

**Canadian Association of Paediatric Health Centres' 2004 Annual Conference  
In Collaboration with the National Child and Youth Health Coalition**

**Partageons nos richesses en optimisant la santé des enfants  
et des adolescents du Canada**

**Congrès annuel 2004 de l'Association canadienne des centres de santé pédiatriques,  
en collaboration avec la National Child and Youth Health Coalition**



**CANADIAN ASSOCIATION OF PAEDIATRIC HEALTH CENTRES (CAPHC)  
ASSOCIATION CANADIENNE DES CENTRES DE SANTÉ PÉDIATRIQUES (ACCSP)**

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## **POSTER PRESENTATIONS**

## **PRÉSENTATION VISUELLE**

**November 7 - 10, 2004  
Fairmont Queen Elizabeth Hotel  
Montreal, Quebec**

**au 10 novembre 2004  
Hôtel Fairmont Le Reine Elizabeth  
Montréal (Québec)**

## **INTRODUCING A NEW POSTER PRESENTATION AWARD FOR 2004!"**

Awards of recognition will be issued to three winners at CAPHC's 2004 Poster

Fair. On the final day of this year's Poster Fair (Tuesday, November 9th, 2004), CAPHC's panel of judges will present first, second and third prize awards to three poster presenters based on overall creativity, innovation and presentation. All poster presenters are welcome to participate!

Prizes for the 2004 Poster Fair will include:

**1st Prize:** Free registration to the 2005 CAPHC Conference at the Fairmont Hotel Newfoundland in St. John's, NF

**2nd Prize:** one complimentary nite at the Hotel Newfoundland and

**3rd prize:** 1 complimentary banquet ticket to the 2005 Gala Dinner

**Best of Luck to Everyone!!**

## **LANCEMENT D'UN NOUVEAU PRIX POUR LES PRÉSENTATIONS D'AFFICHES EN 2004 !**

Des prix d'excellence seront remis à trois gagnants à la foire d'affiches 2004 de l'ACCSP. Le dernier jour de la foire d'affiches de cette année (le mardi 9 novembre 2004), le groupe de juges de l'ACCSP présentera un premier, un deuxième et un troisième prix selon la créativité globale, l'innovation et la présentation. Tous les présentateurs d'affiches sont invités à y participer.

Les prix pour la foire d'affiches 2004 incluent :

**1<sup>er</sup> prix :** Inscription gratuite au congrès 2005 de l'ACCSP à l'hôtel Fairmont Newfoundland de St. John's (Terre-Neuve)

**2<sup>e</sup> prix :** Une nuit gratuite à l'hôtel Newfoundland

**3<sup>e</sup> prix :** Un billet gratuit pour le souper de gala 2005

**Bonne chance à tous !**

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## Family Centred Care - 1

### **EXAMINING THE SURGICAL LIAISON NURSE POSITION IN THE CHILDREN'S OPERATING ROOM**

Kathy Mac Donald, Clinical Educator Children's Operating Room, Perioperative Services, IWK Health Centre Halifax, Nova Scotia, 5850 University Avenue, Halifax, Nova Scotia, B3J 3G9, Kathy.MacDonald@iwk.nshealth.ca

Margot Latimer, Nadia Drisdelle

When children have surgical procedures, parents often find themselves restricted in their ability to cope, due to their state of anxiety and lack of information. We used a two-group (N=92) quasi-experimental pre-post test design to examine the effects of intra-operative communication by a surgical liaison nurse (SLN) on parental anxiety. Group I received in person progress reports from the SLN. Group II received standard peri-operative care. Feedback was also requested from health care professionals impacted by the introduction of this role.

The results showed the anxiety levels were lower for the families who received in person progress reports but the difference by group was not statistically significant. Thematic written responses provided examples of improved care and effective time management behaviors on the part of the health care professionals. Written responses provided validation for the scale scores for both families and health care professionals and were an indication of the support for the role of the surgical liaison nurse. Qualitative findings implied that the surgical liaison nurse facilitated the transfer of necessary information between the peri-operative care team and the family thus providing a support mechanism for families under stress.

This study lends support to the view that the SLN role has enhanced a family centered care environment by providing more focused care to families and improved intraoperative communications among perioperative team members. This study is a demonstration of nurses' autonomy in practice and ability to influence the quality care provided to children and families.

## Family Centred Care - 2

### **CARE COORDINATION OF THE SPINA BIFIDA POPULATION**

Kelly Thorstad, Head of In-Service Education, Clinical Nurse Specialist, Shriners Hospital for Children, 1529 Cedar Ave., Montreal, Quebec, H3G 1A6, kthorstad@shrinenet.org

S Badouri, D Fitz-Gerald, J Ruck-Gibis

Care Coordination/Transition is the health care delivery model of the Shriners Hospital for Children Canada. It is a Shriners system-wide program to meet the needs of high-risk patients and their families, with special health care needs. Coordination of care is organized by the Care Coordinators to provide holistic health care throughout the continuum of care until they are transitioned into the adult health care setting. Family needs assessments are completed with the patient and their families to establish and work towards health goals. This process ensures that the important needs of our clients are met, and identifies issues that need to be addressed clinically and from a research perspective.

### **Family Centred Care - 3**

#### **FAMILY CENTRED COMMUNITY BASED PEDIATRIC INSULIN PUMP THERAPY**

Cheril Clarson, Pediatric Endocrinologist, Children's Hospital of Western Ontario, 800 Commissioners Road E, London, Ontario, N6C 2V5, cheril.clarson@lhsc.on.ca

Ms Susan Rybansky, Ms Wendy McKay, Ms Denise Youmans, Ms Janet Baker, Ms Helen Clark

There are substantial data supporting benefits of pump therapy. These include improved metabolic control and enhanced quality of life. Achievement of these results requires commitment from the pumper, family and diabetes team. Optimal initiation of pump therapy is an intense process necessitating more frequent blood glucose monitoring, detailed record keeping, technical training and multiple appointments. The Children's Hospital of Western Ontario (CHWO) pump program comprises a systematic approach to initiation and maintenance of pump therapy with collaboration between family members and the multidisciplinary diabetes team.

This care option is usually delivered by tertiary centres. CHWO has established partnerships with several community outreach centres. In 2001 a collaborative insulin pump program was initiated to provide full insulin pump service to children and families in the Sarnia area. To date 12 patients have been initiated and remain on pump therapy through this program which comprises 5 visits in total: pump preparation, pump technical training, pump start and a 2 and 6 week follow up. Collaboration between the Sarnia and CHWO team is ongoing with dissemination of revised insulin pump management guidelines and educational material.

This program now provides full pediatric diabetes service to families in the Sarnia community. Benefits include; reduced absence from school or work, increased comfort level for families afforded by the accessibility of the local team and optimal use of local health care resources with continued contact and support from the tertiary centre. This collaborative model offers an alternative approach to delivery of insulin pump therapy with increased availability to families distant from the tertiary care centre.

### **Family Centred Care - 4**

#### **A CHILDREN'S HOSPITAL WITHIN A HOSPITAL-DOING WHAT**

Alida Bowman, RN, BScN, MScN, Program Manager, McMaster Children's Hospital, 1200 Main St West, 3d2, Hamilton, Ontario, L8N3Z5, bowmana@hhsc.ca

Heather McGavin PT, MS, Program Manager, Dr Chuck Cunningham PhD, Clinical Psychologist, Linda Kostrezewa, RN, MHSc, Director

The concept of a "hospital within a hospital" is a common theme for the majority of health care centers providing care for children, but what does it mean? This poster presents both the opportunities and challenges of working within an adult setting and doing what matters most for patients and families. The development of a unique vision, mission and values for McMaster Children's Hospital within the umbrella of the hospital wide vision is described. One of the hospital objectives was the development of a patient centered care philosophy. A task force was engaged in the foundational work required to develop the philosophy. Then an extensive study was conducted using unique survey methodology to ask patients and families what they think matters most to them in their

"ideal hospital". The poster presents the process and methodology in learning about what matter to our patients and families and comparing the differences for the population of children. The changes were incorporated in to a companion document on the family-centered care philosophy for the children's Hospital.

#### **Family Centred Care - 5**

##### **ENTREPRISE-WIDE RISK MANAGEMENT**

Corinne Berinstein, Internal Auditor, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1x8, [corinne.berinstein@sickkids.ca](mailto:corinne.berinstein@sickkids.ca)

Ms Janice Campbell

Internal Audit is not commonly found in Canadian hospitals. This poster will describe how the Board of Trustees at the Hospital for Sick Children has instituted an effective independent objective Internal Audit function that provides assurance to the Board on the functioning of key internal controls both on the corporate side of the house and the clinical processes.

We will share: Internal Audit mandate, structure, processes and results.

In addition Internal Audit and Risk Management have combined their expertise to facilitate an enterprise-wide risk management approach(including identification, assessment, measurement and monitoring), Internal Audit and Risk Management is helping management adopt an approach that includes developing:

- a common risk language,
- a list of top 10 risks (annually updated),
- an approach to address these risks,
- an audit plan to independently test key controls,
- a process to openly discuss risks to promote a patient safety culture and improve risk management
- reporting process from front-line and up (right to the Board)

This poster will be of interest to Board members, senior managers, quality managers, risk managers, and all other staff that are looking for a system-wide approach to manage risk and increase accountability.

#### **Family Centred Care - 6**

##### **FAMILIES WORKING WITH CARE PROVIDERS FOR FAMILY CENTRED CARE**

Danica Rose, Family Advisory Council Liaison, Children's Hospital of Western Ontario, Room 3232 Tower 2, London, Ontario, N6A 4G5, [Danica.Rose@lhsc.on.ca](mailto:Danica.Rose@lhsc.on.ca)

Erin Pearson

The Children's Hospital of Western Ontario (CHWO) supports the key elements of family centered care as defined by the Association for the Care of Children's Health (1992). This philosophy describes families as having the ability to provide a dimension of care unattainable by others. In an effort to improve upon the delivery of family centred care, the Family Advisory Council and staff at CHWO followed in the footsteps of other successful paediatric hospitals and collaborated to create a Family Faculty education program.

Specifically, this initiative is meant to improve communication between staff and families, to find innovative ways to include families as part of the care team, and to generate a care environment that is flexible and responsive to each family's individual needs.

Our Family Faculty is made up of parents of sick children, and health care providers who work in collaboration to teach staff and students what family centred care means to them. The Family Faculty believes that families are some of the best people available to teach health care providers how to care for families. Our Family Faculty members are unique educators because they use a combination of formalized resources and personal experiences as their tools for teaching health care providers how to provide children with the best care possible.

As a highly successful family faculty program, our objective is to share our experiences in creating a program that works for staff, students and families.

### **Family Centred Care - 7**

#### **SUPPORTING FAMILIES: THE 'KEY WORKER' MODEL OF SERVICE DELIVERY**

Peter Rosenbaum, Professor of Paediatrics, Canada Research Chair in Childhood Disability, McMaster University, CanChild Centre for Childhood Disability Research, Institute for Applied Health Sciences, 1400 Main St. West, Room 408, Hamilton, Ontario, L8S 1C7, rosenbau@mcmaster.ca

Ms Alison Drennan, Ms Teena Wagner

The 'key worker' model is a method of service delivery that employs a person in a guide role with families. This person acts as a single point of contact for a family, and coordinates their care, not only within the healthcare system, but also across systems (education, social, financial, recreation, transportation, etc). This poster presents an overview of the 'key worker' model of service delivery, including the value of this position, roles and responsibilities, evidence of effectiveness and implementation possibilities. This information was obtained via a literature search utilizing databases, citation searches and personal contacts. The main concept of the 'key worker's' role is to empower parents providing them with support, resources and information, tailored to meet their individual needs. This role differs considerably from traditional case management. The latter is a process that matches the client's health care needs with the available services and resources and in most cases, but often does not involve coordination across all systems, individualizing approaches for different families based on their specific needs, or taking steps towards empowering parents.

The poster utilizes a framework derived from the Measure of Processes of Care categories to discuss the roles, responsibilities and effectiveness of the 'key worker' model of service delivery. This framework emphasizes the 'key worker' model as a method of service delivery that has the potential to provide family-centred service.

## Family Centred Care - 8

### **A MULTIDISCIPLINARY APPROACH TO INTRODUCING A FAMILY CENTERED MODEL OF CARE IN A NEW PEDIATRIC CRITICAL CARE UNIT**

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Barbara Jennings RN, BA, MSHSA, Program Manager, McMaster Children's Hospital, HHSC, Rose-Frances Clause RN, BScN, MHSc, ACNP

Hospitalization of a child is one of the most stressful experiences for both child and the parents. The primary goal of pediatric patient care is to provide a multidisciplinary approach to deliver safe and effective care to the child and family as a whole. Family Centered Care (FCC) is to be practiced by all disciplines involved in pediatric care, where the family is seen as central in a child's life and should be central in the child's plan of care. To effectively practice FCC, all disciplines must be clear and consistent in their understandings and beliefs regarding FCC. The literature states that generally staff members are aware of the necessary elements of family-centered care, the difficulty lies in the delivery of the care. Complications arise from factors such as the physical environment, lack of support from administration, knowledge deficits, and lack of resources. In the process of developing our new pediatric critical care unit, it was evident that there were inconsistencies in the delivery of FCC practices among our staff. A great deal of resistance has been met when attempting to change FCC practices to better reflect the current FCC models. Therefore, our FCC committee used the Family-Centered Care Questionnaire (Bruce, 1995), to measure the staff's perceptions and practice of FCC. The purpose of this poster is to demonstrate the approach we are taking to establish a FCC practice model to be followed by the staff in the new PCCU. The target audience is all health care professionals.

## Family Centred Care - 9

### **PROFESSIONAL BOUNDARIES WITHIN FAMILY CENTERED CARE: A PROCESS FOR CLARIFYING ROLE CONFUSION**

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Ms Darlene Boliver, Quality Manager Children's Health Program IWK Health Centre

Practicing within professional boundaries is an expectation of all nurses. Two important influencing factors in setting and maintaining therapeutic relationships within professional boundaries are the complex nature of health care and the personal and professional satisfaction nurses receive when building relationships with patients/families (McLinden, D. and Barnsteiner, J. 1999). Pediatric nurses frequently experience difficulties identifying and/or resolving situations where therapeutic relationships have been crossed or compromised. A process was initiated whereby care team members were supported to create a work environment that addressed family needs and provided consistency of care in keeping with professional boundaries.

Care team members identified an immediate need for an intervention to support new and experienced staff struggling with boundary issues. For nurses in particular, the

interrelationship between maintaining professional boundaries and being family centred, created role confusion and inconsistencies in practice. In response, a multi-unit, multi-representative group collaborated to develop a strategy and process to clarify boundary expectations and provide a consistent, workable approach to address boundary issues.

This six-month process resulted in the development of a unit policy that is well supported by staff and provides direction to resolving specific boundary issues. Staff report fewer inconsistencies and greater awareness and understanding of the responsibilities and accountabilities of the professional role. In addition, initiatives are underway to address the need for on-going centre wide learning opportunities to meet the professional challenges of practicing in a ever-changing health care environment.

### **Family Centred Care - 10**

#### **FAMILY-CENTRED SERVICE DESIGN: USING CONSUMER PREFERENCE MODELING STRATEGIES TO INVOLVE YOUTH, PARENTS, AND COMMUNITY STAKEHOLDERS IN THE DESIGN OF AN INPATIENT CHILD AND ADOLESCENT MENTAL HEALTH SERVICE**

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Dr. Chuck Cunningham, McMaster Children's Hospital and Department of Psychiatry and Behavioral Neurosciences, McMaster University Faculty of Health Sciences, Mr Don Buchanan, McMaster Children's Hospital, Mr Paul Agar, Manager of Integrated Child and Youth Mental Health, McMaster Children's Hospital, Mrs Linda Kostrzewa, Director McMaster Children's Hospital, Ms Health Miller, Patient Centred Service Research Unit, McMaster University

Family-Centred care means that the preferences of parents, children, siblings, and extended family members must be considered when designing, delivering, and evaluating children's health services. We used consumer preference modeling methods derived from marketing research to involve parents, adolescents, and community stakeholders in the design of a regional inpatient children's mental health service at McMaster Children's Hospital.

An informative sample of parents, adolescents, and community stakeholders participated in an electronic decision support lab focus group. Participants identified and ranked opportunities for youth, parents, and stakeholder input and generated specific design options. Themes included, how to make the service youth friendly, the logistical supports needed to encourage family involvement, the programs and services provided, the design of the admission and discharge planning processes and the integration of inpatient, outpatient, and community services. Using these themes, we composed 20 four-level inpatient service attributes and designed a partial profile, choice-based conjoint internet survey. Parent, youth, and community stakeholders completed 25 choice tasks presenting three optional inpatient mental health programs described by random combinations of three attribute levels. To ensure a representative sample, informants without internet access completed paper and pencil surveys. We used latent class modeling and Hierarchical Bayes analysis to compute individual parameter estimates and identify segments with different service design preferences.

Importance scores and utility values revealed those attributes that exerted the greatest

influence on parent, adolescent, and community stakeholder service preferences. Simulations and trade-off analyses identified the service design combinations that matched the preferences of different segments.

#### **Family Centred Care - 11**

##### **IMPLEMENTING A CUSTOMER SERVICE PROGRAM IN A CHILDREN'S HOSPITAL: IS IT TOO "MICKEY MOUSE"?**

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A Bowman, V Hutcheon, C Petkoff

McMaster Children's Hospital (MCH) wanted to gain a fresh perspective on customer service and to benchmark our culture of quality service against the best. Initial attempts to engage staff in this initiative were met with cynicism and sarcasm, trivializing our plan. It was labeled "too Mickey Mouse".

Tom Peters and others have identified the Walt Disney World Resort as a company that sets the benchmark for best practices in customer service. We wanted to learn the Disney success formulas and apply them to our children's hospital.

Our goal is to implement the frontline leadership role of Customer Service Coach. By involving frontline staff in a Disney Institute program, we aimed to inspire, motivate and reward our staff.

Two staff completed Disney training in March. They are now Champions for customer service and provide leadership to our program in the development of our quality service plan.

Involvement of key stakeholders, both staff and families, has been critical. The challenge of frontline buy-in has been creatively addressed. A cadre of motivated and committed staff is emerging with numerous ideas and suggestions. And, through focus groups and consumer preference modeling, families have been involved in the design of our customer service program. A sample of parents who use our pediatric medicine and surgery program has identified their priorities for quality service. These priorities have directed the implementation plan.

Is the customer service plan at MCH too "Mickey Mouse"? Our families will answer this.

#### **Family Centred Care - 12**

##### **NEONATAL TRANSFERS AND REPATRIATION: APPLICATION OF A CLINICAL RESOURCE MANAGEMENT TOOL**

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The structure and performance of the perinatal system have received significant attention. Issues of: adequacy of resources to facilitate providing a designated level of care;

consistency of care provided within a designated level of care; and skills and expertise required to support increased complexity of clinical regimens have been identified as, “hot buttons”.

No accurate way of defining and monitoring system capacity existed, thus our ability to address these issues was unclear.

Consequently, McMaster Children’s Hospital (MCH), in their role of tertiary provider of neonatal services to Central South/Central West regions of Ontario, conducted a six-week concurrent descriptive study to pilot an approach that might answer some of these questions.

Clinical criteria from a widely accepted, standardized, concurrent utilization tool, InterQual ISD Tool, were adapted to align with the National Guidelines for Family Centered Care (Government of Canada, 2000).

This tool proved useful in: determining whether the clinical needs of babies located in the MCH Level 1, Intermediate Care and Intensive Care Nursery were being met at the appropriate level of care; identifying process barriers that prevented the movement of babies to the appropriate level of care; and identifying opportunities to repatriate babies from outside the Hamilton-Wentworth region back to their “closest to home” hospital.

While this study illuminated several resource management opportunities, implementation is dependent on similar action being taken in the community hospitals served by MCH. A workplan and project costs are outlined.

### **Family Centred Care - 13**

#### **THE FAMILY RESOURCE CENTRE AT THE MONTREAL CHILDRENS' HOSPITAL**

Lynn Kiraly-Batist, Librarian (MLIS) - Family Resource Library, Montreal Childrens' Hospital, 2300 Tupper Street, Room C-542, Montreal, Quebec, H3H 1P3, [bibliofam@muhc.mcgill.ca](mailto:bibliofam@muhc.mcgill.ca)

MF Haineault (MEd) - Coordinator Child Life and School Services

Child Life Services at the Montreal Children’s Hospital has a long tradition of working with patients and families, dating back to 1936. The Children’s was one of the first pediatric institutions in North America to open a child life department, and over the years the services offered have changed dramatically. Currently Child Life specialists use play, education, and encourage self-expression to promote the psychological well-being and development of infants, children and adolescents. This provides support to the families as well. The goal of these services is to reduce stress associated with the healthcare experience, to foster and encourage children and their parents to adapt to the hospital setting, and to normalize the healthcare experience through activity programs.

A major supplementary service within the Child Life department is the Family Resource Library. Unique to pediatric hospital settings in Montreal, this service provides important support to parents and families seeking current and easy to understand medical information about their children’s medical conditions, parenting and pain management. The libraries’ resources include a Pain Management Resource Centre, a Parents’



Workstation and telephone and an interactive Web site ([www.mchfamilylibrary.ca](http://www.mchfamilylibrary.ca)). The library houses over 1600 materials on a wide range of medical conditions in both English and French. It is staffed by a professional librarian who guides the families in their quest for information and support.

The Montreal Children's Hospital prides itself in the promotion of Family Centered Care and both these services are excellent examples of how our families are provided with an excellent support system to ease the hospital experience for both the children and their families.

