associate Professor Christine Kilpatrick
Chief Executive Officer

Tony Beddison AO
Chairman
12.01am – Emergency

The 20 cubicles in Emergency are full. It’s winter, so there are a couple of children with bronchiolitis. Another has chickenpox and needs isolating. An oncology patient has fractured her leg, there are some children who are vomiting and a newly diagnosed diabetic baby. It’s just another night in Emergency.

12.05am

In a dimly lit cubicle, 18-month-old Luca Vecchio is resting peacefully, his right arm connected to an intravenous drip. His mother, Oriana lies on the seat, trying to rest, while his father, Silvano, sits on a chair next to him, watching over his son. Luca has just been diagnosed with diabetic ketoacidosis. “He’s been sick for the past week,” Silvano says.

“He was drinking a lot, basically,” Oriana says, sitting up sleepily. “He was peeing a lot as well.”

Was the diagnosis a shock? “Well we had sort of an idea because my husband’s Type 1,” Oriana says. She had organised blood tests with her GP, but the results were not due for a few days. “This morning he was very lethargic and breathing quite heavily so we thought we better bring him in.

“Yes, it’s been a bit hard... a knock to the system,” Oriana says. “He’ll have to just pick up and cope with it.” Silvano, who was diagnosed two years ago at age 28, will be able to help, but it’s not the sort of father-son connection he was hoping for.

12.15am

Tonight’s hospital visit is a family affair for the Truong family. Two-month-old Donny is accompanied by his mother, his grandmother and his uncle. Donny is being treated for eczema. Dr Anna Peterson prescribes steroid cream and moisturisers to ease the pain and itching. While the diagnosis and treatment is simple, communication is not, so Donny’s uncle helps out, translating from Vietnamese to English. After the pain and itching has been relieved, Donny settles down happily at his mother’s breast. As soon as he is ready, he can go home. “It’s nowhere near as busy as last night,” Dr Peterson says.
12.20am

It’s been a big week for three-year-old Hayden Menzel. On Monday, he had a tonsillectomy, last night he had an early birthday party with his little sister, Sarah, and tonight he has had a ride in an ambulance, all the way from Bacchus Marsh. “He was bleeding from the mouth,” his mother, Amanda, says. She sits on the bed, with Hayden’s head in her lap, stroking his brow. The bleeding has stopped now and he will be monitored for the next 12 hours. His sister, Sarah, aged one, is spending tonight with her two grandmothers and her Pa back in Bacchus Marsh.

12.30am

A voice announces a ‘code grey’ – part of the hospital’s emergency planing to deal with aggressive behaviour. A security staff member walks purposefully towards a door, but otherwise, there is no sign of any disturbance. “It can happen anywhere,” a nurse says. The person is taken to a safe room, where a team of staff comes together to de-escalate the problem, she explains.

12.40am

Back in the waiting area Hipilito Acosta has turned himself into a human mattress for his son, Gabriel – lying flat on his back on a long seat in the waiting room, with Gabriel stretched out on top of him, half asleep. Gabriel, who is flushed and has one eye oozing pus, has also been vomiting and has a high fever. They have been waiting since 10.30 or so, Hipilito explains.

12.50am

Cruz Elson was suffering from apnoea, which means he was not breathing. His heart rate had dropped and was dangerously low. Nurse Cindy Sheers, says Cruz is now on a litre of oxygen. Although Cruz was born prematurely he is now at his full term.
There are no curtains separating the beds in PICU. It is not necessary as each patient is already separated – alone and unconscious in their own world, wires sprouting from their bodies like slender roots. In this extraordinary world, ordinary conversation about ordinary things seems strange. But after 16 years working in PICU, this is an ordinary night for Leanne Flack, associate nurse unit manager. Opposite her, a teenage boy sleeps, oblivious to the activity around him. “He’s been in a few times,” Leanne says. “He’s in line for a heart transplant.”

Is it difficult working here? “Yes and no,” she says. “Most of the time it’s positive, because with the majority of kids we work hard and they get better and improve their quality of life. Most of the time it’s got good outcomes. It’s great for the children and the families, and you’ve given them back their children, for whatever reason – whether they were born with an abnormality – whether they’ve been involved in an accident or whatever’s happened to them – you’ve given them back their child and that’s something they’ll treasure for the rest of their lives. “It’s not that often that you have a child that doesn’t survive, and obviously if a child doesn’t survive, then one needs to give them as peaceful a death as possible, which can have its satisfactions, too.”

Tonight has been reasonably busy, she says. Her shift started at 7pm and will go through to 7.30am. The inertia of the PICU patients provides a sharp contrast with life at home, where the exuberance of her 21-month-old son, Peter, awaits her.

1.17am

A team of doctors and nurses crowd around a bench – their tiny patient barely visible. Six-day-old Solomona is being intubated in preparation for surgery for hyperplastic left-heart syndrome (HLS), a congenital heart condition that was diagnosed antenatally. “A tube will be placed down the baby’s windpipe so that the lungs can be inflated to control the baby’s breathing,” Dr Timothy Thiruchelvam says. The team, consisting of nurse Nicole Marinner, and registrars Peta Alexander and Daniel Alexander, work intensely, but the atmosphere is not tense. “Hey, we’re trying to work here!” one of them reminds us, when the camera intrudes. In the cot opposite, his little body wired to a myriad of machines, sleeps another cardiology patient, Dylan, 2½ years old, oblivious to the activity and to the fact that he and Solomona will be on a similar journey for heart health.
Lisa is 15. She lies in PICU on an ECMO machine, in an induced coma. “She just collapsed,” her mother Kate says. “They had their Year 10 formal on Friday night, and she had a bit of a headache and she collapsed on Wednesday. I just got her to the Benalla hospital. They still don’t know why. They are still trying to work it out. It could be some sort of bug that’s got there and it’s hit hard.”