#### **Family Centred Care - 14**

### **INTEGRATING ETHNOCULTURAL BELIEFS AND PRACTICES INTO HEALTH CARE SERVICES: INTERPRETER AS CULTURAL BROKER**

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Objective: To sensitize health care professionals to the significance of acknowledging ethnocultural beliefs and practices related to illness, to collaborating with interpreters as cultural brokers, and to integrating these beliefs into assessment and treatment plans for successful outcome. At the MCH, in providing service to recent arrivals, with the assistance of the interpreter for more than 50 languages, it is seen that their experience of Canadian healthcare is a startling and new experience. Much of preventive medicine, psychiatry, testing for tuberculosis is non-existent in their countries of origin where pressing priorities such as fresh water, may take precedence. If services do exist, they are offered differently, and again, priorities vary. If children do not appear ill, parents assume they are well. In addition, newly arrived immigrant families are dealing with settlement issues, housing, employment, seeking culturally appropriate foods etc. In this adaptation phase, newcomers are acutely aware of their otherness: appearance, language, ways of relating. In these first years, there is a need to adhere to that which is recognizable, the culture of origin and those who can relate to it in a sea of difference. MCH Multicultural Program adapts health care services to meet ethnocultural needs of families in a context that is meaningful. In an ever increasing number of cases where a third language is required, collaboration with interpreters as cultural brokers, assists professionals, not only in communicating words, but also in understanding and acknowledging families' ethnocultural beliefs and practices. Thus, ensuring families' full participation in meeting their children's health care needs.

#### **Family Centred Care - 15**

### **LE CODE CANADIEN DU BÉNÉVOLAT , UN MOYEN DYNAMIQUE D'ASSURER DES SOINS CENTRÉS SUR LA FAMILLE!**

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Julie Bergeron

Cette affiche permettra de se familiariser avec le processus d'implantation du Code canadien de bénévolat par le service des bénévoles d'un centre pédiatrique tertiaire. La mise en œuvre du programme et ses retombées intéressera les professionnels de la santé spécialisés dans le développement global des enfants.

Bénéfices observés :

- Le processus de filtrage avec vérification des antécédents judiciaires n'affecte pas le recrutement. Les bénévoles potentiels comprennent l'importance de l'approche auprès d'enfants hospitalisés nécessitant une formation et une supervision plus particulière sur une base continue
- L'organisation appuie une structure qui bénéficie du leadership d'une équipe qualifiée possédant une vaste expérience clinique, une bonne communication avec le personnel et une très bonne connaissance des ressources communautaires. Le mandat de l'équipe est d'assurer la gestion et la coordination des services livrés par les bénévoles

Résultats :

- Les résultats obtenus sont notamment une meilleure adhésion aux normes 5, 6, 7 et 8 du code canadien de bénévolat
- Une amélioration des voies de communication avec les bénévoles.
- Les bénéfices observés pour les bénévoles sont la reconnaissance de leurs compétences et l'augmentation significative du niveau de rétention dans le programme bénévole rattaché à la salle d'urgence. Les objectifs à poursuivre sont la collaboration plus étroite avec le secteur privé pour fin de commandites qui permettraient d'augmenter la capacité d'autofinancer divers services dont la formation/développement des bénévoles, et l'acquisition de nouveau matériel pour les enfants.

#### **Family Centred Care - 16**

### **CHILDHOOD CHRONIC PAIN AND HEALTHCARE PROFESSIONAL INTERACTIONS: SHAPING THE CHRONIC PAIN EXPERIENCES OF CHILDREN AND FAMILIES**

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Dr Janet Rennick, Director of Nursing Research for Child & Adolescent Services, The Montreal Children's Hospital of the McGill University Health Centre, Ms Christina Rosmus, Clinical Nurse Specialist in Pediatric Chronic Pain and Nursing Research Associate, The Montreal Children's Hospital of the McGill University Health Centre

Children with chronic pain and their families meet numerous healthcare professionals during their search for an understanding of their pain. Little is known about the nature of those healthcare interactions and how they influence children's and families' chronic pain experiences. Through semi-structured interviews, this qualitative study sought to understand the experiences of five children with chronic pain and their parents as they encountered healthcare professionals prior to being referred to a chronic pain service. In the majority of these interactions, children and parents reported feeling misunderstood, disbelieved and abandoned. The findings of this study also demonstrated that children and parent experiences with professionals influenced their approaches towards current and future healthcare encounters. All children and their parents discussed their guarded relationships with current healthcare providers. Children and parents also developed negative perceptions about their pain, in particular believing that their experience with chronic pain was life-threatening or incurable, and demanded major life adjustments. Children's interactions with healthcare professionals have a tremendous influence on children's and parents' perceptions and chronic pain experiences. In order to foster positive perceptions, it is essential that healthcare professionals provide children and their families with the opportunity to communicate their unique experiences with pain.

**TEACHING GUIDE FOR THE PREMATURE BREAST-FED BABY  
DISCHARGED BETWEEN 36 TO 40 WEEKS OF GESTATION**

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We know that prematurity is an increasing phenomenon in our society. This reality is very present in the Eastern Townships of the Province of Quebec and it is not unusual for parents to be discharged when their breast-fed premature baby reaches 36 weeks of gestation.

This is a highly practical guide for care givers and parents to help them better understand the steps involved in the breast-feeding of the premature baby. It is also a detailed explanation of the ongoing process of breast-feeding starting with supplements to total breast-feeding (without supplements).

This guide includes systematic steps for:

- 1) Breast-feeding;
- 2) Use of supplements; and
- 3) Use of breast pump.

It is a flexible method, which respects parents in their breast-feeding experience and not a rigid guideline to breast-feed at any price.

The main focuses are:

- a) A better understanding of premature baby's needs in regard to breast-feeding;
- b) Parent's teaching needs upon discharge;
- c) Parenting skills in identifying baby's stage of breast-feeding development before and after discharge; and
- d) Parent's personal notebook pinpointing essential elements of a successful breast-feeding technique.

This guide focuses on well-known and accepted breast-feeding practices with the emphasis on practical hands-on tips for the novice as well as experienced nurses. It enables them to assess the evolving latching-on process of the premature baby as well as his nutritional needs through breast-feeding versus his supplemental requirements.

**BEST PRACTICE IN FAMILY CENTRED CARE**

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Elizabeth Phoenix, Geraldina Meriano, Kristen Fryer, Heather Maxwell, Kathleen McCreath, Janice Balogh

The philosophy of family centred care at London Health Sciences Centre (LHSC), a large tertiary care centre in Southwestern Ontario is strong. LHSC's mission statement "To our Patients and their Families: We will work with you to improve your health and provide compassionate and high quality care" is one that the Child and Adolescent Mental Health

Care Program follows to guide their practice. Given this mission statement, the Registered Nurses Association of Ontario's Best Practice Guideline, "Supporting and Strengthening Families Through Expected and Unexpected Life Events" was an obvious fit for LHSC, The Child and Adolescent Mental Health Care Program, their patients and families.

The benefits and outcomes of implementing this guideline are 1) to foster personal and professional growth in staff, 2) to acknowledge, strengthen and reinforce the accountability the team has to our patients and their families through consistent assessment tools, patient/family education and discharge planning with a family focus. 3) to acknowledge and reinforce the accountability the patient and family have to participating in their care, and 4) develop unit leaders. Pre/post data was gathered to measure the impact of implementing the Best Practice Guideline

The group has emerged as new leaders within LHSC and within Child and Adolescent Mental Health Care. They are the first in both areas to launch the RNAO Best Practice Guideline and will be resources to the LHSC Best Practice Committee looking to implement various guidelines throughout the organization. They successfully facilitated on-going improvement and innovative progress in Family Centred Care.

#### **Family Centred Care - 19**

#### **DISCLOSURE: A NEW MODEL FOR WORKING WITH FAMILIES WHEN HARM IS DONE**

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M Keatings Vice President, Professional Affairs and Chief Nursing Officer, R Sapsford Executive Vice President and Chief Operating Officer, Dr J Everson Chief of Staff, Dr A McCallum Regional Supervising Coroner, Dr P Steer President, McMaster Children's Hospital

Claire Lewis was 11 years old when she died in the care of Hamilton Health Sciences staff in Hamilton, Ontario in 2001. The academic teaching hospital conducted a review of the case, discovered many problems with her care and concluded her death was preventable. Eventually, the hospital provided the Lewis family with the review details, accepted responsibility and apologized. This was a precedent-setting approach for a Canadian hospital and marked a new era of disclosure in relation to patient safety. Now, with assistance from the Lewis family, the hospital has changed its policies and shares its approach with others to highlight the importance of disclosure.

A commitment to patient safety is increasing in Canada, with one of the key tools being public disclosure when things go wrong. Yet in the current environment, there is still a patchwork approach. Hamilton Health Sciences developed a disclosure policy and defined "harm" as part of the lessons learned in the Lewis case. The hospital also developed a set of guiding principles and a sequence of events to assist staff in understanding the importance of disclosure. The principles include: the notion of doing the right thing; the rights of patients and families to know what and when harm occurs; a hospital's obligation to inform others of risks and to prevent similar situations; the need to restore confidence in hospitals; prevention or mitigation of legal action and providing closure for patients, families and staff.

The hospital's disclosure policy and approach is a model that offers concrete steps to changing a culture where health professionals have been trained to know everything and not readily admit mistakes. The model shows how to choose the level and sequence of disclosure, design smart strategies for all stakeholders, use the enterprise liability approach and the ethical and moral benefits of an apology.

#### **Family Centred Care - 20**

##### **STANDARDS OF EXCELLENCE: FACILITATING THE DEVELOPMENT OF INTERDISCIPLINARY PEDIATRIC PATIENT CARE STANDARDS**

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Michele Durrant

Objective of this poster: To describe the process and outcomes of developing and implementing pediatric patient care standards.

Interdisciplinary standards of pediatric patient care developed at the Hospital for Sick Children, Toronto, Canada illuminate the importance of the interdisciplinary team delivering family centered care within a tertiary care setting. Standards provide an infrastructure that links professional practice accountabilities about patient and family care, quality measurement and professional competence. This poster will describe the diversity of the health care professionals who participated, the processes used to achieve our outcome, the seven standards that were generated, the educational strategies used to make the standards come "alive" in day to day practice, and evaluation strategies for this project.

A steering committee consisting of interdisciplinary leaders and key stakeholders from a variety of professional groups was established to develop, implement and evaluate standards of care. A stakeholder analysis helped us to determine a strategic plan for the project and an expert in standard development provided valuable consultation regarding standard development. A consensus building process was used to determine content and format of the standards. An education session was developed for committee members to introduce the standards to staff and elicit feedback. A final document was presented through the executive committees for approval.

Two family satisfaction tools currently used by the hospital will be used to evaluate the standards. Structures and supports that require further development are currently being identified so that a plan to address these needs will be implemented ensuring success of our staff in meeting the standards.

Target Audience: All health care professionals interested in patient care standards. Quality and Risk Management professionals, senior executives and organizational leaders of change.

#### **Family Centred Care - 21**

##### **LE NOUVEAU CENTRE MÈRE-ENFANT DU CHUQ AU CHUL**

Rémi Morency, Architecte concepteur, Bélanger Beauchemin architectes, 819 avenue Moreau, Sainte-Foy, Québec, G1V 3B5, info@groupea.qc.ca

Jacques Bélanger, France Laberge, Émile Gilbert

Le panneau traitera de l'aspect architectural de ce nouveau centre spécialisé en soins pédiatriques et obstétricaux construit au coût de 66M\$ et qui a ouvert ses portes au printemps 2004.

Dans un premier temps, nous présenterons un bref historique des principales données qui auront guidé l'implantation et l'approche volumétrique du projet. Puis, nous présenterons les plans schématisés des trois niveaux afin de bien faire ressortir le maillage caractéristique et unique des fonctions de ce projet. Le rez-de-chaussée comprend notamment le grand hall et la nouvelle urgence dont une grande part (7 lits) est vouée aux urgences pédiatriques. À l'étage, on retrouve toutes les cliniques et services de soins pédiatriques dont notamment l'hémo-oncologie, les unités de soins chirurgicaux et de cardiologie pour les 0-17 ans, les soins intensifs et intermédiaires, la médecine de jour et les services ambulatoires. Le deuxième étage comprend la néonatalogie d'une capacité de 51 lits et tous les services de soins en obstétrique.

À l'aide de schémas et de photos, nous ferons ressortir les différentes stratégies architecturales qui ont été mises de l'avant pour maximiser la fonctionnalité des lieux chez les intervenants de la santé et pour créer des ambiances favorisant la guérison, le repos et la détente chez les usagers. En l'occurrence, nous mettrons l'emphase sur les éléments qui caractérisent la conception du centre mère-enfant en regard de sa clientèle bien spécifique : design des espaces, proportions des ouvertures, stratégie d'éclairage naturel, création de toits jardins, design du mobilier, intégrations des technologies, coloris et textures.

#### **Family Centred Care - 22**

##### **RELANCE TÉLÉPHONIQUE AUPRÈS DES FAMILLES ENDEUILLÉS**

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Dans le cadre du programme de deuil périnatal multidisciplinaire de l'Hôpital Ste-Justine, une équipe d'infirmières effectue une relance téléphonique auprès des familles endeuillées, trois semaines après le décès de leur enfant.

**OBJECTIFS:** 1) Offrir le soutien requis par la famille 2) Répondre aux questions des familles 3) S'assurer que le processus de deuil poursuit son cours et référer si la famille est en détresse.

**CLIENTÈLE-CIBLE:** Les familles dont un enfant est décédé dans un contexte périnatal tels lors d'une fausse-couche, d'une IVG du 2e trimestre, d'une mort in utero ou d'un décès néonatal.

**DÉMARCHE:** L'infirmière qui a établi une relation significative avec la famille durant leur séjour hospitalier ou une infirmière du groupe de la relance téléphonique communique avec les parents. Un questionnaire a été élaboré afin de guider l'appel téléphonique ainsi qu'un algorithme décisionnel requérant l'intervention de l'équipe multidisciplinaire si une famille en détresse est identifiée.

**RÉSULTATS:** Les familles se disent satisfaites de ce soutien. Cette relance permet également d'offrir une aide particulière aux familles en détresse.

**FAMILY CENTERED CARE IN THE NURSERIES OF THE WEST CLUSTER**

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**OBJECTIVE:**

The West Cluster Maternal Child Program was developed through a partnership among 4 hospitals within the framework of the Child Health Network for the Greater Toronto Area. It includes: Credit Valley Hospital, Halton Healthcare Services, Trillium Health Centre and William Osler Health Centre.

In September 2001, Family Centered Care was identified as one of the top priorities in the West Cluster nurseries. A regional multidisciplinary team was assembled whose goal was to develop & deliver a curriculum to the multidisciplinary nursery teams throughout the cluster. Utilizing the FCC Institute Assessment Tool to review the status of each nursery, the following educational needs were identified:

- An increased awareness of the definition & core concepts of family and family centered care
- An increased awareness of the importance of communication
- The importance of considering each family's needs and expectations
- Strategies to involve families in decision making and planning of care

**OUTCOMES:**

In May/June 2002, 185 multi-disciplinary professionals received a four-hour curriculum.

- Family centered care requires an attitudinal shift by health care professionals from a focus of "staff centered" to "patient centered".
- Perceived barriers need to be addressed
- The philosophical shift requires ongoing support and mentoring at all levels
- Family centered care needs to be interwoven into all components of our practice
- The use of a regional multidisciplinary team to achieve our outcomes has been highly successful

A regional family feedback survey is being utilized to evaluate both family participation and satisfaction.

**COMMUNICATION BEST PRACTICES WITHIN THE HEALTH CARE TEAM, HOSPITAL DISCHARGE TO HOME CARE**

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Susan Mcrae RN

**CONTENT:**

The communication and coordination between hospital and community based care is fundamental to the seamless provision of effective care for children with acute and complex healthcare needs. In addition these same challenges exist when these children enter school. These 'Best Practice Guidelines' (BPG's) describe the optimal communication needed between healthcare providers and other professionals who care

for children with acute and complex healthcare needs.

**CONCLUSION:**

These BPG's focus specifically on the main transition facing children and the many professionals that interact with home care nurses to support successful transitions through the life cycle.

**Family Centred Care - 25**

**PARENTS ROOMING-IN DURING THEIR CHILD HEMATOPOIETIC STEM CELL TRANSPLANT**

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Joanne Richer Infirmière bachelière, J-Hugues Dalle Fellow - Hématologie, Michel Duval Hématologue, MartinChampagne Hémato-oncologue - Directeur programme de greffe de moelle osseuse

HSCT for children is a stressful parental experience. At the inception of our program in 1993, we decided to not permit parental-rooming-in. We thought that parents could thus benefit from a rest period, maintain their family system, and conserve energy for the long hospitalization expected for their child. Some parents questioned our policy since, throughout our hospital with the exception of the ICU and HSCT units, children can benefit from the presence of their parents. In contrast to our position, most transplant centers in North America allow parental rooming-in during a child's HSCT. Literature review was inconclusive. We therefore surveyed 120 families whose child has received HSCT at our center to evaluate the effect of our policy on the parental level of stress, the child's anxiety and/or the impact on the nursing team. Families who have had a child recipient of an HSCT between 1993 and 2002 were surveyed by mail. One of the parents answered the questionnaire, which evaluated the degree of information on the rationale of policy; parental and child reaction; current perception of the policy; current choice parents would make and suggestions on possible rooming-in. This poster presentation will give the results of the survey which made us modify our policy on rooming-in. For example, 62% of the surveyed families stated that they would have stayed at night with their child at the time of HSCT if permitted. Also, following the modification of the policy, we are currently studying the benefits and disadvantages of rooming-in for the child, the parents and the nursing team during this period of intensive care.

**Family Centred Care - 26**

**BREASTFEEDING DURING INFANT HEMATOPOIETIC STEM CELL TRANSPLANTATION**

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Enteral nutrition support in young children undergoing hematopoietic stem cell transplant (HSCT) is hampered by severe mucositis and nausea/vomiting. Infants are occasionally



being breastfed at the time of HSCT. A large literature on the benefits of breastfeeding in normal infants is available; however, there is no study of nutritional support with maternal milk in infants undergoing HSCT and its impact. Nutritional composition and other elements contained in the maternal milk confers an advantage compared to prepared formula. Also, maternal milk contains high titers of IgA. Maternal-infant transmission of cytomegalovirus, West Nile virus, and other viruses is however possible during breastfeeding. We report our experience in four babies who were breastfed during their allogeneic HSCT. Infants were aged 21 days to 11 months at time of HSCT. Diagnoses were acute myelogenous leukemia, Krabbe syndrome, leucocyte adhesion deficiency and familial hemophagocytic syndrome. Patients received HLA-matched related or unrelated transplants. The preparative regimen consisted of BuCy with or without VP-16. All four babies had to stop maternal breastfeeding and were given maternal milk by nasojejunal feeding tubes. Additional nutritional support with TPN was required for three patients. Complications during HSCT were VOD (2), septicemia (2), reactivation of CMV (1), EBV (1), post-biopsy duodenal hematoma (1), aGVHD (1), cGVHD (1), pseudomembranous colitis (1) and epiglottitis (1). All babies engrafted and remain alive and well after an average of 35 months post-transplant. In conclusion, breastfeeding is feasible during HSCT. Appropriate anti-bacterial decontamination and microbiological study of the mothers is needed in order to decrease maternal to infant contamination.

#### **Family Centred Care - 27**

#### **FAMILY CENTERED CARE BEST PRACTICE GUIDELINE IN MENTAL HEALTH**

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Kelly Finlayson, Kate McCreath, Geraldina Meriano, Krysten Fryer, Janice Balogh, Sue MacLean

The philosophy of family centred care at London Health Sciences Centre (LHSC), a large tertiary care centre in Southwestern Ontario is strong. Our mission statement "To our Patients and their Families: We will work with you to improve your health and provide compassionate and high quality care" is a mission statement that the Child and Adolescent Mental Health Care Program follows to guide their practice. Given this mission statement, the Registered Nurses Association of Ontario's Best Practice Guideline, "Supporting and Strengthening Families Through Expected and Unexpected Life Events" was an obvious fit for LHSC and The Child and Adolescent Mental Health Care Program's patients and families.

The benefits and outcomes of implementing this guideline are: 1) to foster personal and professional growth in staff, 2) to acknowledge and strengthen the accountability the team has to our patients and their families through consistent assessment tools, patient/family education and discharge planning with a family focus, 3) to acknowledge and reinforce the accountability the patient and family have to participating in their care, and 4) develop within unit leaders as the Family Centred Care Committee emerged as leaders to implement this guideline within their service area. Pre/post data was gathered to measure the impact of implementing the Best Practice Guideline.

The group has emerged as new leaders within LHSC and within Child and Adolescent

Mental Health Care. They are the first in both areas to launch the RNAO Best Practice Guideline and will be resources to the LHSC Best Practice Committee looking to implement various guidelines throughout the organization. This group has successfully facilitated on-going improvement initiative and an innovative project in Family Centred Care.

#### **Family Centred Care - 28**

##### **GROUP INTERPERSONAL PSYCHOTHERAPY FOR DEPRESSION WITH ADOLESCENTS:**

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William B. McIntosh, Child and Adolescent Centre, Mental Health Care Program  
Cindy Goodman Stulberg, Psychological Associate, Southlake Regional Health Centre

##### **Objectives:**

The purpose of this workshop will be:

- To provide a preliminary explanation to participants of the principles of Interpersonal Psychotherapy for Depression.
- To outline the group treatment of Interpersonal Psychotherapy (IPT)
- To learn the assessment process for Interpersonal Psychotherapy.
- To learn about the process of goal setting which occurs by selecting “problem/focal” areas and through the interpersonal inventory recognizing those relationships, which either hinder and/or support the recovery of depression.
- To learn about the relevant strategies and techniques used for problem resolution of heterogeneous focal areas within a group context.

##### **Method:**

This workshop will be presented by the two co-authors in a didactic and interactive presentation enabling the workshop attendees time to dialogue with the presenters about the group process and Interpersonal Psychotherapy for depression.

##### **References:**

Interpersonal Psychotherapy of Depression. (1984) G. Klerman, M.M. Weissman, B.J. Rounsaville & E.S. Chevron. Basic Press.

#### **Family Centred Care - 29**

##### **PARENTS AS PARTNERS PARENT TRAINING PROGRAM - ABSTRACT**

Lisa Schumacher, M.Sc.(A), SLP(C), , Mackay Rehabilitation Center, 3500 Decarie Blvd., Montréal, Québec, H4A 3J5, Lisa Schumacher/Mackay Center/Reg06/SSSS

In order to address the long waiting list for pediatric Speech-Language Services, the Parents as Partners: Managing Speech, Language and Communication Behaviours at Home Program was developed five years ago at the Mackay Rehabilitation Centre. This six-week parent training program is designed for the parents of preschool and school-aged children with severe language disorders and delays at Mackay Rehabilitation Centre.