“The special ambulance came up to Wangaratta, because she went from Benalla to Wang, and they stabilised her and brought her up in the special ambulance. They’ve done open heart on her. That machine’s keeping her going – doing the work of her heart,” Kate says.

The machine is an extracorporeal membrane oxygenation (ECMO) machine, which provides both cardiac and respiratory support oxygen to patients whose heart and lungs can no longer perform their function.

Kate says they’ll keep Lisa on the machine until her heart gets strong. “But it’s very weak because she’s got pneumonia as well.”
2.00am – Laboratory

In the lab on the second floor, medical laboratory scientists, Pat De Marco and Ruth Roa are surprised by visitors. Their work usually involves dealing with machines and test tubes, not people. Ruth and Pat are on night shift, which means working from 10.45pm to 7.15am each day. They number the samples and test them. Tests are a vital part of diagnosis, often determining the next step in treatment. It’s quiet and exacting work — that usually doesn’t require them to be spruced up. “Can we put our lipstick on first?” they joke.

2.30am – Medical Imaging

“I’m the roving imaging person,” says Shane McRobb, technologist, sitting alone at his computer on the ground floor in Medical Imaging next to Emergency “I go upstairs for whatever they want.” Tonight, he has had about a dozen patients, including one-and-a-half year old Joshua, who is being X-rayed for a suspected fractured femur. Joshua looks like a little rag doll — soft and floppy — as his father holds him in place for the X-ray. He doesn’t cry. “His pain was being managed before he came here,” Shane explains. Working with children can be more difficult if they are distressed. “We try to explain what they need to do to help us,” he says. Tonight, Shane started work at 10pm and will finish at 8am. He works a night shift every couple of months. “It can be challenging. It depends a lot on how busy you are. Being here by myself is more responsibility,” he says.
Cruz Elson, 8 weeks, who arrived in Emergency earlier this evening after suffering apnoea due to severe bronchiolitis, is now sleeping peacefully. He’s in isolation in the Neonatal Unit on a ventilator to help him breathe. Bronchiolitis is spread easily so it’s important that infected children be isolated.

Some patients come with instructions – like Alice Jordan. “Dear Nurses,” a notice above her cot reads, “Because I’ve had many operations on my tummy, I get lots of wind pain. When I become unsettled can you please use nursing comfort measures, e.g. swaddling, sleeping me on my tummy, tactics like soothing and dummies.” Alice, who was born prematurely, has spent 185 days of her 194 days of life in the hospital. “She’s the elder statesman of the unit,” says Trudy Holton, associate unit manager.

Alice had inflammation of the bowel, which is prevalent in prems. “She’s had an awful lot of ops. She had a section of the bowel removed and a stoma inserted, then that was reversed.” Trudy says. Alice lies on her side swaddled in pink, one blue eye watching us curiously as Trudy talks. Callum nearby, is in blue. Is it deliberate? “Yes, we do try, but it doesn’t seem to help the doctors figure out what sex they are,” Trudy laughs.

Nearby a nurse takes a moment to sit down, watching her charges. It’s been a long night. A row of sombre teddies keeps a similar watch.

The sickest infants from Victoria, southern NSW and Tasmania are transferred to the RCH Neonatal Unit. Each year the unit cares for almost 800 babies with complex medical and surgical conditions. Some critically ill infants receive intensive care treatments with high frequency or jet ventilation which is only available at the RCH.
4.00am – 7 West Cardiac Renal Unit

Nurse Kartja Johansen talks softly to Luke as she places her hands through the round hole in the humidicrib, securing his nasal tube, before changing his nappy. Luke, who is 89 days old, complains loudly. “He doesn’t like anything – he just screams at me, don’t you?” Kartja chides gently. She tries to soothe him as she works. Luke had heart surgery three weeks ago. “When they’ve got heart problems it doesn’t help to let them cry too much,” Kartja explains.

A mother lies asleep, still fully dressed, on a stretcher beside her child’s cot. The evening quiet is broken only by beeping of machines and the soft murmur of nurses’ voices. Behind the nurses’ station, the bank of screens – green, blue, red and white on a black background – looks like air traffic control at Melbourne airport. The quiet belies what went before. “It’s been very, very busy tonight,” says Kartja looking up from her writing. She started at 8pm and will finish at 7.30am. In the room opposite, nurse Leitha Abrahams, sits cross legged on a bed, checking the contents of the resusc trolley. “It’s usually busier than this,” she says, confirming her colleagues’ view that this is a rare moment. Another nurse checks the fridge for the right bottle and prepares a feed.
On the 5th floor Medical Unit Nicole Russo stands out in her hot pink scrubs like a hot house flower in a desert landscape. “You can choose whichever colour you like,” she says, looking up and smiling.

Nicole is a graduate nurse on her first bout of night duty for a while. “It’s been busy, but it’s been good. It’s always fun,” she says, quietly cradling a baby who had been admitted for failure to thrive and vomiting. “I’ve always wanted to be a paediatric nurse, since Year 10 when I did work experience here,” Nicole says. Why here? “Because it is a great hospital. I’m interested in children and helping families.”

The greatest reward is “just seeing kids that you looked after, especially the babies”. When you see them at six months, they look huge with big heads, she laughs.

Tonight there are “a couple of sickies that need to be specialised (one-on one nursing)”. “When that happens, everyone else gets spread out. We have two parents staying, too.” Tonight, there is a child with cystic fibrosis, one with cerebral palsy and a few with bronchial disorders and pneumonia. “We get children from two weeks to aged 13,” Nicole says. Occasionally there will be a 15 or 16-year-old, but Nicole prefers babies, “They don’t say no,” she laughs.