The goals of the program are to help parents understand the nature of their children's language difficulties, teach techniques and strategies to facilitate language development, and to provide information and support in the areas of behaviour management for difficulties related to language problems. We emphasize the use of motivators and rewards as well as the children's strengths to improve communication skills, and help parents become more actively involved in their child's treatment.

Five weekly two-hour evening sessions are led by a Speech-Language Pathologist and a Psychologist, followed by one practical play session during which the parents apply techniques and strategies learned while playing with their children, under the coaching of the instructors who shape and model the parents' behaviours. All sessions include direct teaching and modeling, group brainstorming, discussion, role-playing and individualized homework assignments.

Feedback from parents has been extremely positive and once children do begin regular therapy, parents have continued to remain active and to influence the rate of change observed. Parents are better informed and better equipped as facilitators and advocates for their children, and therapists benefit from a more equal partnership with the parents of their clients.

#### **Family Centred Care - 30**

#### **TÉLÉSOINS À DOMICILE : SYSTÈME 24-7 POUR SUPPORT AUX CLSC, FAMILLES ET ÉTABLISSEMENT EN RÉGION**

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G Dougherty, C Rodd

But : Présenter les bénéfices aux patients et cliniciens faces à l'utilisation d'une technologie simple et conviviale : ordinateur de poche et téléphone cellulaire, afin de soutenir la réintégration et le maintien à domicile de 982 enfants : 532 enfants inscrits dans 12 programmes de l'unité des soins ambulatoires intensifs, 450 enfants de la clinique de diabète.

Méthode : Un suivi systématique de clientèle, incluant une garde 24-7, est déployé afin d'améliorer les trois indicateurs suivants :

- éviter l'hospitalisation
- éviter la visite à l'urgence,
- réduire la durée de séjour, des enfants qui bénéficient à domicile de soins complexes, chroniques et continus. Les technologies actuellement utilisées sont le « Palm Pilot iPaq pocket PC » et le téléphone cellulaire.

Résultats : Déployée depuis plus de cinq ans, cette technologie rend accessible au clinicien de garde :

- les plans des soins,
- profils pharmacologiques,
- sommaire du dossier médical,
- protocoles de soins,

- alertes,
- guides de pratiques individualisés.

On note une diminution significative d'au moins 1 des trois indicateurs pré-cités. Cette approche est intégrée dans la gestion des épisodes de soins et assiste l'équipe de soins spécialisés du centre tertiaire dans sa mission de soutien aux intervenants de première ligne : CLSC, médecins traitant, écoles, garderies.

Conclusion :

- Technologie peut coûteuse et conviviale,
- Nécessite peut de formation du personnel
- Améliore la qualité du suivi de clienteles
- Réduit les déplacements : familles et cliniciens
- Utilisation plus appropriée des services de santé

### **Family Centred Care - 31**

#### **THE CHILD, YOUTH AND FAMILY HEALTH NETWORK - A VIRTUAL CORPORATION**

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J Desrochers

Objective: The objective is to present a network model and its achievements, based on long-term relationships, mutual trust and reciprocity.

Summary:

The Child, Youth and Family Health Network of the McGill University Health Centre (MUHC) was created in collaboration with the Montreal Children's Hospital. This bilingual network originated over 50 years ago, as an informal association between healthcare providers, built on mutual trust and reciprocity.

This poster will describe the philosophy, mission and goals of this Virtual Health Network dedicated to providing care to infants, children and adolescents as close to their home as possible. Links with hospitals, CLSCs, rehabilitation centres and other organisations across Quebec will be presented.

Recent achievements that contribute to the improvement of accessibility, communication and continuity of care will be described. The network framework of our balanced scorecard will be presented: 4 domains: environmental scanning, project management, evaluation and quality improvement, promotion and communication.

The network has formed strong alliances between partners, creating a synergy to move forward into innovative approaches to support specialized care delivery closer to home. Important success factors will be described, for example: open systems, to every practitioner involved in the process of care, along the continuum without formal signed agreements.

## Family Centred Care - 32

### **THE INTEGRATION OF TELEHEALTH WITH THE CHILD, YOUTH AND FAMILY HEALTH NETWORK**

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Carolle Legault, Anne-Marie MacLellan, Madeleine St-Gelais, Laurent Soussana

**Objectives:** To explain how the rapid expansion of the MCH telehealth program has strengthened clinical and other links with partners in the Child, Youth and Family Health Network.

**Summary:** This poster will summarize the different kinds of telehealth activities deployed from the MCH in cooperation with the Child, Youth and Family Health Network of the McGill University Health Centre. The MCH is the telehealth center for the McGill University Health Centre. First used in pediatric cardiology (1998), the telehealth network expanded rapidly by offering educational activities (Grand Rounds, Pediatric Ambulatory Rounds, Trauma rounds, etc.) to interested Quebec health care centers. Telenursing rounds on topics tailored to the requests of the partners in the regional hospitals, in French or in English, open to all centers, help consolidate links between the MCH, the tertiary care Pediatric Hospital of the MUHC and other centers. Outcome measures will be detailed. The positive impact for patients, families and health care professionals of the clinical applications of telehealth such as echocardiograms, abdominal ultrasounds, and cardiorespiratory monitoring will be highlighted.

The new centralized telehealth reservation system, or "scheduler", will also be described, as a mean to facilitate the coordination of the telehealth activities for both the requesting and the consulting centers.

## Family Centred Care - 33

### **MACKAY REHABILITATION CENTER – EXPLORATIONS PROGRAM**

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The “Explorations Program” was initiated in August, 2003 in response to a practice of decision making which was clearly difficult for parents and clinically unsound. For a period of over a decade, parents of children newly diagnosed with a hearing loss were informed of program options and sent off to visit and make a decision as to where and in what modality they would begin intervention. Parents found this difficult for many reasons: they had to make important decisions about their child’s future with limited information and at a time of intense grief over the diagnosis of hearing loss. They also often felt the dynamic of competition between the available programs.

Discussions between Mackay Rehabilitation Center, Montreal Children’s Hospital and a local oral school for the deaf led to the present “Explorations Program” which is a

collaborative, problem solving approach to Early Intervention for babies and toddlers who are diagnosed with a hearing loss. The program is initiated immediately after the identification of hearing loss and is designed to give families the necessary time and tools to explore their child's intervention needs and options.

The child and his or her family enter the "Explorations Program" for a period of approximately six months. A parent/infant specialist is assigned to provide home-based intervention services weekly as well as to coordinate the interventions of other team members.

The goals of the program include:

- To support parents and the child's family in understanding and coping with the diagnosis of hearing loss
- To guide the family in the stimulation and assessment of their child's language, auditory, and speech development
- To assist families in being able to make well informed decisions about their child's ongoing intervention needs and program options

#### **Health Promotion/Illness and Injury Prevention - 34**

#### **QUALITY OF LIFE AND FUNCTIONAL STATUS IN PRESCHOOL AGED CHILDREN WITH PHYSICAL DISABILITIES: ASSOCIATION BETWEEN THE WEEFIM AND THE PEDSQL4.0**

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Background: Function and health-related quality of life (HRQL) are two outcome measures frequently used in pediatric rehabilitation. There is a paucity of information on the association between these two concepts.

Objectives: To determine the association between functional status, measured by the Functional Independence Measure for Children (WeeFIM) and HRQL, measured by the Pediatric Quality of Life Inventory (PedsQL4.0) for preschool children with physical disabilities.

Patients: Parents of 115 children (2-5 years) with physical disabilities who were referred to occupational or physical therapy in 2002-2003. Mean age of the children was  $3.6 \pm 0.8$

years, 69% were boys and 58% were diagnosed with global developmental delay.

Measurements and Main Results: Parents were interviewed using the WeeFIM and completed the PedsQL4.0 parent-proxy report. Overall, children had more difficulties with self-care tasks and cognitive abilities, as compared to mobility activities on the WeeFIM. The total WeeFIM was moderately correlated with the total PedsQL4.0 ( $r=0.39$ ,  $p<0.001$ ). The WeeFIM mobility and self care quotients were each moderately correlated with the PedsQL-Physical Health Summary score ( $r=0.48$ ,  $p<0.001$  and  $r=0.36$ ,  $p<0.001$ , respectively). There was no significant association between the WeeFIM cognition quotient and each of the PedsQL scores ( $r=0.02$  to  $0.08$ ). Maternal education and family income were not associated with any WeeFIM or PedsQL4.0 score.

Conclusion: The WeeFIM and the PedsQL4.0 appear to assess different, although related constructs. This supports the need to incorporate complementary measures that are not only focused on function but also include well being when measuring the overall status of children with disabilities.

#### **Health Promotion/Illness and Injury Prevention - 35**

##### **MUHC NEONATAL HEARING SCREENING PROGRAM**

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S Julien

The MUHC neonatal hearing screening program comprises a joint effort by the MCH, RVH, JGH to screen and manage all babies who spend time in their NICU units. This poster session will explain why we screen, who is screened, what tests are performed and what follow-up is received. The results of 9 months of joint data collection will be included. The need for universal hearing screening will be emphasized in this session.

#### **Health Promotion/Illness and Injury Prevention - 36**

##### **MOTOR DEVELOPMENT IN INFANTS WITH POSITIONAL PLAGIOCEPHALY**

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A Majnemer, JP Farmer, R Barr

Background: Concurrent with recommendations to place infants in supine for sleep, there has been a dramatic increase in the number of infants with positional plagiocephaly.

Recent literature suggests that developing infants who have decreased exposure to the prone position may have an elevated incidence of positional plagiocephaly (PP) and that these children may in turn demonstrate a delay in the acquisition of certain motor skills

Objectives: The objective of this study was to compare motor skill acquisition between infants with PP and typically developing infants. We also examined the differences in infant positioning practices when asleep and awake between the two groups. Methods: Twenty-seven infants with PP were matched by age, gender and race with typically developing infants. Motor performance was evaluated using the Alberta Infant Motor Scale (AIMS) and the Peabody Developmental Motor Scales (PDMS). Parents completed a diary that recorded infant positioning over a three-day period. Results: Infants with PP

demonstrated a trend towards a delay in the acquisition of motor milestones. Furthermore, improved performance on the AIMS was positively correlated with the amount of awake time spent in prone for both groups of children.

Conclusions: Clinicians should be aware of the possibility of a motor delay when evaluating infants presenting with positional plagiocephaly. It is also necessary for parents to be informed about the importance of prone playtime to enhance the development of early motor skills and to prevent progression of the deformity associated with PP.

### **Health Promotion/Illness and Injury Prevention - 37**

#### **SLEEP ISSUES IN CHILDREN WITH PHYSICAL DISABILITIES**

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A Tancredi, B Yundt, H Larin

Sleep has a significant impact on the daily functioning of children and their families. Health care professionals are involved in the management of sleep related issues through consultation and direct intervention. The purpose of this study was to describe sleep patterns, issues and strategies used to facilitate sleep in children with physical disabilities (CPD) and comparable healthy children (CHC). Data was collected using a questionnaire that was developed based on information from relevant literature and focus groups. Caregivers of 179 CPD (25% response rate) and 69 CHC (38% response rate) completed the questionnaire. Descriptive analyses, Chi square analyses, and identification and coding of trends were used to analyze the data. There were statistically significant differences in the number of caregivers of CPD vs CHC reporting the following: current sleep problems (63 vs 14%), safety concerns (12 vs 0%), uncomfortable at night (21 vs 0%), night waking (67 vs 40%), daytime irritability (39 vs 22%), interference with school/social activities (15 vs 3%), and general health concerns due to lack of sleep (35 vs 7%). Problem areas that disturbed the sleep of CPD were pain 29%, digestion 25%, cardio respiratory 22%, bowel/bladder 15%, behaviour 13%, skin 12%, and circulation 11%. The most frequently cited strategies to address sleep issues in both groups were establishment of consistent routines and provision of calming, supportive sleep environments. There were significant between group differences in the quality and continuity of sleep which impacted on daily life. Health care professionals need to assess sleep issues, recommend the use of routine, identify and address health problems, and ensure comfortable and safe positioning during sleep.

### **Health Promotion/Illness and Injury Prevention - 38**

#### **INJURY PREVENTION AN IMPORTANT PART OF TRAUMA CARE (BILINGUAL PRESENTATION)**

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Diane Richard, Trauma Program Clinical Coordinator, Montreal Children's Hospital,  
Helen Kocilowicz, Trauma Program Clinical Coordinator, Montreal Children's Hospital,  
Patricia Sidhom, Trauma Program Administrative Technician, Montreal Children's  
Hospital



The Montreal Children's Hospital, McGill University Health Centre is a provincially designated Pediatric & Adolescent Trauma Centre and a Neurotrauma Centre of Expertise. The mandate of the Trauma Program is to provide a cohesive, coordinated interdisciplinary approach to the management of all trauma patients which supports patient & family focused, outcome-oriented care: clinical and academic teaching; research; injury prevention & public awareness; quality assurance; and assume a leadership role in the local, regional, and provincial trauma network. As a Trauma Centre our primary responsibility is clearly to be available at all times to provide excellent state of the art tertiary level trauma care. However, Trauma experts at The Children's feel strongly that the majority of injuries seen could have been prevented had awareness of risks, knowledge of prevention information, recognition of early signs of injury, common sense and adequate supervision been implemented in a timely manner. This poster will focus on the injury prevention, public awareness and community involvement aspects of the Trauma Program. Highlighted will be different objectives, projects, community activities and other injury prevention efforts that the Program has been involved in over the years.

#### **Health Promotion/Illness and Injury Prevention - 39**

##### **PATIENT SAFETY -CHANGING THE CULTURE**

Alida Bowman, RN, BScN, MScN, Program Manager, McMaster Children's Hospital, 1200 Main St West, 3d2, Hamilton, Ontario, L8N3Z5, bowmana@hhsc.ca

Dolly Palin RN BScN, Educator, Nancy Wylie RN, BScN, Clinical Leader, Dr Desi Reddy Anesthetist, Ellen Bennett RN, Clinical Leaderesthetist

Patient safety problems dominate the media and produce public fear and mistrust of hospitals. The development of a new culture is required in order to achieve and sustain a successful patient safety program. This poster presentation describes the process in developing a pediatric safety program including strengths and areas for improvement. In structuring a safety program some of the key elements include a staff-centered infrastructure, point of care decision making, regular reporting and systematic analysis of incidents, indicators and trends, a disclosure policy, non punitive reporting structure, a patient safety culture and educational program. Story telling is utilized as a means of teaching/ learning and sharing of lessons learned.

One of the many challenges is promoting a culture where nurses, physicians and other health professionals are able to engage in review of adverse effects in an environment that supports accountability, reporting events and near misses with a focus on prevention rather than blame. Specific initiatives and outcomes are identified with recommendations.

#### **Health Promotion/Illness and Injury Prevention - 40**

##### **PUBLIC HEALTH IMPACT OF THE CANADIAN PAEDIATRIC SURVEILLANCE PROGRAM (CPSP)**

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J Doherty, A Medaglia

(Presented on behalf of the CPSP participants and investigators)

Objectives: To describe public health actions arising from CPSP studies.

Methods: Over 2,400 paediatricians reported high-impact uncommon diseases/conditions monthly to the CPSP. For case reports, physicians completed standardized questionnaires. Response rates were 83% for initial reports and 97% for detailed questionnaires, providing timely, purposeful surveillance data.

Results: Study results demonstrated the impact of vaccines on diseases, the importance of genetic screening, and the astuteness of specific guidelines, and identified needed targeted public health strategies:

- Implementation of universal varicella immunization – 61% of GAS-related necrotizing fasciitis cases were preceded by varicella;
- Herpes vaccine development – established pre-vaccine incidence data, demonstrated that 63% of cases were HSV-1 and 40% of mothers were unaware of their infections;
- Improved educational interventions for vitamin D dietary supplementation – identified 84 nutritional rickets cases, mostly in darker-skinned, breast-fed infants;
- Timely work-up and close follow-up of termed jaundiced newborns – confirmed 145 neonatal hyperbilirubinemia cases;
- Mandatory ban of baby walkers – documented at least 132 current injuries;
- Development and mandatory use of weight-size appropriate car restraints and booster seats – identified at least 47 lap-belt syndrome injuries.

Conclusion: Systematic analyses, interpretation and dissemination of CPSP study findings identified important public health actions that benefit Canadian children and their families.

### **Health Promotion/Illness and Injury Prevention - 41**

#### **APPLICATIONS PRATIQUES DE L'ERGONOMIE DANS UN DÉPARTEMENT DE PHARMACIE**

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Julie Bleau, Sylvie Legault

Introduction : On d efinit l'ergonomie comme  tant l' tude de la relation entre l'homme et son travail. Son but est l'adaptation du travail au travailleur : les  quipements, les m ethodes, les horaires et l'environnement de mani ere   le rendre le plus confortable, s ecuritaire et efficace possible. La pratique pharmaceutique a connu un d eveloppement sans pr ec edent au cours de la derni ere d ecennie avec une intensification des activit es et la robotisation. Objectif :  valuer l'ergonomie de trois zones de travail au sein d'un d epartement de pharmacie.

R esultats : En collaboration avec l'Association paritaire pour la sant e et la s ecurit e du travail du secteur affaires sociales, nous avons proc ed e   l' evaluation des fonctions reli ees   la distribution unitaire dans un centre hospitalier m ere-enfant. Pour chaque poste de poste de travail, nous avons proc ed e   des analyses de processus de travail. Les  tapes du processus ont  t e syst ematiquement collig ees et les circulations des personnes et du mat eriel ont  t e analys ees afin d' liminer les risques   la sant e et les temps improductifs. De plus, des analyses ergonomiques des postes de travail ont  t e effectu ees afin d'identifier les probl emes v ecus au travail (je trouve cette phrase redondante). L'analyse ergonomique permet de mieux documenter les besoins des travailleurs et de fournir des

repères fiables de conception qui élimineront les risques et amélioreront leur confort et leur efficacité. À la lumière de ces analyses, 25 recommandations ont été proposées, discutées auprès de l'équipe de gestion, d'un comité de super-usagers et de l'ensemble de l'équipe puis implantées. Des suivis ont été effectués pour réévaluer les solutions et les réajuster au besoin.

Conclusion : Il existe une méconnaissance de l'apport de l'ergonomie en pharmacie. Compte tenu de l'évolution de la pratique pharmaceutique, on doit favoriser la réalisation et la diffusion d'évaluation ergonomique en pharmacie.

#### **Health Promotion/Illness and Injury Prevention -42**

##### **VIRTUAL HOME SAFETY A REALITY IN THE MARITIMES**

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S Newton

Young children under 5 years of age are at increased risk for home injuries. Making safety changes to the home environment can prevent many of these injuries. Parents, especially new parents, are often looking for information regarding safety, but do not know where to look. Child Safety Link is a Maritime-wide children's injury prevention program located in the IWK Health Centre in Halifax, Nova Scotia. The objective of this poster is to demonstrate the development of an innovative home safety initiative that includes a virtual home component. This initiative targets caregivers with children under five years old and will increase the accessibility of injury prevention information.

A survey of pre-natal classes identified the need for a post-natal child safety workshop. Initially, this workshop included a tour of a mobile trailer set up as a safety home. Eventually it became clear that it was not feasible to educate large groups of parents across the Maritimes with this mobile safety home. Using surveys and direct feedback from parents and injury prevention professionals, a Virtual Safety Home was developed to replace the existing mobile safety home. This interactive virtual tour moves from room to room in a home, pointing out safety tips in a visual manner. It will be used as part of a workshop on child safety but will also be accessed by parents through the Internet. In addition to this Virtual Safety Home, a Keep Kids Safe Booklet was designed to reinforce the information.

The development of a virtual safety home will increase accessibility of credible, timely information to caregivers across the Maritimes.

#### **Health Promotion/Illness and Injury Prevention - 43**

##### **BEST PRACTICE IN OXYGEN SATURATION MONITORING IN NEONATES: REDUCING POOR OUTCOMES AND HEALTH SERVICE BURDEN**

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Ms Barb Jennings, RN, BA, MSHSA, Program Manager, McMaster Children's Hospital, HHS, Dr Susan Blatz, RN, BScN, MEd, PhD, Clinical Nurse Specialist, McMaster

Children's Hospital, HHS, Ms Kelly Vaillancourt, RRT, Respiratory Therapy Clinical Leader, McMaster Children's Hospital, HHS

The objective of this poster will be to learn about best practice target ranges of oxygen saturation monitoring in the neonate. It is a key safety initiative in the NICU without which there may be short and long-term adverse sequelae. Appropriate for health professionals interested in the care of neonates and their outcomes into childhood.

Neonatal ICU oxygen saturation parameter ranges are an evolving concept as new data concerning best practice continues to be discovered and as technology improves our ability to monitor saturation levels. This topic has spanned the neonatal literature for the last 6 decades. Each program within the McMaster Children's Hospital identified a key safety initiative to target and the Neonatal Operations Advisory Group selected Oxygen Saturation Monitoring as our initiative. Our ongoing process is being shared at the unit and program council level as well as across the continuum of care at McMaster Children's Hospital. This poster will address the most recent changes and challenges in the Neonatal ICU, in oxygen saturation monitoring management. Our goal is to ensure patient safety, implement best practice and maintain ongoing evaluation.

Improper Oxygen Saturations can lead to hypoxemia or hyperoxemia that may result in poor growth and development, increased risk of Retinopathy of Prematurity, increased risk of poor pulmonary outcomes, and an overall Increased burden on health services. The evaluation of our success and the challenges we face with this significant change in practice for our multidisciplinary team will be demonstrated.

#### **Health Promotion/Illness and Injury Prevention -44**

### **ÉTAT ACTUEL EN MATIÈRE DE VACCINATION AU CENTRE TERTIAIRE PÉDIATRIQUE CHU MÈRE-ENFANT SAINTE-JUSTINE DE MONTRÉAL: L'ENTRÉE EN VIGUEUR DE LA LOI 90?**

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J Bouchard inf BSc, M Dionne inf BSc, P Germain inf MSc, D Tremblay inf BSc, M  
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Le centre hospitalier universitaire (CHU) Mère-Enfant Sainte-Justine de Montréal est un établissement de soins de santé tertiaire pédiatrique. La promotion de la santé dont la vaccination est une mission importante de notre centre. Depuis janvier 2003, le Gouvernement du Québec a mis en application le projet de loi 90 modifiant le code de plusieurs professions dont les infirmières. Par cette loi, les infirmières sont habilitées à décider, sans ordonnance individuelle ou collective, à administrer des produits immunisants. Un groupe de travail sur la vaccination, composé d'infirmiers(es) de différents milieux (clinicienne, infirmières soignantes, infirmières gestionnaires) a donc été créé en juillet 2003. Quatre constats ont été mis en évidence suite aux réunions du groupe: 1) Actuellement, la plupart des vaccins sont administrés par les infirmières oeuvrant en milieux ambulatoires. 2) Une récente étude menée auprès des infirmières de notre établissement a identifié un besoin de connaissances relié à la vaccination. 3) Avant 2003, aucune formation sur la vaccination à l'embauche ni en cours d'emploi n'était planifié chez le personnel infirmier. 4) L'outil de référence sur la vaccination utilisé est le Protocole d'Immunisation du Québec (PIQ) et n'est pas actualisé dans plusieurs unités de soins. En conclusion, l'entrée en vigueur de la loi 90 a amené le groupe de travail à se

questionner sur la pratique face à la vaccination. Des lignes directrices devront être établies afin d'appliquer la loi en tenant compte de plusieurs facteurs dont une clientèle avec condition médicale particulière, l'acquisition et le maintien des connaissances, l'enseignement clinique des vaccinateurs et la mise à jour de la documentation clinique.

#### **Health Promotion/Illness and Injury Prevention - 45**

##### **SCRUB-A-DUB-DUB: OBSERVATION AND KNOWLEDGE OF HANDWASHING PRACTICES IN THE NEONATAL NURSERIES**

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Susan Blatz, Lyubov Aghayeva, Kyla English, Jing Shen, Sara Trushinski

The objective is to present information about handwashing practices and compliance in the Neonatal Nurseries.

Handwashing has been identified as one of the most effective methods to prevent or reduce the occurrence of nosocomial infections in the hospital setting. RN staff has anecdotally noted that families, physicians and other support staff do not perform a 2-minute scrub upon entry to the neonatal nurseries. Unit policy requires all staff, families and visitors to complete a scrub upon entry into the nurseries. Education over the last 8 months included interactive inservices, scrubbing instruction sheets at sinks, parent teaching sheets, reminder posters at entry points, and annual review sessions. RN staff continue to note that people are not washing their hands!

This study was done to discover whether there is consistent compliance with the handwashing policy and to assess staff knowledge about scrubbing.

An observation and verbal survey were done to collect data. Collection dates were selected randomly (observer availability) and occurred during shift changes, lasting over a 5-hour period, observing multiply roles. A short verbal survey collected data about scrubbing practices for that day. Staff was informed via email about the handwashing observational study. Data collectors openly completed observations and accepted refusals for the survey.

Data collection is completed and analysis is in progress. Analysis, using SPSS should demonstrate scrubbing knowledge and compliance levels. Analysis may also reveal roles and disciplines that require further education about scrubbing practices.

Implications for practice will vary depending upon results. Strategies for education, dissemination of these study results and how to monitor compliance in the future may need to be addressed.

## **Health Promotion/Illness and Injury Prevention - 46**

### **ADEQUATE AND AFFORDABLE HOUSING: A CHILD HEALTH ISSUE**

Jama Watt, Project Coordinator, Children's Hospital of Eastern Ontario, 401 Smyth Road, Ottawa, Ontario, K1H 8L1, [jwatt@cheo.on.ca](mailto:jwatt@cheo.on.ca)

Housing affects health. Asthma, injuries, communicable and infectious diseases, mental health issues, malnutrition, respiratory disorders, family functioning and exposure to toxins all have been linked to housing conditions and can seriously effect the health of children, youth and their families. Investing in affordable and adequate housing and developing a cohesive, integrated housing strategy are steps towards improving the health and well-being of people in Canada.

In an attempt to raise awareness for the critical need for adequate and affordable housing in Canada, the Child and Youth Health Network for Eastern Ontario has developed a research-based package which is an overview of research literature highlighting the link between housing conditions and child and youth health status.

## **Health Promotion/Illness and Injury Prevention - 47**

### **KIDS IN THE MIDDLE: PROMOTING HEALTHY DEVELOPMENT FOR CHILDREN 6-12 YEARS. AN INNOVATIVE STRENGTHS-BASED APPROACH TO MIDDLE CHILDHOOD**

Jama Watt, Project Coordinator, Children's Hospital of Eastern Ontario, 401 Smyth Road, Ottawa, Ontario, K1H 8L1, [jwatt@cheo.on.ca](mailto:jwatt@cheo.on.ca)

Children age 6 to 12 years are caught in the middle; too old for early years programming, too young to get services from adolescent-based agencies. As a result, many children in this age group lack services, resources and programs designed to meet their developmental needs.

Recognizing this dilemma, the Child and Youth Health Network for Eastern Ontario and United Way /Centraide Ottawa have developed a framework, anchored in outcomes, which identifies assets and needs for this age group. Grounded in evidence-based research, the framework outlines key factors that influence and enhance children's lives and contribute to their overall health and well-being.

Grounded in evidence-based research, the framework focuses on four key elements and some of their influences that enhance children's lives and contribute to their overall well-being. This will help to identify strengths in the community, the gaps that exist, and help recognize opportunities for greater collaboration among community groups.

The framework and accompanying research is a starting point, where we begin to investigate the major components for healthy development of children in this age group. Our aim is for communities to use the action-orientated document to build on existing partnerships so that no child is caught in the middle.

## Health Promotion/Illness and Injury Prevention - 48

### STRATEGIES FOR ENCOURAGING AND SUPPORTING BREASTFEEDING AMONG TEENS/YOUNG MOTHERS

Gillian Sippert, Birth Companion Coordinator, Canadian Mothercraft, 475 evered Ave, Ottawa, Ont, K1Z 5K9, Gill@mothercraft.com

#### Objective:

To prevent strategies used to support teen/young mothers in their effort to breastfeed exclusively. Topics to be covered include: Issues specific to this group; How to identify core issues; Confidence building; Barriers to breastfeeding; Support strategies that work; Building a successful support program; Working towards a community approach.

#### Description of project:

Our “Young Mom’s Breastfeeding Support” group came about when we discovered that although over 90% of the young/teen mothers in our Birth Companion Program initiated breastfeeding after birth less than 20% were still breastfeeding at 6 weeks.

In an effort to change this outcome we established a breastfeeding drop in for young mums with a core curriculum In one year our breastfeeding at 6 weeks rate climbed from 20% to 60%. And all of the mothers who were breastfeeding at 6 weeks were still nursing their babies at 6 months.

The program continues to grow in popularity and the rates of exclusive breastfeeding are also climbing.

## Health Promotion/Illness and Injury Prevention - 49

### VALIDATING A PRACTICAL APPROACH TO DETERMINE WEIGHT CONTROL IN OBESE CHILDREN AND ADOLESCENTS.

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Linda Gillis, Oded Bar-Or

The objective of this study was to examine the usefulness of a mathematical index for assessing changes in body composition of obese children and adolescents who undergo a weight control program. The study was a short-term longitudinal cohort study involving sixty-seven obese children and adolescents participating in a clinic-based weight control program. There were 38 males and 29 females aged 6-16 years. Percentage of body fat was assessed at the start of the program by underwater weighing (UWW) and by bioelectrical impedance (BIA). Response to the program was assessed by a mathematical index (MI), based on observed and expected changes in height and weight and by changes in percentage of body fat as measured by BIA. Results indicated that adiposity, as assessed by BIA, at the start of the program, was highly correlated to that obtained by UWW ( $r=0.95$  for fat-free mass). Changes in the MI over the program were correlated fairly well ( $r=0.81$ ) with changes in percentage fat as assessed by BIA. In conclusion, using change in BIA as the criterion, the MI is valid for assessing changes in percentage body fat of obese children and adolescents over time. This index is of use to clinicians who lack body composition equipment and need a quick method to analyze the effectiveness of a weight control program in obese children and adolescents.

## **Health Promotion/Illness and Injury Prevention - 50**

### **THE VACATION STUDY: DO CHILDREN DO WELL THROUGHOUT THE YEAR IN A WEIGHT CONTROL PROGRAM?**

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Linda Gillis

The Children's Exercise and Nutrition Centre offers a weight control program for children and adolescents four to 18-years of age. Over the years the clinical group has noticed an inconsistent pattern of weight control success over the calendar year. The present study was performed to evaluate seasonal variation in weight control. We studied 73 patients for one calendar year. The year was partitioned into 6 seasonal periods: period one - January and February, period two - March and April, period three - May and June, period 4 - July and August, period 5 - September and October, and period 6 - November and December. Height and weight were measured to determine percent ideal body weight at each time period. This allowed us to account for growth during the year. On average, children lost weight during each time period except the summer vacation (period 4). Weight loss was achieved in 52 - 67% of the children in all periods except the summer. During the summer only 34% of the children lost weight. The range of weight change, expressed as a percentage of body weight, was -0.3% in period 6 to -2.0 % in period 3. During the summer weight change averaged +1% body weight. The main reason associated with the summer weight gain was sweet drink consumption. This includes fruit juice, regular pop, iced tea, sports drinks, popsicles, etc. Our current clinical recommendation is to limit pure juice to 250 ml (8 oz) per day and other sweet drinks should be used as occasional treats.

## **Health Promotion/Illness and Injury Prevention - 51**

### **LE SYNDROME RESPIRATOIRE AIGU SÉVÈRE, LES MALADIES INFECTIEUSES ÉMERGENTES ET LES BIO RISQUES: BILAN D'UN EXERCICE DE SIMULATION**

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Beaudreau L Hôpital Ste-Justine, Blondin M Hôpital Ste-Justine, Desmarais N Hôpital Ste-Justine, Laferrière C Hôpital Ste-Justine, LeMay M Hôpital Ste-Justine

Objectif:

L'éclosion de SRAS au printemps 2003 a pris les travailleurs de la santé par surprise. Un exercice de simulation a été planifié à l'Hôpital Ste-Justine dans le but de vérifier l'assimilation des procédures de prévention et la capacité de répondre à une menace biologique.

Méthode:

Un sous-comité des mesures d'urgence formé des représentants des secteurs concernés par une menace potentielle de risque biologique a été constitué. Les membres du comité ont conçu un scénario clinique qui prévoyait la participation des intervenants internes dont ceux de l'urgence, des soins intensifs et de l'unité d'isolement. Les partenaires du réseau externe étaient également impliqués. L'exercice s'est tenu dans un contexte d'urgence. Une évaluation de la simulation a été faite en plusieurs étapes: verbalement et par écrit.



Résultats:

L'implication des intervenants a dépassé les attentes dans tous les secteurs. L'exercice a permis de mettre en évidence des lacunes dans la coordination de la prise en charge des cas et des accompagnateurs, l'organisation physique des lieux, l'utilisation du matériel de protection individuelle et certaines procédures. Certaines situations ont provoqué un état de panique.

Conclusion:

L'exercice de simulation a mis en évidence l'importance d'une bonne préparation à tous les niveaux et la nécessité de pratiquer les procédures mises en place. Un gros travail reste à faire pour consolider les apprentissages et faire en sorte que les intervenants demeurent aptes à répondre à une menace biologique. Il est essentiel de maintenir la vigilance par d'autres exercices de simulation et d'implanter la "nouvelle étiquette respiratoire".

**Health Promotion/Illness and Injury Prevention - 52**

**A ONE DAY WORKSHOP: THE JUVENILE OBESITY EPIDEMIC: THE PROBLEM AND SOLUTIONS, A MULTIDISCIPLINARY APPROACH BY THE CHILDREN'S EXERCISE AND NUTRITION CENTRE.**

Randy Calvert, Clinical Manager, McMaster Children's Hospital, 1200 Main Street, Hamilton, ON, L8N 3Z5, rcalvert@hhsc.ca

The Children's Exercise and Nutrition Centre provides a multidisciplinary clinical, research, and educational service. Our clinical program involves consultation, education, and prescription of physical activity, nutrition, and lifestyle alterations to modify health-related behaviours of children and adolescents, their families, and caregivers. Our 'Shaping-Up' program for weight control has evolved over the last 20 years and is currently the most prominent component of our service. We developed and offered a workshop for health professionals on our treatment modalities. The workshop begins with an introduction by the Director who introduces the notion of the obesity epidemic. The Clinical Manager outlines our weight management program and offers some suggestions on the 'ideal program.' The Registered Dietitian discusses food and its relationship to obesity, dietary assessment, goal setting, and outlines some of the obesity-related research that has been conducted at the Centre. The Kinesiologist / Activity Therapist discusses habitual activity assessment, weight training for youth, and activity challenges as a motivational tool. The Behaviour Therapist discusses behavioural assessment, therapeutic factors and methods involved in treatment, and family focused treatment. Participants will also be involved in two practicum, hands-on sessions. One session is on the red, yellow, and green approach to food and activity and the other focuses on relaxation as a form of behaviour modification therapy. Finally, the Exercise Physiologist will present some ideas on anthropometry; some practical tips on how to evaluate height, weight, and body composition. The Centre has held this workshop twice and plans to offer the workshop twice per year.

### **Health Promotion/Illness and Injury Prevention - 53**

#### **FROM HOSPITAL TO COMMUNITY, A CONTINUUM OF UNIFIED CARE FOR ASTHMATIC CHILDREN AND THEIR PARENTS : CASE MANAGEMENT AND PRIISME PROJECT AT CHU MÈRE-ENFANT SAINTE-JUSTINE**

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France Choquette, Suzanne Durocher, Geneviève Harbec, Sylvie Laporte, Huquette Paquette, Robert Thivierge

According to the Angus Reid survey (1999), 78% of asthma-related ED visits could have been avoided with a better control of the patient's asthmatic condition and regular medical follow-ups. The Sainte-Justine Hospital has begun an asthma case management project to ensure a post-hospitalization medical and educational follow-up. In order to facilitate hospital-community links, this case management project is associated with the GlaxoSmithKline's PRIISME project. The objectives of this poster presentation are to illustrate the case management and patient-oriented approaches to describe the implementation process at Sainte-Justine Hospital, and to identify the expected results. The objective of this project is to ensure that the child and his family will receive appropriate care, at the appropriate time and place and from the appropriate person during the continuum, as well as the post-discharge clinical follow-up. The expected results include a reduced number of recurrent ED visits and hospitalizations, and an improvement in patient care delivery. In conclusion, the project aims to orient patients and their families towards an improved quality of life by offering better asthma control and the educational and medical follow-up their condition requires.

### **Health Promotion/Illness and Injury Prevention - 54**

#### **LE PROGRAMME DE GESTION DES RISQUES CHU SAINTE JUSTINE**

Martine Dubé, Directeur adjoint, CHU Sainte-Justine, 3175, Côte Sainte-Catherine, Montréal, Québec, H3T 1C1, martine\_dube@ssss.gouv.qc.ca

Au Québec, depuis décembre 2002, le droit à la sécurité est formellement reconnu comme droit des patients. L'adoption de la Loi modifiant la Loi sur les services de santé et les services sociaux concernant la prestation sécuritaire des services de santé et des services sociaux introduit des changements importants concernant :

- La reconnaissance du droit à la sécurité ;
- L'obligation de toute personne de déclarer les incidents et accidents ;
- L'obligation de divulguer au patient l'accident et les mesures prises pour éviter sa répétition ;
- Les mesures de soutien offertes au patient et à ses proches ;
- La mise en œuvre d'un Comité de gestion des risques ;
- L'établissement d'un registre national et local des accidents et incidents.

Pour répondre à ces obligations, un programme de gestion des risques a été élaboré et comprend les règlements et les procédures qui découlent des obligations de notre établissement en matière de gestion des risques. Il inclut aussi des méthodes et des outils efficaces, nécessaires à la coordination des activités et des efforts de chacun, assurant ainsi l'atteinte de meilleurs résultats. De plus, il s'harmonise avec les autres programmes

et activités centrés sur la qualité tels la gestion des plaintes, le programme d'amélioration continue de la qualité et la gestion de l'environnement.

Notre programme vise à :

- Créer et maintenir les conditions permettant une prestation sécuritaire des soins et services ;
- Éliminer ou réduire les conséquences de la réalisation des risques ;
- Prévenir la récurrence des accidents/incidents ;
- Maintenir un lien de confiance entre le patient et l'établissement ;
- Protéger les ressources humaines, matérielles, financières et informationnelles de l'établissement ;
- Répondre à la notion de reddition de comptes.

### **Health Promotion/Illness and Injury Prevention - 55**

#### **COMFORTABLE AND COZY: INFANT POSITIONING IN THE NEONATAL NURSERIES**

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Julie Whitley, Julie Cornwell, Heather Watson, Barbara Czerniawski-DeLaCruz, Aune Hjartarson

Health care professionals working with preterm and high-risk infants may find this evaluation study of infant positioning helpful in the clinical setting, and the new audit tool useful as an adjunct to patient assessment. Correct infant positioning using rolls to achieve optimal alignment can facilitate future infant developmental milestones such as lifting head and shoulders, crawling, and walking. A pilot study was conducted in October 2003 at McMaster Children's Hospital Neonatal Nurseries, a 47 bed NICU and 10 bed intermediate care nursery (ICN). Forty-two infants' positions were assessed using a new, 5 point Likert scale audit tool consisting of 5 different criteria specific to each position. Mean scores for each of 3 positions were: supine =3.2, prone =3.8, and side-lying =3.4. A variety of educational sessions were provided to the nursing staff during the next six months. An additional 123 infants' positions were assessed using the same audit tool. The mean scores improved for all 3 positions in the follow-up assessment: supine = 3.94 (p=.00), prone = 4.39 (p=.057) and side-lying = 4.09 (p=.077). Nurses were observed to position the infants more in side-lying (50%) rather than supine (37%) and prone (12%), which was not significantly different from the pilot study. Recommendations for further education, and encouraging nurses to integrate the audit tool criteria into their own personal assessment of the infant's position may lead to further improvements with infant positioning.

Special thanks to Gloria Beddeker & Marsha Montgomery, 4th year McMaster Nursing Students.

## **Health Promotion/Illness and Injury Prevention - 56**

### **PREVENTING LOW BIRTH WEIGHT - A MULTICULTURALLY SENSITIVE APPROACH**

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Ottawa Coalition Members

Infants who weigh less than 2500 grams at birth are considered to be low birth weight. These babies are at risk for immediate and long-term health concerns as well as developmental problems. Health care professionals have an important role to play in the prevention of low birth weight. Education about the causes of low birth weight, the signs and symptoms of preterm labour and the impact of low birth weight on the infant and family are paramount. To that end, the Ottawa Coalition for the Prevention of Low Birth Weight developed resources entitled “Low Birth Weight – What You Need to Know” to meet the needs of a variety of multicultural groups in Ottawa. A description of this process, examples of the resources developed and the dissemination strategy will be provided.

## **Health Promotion/Illness and Injury Prevention - 57**

### **SYSTEM CHANGES TO MAKE HANDLING OF EXPRESSED BREAST MILK SAFER IN A PAEDIATRIC HOSPITAL**

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Wray, R RN BA CIC, Campbell, J RN BScN, Dello, S RD

Background: The Hospital for Sick Children (HSC) is a 300 bed pediatric, tertiary care centre where over 60,000 containers of expressed breast milk (EBM) are handled annually. A five year (1998-2003) review of hospital risk reports revealed 19 incidents related to handling and administration of EBM; nine were classified as actual and ten as near miss events. Improvements were required.

Improvement Initiatives: The following changes have been made: 1) A unique labeling system has been introduced to ensure two patient identifiers are present on all vessels containing EBM; a peel off portion can be affixed to the health record as part of double checking and co-signing requirement. 2) A similar labeling system in the milk preparation room requires double check and co-signature for the release of EBM. 3) A newly installed alarmed central storage freezer and racking system allows better inventory control and EBM identification. 4) Educational approaches have been initiated. 5) Related policies and procedures have been written or updated and are available on-line. The change processes have been audited and demonstrate some key areas of success; however, incidents continue to occur, underscoring the need for ongoing vigilance when any system change occurs.

Conclusions: Adopting some safeguards that have been used for blood transfusion (eg. double checking) has proven useful for safe EBM administration. System changes in one area of the process have uncovered new potential for error, however, increasing redundancies and standardization in the system is already leading to a safer system. Audits and improvements are ongoing.

## **Health Promotion/Illness and Injury Prevention - 58**

### **HEALTHY ACTIVE LIVING FOR CHILDREN: A RESIDENT EDUCATION MODULE**

Heather MacDonnell, Pediatrician, Children's Hospital of Eastern Ontario, University of Ottawa, 33 Fourth Avenue, Ottawa, ON, K1S 2L1, heathermacdonnell@yahoo.ca

Claire LeBlanc, Mona Jabbour

Obesity is increasingly being recognized as an emerging children's health issue reaching epidemic proportions worldwide. The Canadian Pediatric Society with Health Canada has developed a Healthy Active Living strategy for children and youth which outlines physical activity guidelines and recommendations to decrease sedentary behaviours. To date, education efforts have been targeted towards practicing pediatricians. The goal of this project was to develop, pilot and evaluate Pediatric residents on the Healthy Active Living strategy with emphasis on the following: (1) increasing awareness of the childhood obesity epidemic, (2) identification and diagnosis of children at risk for obesity, and (3) awareness of strategies for further investigation and management of affected children. The program was piloted at the University of Ottawa as two 3-hour education modules with focus on history-taking, physical exam skills and management plans.

Through program evaluation, positive resident feedback validated the importance and acceptance of the program. Individual resident improvement on pre vs. post-test multiple choice questions (30 questions) reflected knowledge acquisition (mean increase = 8.2,  $p < 0.001$ ). Higher OSCE scores in the exposure group of residents (72.9% vs. 56.8% unexposed,  $p < 0.004$ ) reflected knowledge retention and practical application. The ultimate goal will be to deliver this program to all Pediatric residents across Canada. By introducing obesity screening and prevention strategies at the post-graduate training level, future pediatricians will be better equipped to approach this important health concern with their patients and families in order to successfully advocate for their physical, emotional and psychosocial well being.