5.15am

It’s a long night for Mohammed, as he watches over his son, Meyra, 20 months who is asleep in his cot. Meyra has been here for 24 hours, being treated for pneumonia, which he has had several times. Mohammed, who came to Australia from Ethiopia four years ago, now lives in Collingwood. “It’s a good opportunity to be here for our son,” he says quietly. “Otherwise he would not survive. When he was born, he can’t even breathe.”

Liver transplants, bronchiolitis, eczema, croup... these are just some of the conditions cared for by the staff on the 5th floor Medical Unit. Some patients stay a day or two, but many are long term or frequent visitors so the ward is as familiar as home for many children and their families. The Medical Unit is also a stepping stone from hospital to home for children requiring long term ventilation. The staff provides an education program for parents and carers ensuring a smooth transition to home after many months in PICU.
5.30am – Behind the Scenes

The eerie quiet of the corridors is gradually broken by the sound of laundry trolleys rolling on the lino, of buckets clanging and cleaners calling out to each other. The sound jars as the silence of the evening is broken. Linen must be collected and washed, floors must be cleaned and meals must be cooked. The army of people responsible form part of the hospital landscape, but are rarely in the foreground.

7.00am – Kitchen

It’s breakfast time soon, “Not a lot of children have a hot breakfast,” Jo Pyle, food services supervisor, says. “Mostly, it’s cereal and toast”.

This morning there are about 30 hot breakfasts. “Last night we had 69 hot dishes, and 120 for dinner.” Jo says. Thirty nine kids had spaghetti bolognese, and 69 had roast lamb, the two favourites.” Most of the food is cooked freshly. Mylan Trung is preparing the food trays. The kitchen also caters for halal diets and kosher diets. “We try to cater for them all, we are not an a la carte restaurant – but we try.

“Some have a very strict metabolic diet. Anything with protein has to be weighed and measured.” Children who have had transplants must have a “clean” diet, with food less than an hour old.

Then there are children whose diet must be gluten free, dairy free or nut free. What’s left to eat? “Thank goodness for tomato” Jo laughs. “And pears. Most kids can eat pears.”

The food is transferred via a trolley by the patient services assistant from each ward. Underneath the trolley is a door, where food can be kept cold or can stay hot for up to two hours.
Junior residents Alice Baker and John Swan, registrars Tom Treseder and Guan Tay and Fellow Ben Shore have completed bedside visits on the Orthopaedic Unit and are now developing plans for ongoing treatment or discharges. Daily ward rounds are an opportunity for junior doctors to learn from the senior medical staff.

RCH is a major teaching and learning hospital, partnering with the University of Melbourne Department of Paediatrics based at the RCH. Every interaction between junior and senior medical staff is an opportunity to learn and an opportunity to teach. Patient focussed medical knowledge, as well as critical thinking, evidence based medicine and the importance of leadership and advocacy are core principles that develop in a ‘university hospital’ and are being taught on a daily basis on the RCH campus.

In addition, through hospital departments, and the University of Melbourne Department of Paediatrics there are multiple other opportunities each week for the junior doctors to learn formally and informally. This is part of the reason why the on site university presence is so critical to the development of our future workforce and part of being a great children’s hospital.
8.00am – 4 North Orthopaedic Unit

Oscar stares into space, ignoring questions. In fact, most of the children in the Orthopaedic Unit seem to be suffering the same symptom. The diagnosis: cartoon time on TV. Watching telly seems to be the best way of waiting for breakfast. Oscar has been admitted for osteomyelitis, a bone infection caused by bacteria. Previously he had been treated at home, as part of the Hospital in the Home program. A nurse came daily to check the intravenous drip which was delivering antibiotics to his body. But this morning his temperature was up, so he was readmitted.

8.00am – 4 North Orthopaedic Unit

8.15am

A teddy wearing a Yamaha shirt sits to the left of Emma Milesevic’s bed, a gift from the manager of Yamaha bikes. Yamaha is the preferred choice of Emma, 10, who recently came fifth in the Victorian motocross championships. “She rides a Y285,” her mother, Doris, says. “It’s kind of in the blood,” she explains. Emma’s father, sister and brothers all race.

Emma fractured her femur in the right leg during a recent training session. “We don’t actually know how it happened,” Doris says.

It’s not the first injury. “But this has been the worst one,” Doris says. “In another five days, they’ll put a plate in her leg.”

“They are fabulous here,” Doris says. “She’s doing very well.”

But it will be possibly two years before the leg fully heals, she says, which means racing is out. “I think that’s the hardest part. It’s such a big part of her life.”

8.30am

Ben is eating cereal – nothing new in that, as it’s breakfast time. Except he’s lying down, which makes it difficult. Ben’s right leg is heavily strapped and bandaged, with just his toes protruding. “He has one leg shorter than the other,” his father, Jason, explains. “They split the bone to lengthen it.”

Ben has been in for five days so far and is bearing up well. “The pain’s pretty good now,” Jason says. “I get a lot of pins and needles,” Ben explains. “I don’t get comfortable.”

“He used to walk and run on his toes,” Jason says. “It hasn’t really affected him, but it will.” That’s why it’s being addressed now.
8.45am
Brooke’s main problem today is itchiness. The cast on her left leg, with its hot pink bandage, is irritating. “They took part of my hip and put it in my leg to straighten up my leg,” she explains. “It used to always turn in.”

Brooke has had single event multi-level surgery, which means lots of surgeries all at the one time. Today, she is going home. “The ambulance is coming,” she says. What is she most looking forward to about going home? “Being able to walk straight, hop on my left leg and jump a bit better.”