## **Health Promotion/Illness and Injury Prevention - 59**

### **SEND CHILDREN HOME SAFELY: CHEO'S CAR SEAT STRATEGY**

Reid Shelley, RN, Hospital Injury Prevention Coordinator, Plan-it Safe, Children's Hospital Of Eastern Ontario, 401 Smyth Road, Ottawa, ON, K1H 8L1, reid\_s@cheo.on.ca

Motor vehicle crashes remain a leading cause of death and injury in children, but many of these deaths could have been prevented with the proper use of a child safety restraint. Thousands of children are discharged home each year from hospitals across Canada, but other than policies concerning the transportation of newborns most hospitals do not provide families with recommendations about the safest way to transport their children home. With this motivating them, the Children's Hospital of Eastern Ontario (CHEO) formed a team to examine the issue and make recommendations for guidelines to promote safe transportation for infants and children after discharge from the hospital. Draft guidelines have been developed and are currently being reviewed prior to dissemination to the nursing staff and implementation by the end of 2004. This poster will share the proposed guidelines and our ongoing progress to inform other pediatric health care professionals who may wish to address this important issue in their own institution.

## Health Promotion/Illness and Injury Prevention - 60

### **PROJET-PILOTE DE PRÉVENTION DU SYNDROME DU BÉBÉ SECOUÉ PAR UNE INTERVENTION D'ÉDUCATION AUPRÈS DES PARENTS LORS DE LEUR SÉJOUR EN CENTRE HOSPITALIER APRÈS OU APRÈS LA NAISSANCE DE L'ENFANT**

Sylvie Fortin, Responsable du module post-natal de prévention du SBS, CHU mère enfant Ste-Justine, 3175, Côte Sainte-Catherine, Montréal, Québec, H3T 1C5, [sylvie.fortin.hsj@ssss.gouv.qc.ca](mailto:sylvie.fortin.hsj@ssss.gouv.qc.ca)

Céline Goulet

L'objectif de la séance est sensibiliser les participants sur la possibilité de prévenir le syndrome du bébé secoué par la description d'un programme innovateur au Canada.

Cette présentation s'adresse aux cliniciens professionnels de la santé (infirmières, médecins) et aux gestionnaires et administrateurs intéressés à la prévention de la maltraitance infantile en milieu hospitalier pédiatrique.

Un projet-pilote est débuté au CHU mère-enfant Ste-Justine ainsi que dans un autre centre hospitalier membre du Réseau mère-enfant supra-régional. L'affiche décrit les objectifs du programme, les moyens et les outils développés pour prévenir le SBS dès la naissance en centre hospitalier. Il s'agit d'une intervention, faite par les infirmières des unités des naissances auprès de tous les parents dans les heures suivant l'accouchement. Les causes du SBS sont de près associées aux pleurs persistants du nourrisson, à l'expression de la colère de l'adulte et à la méconnaissance des dangers de secouer un nourrisson. Dans une approche universelle les infirmières abordent les parents sur ces trois causes consécutivement. Elles leur présentent 3 fiches d'information au sujet des pleurs du nourrisson, de la colère chez le parent, une émotion normale qu'il doit tenter de gérer par des stratégies adaptatives et du SBS et ses conséquences chez l'enfant et la famille. Cette intervention fera partie du programme usuel d'éducation offert aux parents avant leur congé de l'hôpital suite à la naissance de leur enfant. Ce projet-pilote fera l'objet d'une évaluation visant à apprécier ses effets et identifier les améliorations à apporter. À terme, il sera généralisé à l'ensemble des centres hospitaliers du Québec, en collaboration avec le MSSS.

## Health Promotion/Illness and Injury Prevention - 61

### **CREATING OPPORTUNITIES FOR GIRLS AND WOMEN THROUGH PHYSICAL ACTIVITY AND SPORT**

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Shelley Callaghan, ACTive Strategy Coordinator

The Canadian Association for the Advancement of Women and Sport and Physical Activity (CAAWS), is a 21-year old not-for-profit organization working to encourage girls and women to *participate and lead* in sport and physical activity. CAAWS offers services, programs and resources to a variety of clients including sport and physical

activity organizations, teachers, coaches, health professionals and recreation leaders. Below please find initiatives that will be highlighted in this poster presentation.

- **ACTive:** A Canadian Strategy focused on increasing physical activity and sport opportunities for girls and women. ACTive supports individuals and organizations by providing access to national networks, success stories, listservs and regular updates on what is happening across Canada and around the world for girls and women.
- **On the Move (OTM):** A national initiative to increase opportunities for non-active girls and young women, ages 9-18 to participate in physical activity and sport. The *On the Move (OTM)* Diabetes project builds on the success of OTM by increasing the capacity of multisectoral organizations to integrate OTM concepts into their policies, programs and services.
- **Mothers in Motion:** Sponsored by Whirlpool Home Appliances, this website is for women who want to lead a healthy lifestyle and mentor their children to do the same.
- **Women and Leadership:** A professional development program that blends theory with practical applications to train women to improve communication, to deal more effectively with conflict and to influence change.

## Health Services/ Resources - 62

### ANALYSE DESCRIPTIVE D'UN DÉPARTEMENT DE PHARMACIE EN CENTRE MÈRE-ENFANT

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Denis Lebel, Sylvie Legault

Introduction : La pratique pharmaceutique a vécu une évolution considérable au cours de la dernière décennie. Bien que les activités reliées à la dispensation du médicaments demeurent essentielles, la plupart des activités des pharmaciens en établissement de santé de santé portent sur des activités de soins pharmaceutiques, d'enseignement et de recherche.

Objectif : Décrire la réorganisation du département de pharmacie du centre hospitalier universitaire mère-enfant Sainte-Justine.

Méthode: Description des 5 axes de pratique soit gestion, services, soins, enseignement et recherche à l'aide de deux planifications stratégiques (1996-2001 et 2002-2007)

Résultats : Depuis 1996, le département de pharmacie a vécu une réorganisation de ses espaces (&#8593; x m<sup>2</sup>), de ses ressources humaines (&#8593; x ETP), une prise en charge du circuit du médicament (&#8593; % du nombre de transactions, de x % du nombre de préparations, de x % du nombre de demandes d'information, de x % du nombre d'interventions pharmaceutiques et de x % du nombre de jour-présence enseignement). La plupart des pharmaciens ont opté pour un secteur de spécialisation fondé sur les besoins des clientèles. Afin de documenter l'évolution de ses pratiques, l'équipe de gestion a mis en place un tableau de bord et des indicateurs qui seront présentés.

Conclusion : Compte tenu de l'importance grandissante du médicament au sein de notre réseau de santé, le pharmacien est un intervenant clé. Le développement d'activités de soins, d'enseignement et de recherche en pharmacie est nécessaire à la pleine réalisation de la mission d'un centre hospitalier mère-enfant universitaire.

## Health Services/Human Resources - 63

### **DIAGNOSTIC TRAJECTORIES IN CHILDREN WITH PHYSICAL DISABILITIES**

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M Couture, OT, MA, Université de Montréal, L Grilli, PT, Université de Montréal, MN Simard, OT, MSc, Université de Montréal, L Azoulay, MSc, Université de Montréal

**Objectives:** Time of diagnosis of childhood disabling conditions depends on a variety of factors including severity of the problem, parent or physician's concern, and access to primary health care services and may have consequences regarding treatment and outcomes. The study objectives were to describe trajectories leading to diagnosis and related factors in a cohort of children with physical disabilities. We compared trajectories and initial age of concern for children with various diagnoses of physical disabilities. Also, we evaluated whether age of concern influenced age at referral to rehabilitation.

**Methods:** Parents of 144 children (age 0-6 years) who were on the waiting list for physical or occupational therapy services were interviewed regarding medical history and health care services. Severity and family empowerment were also assessed.

**Results:** Parents were concerned later than physicians regarding their child's health status ( $p=.0004$ ). Global developmental delay was detected, on average at 14.3 months as opposed to other diagnoses (syndromes and neurological conditions) which were recognized at 11.2 months ( $p=.06$ ). After controlling for diagnosis, parental concern occurred later than physician concern and problems for boys were detected later than for girls. Age of initial concern was significantly associated with age at referral to rehabilitation ( $p<0.0001$ ).

**Conclusion:** Early recognition and diagnosis is important in order to benefit from early rehabilitation. Since parental concern occurs later than physician concern, it may be important to improve primary care screening of children for developmental disabilities. An alternative approach may be to increase parental awareness regarding normal development of their children.

## Health Services/Human Resources - 64

### **PROVIDING CARE CLOSER TO HOME; EVOLVING AS A REGIONAL PAEDIATRIC CENTRE OF EXCELLENCE**

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KE Hayward-Murray, C Chapman, P Coates

The Credit Valley Hospital is located in Mississauga (Ontario) the 6th largest city in Canada with a multicultural population of more than 680,000 people

The Credit Valley Hospital is designated as a regional maternal child centre to provide advanced Level II maternal/newborn care and enhanced paediatric services, operating within the West Cluster of the Child Health Network for the Greater Toronto Area.

The Regional Children's Health Centre at The Credit Valley Hospital is evolving as a centre of excellence in the delivery of care closer to home for paediatric patients and their families. A number of initiatives have been put in place to meet our mandate as a



regional centre and are described in this poster:

- Asthma Education Program
- Neonatal Follow Up Program
- Advanced Practice Nurses
- Satellite Oncology Program
- Diabetes Education Centre
- Therapeutic Clown
- Child Life Services
- Diagnostic Testing - MRI
- Transitioning Patients from Tertiary to Regional Care
- Palliative Care

The challenges/opportunities and strategies of integrating these services into a general hospital will also be highlighted.

### **Health Services/Human Resources - 65**

#### **MOVING FORWARD: EVOKING CHANGE IN PATIENT SAFETY**

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Dr Jackie Halton, Carolyn Kennelly, Susan Richardson

Background: Ryan was a 4-year-old boy being treated at our center for a stage 4 neuroblastoma. He had received chemotherapy, stem cell transplant and radiation. He was enrolled in an international clinical trial and was given an overdose of one of the non-study drugs. CHEO discovered that we had made an error in creating the pre-printed order set. Units were expressed in weight instead of body surface area. Ryan died 4 days after the error was discovered.

CHEO was immediately committed to full disclosure to the family, the media and the staff. A blame free systems analysis approach was taken to understand how this happened and how we could prevent future errors. A review committee was formed and developed recommendations to change practice to create a safer system for our patients.

Goal and Objectives: The goal in implementing the recommendations was to create a safer system for the patients. CHEO learned that building safety checks in the system is a valuable practice. The recommendations included the development of checklists, enhancing education, and redesigning the pre-printed medication orders and review process.

Changes Made: The oncology team was obviously devastated about what happened to Ryan and was very committed to making changes in their practice and to patient care in order to build a safer system. A project manager was hired from outside of the organization to oversee the implementation of the recommendations. The team was able to understand the rationale for change and was part of the change process. This allowed the team to feel like they were part of the decision making process and were allowed to make suggestions which would impact their practice.

Conclusions: CHEO learned that health care must not be predicated on human perfection because humans will make errors. A team approach to implementing the recommendations provided this team with greater visibility and acceptability for the

recommendations.

Future Plans: With any new measures to improve safety there is a need to ensure they do not create new potential areas for error. Once the work in oncology is complete and the team is satisfied with its effectiveness, the checklist etc. will be implemented in other areas of the hospital.

## **Health Services/Human Resources - 66**

### **PEDIATRIC DIABETES**

Alida Bowman, RN, BScN, MScN, Program Manager, McMaster Children's Hospital, 1200 Main St West, 3d2, Hamilton, Ontario, L8N3Z5, bowmana@hhsc.ca

Janice Muileboom RN, Sarah Mizener RN, Marilyn Rothney RN, Val Carroll RN, BS, Dr. John Vandermeullen Medical Director, Carrie Henderson RD, CDE

Diabetes in young children and youth is a new epidemic. There are numerous risk factors including genetic and environmental risk factors but obesity is one of the most significant. Poor nutrition, eating habits and sedentary lifestyles has contributed to the illness. This poster presentation provides an overview of a new pediatric diabetes clinic that was implemented through the support of the Northern Diabetes Network and the change from an adult focused unit. The child and family friendly environment is described with emphasis on diabetes treatment, research and health promotion. The role of the health care team in educating patients and families in the clinic as well as the community includes outreach and shared care models. The goal is to teach children and their families to provide them with the skills to assume control of their day-to-day diabetes management and provide access to safe and effective new diabetes-related therapies as soon as they become available. Examples are displayed including point of care testing for glycosylated hemoglobin in order to assist with the prevention of diabetes related complications. Clinical Practice Guidelines for diabetes provide a means for best practice and continuity. Attention to transitional needs for youth and positive communication strategies reduce gaps and promote seamless comprehensive care between pediatric and adult health care service.

## **Health Services/Human Resources - 67**

### **HOW'S THE QUALITY OF YOUR WORK LIFE?**

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Ms Kim Simmons, Dr Susan Blatz, Ms Julie Whitley, Ms Debbie McKeown, Ms Kelly Vaillancourt, Ms Barb Jennings

The objective is to share ideas related to improving Quality of Work Life(QWL)in the Neonatal Nurseries with other Children's Hospitals.

The QWL committee was designed by the Neonatal Nurseries staff, to promote a healthy and positive workplace environment, by providing a forum to address issues that affect the quality of their work life. The multidisciplinary QWL committee, which is accountable to the Neonatal Operations Committee, complements one of the organization's objectives for 2004 and serves the staff of a 47-bed tertiary care Neonatal Intensive Care Unit (NICU) and 10-bed Intermediate Care Unit (ICN) at the McMaster

Children's Hospital, Hamilton Health Sciences (HHS), Ontario.

The responsibilities generated by the staff include: 1. Identify and clarify issues in a timely fashion; direct concerns to appropriate resources. 2. Brainstorm and suggest solutions incorporating staff input and feedback. 3. Facilitate and evaluate implementation of resolutions. 4. Provide information on promotion of a healthy lifestyle.

Strategies implemented are: 1. Communication: the monthly newsletter and bulletin board display; improved use of email by staff; posted picture identification welcoming new physicians; and a pilot project of new name tags. 2. Team Morale and Cohesiveness: monthly potluck lunches and jeans day; sessions on both conflict management and caring for one another in stressful times; cards of recognition; a solution box; staff lounge improvements; a humor board and celebrations of all professional roles and support services. 3. Workload Issues: researching self scheduling; introduction of a quality tracking tool to improve patient care. 4. Healthy Lifestyles: displays and community partner presentations; quick tips in the newsletter. 5. Ongoing Evaluation: QWL staff survey conducted biannually with results presented in a "Quality Counts" booklet.

In conclusion, verbal and survey feedback, and participation in activities showed a positive attitude and enthusiasm about the improvements in our QWL. Innovative, creative and fun activities continue to be implemented by the staff to improve QWL in the Neonatal Nurseries.

#### **Health Services/Human Resources - 68**

#### **ONTARIO CHILDREN'S HEALTH NETWORK BENCHMARKING INITIATIVE: ONTARIO HOSPITAL PAEDIATRIC UTILIZATION REVIEW: AN EXAMINATION OF BOTH INSTITUTION AND POPULATION BASED PATTERNS**

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Kathy Watts, Director, Finance and Information Support, Hamilton Health Sciences,  
Wendy Gerrie, Manager, Decision Support Services, Hamilton Health Sciences, Murray  
Glendinning, Chief Financial Officer

Hospital funding has been influenced for many years by a variety of formulae used to measure cost efficiency and, more recently, per capita utilization of hospital services. It is the intention of the Ontario Ministry of Health and Long Term Care to increase the use of the Joint Policy and Planning Committee, Integrated Population Based Allocation Formula to support funding allocation decisions for all hospitals including specialty hospitals.

Cost efficiency performance of paediatric hospitals is not well understood as the models often exclude stand-alone paediatric hospitals and specialty centres or generalize overall hospital cost performance to paediatrics in the "paediatric hospitals within hospitals".

In an attempt to better understand paediatric efficiency performance at both the institution and population level, the members of the Ontario Children's Health Network will embark on a review of acute inpatient, same day surgery, and emergency room utilization. The project will utilize data from the Canadian Institute of Health Information relevant databases for the fiscal year of 2002/2003. The project will apply the CIHI/HAYGROUP

teaching hospital benchmarking methodology, for clinical and operational efficiencies and quality measures to the five paediatric academic health sciences centres and community hospitals in Ontario. The project will also explore patterns of population utilization across the province with specific focus on comparing counties with and without a paediatric health sciences centre.

#### **Health Services/Human Resources - 69**

##### **“BUILDING THE FOUNDATION BLOCK BY BLOCK” DEVELOPING A PAEDIATRIC CRITICAL CARE FRAMEWORK**

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Mrs Nancy Wylie, RN, BHSN, Clinical Leader, Mrs Jennifer Watson, RN, Clinical Leader

Recognizing the distinct differences between adult and paediatric patients the McMaster Children's Hospital assumed responsibility of the paediatric critical care unit in January 2004. This provided an opportunity to develop a paediatric critical care framework while assisting staff through a challenging change process and utilizing a transformational leadership model.

Health services for paediatric critically ill children and families require excellence in the provision of paediatric critical care. Staff were invited to participate in a retreat where they collaborated in the development of shared values and visions. From these shared values and visions seven building blocks were identified. The seven blocks are staff development and education, recruitment and retention, policy and procedure, standards of practice, best practice guidelines, family centered care and the development of critical care operations committee. Together the building blocks and the critical care operations committee provides a platform where staff share ideas and assist with the planning of care. It is here where the implementation of quality initiatives, changes, and decision making occur. This framework will support the team in the preparation of the Paediatric Critical Care Unit expansion in 2005. While our experience is unique to the division of a service this framework can be adapted. All health professionals may benefit from using the framework developed at McMaster Children's Hospital when faced with complex change associated with the current health care environment.

#### **Health Services/Human Resources - 70**

##### **CANADIAN CHILD HEALTH CLINICIAN SCIENTIST PROGRAM**

Norman Rosenblum, Principal Investigator, Hospital for Sick Children, 555 University Ave, Rm 7252, Toronto, ON, M5G 1X8, heather.nash@sickkids.ca

Heather Nash, Project Manager

The goal of the Canadian Child Health Clinician Scientist Program is to provide interdisciplinary research training to equip child and youth health clinicians to become career clinician scientists. The CCHCSP seeks to develop national standards for clinician scientist research training in child and youth health and to enhance child and youth health research nation-wide.

The CCHCSP designed a new program for training/sustaining child health clinician scientists. It successfully recruited, and will continue to recruit, a cadre of outstanding trainees within a novel partnership constituted by 13 Canadian universities and 3 funding

partners, led by Canadian career scientists.

With a core curriculum that is web-based, Partner Centres have formed local groups to discuss monthly case studies through the online curriculum. The CCHCSP has over 60 active monthly participants in the curriculum, including seven funded trainees.\*

Two mini-symposia were held in the past year, (Halifax and Winnipeg) focusing on a child health research question. Participants worked within multidisciplinary groups to arrive at a solution.

The Rising Researcher Support Program was added in 2004 to provide highly qualified individuals training towards certification as child health clinicians with opportunity to engage in research career planning prior to application to the CCHCSP Doctoral or Postdoctoral Training Programs. The award is used to identify a child health research focus and outstanding research mentors and programs in Canadian Universities and Health Science Centres.

In summary, the CCHCSP's program for training and sustaining child and youth health clinician scientists has been successful in recruiting a cadre of outstanding trainees and will continue to recruit outstanding trainees.

\*at the time of writing a final decision for funding in the current competition has not been finalized.

#### **Health Services/Human Resources - 71**

##### **LEADERSHIP AND QUALITY PATIENT CARE**

Sandra Bressler, Director, Therapy Services, Audiology, Speech Pathology, Communication Development, British Columbia's Children's Hospital, 4500 Oak Street, Vancouver, British Columbia, V6H 3N1, sbressler@cw.bc.ca

Leadership of professional disciplines has undergone significant change since the implementation of program management in healthcare organizations in the early 1990s. This presentation describes a research study that included discipline leadership, in an academic health centre, which was established as a result of a merger of three independent organizations where different models of program management existed. Shortly after the new organization was formed, the professional disciplines were integrated under department directors.

This study investigated the important components of a matrix management structure, including leadership, for the Therapy Department (occupational therapy, physiotherapy and rehabilitation engineering) at Children's and Women's Health Centre of British Columbia, in Vancouver, British Columbia, to deliver quality patient care.

The first purpose of this presentation is to share the results of the part of the study that investigated 2 aspects of discipline leadership: roles and responsibilities and leadership characteristics as important components to health professionals delivering quality patient care. The second purpose is to present conclusions and recommendations which have been incorporated into an organizational model for an academic health centre that supports these aspects of discipline leadership.

**THE CHANGING FACE OF PAEDIATRIC HOME CARE: KNOWLEDGE AND SKILL OF PAEDIATRIC HOME CARE PROVIDERS**

Marilyn Booth, Executive Director, Ontario Children's Health Network, 555 University Avenue, Toronto, Ontario, M5G 1X8, marilyn.booth@sickkids.on.ca

L McGillis Hall, K Spalding, H Lacroix, C Acton, J Rajroop, N Bandali

In recent years, there has been a steadily increasing demand for home and community services across Ontario (Ontario Ministry of Health and Long-Term Care, 2000). While hospitals and other institutions dedicated to the care of children base health services on the grounds that children's needs are different and require special treatment including specialized nursing services, it is not clear the extent to which this distinction is made to current approaches to home and community care services. The purpose of this research study was to examine current approaches for measuring paediatric nursing knowledge and skill in a convenience sample of home care settings in Ontario. Specifically, this pilot study investigated the type of mechanisms used to measure home care nursing knowledge and skill and the structures in place in a sample of metropolitan Toronto CCACs and home care provider agencies to promote the development of knowledge work in nursing. Findings from this study begin to address an important gap in the literature and research in the area of nursing knowledge development in paediatric home care. A number of key issues related to workforce planning as well as linkages and relationships between the acute care and home care sectors regarding care delivery for this population were identified. The findings of this study provide the opportunity for dialogue between the acute care sector, home care sector and government on these key priority areas.

**ELEARNING AND ETESTING: PRINCIPLES, AND PRACTICE AT THE HOSPITAL FOR SICK CHILDREN (SICKKIDS)**

Alistone Skepple, RN, MSN, Central Nurse Educator, The Hospital for Sick Children, 555 University Ave, Toronto, Ontario, M5G 1X8, alistone.skepple@sickkids.ca

**Description**

This poster will review and showcase the four major principles utilized at SickKids to provide eLearning to Nursing staff: Online Reference Material; Online Video; Online Lectures; and Interactive Learning.

**Important Conclusions**

eLearning can be used to augment the teaching and training provided to SickKids Nursing staff in a number of ways, but it should not be considered a replacement for face-to-face interaction with an educator. It is a tool which allows the face-to-face time to be used for discussion and questions rather than didactic presentations.

At SickKids, eLearning goes hand-in-hand with the principles of Self-paced and Problem-based Learning. In combination with eTesting, this should result in a net saving in the educator's time and an increase in the "quality" of that time for both the educator and the learner. eTesting can also be beneficial in simplifying the task of evaluating the knowledge level of Nursing staff after they have completed their training, or checking Nursing staff competency on a regular basis.

This poster will describe, to the conference participants, the range of possibilities that can be utilized in creating eLearning experiences and the ways in which eTesting can be used to manage the evaluation of Nursing staff. Each of the eLearning and eTesting initiatives undertaken at SickKids are and will be accompanied by an evaluation of the benefits realized. The lessons learned from these evaluations will be used to guide the development of subsequent projects.

Target Audience: All health care professionals interested in utilizing eLearning to provide education.

#### **Health Services/Human Resources - 74**

##### **INNOVATIVE PLANNING: A TRANSFORMATIVE PROCESS FOR A TRANSFORMATIVE TIME**

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Denise Albrecht Director, External Development, Children's Hospital of Eastern Ontario, Shannon Watson Program Co-ordinator, Children's Hospital of Eastern Ontario

This presentation will be of benefit to all senior decision-makers involved in planning for their program and/or institution (Board, management, research, education and clinical services).

Strategic Planning, a key responsibility of a health centre's Board, involves articulating an organizational vision and strategies to lead to that vision, and ensuring an environment conducive to implementing those strategies. Confronted with complex scientific, social and health care trends (including regionalization, 'boomer' retirement, changes in information and clinical technology, bio-ethics, increased acuity and complex care issues, to name a few), the Children's Hospital of Eastern Ontario (CHEO) wanted to provide for a broad consultative and participatory process prior to and during its strategic planning exercise. CHEO's objective was to ensure that all stakeholders would help plan the best care and support for children, youth and their families in its region.

This presentation will provide a 'recipe' describing how CHEO developed and implemented such an innovative and effective process. This allowed broad participation in identifying issues and determining appropriate responses through open, transparent and inclusive input and feedback, continuing into the implementation phase. The Board's Planning Committee invited all staff and physicians, as well as youth patients, parents and CHEO's external partners, to attend focus groups and to provide ongoing input by any means. The result was a major increase in the levels of participation, ownership and understanding of planning by hospital staff. The new Strategic Plan is more of a 'living document' than ever before and its implementation continues the transparent and inclusive approach.

## Health Services/Human Resources - 75

### **SURVEY OF THE 16 CHILD AND YOUTH PROTECTION PROGRAMS ACROSS CANADA "A THREADBARE PATCHWORK QUILT"**

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Morag Mackay, Amy Plint

Child Maltreatment represents a significant public health and societal problem and has been described in epidemic proportions. At the present time, there are no Canada wide comprehensive data on child maltreatment injuries and their outcomes. This lack of data has hampered the ability of Pediatric Health Sciences Centres to develop policies and programs that effectively address the needs of child and youth victims of maltreatment as well as their families who are often secondary victims.

The objective of this study was to begin to describe the services, case volume, staffing and funding of the 16 existing hospital based Child & Youth Protection Programs in Canada. While it is recognized that the maltreated children & youth seen at these centres are the most serious and "tip of the iceberg" cases, these Programs are an important starting point in identifying solutions to the existing challenges. Between June and August 2004, the Program Directors for each of the Programs will participate in a one-hour telephone survey eliciting detailed information on the program services, case volume, staffing and funding. Survey information will be analyzed, synthesized and recommendations will be developed.

An initial look at the first five interviews completed shows large disparities between Programs. None of these sites had information systems that could provide complete data on all cases. Full findings for all 16 sites will be available at the time of presentation.

## Health Services/Human Resources - 76

### **WHAT INFORMATION CAN BE PROVIDED FROM A WORKLOAD MEASUREMENT SYSTEM? AN EXAMPLE OF ONE PEDIATRIC HEALTH INSTITUTION'S USE OF DIETITIANS' WORKLOADS**

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Diana Mager, Deborah O'Connor

The registered dietitians (RD's) at the Hospital for Sick Children (Sick Kids) record workloads using a computerized workload recording system (INFOMED Dev Corp). Direct and indirect time with patients, and time devoted to professional/educational activities are recorded. Data collected have allowed for calculation of nutritional support time per patient, per program, for both in- and out-patients. The average RD hours required for nutritional support range from 1-5 hours per patient, per month, depending on patient acuity, and the program. This does not include time required for professional support, such as education, or department meetings (30%). These data can be used by health administrators to determine cost for nutritional services and to assess the efficiency of nutrition support services. For example, knowing the number of RD hours required per patient per month in a specific program can offer more precise information for budget planning for a new clinic, or new transplant program. The data can also be used to determine cost of nutritional support compared to savings provided by the RD, allowing



for calculation of cost effectiveness of nutritional support. Documentation of decreased ordering errors of total parenteral or enteral nutrition support, supported by workload measurements, provides cost benefit analysis of nutritional services.

As Sick Kids is a teaching hospital with ~ 50% of the RD's having a graduate degree, and the majority involved in evidence-based practice research, the workloads can also be used as a benchmark for nutritional support for other pediatric institutions.

#### **Health Services/Human Resources - 77**

#### **ANOTHER 100 YEARS OF PRESTIGE AND EXCELLENCE - THE MONTREAL CHILDREN'S HOSPITAL ON THE GLEN SITE**

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Jean Dufresne, Pierre Major

Officially formed in 1994, the McGill University Health Centre (MUHC) is the largest voluntary hospital merger in Canadian history. It brings together five McGill University affiliated hospitals - the Royal Victoria Hospital, the Montreal Children's Hospital, the Montreal General Hospital, the Montreal Chest Institute and the Montreal Neurological Hospital and Institute. Each institution brings diverse traditions and internal cultures to the new entity, presenting the challenges of incorporating those aspects of each that add value while fostering integration of the whole. In the course of securing broad consultation on facility needs and collaboratively planning the new environment, the new MUHC must also reflect the latest medical knowledge, provide a setting that promotes healing and offer the flexibility to adapt to changes in health care delivery to the citizens of Montreal.

As one of the founding partners, the Montreal Children's Hospital has been actively engaged in planning for a new academic child and adolescent health centre and research institute on the Glen site. Planning for the new Children's hospital was defined and developed during three phases, involving more than 200 participants including patients, physicians, clinical and administrative staff and health care network partners. The new Children's hospital will reflect the collection of world-class clinical, academic and research programs that are its component parts. Its distinctiveness will be reflected not only in the facility, but the programs and services it houses, with its unique culture and tradition. The children's hospital will have distinct patient flows, and the spaces in which children are to be cared for will be dedicated for the care of children.

Flexibility and a healing environment are the hallmarks of the institution's design principles for the new facility. Space will be planned to facilitate the simplest possible reconfiguration for different uses, as well as for expansion when needed. Materials and organization of space will promote a sense of calm and, to the extent possible, mitigate the chaotic activity associated with a busy Children's hospital.

From the patient's viewpoint, the new Children's hospital will be organized in inpatient and ambulatory zones, with a shared zone for diagnostic and therapeutic services.

- Inpatient care will occur in single and double-bedded rooms
- Ambulatory facilities will be organized based on clusters of specialties, focused on disease entities and/or organ systems within which cross referral and consultation is common

- Separate emergency treatment facilities will be provided for adults and children
- Those diagnostic and therapeutic services dedicated to outpatients will be arranged to promote patient flow directly from the exam room modules to the testing modality in dedicated space.
- MCH physicians will be accommodated in facilities proximate to patient care and research areas.
- Invasive services will be grouped on a common platform to enable sharing of support and equipment
- Organized research centre for innovations medicine with organized neighbourhoods to promote opportunities for enhanced clinical and translational research efforts.
- Centralized and satellite (in care area) educational program support planned in the facility.

The McGill University Health Centre has been conceived as a major means for improving the standard of health care available to the people of Montreal and the surrounding communities in Quebec. The bringing together of four McGill University teaching hospitals on two sites provides an unprecedented opportunity to create a new vision for health care delivery, teaching and research.

#### **Human Resources - 78**

##### **VISER L'EXCELLENCE EN SOINS INFIRMIERS - UTILISATION D'UN BILAN DES 24 HEURES EN NÉONATOLOGIE**

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Suzanne Létourneau, Ginette Thibault, Nathalie Pineault

Dans une unité de néonatalogie ultra-spécialisée de Montréal, la rédaction des notes d'observation infirmière se faisait sous forme narrative. À l'automne 2003, une équipe d'infirmières implante le Bilan des 24 heures, outil de soins infirmiers, après plus de 18 mois d'élaboration.

OBJECTIFS: 1) Améliorer la qualité des notes d'observation consignées au dossier par l'infirmière; 2) Améliorer la qualité des soins en établissant des normes d'évaluation et en uniformisant la pratique; 3) Diminuer le temps requis à l'inscription des notes au dossier.

CLIENTÈLE CIBLE: Tout nouveau-né hospitalisé à l'unité de soins en néonatalogie.

RÉSULTATS: Les infirmières se disent hautement satisfaites de ce nouvel outil de soins infirmiers. De plus, cet outil permet une optimisation du temps consacré aux soins directs au nouveau-né et diminue le temps supplémentaire généré par la rédaction des notes au dossier.

#### **Knowledge Translation - 79**

##### **LEVERAGING AN ONLINE DISCUSSION FORUM TO BUILD A COMMUNITY OF PRACTICE**

Janet Curran, Professional Development Coordination, IWK Health Center, 5850/5980 University Ave, Halifax, Nova Scotia, B3K 6R8, janet.curransmith@iwk.nshealth.ca

Ms Paula Forgeron, Ms Shauna Best

Collaboration and communication are two elements critical to the success of a knowledge translation environment as these activities not only serve as the mechanism for knowledge explication but also serve as the medium for knowledge sharing. Online

communities are increasingly emerging in a number of disciplines, each with the common objective of supporting the community by sharing experiences, knowledge and resources. This poster presentation will outline a number of projects currently underway at the IWK Health Centre which are leveraging online discussion forums to support communities of practice around pediatric care. Project I: Effective management of pediatric pain requires pro-active and effective collaboration between health practitioners from a variety of health disciplines. We present a knowledge management solution that leverages an online discussion forum as a collaborative learning environment rooted in the team members sharing experiences, offering support to solve problems, guiding members to information/knowledge resources, inform about clinical practice guidelines and to simply seek advice on matters pertaining to pediatric pain management. Project II: The provision of quality care in an Emergency Department requires the coordinated efforts of a number of health care professionals. Sharing knowledge and participating in interactive discussions of patient care issues presents as a daily, continuous challenge for the multidisciplinary health care team in rural and urban Emergency Departments. Emerging informational and instructional technologies provide an alternative to the traditional mode of face-to-face interaction and holds great promise as a tool in a constructivist learning paradigm.

#### **Knowledge Translation - 80**

#### **SAFE KIDS CANADA: INTEGRATED APPROACH TO CHILDREN'S INJURY PREVENTION**

Allyson Hewitt, Executive Director, Safe Kids Canada/The Hospital for Sick Children, 2105 - 180 Dundas Street West, Toronto, Ontario, M5G 1Z8, [allyson.hewitt@sickkids.ca](mailto:allyson.hewitt@sickkids.ca)

Preventable injuries continue to be the leading cause of death and disability among Canadian children. Safe Kids Canada, the national injury prevention program of Toronto's Hospital for Sick Children, works as a knowledge broker with a network of community partners and stakeholders by conducting, translating and disseminating research to prevent unintentional injuries. We use evidenced-based information to create injury prevention programs that have real-world applicability – raising awareness and educating parents on how to keep their children safe. In addition, Safe Kids Canada advocates for safer environments through changes to standards and legislation.

This poster describes the components of the Safe Kids Canada integrated knowledge translation and exchange model. This model encompasses linking the relationship between research and researchers with community-level public health policy and practice, the exchange of information about best practices and program evaluation, creation and promotion of education and awareness strategies, and leadership in public policy and advocacy initiatives. The integration of these elements will be highlighted using illustrations of past and current initiatives such as the Safe Kids Week campaign. The diverse range of programming to promote effective injury prevention strategies on a national level is possible using an integrated knowledge translation and exchange model.

## Knowledge Translation - 81

### THE BUILDING BLOCKS OF COMPETENCY

Dori Van Stolk, Clinical Education Leader, Children's & Women's Health Centre of BC, 4500 Oak Street -Rm B211, Vancouver, BC, V6H 3N1, dvanstolk@cw.bc.ca

Tracy Lust, Pia Dezorzi, BCCH Educators

In response to changes in the economic climate of healthcare, British Columbia's Children's Hospital (BCCH) established the NRT and amalgamated specialty units. This would lead to the merging of specialty practices, patient populations and nurses with varied competencies. Together, these two major changes highlighted the gap in the development of pediatric nurses competent in foundational pediatric competencies. To improve our quality practice environment and address recruitment and retention needs, it became a priority to focus on the issue of pediatric nursing professional development.

Competence in clinical practice is linked with continuous professional development. A pediatric professional development plan was developed in a competency based education approach and implemented to pediatric nursing practice within a personal accountability framework. Foundational, advanced and complex level competencies were developed to support the orientation process of nurses hired to BCCH. This process involved the hiring, competency assessment, development of a learning plan, orientation, preceptorship and evaluation process for each individual RN. In order for this process to be successful, it was necessary for enhanced collaboration and partnership between the RN, the Educators and the Clinical Nurse Coordinator (CNC) group at BCCH.

Validation of competence was done over a three-month period and culminated in a final Competency Validation Day using the OSCE approach, a theory exam and a Pediatric Jeopardy game. The day ended with individual feedback sessions for each participant.

This presentation will present a model for hiring and developing pediatric nurses using a competency based education framework.

## Knowledge Translation - 82

### WHAT? NO BURETROLS? IMPLEMENTING A PEDIATRIC PARENTERAL AND INFUSION THERAPY PRACTICE CHANGE

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Kim Shearer, Marianne Tofan, Bernadette Kondor

Increasing patient acuity, complicated medication regimens and new technology pose increasingly complex challenges for the delivery of pediatric parenteral and infusion therapy. The introduction of new pump technology at British Columbia's Children's Hospital (BCCH) offered an opportunity to engage in an extensive project to review and revise parenteral and infusion practices. Buretols, a standard of practice for many years in the pediatric population for medication administration and to minimize fluid overload, were deemed unnecessary given the pumps new features. The implementation of new infusion pump technology was intended to introduce the new pumps and modify parenteral therapy practice by using some of the options the pump allowed. The introduction of this new technology revealed or highlighted variations in parenteral therapy practice. In addition, concerns were being expressed about medication and

infusion related errors. Together, these factors indicated the need for a thorough examination of practice.

Nursing and Pharmacy jointly initiated the Pediatric Parenteral Therapy Project. The project goal was to develop recommendations for intravenous therapy system improvements including enhanced accuracy of drug dosing; simplification and standardization of the system; improved operational efficiencies and improved patient and family and staff satisfaction with the system. Once the recommendations were approved, the practice change was implemented.

This presentation describes the review process (literature review, survey to pediatric hospitals), recommendations for changes in the practice of intermittent intravenous medication administration and the education and implementation of the practice change

### **Knowledge Translation - 83**

#### **BRIDGING THE GAP - MENTORING IN THE NEONATAL NURSERIES: A PILOT INTERNSHIP PROGRAM**

Wendy Seidlitz, Data Management Specialist, McMaster Children's Hospital, HHS, 1200 Main St. W., Hamilton, Ontario, L8N 3Z5, seidlitz@hhsc.ca

Ms Barb Jennings, Program Manager, McMaster Children's Hospital, HHS, Dr Susan Blatz, Clinical Nurse Specialist, McMaster Children's Hospital, HHS, Ms Jesika Nutt, McMaster Children's Hospital, HHS, Ms Rachel Bazuin, McMaster Children's Hospital, HHS, Ms Heather Matter, McMaster University School of Nursing, 4th Year

This poster presents the creation, implementation and evaluation of a novel program for new graduates in critical care nursing and evaluates the impact on staff of bringing new graduates into this setting. Suitable for all health professionals.

A Nursing Internship Program was developed to promote the profession of nursing, to foster enthusiasm and interest amongst baccalaureate-prepared new graduates, and to impart a culture of growth and opportunity in the Neonatal Nurseries. The program goals were to provide experience, exposure, and knowledge through a variety of approaches. Knowledge included formal education, through a partnership with Mohawk College, and informal education supported by our clinical educator. The interns developed teamwork links during exposure to our multidisciplinary health care team using dedicated shadowing time. Experience was gained over a six-month period facilitated by a direct relationship between the intern and the mentor in both the Intermediate Care Nursery and the Neonatal Intensive Care Unit at the McMaster Children's Hospital, Hamilton, ON.

At the conclusion of the program, each intern completed performance evaluations with their mentors. Feedback about the program was obtained from the mentors, the interns, and nursing staff. Literature supports mentorship and internship programs for new graduates entering critical care areas. The Nursing Internship Program has value for the clinical unit and may help the new graduate to succeed professionally. The program and our outcomes, along with recruitment and retention issues, were evaluated at 7 and 14 months. The results and future plans will be presented.

## Knowledge Translation - 84

### KNOWLEDGE AND ATTITUDES ABOUT PAIN FROM STAFF IN THE NEONATAL NURSERIES

Barbara Czerniawski-DeLaCruz, Clinical Nurse Specialist, McMaster Children's Hospital, Hamilton Health Sciences, Neonatal 4A, 1200 Main Street W; PO Box 2000, Hamilton, Ontario, L8N 3Z5, czerniawski@hhsc.ca

Susan Blatz

To present to other Children's Hospitals, survey results on neonatal staff knowledge and attitudes about neonatal pain.

Phase one of this study was done to assess knowledge and attitudes about pain from staff working in the Neonatal Intensive Care Nurseries at McMaster Children's Hospital, Hamilton Health Sciences, prior to implementation of a pain assessment tool.

A survey was given to 200 staff to collect data on the knowledge and attitude of pain in neonates. Staff were asked to record their employee ID number and work experience. Staff were encouraged to complete the 20 minute survey.

One hundred and thirty five completed surveys were collected from RN (80%), RT (5%), MD (1.5%), CNS/NP (6%) and Allied Health (6%), with an average of 18.1 ( $\pm$  9.85) years work experience and 13.9 ( $\pm$  9.1) neonatal experience. Mean scores (1= very insufficient, 5 = very sufficient) on the main themes of knowledge = 3.97 ( $\pm$  .84), assessment = 3.39 ( $\pm$  1.15) and treatment = 3.02 ( $\pm$  1.18) indicate a need for further education. Using a scale of 1 = insufficient to 10 = completely sufficient, staff rated the treatment of pain in the neonatal nurseries as 4.90 ( $\pm$ 1.91) and their own ability to assess and alleviate preterm infant's pain as 6.5 ( $\pm$ 1.77).

Specific themes and items reported from the survey will be integrated into a multi-media education program to be offered to the staff of the Neonatal Nurseries over the summer of 2004. A follow-up survey is planned for the fall, to evaluate progress and changes in attitude and skills for pain assessment and treatment.

## Knowledge Translation - 85

### EXPÉRIENCE D'UN CLUB DE LECTURE DES INFIRMIÈRES AU CHU MÈRE-ENFANT SAINTE-JUSTINE: 1995-2003

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D Blais inf Bsc, H Paquette inf BSc, D Tremblay inf BSc

Introduction: Un club de lecture permet l'actualisation de connaissances et le partage des expertise entres infirmières de différents secteurs. Le club de lecture des infirmières visent à briser l'isolement de plusieurs infirmières des secteurs ambulatoires. Historique: En 1995, un groupe d'infirmières a fondé le club. Bien intentionnées au départ pour axer le club de lecture sur la critique d'articles scientifiques de revues spécialisées en soins infirmiers, les membres opteront plutôt pour le partage des savoirs au niveau de leur pratique clinique. Méthodologie: Chaque membre du comité du club sollicite la participation des infirmières. Des convocations écrites sont distribuées personnellement aux infirmières. Depuis 2002, un horaire des présentations est établie à l'avance sur

plusieurs mois. L'activité se tient tous les 2 semaines, la durée des présentations est de 45 minutes. Résultats: Un total de 125 infirmières sont rejointes directement par les convocations écrites (papier ou e-mail). Entre 1995 et 2003, 1025 infirmières ont assisté à 87 présentations. Les présentateurs proviennent majoritairement de l'établissement. L'activité attire une moyenne de 13.3 infirmières/présentation. Les infirmières ont présenté des sujets touchant majoritairement leur pratique clinique dans 62% des cas. La formation des présentateurs était de niveau baccalauréat chez 58% des infirmières. Conclusion: Le club de lecture des infirmières du CHU Mère-Enfant répond aux besoins d'actualisation des infirmières. Cette activité renforce l'identité professionnelle et la collégialité. Nous souhaitons toujours une plus grande participation des infirmières afin d'inculquer une culture du savoir.

## Knowledge Translation - 86

### **IMPLEMENTATION OF COMPUTERIZED SAFETY REPORTING IN AN ACADEMIC PEDIATRIC HEALTH CENTER: LESSONS LEARNED & FUTURE DIRECTIONS**

Cheryl Jackson, Associate Risk Manager, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8, cheryl.jackson@sickkids.ca

L Urmsen, A Williams

In 2004 a web-based safety reporting system was established in a 350-pediatric bed hospital with >6000 employees. This initiative encompassed medication, patient and employee incident reports and a change from multiple paper-based forms to a standardized on line reporting system. Pilot results reflected improvements with timeliness, processing and identification of safety issues. Additionally, gaps in practices and technological resources associated with the paper-based reporting were identified and addressed collaboratively.

Impetus for this initiative stemmed from the belief that improvements in patient safety require a comprehensive understanding of what is going on in the organization and an on line reporting system facilitates staff reporting of risks, timely analysis of data and staff feedback. The National Steering Committee on Patient Safety(2002) promotes "safe patient care as fundamental to quality health-care services" and studies (Fortescue et al, 2003) show hospitalized children are more prone to medication safety risks due to less physiologic reserve with which to buffer errors.