The staff have been “very friendly and nice” during her long stay. But there’s one thing she’ll miss when she leaves – “the bed, because it goes up and down!”

8.50am
Assessing pain for adults is easy. You ask them. But for kids, you need multiple assessment tools, depending on their speech development, says Beth Sadler, clinical nurse consultant for the children’s pain management service. “And I know it sounds funny, but it’s experience,” she says. “In babies for example, the pitch of the cry is important.”

You can also tell the level of pain if they are comforted by breastfeeding or cuddles she says. “Babies feel pain as much as you and I would.”

But it’s not just babies that the pain management service helps. “We see kids from day one of life up to adolescents,” she says.

On her team are three nurse consultants and two consulting anaesthetists who are pain specialists, as well as a pain fellow – a doctor in the final year of training. Working at a children’s hospital is different, because you are also dealing with parents as well, Beth says. The team does two rounds a day, speaking to parents and patients in assessing the pain. “A lot of our work is with orthopaedic patients. Bone surgery is very painful.”
9.00am – Front Entry

The volunteers for the various hospital auxiliaries are setting out their wares – brightly coloured totes and teddies. Weary parents and children, some pushing prams and carrying bags with supplies from home, are heading for coffee in one of the hospital cafes. Hospital day shift staff are trickling in, looking fresh and ready for the day.
10.00am – 3D Imaging

In 3D imaging, medical photographer Lloyd Ellis greets Amanda Sellers and her daughter, Kyra Boon. Kyra is being monitored for plagiocephaly, or in lay terms ‘flat head syndrome’.

This is Kyra’s second visit. The first was three months ago. “I noticed she had a flat head when she was about six months old,” Amanda says. “She used to sleep on her back and turn her head to the right. Amanda admits to being quite depressed about it. "I went through a stage when I felt like I’d let her down," she says.

"Can I put this on your head?" he asks Kyra, holding up a white stocking. Kyra is amenable. He stretches the stocking over her hair, makes a topknot with the remainder and cuts it off. “It creates a smooth surface for the infrared light source," he explains.

Kyra is placed on a stool centrally located between five cameras, four at each corner and one above. Lloyd calls her name and smiles to get her to look in the right direction. She obliges happily. The images are then examined on the computer, to compare them against those taken at the previous visit, ready to be examined by her doctor.

Amanda is feeling relaxed about the process. “It’s good this time. The first time my father in law came in to support me but in the end it wasn’t necessary as I felt much better when I saw the doctor.”

The RCH medical photographers provide photography services for medical records, diagnosis, research and teaching purposes. The state-of-the-art 3D Imaging Centre was established to assist the Plastic and Maxillofacial Unit monitor and assess craniofacial surgical treatments. Clinicians are able to analyse and calculate measurements, assisting with pre-operative diagnosis, planning treatments and post-operative outcomes.

10.30am – Physiotherapy

This year, Priscilla Mallis hasn’t been to school at all. “This year, we’ve been in too many days because she’s been too sick,” says her mother, Angela. Priscilla, 14, suffers from cystic fibrosis. “I’ve been in nearly every school holidays,” she says despondently. Priscilla has physiotherapy and antibiotics while she’s in hospital. “It gets boring,” she says. Sometimes her three older brothers visit. “They are nicer when they come in here,” she observes. “We try to treat you normally at home," her mother says. Priscilla has her favourite bed in the Adolescent Unit – near the door, which gives her a good view of what’s going on. When it was taken, she had to take another bed. But the minute it became available she said to her mother “Pack up my stuff, I’m moving.”

Cystic fibrosis (CF) is the most common lethal inherited condition in the western world and remains incurable and life limiting. CF primarily affects the lungs, pancreas, liver, reproductive organs and sweat glands. The management of CF at home involves a high level of commitment from families with the need for daily chest physiotherapy, oral antibiotics, a high fat diet, enzymes, salt tablets and nebulizer treatments. It is impossible to predict the outcome for any individual with CF but over the last few decades the outlook has improved significantly.
Jasmine Fish is 11-and-a half years old and like most girls her age, her favourite colour is pink – as shown by her pink top and the pink bag hanging off her wheelchair. “I gave her the choice and that’s what she chose,” her mother, Judy, says.

Jasmine, who is the youngest of eight – three of whom are disabled – was adopted by Judy as a baby. “I guess I was just a sucker for a pretty face,” laughs Judy, as Jasmine grins back.

Jasmine suffers from multiple disabilities, including quadriplegic cerebral palsy, and attends multiple clinics at the hospital. Today, she is seeing Dr Guiliana Antolovich in the Developmental Medicine.

Jasmine also has complex movement disabilities, including spasticity and dystonia, resulting in rigid curled fists and uncontrolled spasms. This has a big impact on the quality of her life and her ability to function, Dr Antolovich, explains.

She and Judy are discussing the intrathecal baclofen drug therapy, which aims to help relax Jasmine’s limbs and improve function. Jasmine and Judy travel from Tasmania every three months to have the drug topped up.

The baclofen is administered by a chamber roughly the size of a builder’s tape measure, which is implanted under Jasmine’s skin in her abdomen. The drug is fed via a catheter, also implanted under the skin, which goes directly into her spine. “If not for the therapy, her arm would be continually spasming and moving,” Dr Antolovich says.

Although there has been no improvement since the last assessment, with Jasmine’s level of disability, deterioration is usually ongoing, so maintaining the same level of function is still a plus, explains Dr Antolovich. “The aim is to try to maintain a good quality of life that is pain free and to help her participate as much as she can.”

For people like Jasmine, inclusion begins with acceptance, she says. “Jasmine is never going to be able to solve a complex maths problem, but everyone knows her in the Starlight Room in the hospital.” Jasmine also has a “wicked sense of humour,” she says – especially if the joke is at Dr Antolovich’s expense.

“Part of our job is understanding the goal. I suppose my job is to never put a limit on what a child can do.”

Part of Judy’s job is to push for as much improvement as possible, she tells us later, when Judy and Jasmine have left to see the surgeon. “Jasmine is as good as she is because Judy is an extraordinary woman.”

Approximately 7.6% of Australian children in the 0–14 age group have a disability, including intellectual disability, cerebral palsy, spina bifida, severe visual impairment, hearing impairment, autism spectrum disorders and acquired cerebral insults. Cerebral palsy is the most common cause of physical disability in childhood, with about 130 new infants born with cerebral palsy in Victoria each year. ‘Solve! At the RCH’ was established in 2006 to conduct research into the causes of childhood disabilities and improve the outcomes for these children.
Nine year old Tyler Woodward, has dialysis three days a week. Both his kidneys were “faulty”, his mother, Sharon Manson, who sits next to him, says. “He had a transplant in 2002. That worked for five years. They removed one diseased kidney the year of the transplant, and removed the other in March, because it was causing problems.” Tyler comes in for dialysis on Monday, Wednesday and Friday and attends school on Tuesday and Thursday “And we have work we bring in that he does from here,” Sharon says. Tyler reads clearly and fluently from his book for us. With three siblings at home, Matthew 12, his twin sister Holly, and Bella aged six, it’s a bit of a break for him. “He loves it. He was moving in a few weeks ago,” Sharon says. “He had all his bags packed.”

Zavier Mancer, 17, from Shepparton, freckle faced and dressed in a hoodie and track pants, lies on the red recliner, attached to a dialysis machine, checking his mobile and half-heartedly watching telly. Zavier uses the dialysis machines at the hospital whenever he’s in Melbourne. It’s not painful – just boring. “I text my friends”, he says. His twin brother, Kyellan is with him today. He’s used to waiting. At least when they are in Melbourne they can go to the footy. They support Richmond and have already seen quite a few games this year.

Patients with chronic medical conditions regularly visit the Ambulatory Care Centre for treatment. The nursing staff are responsible for ongoing management of conditions such as haemoglobin and blood disorders, bone and joint disorders, gastroenterological disorders, immune deficiencies and children requiring long term haemodialysis.
Speech therapist Rachel Pinczower is preparing to have lunch with Yuli – Coco Pops, tomato sauce, strawberry jam and chocolate yoghurt. It may not be everyone’s taste but Yuli is looking forward to it. “It’s dinner time,” she says. “My Rachel is coming.” Yuli, aged three, was born with a condition called intestinal pseudo-obstruction, which makes swallowing and eating difficult. A slight bulge under her pink fairy costume is the only sign that she is being fed intravenously. For now she is trying to progress to oral feeding.

Swallowing and feeding therapy is another form of speech therapy, which is why Rachel is helping. Coco Pops are small and dissolve quite easily, Rachel explains. The sauces and jams are there to encourage Yuli to taste different foods.

“Lately she has been upset when I try to take the food away, which is great.” Yuli is placed in a high chair, with Rachel sitting facing her.

“Want a pop?” asks Rachel. “Yes,” says Yuli, so Rachel empties a few Cocoa Pops into Yuli’s bowl. Yuli places one her mouth, but it drops out.

“Catch it, catch it! You have to catch it!” says Rachel as the elusive Coco Pop sticks to Yuli’s cheek, just out of reach of her tongue. “Can you show me? Is it gone? Well done!” says Rachel, smiling triumphantly when the Coco Pop is caught and swallowed.

Yuli’s mother Linda watches nearby. “Yuli wasn’t eating anything. She was quite anxious about food, not tolerating it, as when she did it came right up,” she says.

“Now she’ll come home and she’ll try things but they’ll be things like rice bubbles that dissolve and are not hard on the throat to swallow.”

“Can I have another one?” asks Rachel, picking up a Coco Pop. “They are very yummy.” Yuli graciously grants her request. Although she has never eaten a full meal, she knows all about chocolate. “The first thing she ate was a Malteser,” Linda says. She licked all the chocolate off and it melted. We were all very shocked.”

Speech Pathology is part of the Allied Health group of services at the RCH. Speech pathologists work with infants, children and adolescents who have problems with fluency (stuttering), language, speech, swallowing, and voice. Physiotherapists, occupational therapists, educational play therapists, audiologists, orthotists, medical photographers, social workers and dietitians are members of other Allied Health teams who provide a vital clinical service alongside medical and nursing staff.
Up in theatre, they are waiting for William, 13. William was brought in five weeks ago, suffering severe burns to the back of his legs, arms and hands. This will be his sixth operation – a bandage change and any further skin grafts that may be required. William’s mother, Tammy and grandmother, Glenys, accompany him as his bed is wheeled into the waiting area “He’s been very brave”, his mother says. William is unfazed about the operation. “It’s actually exciting because every surgery gets me closer to going home,” he says.

William is taken to an anteroom next to the theatre where the anaesthetist prepares him for the operation. Inside the theatre, there is quite a crowd – apart from the theatre staff, there is an undergraduate doctor who is observing, and two physiotherapists who are conducting an assessment. “It’s important for us to know what we should be doing in terms of position and movement,” physiotherapist Lisa Williams says. “It’s just easier, as usually he’s always wrapped up in the wards”.

William, now asleep, is wheeled in and transferred from the bed to the operating table, which is longer and narrower to allow greater access. Theatre is a noisy place. People talk, someone whistles, machines beep, dressings are torn open, instruments arranged, instructions given.