Strategic processes setting the stage for this initiative include:

- selecting & customizing on line system
- promoting a cultural shift to "safety"
- piloting
- educating & supporting staff
- evaluating & modifying system design

Results two months post implementation indicate a 25% increase in medication reports & 50% increase in patient safety reports. Departments are using reports to identify significant safety issues and demonstrate a positive attitude towards rectifying system limitations. Future directions will target: data integrity; system change initiatives associated with data utilization; and evaluation of web-based training site.

## **PERSPECTIVE SUR LES STAGES EN PHARMACIE OFFERTS À DES ÉTUDIANTS ÉTRANGERS**

Jean-François Bussières, Chef, BPharm MSc MBA FCSHP, 3175 ch. Côte Sainte-Catherine, Montréal, Qc, H3T1C5, jf.bussieres@ssss.gouv.qc.ca

Sonia Prot

Au Québec, il existe peu d'échanges en pharmacie avec des étudiants étrangers dans les établissements de santé. Dans le cadre d'un projet avec l'Association des pharmaciens en établissements de santé du Québec, nous avons implanté une plate-forme électronique ([www.apesquebec.org/echanges](http://www.apesquebec.org/echanges)) afin de favoriser les échanges France-Québec. Objectif : Décrire l'organisation de stages-types en pharmacie pour les étudiants étrangers dans un établissement mère-enfant canadien. Méthode: Description des objectifs et des stages, organisation physique, rémunération, évaluation. Résultats: Depuis 1996, le département de pharmacie de Sainte-Justine a accueilli plus de 15 étudiants français. Il est possible d'accueillir des étudiants en pharmacie de 5<sup>ème</sup> année hospitalo-universitaire pour des stages de 3 mois, des étudiants en pharmacie de l'internat pour des stages de 6 mois à 1 an et des pharmaciens pour des formations post-doctorales. Ces stages peuvent être crédités par les universités françaises. Nous décrivons la contribution de ces étudiants à la vie académique et au rayonnement de l'institution. Conclusion : Le développement de stages avec des étudiants étrangers a un impact favorable sur la pratique pharmaceutique. Il est souhaitable de mener une évaluation à posteriori auprès de ces étudiants afin d'améliorer la qualité et la pertinence des stages offerts. Enfin, nous souhaitons développer des opportunités de stages à l'étranger pour des étudiants québécois.

## **UN TABLEAU DE RÉFÉRENCE POUR LES ARYTHMIES CARDIAQUES PÉDIATRIQUES**

Monique Dufour, Infirmière, Centre hospitalier universitaire de Québec (CHUQ), 2705 boulevard Laurier, Sainte-Foy, Québec, G1V 4G2, Carmen.allard@chuq.qc.ca

M Chamberland Infirmière, CHUQ, J-Marc Côté Cardiologue pédiatre, CHUQ, Alain Cloutier Cardiologue pédiatre, CHUQ

Malgré de nombreuses mesures mises en place pour essayer de maintenir à jour les connaissances des infirmières en arythmies cardiaques pédiatriques, le maintien des compétences infirmières dans ce domaine ultraspécialisé demeure toujours problématique, dû entre autres choses, au mouvement constant du personnel infirmier qualifié en cardiologie pédiatrique. Il est essentiel que les infirmières oeuvrant dans ce domaine de soins soient toujours à la fine pointe des compétences en arythmies cardiaques pédiatriques. C'est dans cette optique qu'a été développé au Centre mère-enfant du CHUQ un tableau d'arythmies cardiaques pédiatriques permanent et accessible rapidement pour les infirmières. Ce tableau est d'une grande utilité pour les unités spécialisées qui reçoivent une clientèle pédiatrique, en l'occurrence l'unité de cardiologie pédiatrique, l'unité néonatale, les soins intensifs et l'urgence. Pour faciliter l'interprétation rapide des bandes de rythme en cas d'urgence, le tableau est intégré à l'environnement de travail des infirmières. Il est accessible pour une révision complète et rapide des connaissances. Un tel tableau est, à notre connaissance, unique en Amérique du Nord. Dans le contexte actuel de pénurie d'infirmières spécialisées et de complexité



des soins, cet outil pédagogique nous apparaît indispensable dans une unité de cardiologie pédiatrique. Des formats de poche sont aussi disponibles sous forme de brochures pour diffusion dans les centres pédiatriques.

#### **Knowledge Translation - 89**

##### **A REGIONAL APPROACH TO PAEDIATRIC EDUCATION - "PAEDIATRIC PEARLS AND PITFALLS: PUTTING THE PIECES**

Ruth Turner, Regional Maternal Child Education Coordinator, West Cluster Maternal Child Program, The Credit Valley Hospital, Valley House, 2200 Eglinton Ave., Mississauga, ON, L5M 2N1, rturner@cvh.on.ca

##### **OBJECTIVE:**

The West Cluster Maternal Child Program was developed through a partnership among 4 hospitals within the framework of the Child Health Network for the Greater Toronto Area. It includes: Credit Valley Hospital, Halton Healthcare Services, Trillium Health Centre and William Osler Health Centre. The West Cluster is committed to the development and implementation of a coordinated, high quality, regional program of maternal, newborn and paediatric services. Regional educational initiatives are coordinated by the Regional Maternal Child Education Coordinator.

In September 2003 paediatric education was identified as a top priority. Under the leadership of the Regional Education Coordinator, a regional multidisciplinary team was assembled whose goal was to develop an educational workshop. The objective was to increase knowledge and the development of critical thinking skills in the following areas: fluid & electrolyte balance, respiratory assessment, Type 1 Diabetes, seizure disorders and code review.

##### **OUTCOMES:**

In May and June 2004, 265 multi-disciplinary professionals participated in an eight-hour workshop. The use of a regional multidisciplinary team to achieve our objective was highly successful. It supported the sharing of knowledge between individuals and organizations, enriching the diversity of our work while utilizing local expertise in an efficient manner. This model recognizes that there is more than one way to do things and therefore the focus becomes evidence-based practice. Leadership abilities are developed as front line staff are engaged as active participants.

We will continue to nurture knowledge and skills of the paediatric team by adapting this curriculum for orientation of new paediatric care providers throughout the West Cluster.

#### **Knowledge Translation - 90**

##### **TRANSITION OF THE NEWBORN - UTILIZING A REGIONAL APPROACH TO ACHIEVING BEST PRACTICE**

Ruth Turner, Regional Maternal Child Education Coordinator, West Cluster Maternal Child Program, The Credit Valley Hospital, Valley House, 2200 Eglinton Ave., Mississauga, ON, L5M 2N1, rturner@cvh.on.ca

Cori Chapman, Kathryn Hayward-Murray, Cindy MacDonald, Jo-Anne Oake-Vecchiato, Lisa Shiozaki

#### OBJECTIVE:

The West Cluster Maternal Child Program was developed through a partnership among 4 hospitals within the framework of the Child Health Network for the Greater Toronto Area. It includes: Credit Valley Hospital, Halton Healthcare Services, Trillium Health Centre and William Osler Health Centre. The West Cluster is committed to the development and implementation of a coordinated, high quality, regional program of maternal, newborn and paediatric services.

Newborn transition is the period from birth through the first 6 hours of life. This is a critical period of stabilization for the infant. In 2002 the West Cluster hospitals identified high newborn admission rates to the nursery during the transitional period. Under the leadership of the Regional Maternal Child Education Coordinator a multidisciplinary regional taskforce was assembled to review factors affecting nursery admission rates. Evidence based newborn care guidelines were developed to support optimal transitioning and thereby keep babies and mothers together. A multidisciplinary education group was formed to develop an educational curriculum to facilitate changes in practice and implementation of the guidelines.

#### OUTCOMES:

In Spring and Fall 2003, over 600 regional perinatal care providers participated in a four-hour workshop. The use of a regional multidisciplinary team to achieve our objective was highly successful. It supported the sharing of knowledge between individuals and organizations, enriching the diversity of our work while utilizing local expertise in an efficient manner. Each hospital executed its own implementation plan. Immediate improvement in outcomes was achieved, significantly decreasing nursery admissions and increasing our ability to keep babies and mothers together. We continue to monitor regional nursery admission rates in an effort to sustain best practice.

### **Knowledge Translation - 91**

#### **PAPER, MIGRATION AND AUTOMATION**

Maggie Wilson, Quality Analyst, HSC, 555 University Avenue, Toronto, Ontario, M5G 1X8, margaret.wilson@sickkids.ca

Streitenberger Kim, Harris Cheryl

The availability of accurate and up to date information plays a critical role in enhancing quality and patient safety in today's complex and continuously evolving health care environment. In 1995, The Hospital for Sick Children (HSC), determined that hard copy policy and procedure manuals were not meeting this need. A decision was made to move all of the organizational documents to the hospital Intranet site. Although this initiative did provide certain benefits, a number of new issues became evident including the inability to search for policies and the difficulty in maintaining a timely review and revision process without the addition of significant resources. In 2001-2002, all organizational policies, procedures and guidelines at HSC were migrated to a custom designed Policy and Procedure Database using the organization's Lotus Notes e-mail application. The decision to create this database using Lotus Notes was made in part because of existing functionality within the application that facilitated automation of document management processes including development, approval, review and revision. An added feature is that this database is integrated with the hospital's email system enhancing communication between staff, authors, and issuing authorities. The central

automation of document management processes and the ability for staff to access all currently approved hospital policies, procedures and guidelines in a single central location have enhanced our ability to have up to date and accurate information available to guide staff decision making. The presentation will describe the challenges of implementing an on-line policy and procedure database including lessons learned.

### **Knowledge Translation - 92**

#### **BONE MARROW TRANSPLANTATION FOR SICKLE CELL DISEASE: REPORT OF TWO CASES**

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Nancy Cloutier Infirmière bachelière, Stéphane Barret Hématologue, J-Hugues Dalle Fellow - hématologie, Michel Duval Hématologue, Martin Champagne Hématologue - Directeur Programme de greffe de moelle osseuse

Sickle cell disease (SCD) is a serious and life-threatening genetically transmitted disease causing severe disability. The predominant pathologic features of SCD are hemolytic anemia and vaso-occlusion. Complications include painful vaso-occlusive crisis, splenic sequestration, severe infection, acute chest syndrome and cerebro-vascular infarction. Median life expectancy is 42 years. Hematopoietic stem cell transplantation currently represents the only hope of cure in these patients. Previous experience reports and increased risk of rejection and neurological complications in these patients in comparison to other HSCT recipients. Patients who had presented life-threatening complications such as recurrent acute chest syndrome, cerebral infarction or severe, recurrent vaso-occlusive crises causing major disability of other significant events were considered for HSCT if they had an HLA-matched sibling donor. Preparative regimen consisted of BuCy4 associated with rabbit ATG and CSA+MTX as GVHD prophylaxis. Anticonvulsant therapy was given through out the HSCT period as well as "standard" supportive care. Both patients were 12 yo girls with HbSS disease. One has had CVA while the other suffered from severe, repetitive and debilitating vaso-occlusive crises. In both, complete chimerism was documented, with resulting HbA0 production. Patients remain free of GVHD more than 6 months following transplant. Our early experience of HSCT in SCD patients has resulted in correction of hematopoiesis in both patients. Both have encountered a number of early complications common to HSCT recipients. Currently, 5 patients meet our criteria of "high-risk" SCD, have a sibling HLA-matched donor and are awaiting HSCT in our program

### **Networking/Connectivity - 93**

#### **ONTARIO CHILDREN'S HEALTH NETWORK/CHILDREN'S MENTAL HEALTH ONTARIO: PAEDIATRIC TELEPSYCHIATRY INITIATIVE**

Beverly Guttman, Senior Project Manager, Ontario Children's Health Network, 555 University Ave., Toronto, Ontario, M5G 1X8, [beverly.guttman@sickkids.ca](mailto:beverly.guttman@sickkids.ca)

Mr Jeffrey Hawkins, Executive Director, Algonquin Child and Family Services, Dr Simon Davidson, Chair, Division Of Child And Adolescent Psychiatry, U Of Ottawa; Chief Of Psychiatry And Medical Director Of MHPSU, CHEO

Paediatric telepsychiatry services are currently provided to rural and remote locations in

Ontario by 4 separate programs associated with Ontario's Paediatric Academic Health Science Centres. An initial review showed system enhancement and transformation could be achieved through provincial planning and coordination.

The Paediatric Telepsychiatry Initiative is a collaboration between the Ontario Children's Health Network (OCHN) and Children's Mental Health Ontario (CMHO). The Paediatric Telepsychiatry Task Group was established in May 2004 to:

- Develop a provincial framework for paediatric telepsychiatry services that promotes equitable access to mental health services and improves outcomes for the children and youth of Ontario and their families.
- Supplement and build the capacity of community resources where they do not currently exist.

The service framework will be planned provincially and delivered regionally in the context of local community needs, services and collaborative relationships. The system will facilitate appropriate linkages across the network in order to meet language, cultural and other special needs of the children, youth and their families. Recommendations will be made to the Ontario Ministry of Children and Youth Services upon completion of the project.

This poster presentation will demonstrate the process used by the task force to achieve their goals.

#### **Networking/Connectivity - 94**

##### **THE ONTARIO CHILDREN'S HEALTH NETWORK**

Marilyn Booth, Executive Director, Ontario Children's Health Network, 555 University Avenue, Toronto, Ontario, M5G 1X8, [marilyn.booth@sickkids.ca](mailto:marilyn.booth@sickkids.ca)

In July 2003 the 6 paediatric academic health sciences centres in Ontario came together to form the Ontario Children's Health Network (OCHN). OCHN's vision is for timely access to world-class paediatric care for Ontario's three million children and youth as close to home as possible. OCHN partners are committed to collaborating with each other, the Ministry of Health and Long Term Care, The Ministry of Child and Youth Services, regional networks and community and academic partners to make that vision a reality.

Early efforts focused on:

- A project to define the role the OCHN members collectively play in paediatric clinical care, education and research in Ontario
- Identification of goals and aspirations
- Identification of priority areas of focus
- Development of a framework for measuring the impact of OCHN initiatives

The poster will summarize the accomplishments to date in several of the areas of focus. Examples include:

- Work on a provincial framework for a child health alternative funding plan for physicians
- Strategies to enhance electronic connectivity between the OCHN members and beyond to our regional partners
- Strategies to promote efficiency and effectiveness in the provision of patient education

materials

- Coordinating and enhancing services to rural and remote areas
- A commitment to the creation of provincial benchmarks for paediatric services and
- Advocacy initiatives

#### **Networking/Connectivity - 95**

##### **CONNECTING PEOPLE AND PROCESS: AN APPROACH TO COLLABORATIVE DECISION MAKING**

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Ms Brenda Belliveau, Professional Development Coordinator, Children's Health Program, IWK Health Centre

The Children's Health Program, IWK Health Centre has utilized Program Based Care, structured around specific populations of children, to examine current processes and make improvements across multi-disciplinary teams. This approach has resulted in numerous examples of improvements that may not have been considered in a model that is less collaborative and multi-disciplinary.

A unique feature of this model is recognition that quality and education are complementary and co-dependent and are strongly integrated across the Program. Therefore, both quality and education representatives are active members of Operation Committees at the Care Team, Team, and Program level. This linkage facilitates quality and educational input from the discussion stage through to the decision and implementation stage of all recommendations that have potential for impact on morbidity.

One example is utilized to demonstrate our comprehensive model of improvement which illustrates how issues identified by an individual care-team are connected to other care-teams, include input from a quality and education perspective, lead to process change recommendations and include feedback loops to and from the Program Leadership and Operations Committee.

The strength of this model is its outcomes approach and the recognition that in a rapidly changing and complex health care environment decisions must be timely, involve the "right" team members, represent comprehensive multi-disciplinary care processes, and ultimately provide benefit for patients/ families. This model has helped to build capacity within and among teams and to live one of our guiding principles that states "quality care/service is an ongoing process and everyone's responsibility".

#### **Networking/Connectivity - 96**

##### **CHILD & YOUTH HEALTH NETWORKS OF CANADA: BUILDING BEST NETWORK PRACTICES**

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Team, Calgary Health Region, Ron Lindstrom, PhD Candidate, University of British Columbia, Charmaine MacPherson, Assistant Professor, Faculty of Nursing, St Francis of Xavier, Elaine Orrbine, Chief Executive Officer, Canadian Association of Paediatric Health Centres

Issues in child and youth health have become so complex that no one organization can be effective alone. This has led to an increasing interest in networks as a means to facilitate collaboration and partnerships to address broad child and youth health issues. A working group, Child & Youth Health Networks of Canada, has had seven national meetings over the last three years with the goal of building best network practices.

This presentation will:

- Introduce you to the current members of the Child & Youth Health Networks of Canada
- Provide an overview of the goals of the group
- Outline accomplishments to date
- Relate results of a preliminary national survey of networks undertaken in Fall 2003
- Describe current activities to develop a multi-site network evaluation strategy.

As a new organizational model, networks can assist with changing expectations for innovation in service delivery, partnership development, and shared planning, decision-making, and accountability. This presentation therefore will be of interest to board members, senior administrators, managers, and front-line clinicians.

#### **Networking/Connectivity - 97**

#### **A HEARTBEAT AWAY...VIDEOCONFERENCING PAEDIATRIC CARDIOLOGY CONSULTATIONS IN SOUTHWESTERN ONTARIO**

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Debora Robinson, Liz Burrill, Karen Fontana Chow, Irene Vermey

Objective: To illustrate how a tertiary academic health care centre can leverage videoconferencing to enhance paediatric cardiac care in Southwestern Ontario, both as a consulting site to Windsor Regional Hospital (WRH) and as a referring site to the Hospital for Sick Children (HSC).

Background: While Children's Hospital of Western Ontario (CHWO) has a paediatric cardiology service, children undergo cardiovascular surgical procedures at HSC. Recently, CHWO identified cardiology as one of the key programs through which videoconferencing could enhance.

Recent initiatives: First, a paediatric cardiology link has been established between CHWO and HSC in Toronto. At weekly "Surgical Discussion" and "Surgical Review" rounds, both organizations can present cases and transmit cardiac echo images directly from their peripherals. CHWO clinical staff members no longer travel to HSC. Reviewing the patient's heart condition via videoconferencing streamlines the process so that there is in some cases earlier access to answers regarding surgical or catheter intervention.

Second, CHWO will be reading "urgent" echo readings via videoconferencing transmitted from the NICU at WRH. WRH staff members will no longer have to submit

urgent echo tapes to HSC or Detroit, and will be able to transmit images to CHWO quicker than sending the tapes by courier.

Conclusion: Videoconferencing reduces staff travel time and provides earlier access to answers regarding intervention. It also enhances continuity of care by leveraging traditional referral patterns and fosters partnerships and learning between institutions.

Target audience: Health care administrators, IT specialists, Nurses, physicians

#### **Networking/Connectivity - 98**

### **TRANSFERT À REBOURS DE LA CLIENTÈLE NÉONATALE D'UN CENTRE DE SOINS TERTIAIRES PÉDIATRIQUES**

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Lucie Fortier

OBJECTIFS: 1) Favoriser un transfert dans un centre hospitalier près du domicile des parents tout en assurant une continuité de soins entre les milieux. 2) Assurer à la famille une transition harmonieuse entre l'hôpital de leur région et la maison. 3) Respecter la mission de l'HSJ en regard des soins tertiaires et quaternaires en néonatalogie. 4) Faciliter l'accès à des soins primaires et secondaires en périnatalité dans les centres hospitaliers partenaires.

DÉMARCHE: Afin d'implanter le processus du transfert à rebours, une collecte de données concernant les besoins des centres référants a été effectuée. Des outils de soins ont été développés tels Bulletin de sortie, plan de soins, grille d'évaluation relance post-transfert, préparation et feuille d'enseignement aux parents. De plus un programme de formation s'adressant aux intervenants a été élaboré.

RÉSULTATS: La démarche de transfert à rebours a été validée auprès de 25 centres référants et tous se sont dits satisfaits du processus. Les familles se disent également bien préparées et satisfaites du transfert de leur nouveau-né dans leur milieu.

#### **Networking/Connectivity - 99**

### **PROJET ARC-EN-CIEL - DOSSIER PATIENT PARTAGEABLE**

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Sylvie Talbot Coord de projets

Le projet Arc-en-ciel est une vitrine technologique du Réseau mère-enfant et un projet de partenariat qui consiste en un dépôt de données cliniques partagé, apte à soutenir la dispensation des soins, la continuité et l'intégration des services d'un réseau de soins, principalement avec ses partenaires, le CHU mère-enfant Sainte-Justine, le Centre Hospitalier Saint-Eustache, Cité de la Santé de Laval et cinq cliniques pédiatriques privées. Le défi: introduire le concept de partage et de circulation de l'information entre les divers intervenants en expérimentant trois solutions:

1. Le dépôt d'informations cliniques mère-enfant en intégrant les données informatisées provenant de différentes applications des centres partenaires.
2. Un index-patient maître du Réseau mère-enfant.
3. Un dossier patient en télémédecine intégré au dépôt.

Ce dossier est la première implantation de ce type au Québec. Il intègre des données cliniques, des documents de type image (dossier numérisé), donne accès aux images médicales provenant des examens de radiologie, et des rapports, images et vidéo en télémédecine. Ce projet a aussi permis le développement d'une application de gestion du consentement ainsi que le développement d'un dictionnaire d'entités médicales. Aujourd'hui, 86,500 dossiers patients sont accessibles à plus de 130 utilisateurs (médecins, infirmières, archivistes et personnel clérical) et ces chiffres continueront d'augmenter. Après six mois d'expérimentation, les résultats sont tangibles. Tous, clientèle et utilisateurs, peuvent apprécier et bénéficier des avantages qu'apporte le partage des données cliniques justes, en temps réel et opportun. Arc-en-ciel c'est l'accès aux données médicales du patient, et son avenir, c'est l'accès tout au long de sa vie, peu importe où il se trouvera...

#### **Networking/Connectivity – 100**

### **TELEHEALTH CAN REDUCE THE TRANSFERT TO TERTIARY CENTRES OF NEWBORNS WITH CARDIORESPIRATORY RHYTHM PROBLEMS**

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**Introduction:** Newborns are prone to cardiorespiratory rhythm anomalies (apnea, bradycardia) leading potentially to serious decrease in blood oxygen levels. The evaluation of these problems, when persistent, is usually done in tertiary pediatric centres, which implies the transfer of newborns from regional centres.