The burn at the back of his right leg needs a further graft. Dr Tom Clarnette, paediatric surgeon specialising in burns, shaves a papery layer of skin from the top of William’s thigh and places on a sterile gauze strip where a nurse stretches it to the width of the wound. The skin is then handed back to Dr Clarnette, who places it carefully over the wound and staples it in place, like a piece of patchwork on a quilt. In seven days, the dressings will be removed and the skin will be examined to see if it has taken, says nurse Kate Tupper. “The objective of burns treatment is to get the area covered to prevent infection.”

William has made good progress during his stay at the RCH. “He will fully recover but he will be scarred for life,” his mother says. He has also been working with Pippa from the RCH Education Institute and working with his teachers at St Bedes who are working out a transitional program from year eight to nine, so he won’t have to repeat.
The eighteen nurses in the Mackinnon Collaborative Practice Centre (MCPC) classroom are having fun. They’ve been in the one-day interactive workshop since this morning, it’s now the afternoon and they’re into the interactive ‘game show’ session. A box of chocolates is the prize for the winning team so the competition is hot.

The ‘recognition of serious illness in childhood’ workshop will assist them to identify the markers of serious illness in infants, children and adolescents. The participants have completed all the pre-readings, and the workshop will help them consolidate and apply the knowledge they’ve gained.

During the workshop they’ll look at the differences in the anatomy of adults and children and learn about recognising and managing serious illness in children. Finally, they’ll work through a range of video clips of unwell children, utilizing a primary/secondary survey method of assessment. The workshop is open to nurses from the RCH as well as those from regional and metropolitan centres.

The RCH encourages and supports nurses wishing to further their career with post graduate studies. The RCH partners with the University of Melbourne, and much of the coursework is delivered on site. In addition to this there are numerous short courses in various specialties and many nurses pursue other qualifications while gaining their clinical experience at the RCH.

Six month old April McWilliam is here for her follow up examination but right now all she wants is to get her hands on Associate Professor Mimi Tang’s stethoscope. Assoc Prof Tang, director of Allergy and Immunology is happy to indulge her while she confers with MCRI research nurse Christine Axelrad. April is involved in a research project looking at a new approach to prevention of eczema and allergic disease. The study is a joint initiative between the RCH and the Murdoch Childrens Research Institute.

“The allergic disorders which include eczema, asthma and food allergy are the predominant chronic diseases of childhood in Australia,” Assoc Prof Tang says. “Allergic disorders have more than doubled in the last 30 years. Eczema has a major impact on quality of life equivalent to that of diabetes. There is also a strong association with food allergy and asthma, making the prevention of this allergic disease a priority.”
3.00pm – Immigration Clinic

The immigration clinic looks more like an international airport than a hospital clinic, a kaleidoscope of cultures as families of different nationalities fill the room. Here, families for whom English is not their first language, can get help understanding hospital procedures and treatments and how to access other services. Georgie Paxton, who runs the clinic, is tall and commanding, and anxious not to upset her clients with our request to speak to them. We wait. After a while we are invited into Georgie’s room, where Sudanese interpreter, Gai Daniel, is speaking to a father of five children, here to catch up on immunisations and attend to some acute health problems. While the individual problems aren’t complicated, the management of all five children and the fact that the father does not speak English creates a challenge, Georgie says. The children’s father, with two of the five children sitting on his knee, listens patiently to our request. He likes the idea of a report that documents a day in the life of the hospital, the interpreter says. Yes, we can take a photo.
Since Victorian Premier John Brumby, Minister for Health Daniel Andrews and RCH Chairman Tony Beddison turned the first sod on the new RCH site in 2007 everyone has watched in amazement as the new hospital has grown. The new $1billion ‘hospital in the park’ will make use of the green healing environment of the surrounding parkland. The RCH philosophy of child focused family centred care is at the core of the design. 85% of the inpatient rooms will be single rooms providing privacy and rest for patients and families and improved infection control. The new RCH will provide an environment worthy of the world class clinical care, research and teaching that already exists on this site. The new hospital will open in 2011.

Alex Campbell and Paul Longridge from the new RCH project team and director of nursing Jenni Jarvis are checking out the mock-up rooms. In this first stage they’re looking at the placement of the windows in the inpatient and critical care rooms. They want to be sure they provide the best line of sight for safe patient care but also provide appropriate privacy for patients. Today’s visit identified some problems so the windows will be modified and checked again.

Later there’ll be a full mock-up where staff can comment on the placement of doors and fittings such as lights and medical equipment. Patient and family representatives will also be invited to see the rooms to be sure the proposed design is “fit for intended purposes”.

3.30pm – New Hospital
In a isolation room, on the 5th floor Medical Unit, Associate Professor Winita Hardikar, head of hepatology, is completing her ward rounds with her team – checking the patients’ charts, temperature and blood tests and examining them to determine the next step.

This is not new for 16-month-old Meg and her mother Sophia. After six months in hospital being treated for liver disease, little Meg knows the routine. She writhes and cries when Dr Hardikar lifts her shirt to place the stethoscope on her chest – a tiny stethoscope to match a tiny chest. Dr Hardikar talks to her softly, but Meg’s little tummy is distended and obviously uncomfortable and her skin is yellow. “She hates all the poking and prodding,” Sophia says, repositioning and reassuring her. “She knows when the tourniquet goes on it means blood.

“She used to cry when the nurses and doctors came in the room, but she’s got a bit better now,” Sophia says. “All the nurses are very good with her. They know her pretty well.”

Liver transplantation is a now a successful life giving procedure for children with liver disease. Most of the children have conditions that they were born with, and so they have never experienced a normal life. “It is a real joy to see them spring back to life once they have had their transplant,” said Associate Professor Winita Hardikar. “Unfortunately our waiting list is getting longer and the children on it are therefore getting sicker while they wait. This puts parents under an enormous amount of stress and sometimes families break down under the pressure.

“If we want the best outcome we really need to transplant much earlier. Sadly we cannot do this because of a lack of organ donors.”
We met Alice in the early hours of the morning: she’s awake now and mum is with her. Alice was born at just 27 weeks and suffered necrotising enterocolitis (NEC) and bowel problems. Now, at five months, she weighs three kilos. “Two weeks ago, she had bowel surgery,” her mother Sandy, says. “They are all saying it’s the last of it.” Sandy hopes so, as they are ready to go home to their farm in Ballarat now.

“It’s been difficult, but ultimately the hospital’s saved her life, really, so I’m very grateful,” she says. “But it’s been a very difficult road. She’s had a lot of operations.”

Necrotising enterocolitis or NEC, is the most common life threatening condition of the intestine in newborns. It occurs in up to 5% of infants who are born prematurely, but can also affect infants who are born at term. Each year the RCH sees approximately 50 severely affected infants needing surgical or intensive medical management. Left untreated this condition can result in death or in serious long term problems. NEC is initially treated by withholding feeds and treating infants with intravenous nutrition and antibiotics. The exact cause of NEC remains unknown.
Stroke is among the top ten causes of death in newborns and children. Fifty new cases of stroke present at the RCH each year. Globally, only two other hospitals see more children with stroke than RCH. Early recognition of stroke results in better outcomes. At least 50% of stroke survivors are left with significant disabilities and 20–40% of children have recurrent strokes.

Children with stroke can live with the outcome for 70 years so the impact of disability is more significant in children. Children do not have the same risk factors as adults – smoking, stress, high-blood pressure – therefore results of research in adults are less relevant. The RCH Stroke Program focuses on clinical care, research into the cause of stroke and support for parents.
Day oncology has turned into night oncology for Mitchell Williams, who is the lone patient in the department, sitting in his cot connected to a drip. The red recliners at the other end of the room with the chemo machines are all empty, and a nurse is packing up the toy box, but Mitchell and his mother Janelle and father Troy, are waiting for his treatment to finish. “This is long day. It’s usually shorter than this,” Janelle says.

“We’re waiting for the fluid to go through his body,” Troy explains.

Mitchell suffers from acute lymphoblastic leukaemia (ALL). “He has fluid before this, then goes on chemo for an hour, then has five hours of fluid. They’ve got to make sure he can wee okay,” Mitchell usually has a block of chemo for 50 days, Troy says.

“He’s doing very well,” Janelle says. “This is his last block of treatment and then he can go on the maintenance.” It made the recent celebration of his first birthday all the more joyous. “We lived across the road at Ronald McDonald House for five months,” Janelle says. Now things are looking up, life is becoming more normal. “I’m just going back to work. I had about two months off,” says Troy.

Acute lymphoblastic leukaemia (ALL) is the most common form of childhood cancer and is curable in 75-80% of children. The cause of the disease is unknown. It is one of a number of childhood cancers we treat at the RCH. Chemotherapy is the primary type of treatment for ALL and continues for just over two years for girls and three years for boys. During treatment children are encouraged to attend school and participate as much as possible in normal activities. Children with ALL may be invited to participate in clinical research trials. Some of these are randomised clinical trials where two or more different treatments are compared. Clinicians and researchers from the RCH and Murdoch Children's Research Institute work in partnership in the Children's Cancer Centre laboratories.
Sometimes, it’s hard to wait for visitors. That’s why Olivia Wilson is sticking her head out of her room. Are they there yet? Her mother, Christina, explains that Olivia was diagnosed with ALL earlier this year. She’s had a chest infection, but is in remission at the moment. Now, Olivia and her sister, Sonya, 5, are waiting for their aunties and grandma from Geelong. Suddenly, they arrive, and it’s warm smiles and hugs and kisses. It could be any family gathering, anywhere.

8.30pm

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8.45pm

In oncology, 20-month-old Chad Huggins, is sitting in his cot wearing a saucy smile – spaghetti sauce that is – as he digs into a bowl with a spoon. But the smile vanishes when he sees us and drops his head shyly – pale and bald except for a few stray hairs. “He normally flirts with all the girls,” his mother, Megan, says, trying to coax him up. A few moments later, hunger wins and he goes back to his bowl. “This is my dinner actually,” Megan says in mock outrage.

Chad has acute myloid leukaemia, a type of cancer that affects the blood and bone marrow. “He has had four rounds of chemo,” Megan says, “And he’ll have five then a bone marrow transplant. We haven’t got a donor yet.” None of the family is compatible.

“We all had a blood test, including Darby, (Chad’s brother), Darby turned six yesterday. But birthdays are different now, “He knows Chad’s sick but he doesn’t really understand how bad. He’s got used to the hospital life,” Megan says. “He never knows who’s going to pick him up from school.”

For Chad, “it’s just day to day,” she says. “It’s been pretty tough. It’s tough on the family. He was so sick.”

We say goodbye and good luck, but 10 minutes later, Megan comes down the corridor looking for us. “Could you take a photo of Chad in the bath?” she asks shyly. I thought he looks so cute.”
Seventeen-year-old Annie sits on the bed in the Adolescent Unit. Her mother Fran, seated on a chair to her left. Behind her, are the smiling faces of her friends at Melbourne Girls College in a photo collage — glamorous in their evening dresses and make up at the school formal — reminder of what she is missing out on.

Annie has been coming to the RCH for five years for an eating disorder. It’s been a long hard journey, she says. “In the first year, I was in for eight weeks. Every year I’ve had an admission.”

This time, she is hoping to break the flow. “As much as I hate being in here, they are good,” she says.

Her mother, Fran, says “It’s good now. When you first come in, you don’t know. There’s been a lot of tears and anger.”

Annie says her friends sometimes visit. “They’re not meant to, but they do,” she grins. Why not? “It’s part of the protocol. They think you do it for attention, but that isn’t the case for me. I chose to come in this time.”

The choice means other compromises — like having to do a Year 12 English SAC in the hospital earlier today. “It wasn’t too hard”, she says. “I was ready,” The teachers come in and help, along with the hospital’s Education Institute. The extra time she has had in hospital has put her ahead. She studies in bed, using her ipod to block out the noise of the ward, although she says she can go to another room if she wants.

Annie wants to do “something to do with science”. But for now, her focus is on getting well. Her advice to other teenagers who might have similar problems is “accept that there is something wrong”. “The hardest thing is to tell someone, and then they can take control. You need to find a psychologist that you really click with and that you can talk to.”

For now she is most looking forward to “being able to do what I want to do”. But the ultimate freedom will come when she turns 18 in October. “I’m going to get a car,” she says excitedly.

Elsewhere in the unit nurses and parents join the patients for a late night game of Uno. Young people still stay up late and wake late, even when they’re in hospital.
10.00pm – Short Stay Unit

Tyler Turpin, 3, sits up in bed, naked except for a nappy. His right hand bandaged and attached to a drip, after being diagnosed with cellulitis, a skin infection. “His hand is a lot better, but he has a fever and they can’t get it down,” his mother, Linda says. He visits the hospital every three months for treatment for eczema but he has never had anything like this, she explains.
Every cubicle in emergency is full and the queue is growing. Some are referred to the GP clinic located nearby in the hospital.

The low buzz of conversation is silenced by an announcement. Eight children have been diagnosed as requiring urgent treatment, but for the others the wait will be about five hours, the voice apologises. It is greeted by quiet acceptance.

“A few hours ago they announced it was a six hour wait but nobody left,” says Heather Morrison who is dealing with a request from another hospital to send a patient here.

Heather is handing over to Branka; they’re sitting in front of the computer in the coordinator’s office discussing patient roster details and staffing – “and anything that is going to set the bells off”. As usual, there are staffing shortages and a full theatre list scheduled for the next day. “There are a lot of sick, long-term patients in the hospital,” says Branka. “They are going to be busy tonight.”

The after hours coordinator is also responsible for all other emergencies. “One night I came in and Heather was in the car park standing in water. There was a burst pipe,” she says.

“That’s why we are in the job we are in, because we would hate to have two days that were exactly the same,” jokes Heather.

Branka and Heather are not only colleagues but good friends. Both trained at the RCH. “I’ve been here since 1981,” Heather says. “I always wanted to work at the children’s hospital. I did six months at an adults’ hospital and realised paediatrics was where I wanted to be.”

Paediatrics is completely different, she says. “If a child whinges they whinge for a reason.”

“Is it for Meg?” we ask. A few glances are darted around. They are not supposed to say – but yes. Meg has waited six months. They all hope it will work out for her.

Meanwhile, the wait continues in the emergency department as the queue grows – among them a teenager who has facial injuries from a skiing accident and a baby is suffering seizures.

Soon it will be midnight again… the 24th hour. Our day is over. But for many like Branka it is just beginning.
On this day:

4 children were seen in the continence clinic
4 plasters were applied by the plaster technician
4 patients went to the chronic fatigue clinic
5 children attended the diabetes allied health clinic
6 children were visited at home by the Community Asthma Program
6 children went to immunology
7 children were cared for by the Accelerated Care in Emergency program
11 recovery nurses cared for children after surgery
12 children attended play groups at Uncle Bobs Development Centre
13 had burns attended to
17 fractures were checked
18 children had speech pathology appointments
18 children cared for by hospital in the home
19 children had dialysis or drug or blood infusions in the Ambulatory Care Centre
19 children received post acute care at home
25 children attended the deformational plagiocephaly clinic
25 children came to developmental medicine
27 children went to infectious diseases
28 nurses were in the operating theatre
28 volunteers gave their time to help the hospital
29 children enjoyed music therapy
29 units of blood products were issued by laboratory services
30 children went to ENT
30 families visited the immigrant health clinic
30 children went to dermatology
35 patients attended the eczema clinic
36 went to the cancer centre
40 children visited physiotherapy
40 children went to neurology
43 children had day surgery procedures
43 patients attended the plastic surgery clinic
49 children visited general medicine
54 children went to orthopaedics
59 patients went to the eye clinic
68 anaesthetics were administered
68 children had surgery
75 children were cared for in crèche
94 patients saw dietitians
103 families were assisted by the Equipment Distribution Centre
113 new patients were registered
117 pieces of medical equipment were processed by biomedical engineers
118 specimens were collected in outpatients
138 children were admitted
150 children were discharged
226 medical imaging procedures were performed
234 children came to emergency
250 prescriptions were filled by the hospital pharmacy
268 families were assisted by family services
405 meals were prepared
588 bottles of baby formula were prepared
674 requests were made for laboratory services
829 medical records were retrieved
832 items of surgical equipment were processed
950 medical records were filed
1000 medication orders were reviewed
1544 tests were performed by laboratory services
Another day

Meg, with her mother Sophia, is pictured after her liver transplant.
Photo courtesy Geelong Advertiser

We remember...

Chad Huggins 30/11/2006 – 18/10/2008 p.27