**Description:** Since 2002, we have developed a telehealth service with regional centres that consists of local acquisition of physiological data (respiration, ECG and hemoglobin-oxygen saturation levels) and transfer of electronic data to tertiary centres for immediate interpretation. Personnel from regional centres have been trained to perform the studies and continuous telehealth education is provided for both physicians and health professionals through conferences and a website.

**Results:** 245 transmissions of cardiorespiratory and oxygenation data have occurred (97 newborns). The results of the tests have led to change in therapy, further investigation, or have reassured the local medical team of the benignity of the condition. Infants had 1 to 7 additional recording studies to monitor progress over the course of their illness, all performed in the regional centres. Only three newborns were transferred to a tertiary centre, two due to rapid deterioration of their respiratory status documented with the recording system, and one due to equipment failure.

**Conclusion:** Telehealth has the potential to significantly decrease the transfer to tertiary centres of newborns with cardiorespiratory rhythm problems. In addition, the education program provides expertise in regional centres.



**A COMMUNITY PARTNERSHIP MODEL AT THE TORONTO EAST  
GENERAL HOSPITAL CHILD DEVELOPMENT CENTRE**

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The *Toronto East General Hospital Child Development Centre (TEGH CDC)* is an innovative model for assessing children with developmental concerns and linking them with community services in the south-east Toronto area. Children served by this clinic include those with autism spectrum disorders, developmental delays, and other cognitive concerns. Opened in March 2004, the TEGH CDC has partnered with a local inter-agency coordinating body, *Kids Included in Daycare and Early Childhood Services (KIDS)*, which includes representatives from 18 community agencies that provide services to children with special needs and their families. KIDS acts as the intake source for children referred to the TEGH CDC. This process ensures that children and families are able to receive coordinated services through the partner agencies from the moment they are referred, rather than having to wait for an official diagnosis. Following a developmental assessment, KIDS is also able to facilitate the implementation of the assessment team's recommendations at home and in the child's daily programming. The TEGH CDC assessment team currently consists of consulting paediatricians, a psychologist, an occupational therapist and a speech-language pathologist. The team also works closely with the Early Childhood Liaison, who is the TEGH CDC representative at the KIDS table. She visits the family in their home, guides them through the developmental assessment process, and ensures that they are able to access the services and additional funding that they may need. This poster will present a summary of the clinic's structure, development and a discussion regarding its current issues

**FETAL ALCOHOL SPECTRUM DISORDER (FASD): BEYOND DIAGNOSIS -  
COMMUNITY PARTNERSHIPS**

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Gayle Schuller

The Glenrose Rehabilitation Hospital, in partnership with Alberta Health and Wellness, developed the Glenrose Fetal Alcohol Spectrum Disorder (FASD) Clinical Service. One of the goals of the FASD Service is to work collaboratively with the community to provide a seamless coordinated service for individuals with FASD and their caregivers across systems and across their life span. These community partnerships may include education, health, justice, child welfare, First Nations, caregiver support, rehabilitation services, and the family system. The development of such partnerships is critical to the overall management of the child and the family, and assist in identifying resources, raising awareness, identifying gaps in service, and allowing the partners to work together to close gaps and advocate for new resources. This poster will describe the partnerships involved in this FASD clinic and the role they play in the overall management of the child and family. It will also describe the critical importance of linking diagnostic services with community partners to ensure the required followup for management can be facilitated.

## Networking/Connectivity - 103

### **PARENTING A CHILD WITH DEVELOPMENTAL NEEDS: AN EDUCATIONAL TOOL FOR PARENTS AND PROFESSIONALS**

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Lorna Reimer, Sandy Litman, Ellen Carlisle, Hazel Sutherland

The Glenrose Rehabilitation Hospital has developed a CD-ROM-based tool, as part of the Alberta Caregiver College, to provide a virtual educational resource to help address questions and needs of parents with children who have developmental challenges, and to provide professionals with knowledge, strategies and resources regarding this population. A wide variety of topics are included, ranging from assessment to management. The user-friendly format allows parents or professionals to access a topic area most suited to their present needs, with references and websites included for additional information. This tool helps extend the impact of the clinical team by providing families and other care providers with close at hand information and guidance throughout the child's development. The poster outlines the development process, the content and format of the tool, potential applications, limitations and ways of overcoming those limitations.

## Research & Evaluation - 104

### **CRITICALLY ILL CHILDREN STABILIZED BY STAY AND PLAY MOBILE ICU TRANSPORT TEAMS HAVE IMPROVED CONDITION AND UNCOMPLICATED TRANSPORTS**

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Sataporn Muang-In, Transport Fellow, Acute Care Transport Services, Hospital for Sick Children, Adrian J A Ziino, Transport Fellow, Acute Care Transport Services, Hospital for Sick Children, Hilary E Whyte, Medical Director, Acute Care Transport Services, Hospital for Sick Children, Patrick Mc Namara, Associate Medical Director, Acute Care Transport Services, Hospital for Sick Children

Physiological deterioration or adverse events during the retrieval of critically ill children is reduced by dedicated paediatric teams. The Acute Care Transport Services (ACTS) team has expanded its mandate to retrieve children up to 2 years and has translated its neonatal stabilization philosophy of stay and play into paediatric critical care transports. However other teams consider scoop and run to be a more effective and safer means of transporting critically ill children.

Data was prospectively collected on all paediatric transports by ACTS from Nov 2002 to Nov 2003. Details recorded included patient demographics, referral problem, transport mobilization stabilization times and adverse events during transport. A physiology score based on a modified PRISM score was used as an index of illness severity and recorded on arrival and following departure of the team from the referral hospital. The effectiveness of transport stabilization was assessed by comparing pre and post stabilization physiology scores. An intervention score was constructed to assess details of the stabilization process. The relationship between intervention scores and stabilization times was examined using linear regression methods.

Thirty-five children were retrieved with an average referral age of 5.7 months. Ninety-four percent of patients demonstrated improvement or plateau in their physiology score with a significant reduction in physiologic score over the stabilization period. There was a positive relationship between the length of stabilization and the calculated intervention score. There were no critical incidents, adverse patient or equipment events during transport.

The physiologic condition of critically ill children is improved and the likelihood of adverse events is reduced following aggressive stabilization by a dedicated paediatric mobile ICU team.

## **Research & Evaluation - 105**

### **GENETICS, ENVIRONMENT, NUTRITION EXPLORING AUTISM IN CHILDREN: THE GENE-A TRIAL**

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Eric Fombonne, Director of Psychiatry, Montreal Children's Hospital, Patricia Assouad, Research Assistant, Montreal Children's Hospital, Eric Dewailly, Director Public Health Research Unit, CHUL-CHUQ

Recently, there has been a heightened awareness by professionals and parents on the frequency of Autism and Pervasive Developmental Disorders (PDD) (Fombonne, E. 2004). Considering the rise of Autism and PDD diagnoses, there is concern that environmental risk factors or diet may be causing this increase.

**Objective:** Compare dietary intake and exposure to environmental factors of autistic and normally developing children.

**Methods:** Patients are recruited from the Autism Spectrum Disorders Clinic of the Montreal Children's Hospital. Patients are assessed by the primary author, resulting in a confirmed diagnosis of Autism/PDD. Blood, hair, and toenail specimens are collected from children and mothers. Children's eating and sleeping habits are recorded in a 3-day Food Diary and a 7-day Sleep Log (Shapiro, H. 1998). A telephone interview with mothers is conducted to gather dietary, environmental and medical information on their pregnancy and their child's first year of life.

**Results:** Presently, data is collected on 59 autistic children and their mothers (mean age=3.7 years; age range=1.6 years to 6.8 years). 86.4%(n=51) are males and 13.6%(n=8) are females. Blood, hair and toenail specimens will be analyzed for traces of Metal, Mercury and Selenium levels. Immunology levels will also be reported. Contents of the Food Diary will be analyzed using the software The Food Processor, providing a breakdown of all nutrients.

**Conclusion:** Preliminary findings of this study may provide important information on possible contributing factors to childhood autism.

## Research & Evaluation - 106

### **PREVALENCE OF PDD AMONGST ENGLISH SPEAKING SCHOOL-AGED CHILDREN IN QUEBEC**

Rita Zakarian, Research Coordinator, Montreal Children's Hospital, 4018 St. Catherine Street West, Room K-241, Montreal, Quebec, H3Z 1P2, rita.zakarian@muhc.mcgill.ca

Andrew Bennett, Psychologist, Lester B Pearson School Board, Eric Fombonne, Director of Psychiatry, Montreal Children's Hospital, Diane McLean-Heywood, Director of Student Services, Lester B Pearson School Board

There is continuing debate about the prevalence rates of autism and other pervasive developmental disorders (PDD). Recent studies have yielded estimates ranging from 34 per 10,000 (Yeargin-Allsopp et., 2003) to 63 per 10,000 (Chakrabarti and Fombonne, 2001). If rates of 60-70 per 10,000 are confirmed as suggested in a recent review (Fombonne, 2003), Autism and PDDs should be regarded as relatively common conditions with prevalence rates higher than other childhood handicaps such as Down Syndrome or Cystic Fibrosis.

**Objective:** There has been no prevalence study of PDDs in Quebec. Current estimates of the magnitude of PDDs in Canadian children are needed. This study will estimate the prevalence rate of PDDs in children in Quebec.

**Methods:** A survey of PDD children enrolled in schools in the Lester B. Pearson School Board (LBPSB) was conducted. All children with a PDD diagnosis based on DSM-IV criteria were identified and data on their socio-demographic, medical, and educational characteristics were collected.

**Results:** Out of 27,749 children enrolled in the LBPSB, a total of 187 children were identified with a PDD diagnosis. This translates into a prevalence of all PDD combined of 67.4 per 10,000 (95% CI; 58.1-77.7).

**Conclusion:** The overall prevalence estimates in this study is highly consistent with the most recent surveys performed in several countries (Fombonne, 2003). This is remarkable, as surveys that rely on administrative sources for case identification (e.g. hospital data or school data) usually yield lower prevalence estimates. It could well be that the increasing awareness about autism and PDDs, associated with positive changes in special education policies, have contributed to our results being more valid estimates of population parameters.

## Research & Evaluation - 107

### **A SURVEY ON MENTAL HEALTH ISSUES IN ADOLESCENTS WITH DOWN SYNDROME**

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W Mahoney, J Summers, K Kitching, M Kim, G Ho, D Frieden

The rate of mental health problems among individuals with Down syndrome is higher than in the general population but lower than other individuals with non-specific developmental disability or syndromes in an Australian sample. The purpose of the study was to conduct a survey of mental health problems in adolescents with Down syndrome in a Canadian sample. 63 families of adolescents enrolled in a regional Down syndrome

clinic were invited to participate. 62% of eligible families participated in the study. Parents completed a demographic questionnaire, Aberrant Behaviour Checklist (ABC), and Developmental Behaviour Checklist (DBC). Compared to an epidemiological survey, adolescents with Down syndrome scored significantly lower on five subscales of the DBC-P. The overall rate of psychopathology among the adolescents with Down syndrome was 28%, lower than the 41% of the epidemiological study. On one subscale of the ABC-C, adolescents with Down syndrome scored significantly lower than a community comparison group. Consistent with the assessment literature, adolescents with Down syndrome had lower rates of mental health problems than comparison groups with developmental disabilities of mixed etiology. The majority of parents indicated concerns regarding their adolescents' behavioural and emotional functioning. Parents identified speech and language as a common area of concern and as a need for additional support. Further research is necessary to explore the subgroup of adolescents with Down syndrome experiencing higher levels of difficulties as identified by their parents.

#### **Research & Evaluation - 108**

##### **EVALUATION OF THE USE, UTILITY AND IMPACT OF AN INFORMATION KIT FOR PARENTS OF CHILDREN AND YOUTH WITH SPECIAL NEEDS**

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M Law, P Rosenbaum, C Missiuna, G King, J Burke-Gaffney, T Szkut

The objective of this project was to evaluate the use, utility and impact of an Information KIT for parents of children and youth with special needs. The KIT (“Keeping It Together”) is a resource for parents to give, get and organize information. It includes a User’s Manual with tips and strategies about information, and a Binder for keeping their own information together. A “Research-in-use” design was employed to evaluate the use, utility and impact of the KIT with a voluntary sample of over 450 parents of children and youth, from birth to 21 years of age, with a variety of special needs in Ontario.

The results of the evaluation has provided support for this type of resource for parents of children and youth with special needs. There was a significant increase in the parents’ perceptions of their ability to use information effectively in a variety of situations. Their perceptions of service delivery also improved significantly in several domains of the Measure of Processes of Care (MPOC). Interviews with a purposefully selected sample of 20 parents revealed key themes about the importance of timing in receiving the KIT, the need for orientation or training to get started, and suggestions for additional forms. This poster presentation will highlight the results of the KIT evaluation and future plans. The target audience is service providers and parents.

#### **Research & Evaluation - 109**

##### **RESEARCH RESULTS FAMILY-CENTERED CARE**

Alida Bowman, RN, BScN, MScN, Program Manager, McMaster Children's Hospital, 1200 Main St West, 3d2, Hamilton, Ontario, L8N3Z5, [bowmana@hhsc.ca](mailto:bowmana@hhsc.ca)

This poster presents the results of research study on parent’s perceptions of family-centered care. The study was designed to discover whether parents of children receiving care in a hospital setting perceive elements of family-centered care to be important.

Secondly, to evaluate parent satisfaction with care. The study design was a quantitative descriptive approach. A questionnaire was used based on key concepts of family-centered care in the literature. The data for analysis were collected by the use of questionnaires completed by parents of ill children who had been admitted to the hospital or seen in the outpatient clinic. The data were analyzed through descriptive and inferential statistics and the results were reported with the use of tables. The sample size was 80 families (N=80). The results of the study demonstrated that the parents in this sample rated selected elements of family-centered care in the study as important. The variables were prioritized in this sample by parents in the following order: accessibility of nurses, interaction and communication, interpersonal support, respect, and empowerment. Secondly, the results indicated that parents were highly satisfied with the majority of nursing service provided for their child. Parents rated certain aspects of family-centered care as more important than others. There was an identified gap in knowledge about family-centered care from a parent perspective.

#### **Research & Evaluation - 110**

### **SEVERE NEONATAL HYPERBILIRUBINEMIA IN CANADIAN NEWBORNS: A PREVENTABLE DISEASE?**

Douglas Campbell, Director of Medical Education, Department of Pediatrics, St. Michael's Hospital, University of Toronto, 15-014 Cardinal Carter Wing, 30 Bond Street, Toronto, Ontario, M5B 1W8, campbelld@smh.toronto.on.ca

Dr Vibhuti Shah, Dr Michael Sgro

A number of reports continue to describe severe neonatal hyperbilirubinemia and subsequent encephalopathy in breast-fed babies who were well prior to discharge from hospital. Risk factors known to be associated with hyperbilirubinemia in the newborn include: early jaundice, Rh & ABO incompatibility, and G6PD deficiency. Attempts to better describe the epidemiology of severe neonatal hyperbilirubinemia would be of value in developing strategies for risk reduction. Data on term infants 60 days of age or less with unconjugated hyperbilirubinemia was collected from July 2002 through the Canadian Pediatric Surveillance Program. Criteria for inclusion were: peak serum total bilirubin >425  $\mu\text{mol/L}$  or neonatal exchange transfusion. We excluded preterm infants and those newborns with Rh incompatibility. After 18 months of surveillance 270 cases were reported. 205 were confirmed, 55 were duplicates or discards, and 10 were incomplete. 69% of cases were readmitted to hospital. The mean age at presentation was 110 hrs (range 1-408). 82% were exclusively breastfed. In only 83 cases (40%) was the cause identified. The etiologies included ABO incompatibility (n=40), G6PD deficiency (n=17), other antibodies (n=4), and spherocytosis (n=2). 47 required exchange transfusion (23%). All required phototherapy. 6 neonates had documented hearing loss and 4 had significant neurological sequelae. This study shows that severe neonatal hyperbilirubinemia continues to occur in term neonates with significant morbidity. It highlights the importance of a complete workup for these children and brings in to question the need for a serum bilirubin prior to discharge and screening for ABO incompatibility & G6PD deficiency.

**PEDIATRIC MOCK CODES**

Tosha Sarachman, RN, BScN, PCCU Clinical Educator, McMaster Children's Hospital, Hamilton Health Sciences, 1200 Main Street West, Hamilton, Ontario, L8N 3Z5, sarachma@hhsc.ca

In the event of a pediatric cardiopulmonary arrest, the dynamic health care team must pull together to deliver supreme lifesaving interventions. As health care professionals, our primary objective is to prevent a child from reaching the need for resuscitation. However, in reality, it does happen. It happens infrequently enough, that when it does occur, those health care professionals are shocked and unprepared. In our PCCU the nursing staff feel especially apprehensive and anxious with the thought of having to face the event of a “crashing” child. It is also the responsibility of the PCCU nursing staff to respond to all intra-hospital pediatric code blues. This added responsibility creates a heightened level of stress among the staff. This poster presentation will be of particular interest to RN’s working in a pediatric environment where the potential for having to resuscitate a child exists. The objective of the poster is to convey how the PCCU deal with anxiety and unease of the nurses with regards to pediatric resuscitation. In attempts to decrease the level of stress through education, the PCCU has started running weekly mock codes encompassing real pediatric scenarios. The State-Trait Anxiety Inventory (Spielberger, 1983) was used to assess the staffs stress levels prior to the implementation of weekly mock codes. The Inventory will be completed every 3 months to measure the staff’s level of stress. The goal is to find a decline in the level of stress and a potential rise in competency and control over unexpected pediatric resuscitation. (word count 248).

**EVOLUTION OF THE PHYSIOTHERAPIST'S ROLE IN THE BOTOX ASSESSMENT CLINIC**

Linda Kealey, Physical Therapist, Ottawa Children's Treatment Centre, 395 Smyth Road, Ottawa, Ontario, K1H 8L2, lkealey@octc.ca

Antoinette Megens

The objective of this poster is to highlight the process of evolution of the physiotherapist's role within the Botox Assessment Clinic. A research project was designed to gather information regarding physiotherapy practice and therapists' experience with regards to assessment and treatment for children following injection with Botulinum Toxin (Btx-A). For the process of information gathering, the health records of 45 children who had received Btx-A injection to the lower extremities during the years 2001 and 2002 were included in the chart review in order to determine the current practices within the clinic. In addition, community physiotherapists who work with the clients seen in the Botox Assessment Clinic were contacted through a mail-out survey, gathering information regarding current assessment and treatment practices. Data analysis was performed by calculating and summarizing descriptive statistics. In conclusion, findings were used to help shape the role of the physiotherapist within the Botox Assessment Clinic, with particular attention directed at identifying and addressing gaps in the health care continuum from tertiary care centre to the community setting, where many children receive services. This poster presentation is targeted towards clinicians who work with children with cerebral palsy, or other neurological conditions, and their families.

## Research & Evaluation - 113

### **BOTULINUM TOXIN-A TREATMENT VS COMBINED INTERVENTION WITH BOTULINUM TOXIN-A AND CASTING/SPLINTING**

Antoinette Megens, Physical Therapist, Ottawa Children's Treatment Centre, 395 Smyth Road, Ottawa, Ontario, K1H 8L2, tmegens@octc.ca

Linda Kealey

The objective of this poster is to highlight the findings of a retrospective research project. The project was designed to investigate whether casting or splinting in conjunction with Botulinum Toxin-A (Botox) injection significantly increased the ROM gains possible for treated muscle groups in children with cerebral palsy.

The subjects included 45 children with cerebral palsy who were seen in the Botox Assessment Clinic during the study period. Data was obtained via a retrospective chart review. Thirty-three subjects had Botox injection to the gastrocnemius muscle group, and 27 subjects were casted in addition. Seventeen subjects had Botox injection to the hamstrings muscles, with 8 having knee immobilization splints. Five subjects had Botox injection to the hip adductor muscles, with two using hip abduction wedges. There was a statistically significant difference in ROM for all groups when comparing pre-Botox ROM with post-Botox ROM. For subjects who had injections to the gastrocnemius muscle groups, there was a significant difference in change in ROM for casted subjects, versus not casted. There was not a significant difference in the change in ROM for subjects who used knee immobilization. There were too few subjects to determine the effect of hip abduction wedges on ROM gains. This poster presentation is targeted towards clinicians who work with children with cerebral palsy, or other neurological conditions, and their families.

## Research & Evaluation - 114

### **THE JOINT STATEMENT ON PHYSICAL PUNISHMENT OF CHILDREN AND YOUTH**

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The joint statement was developed by a national partnership of organizations concerned with the well-being of children and their families.

Based on extensive research evidence, the statement provides an overview of the developmental outcomes associated with the use of physical punishment on children and youth.

This poster presentation will highlight the findings, conclusions, and implications, and provide recommendations for action in Canada.



**CANADIAN PARENTS' UTILIZATION OF HEALTH CARE SERVICES**

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Raynald Pinault University of Montreal, Claire Chapados University of Montreal

The objective of the poster is to describe parents' utilization of health care services during a specific period of time that is: frequency of consultation, type of services and healthcare facilities. The sample was formed of 323 French and Anglo-Canadian parents of a child having a day surgery at two university affiliated pediatric hospitals. The instrument used, the Questionnaire on Utilization of Health Care Services, adapted and validated by the authors for the study, comprises seven (7) open-ended questions on the type and frequency of utilization of health care services, and three (3) questions on socio-demographic/personal variables.

Results showed that parents, during the last 12 months, consulted 10.4 (range 0-113) times health care professionals. Most of the consultations (82.5%) were for medical reasons. The health care professionals mostly consulted were family doctors/general practitioners. The health care facility mostly used by parents and children was the family doctor office (79.7%). Services were mostly curative followed by preventive.

There were some differences between the two samples.

Results will be used first to better identify types of services more utilized and later to analyse these services in term of costs. This will help researchers and health care managers to better direct preventive and curative health interventions in order to increase quality of care for children and to reduce costs.

**WHAT HAVE WE LEARNED? FINDINGS FROM A NATIONAL VALIDATION STUDY TO DEVELOP A STANDARD PATIENT EXPERIENCE QUESTIONNAIRE FOR USE ACROSS CANADA.**

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Rathert Cheryl, Gustavson Kris

The proposed poster will describe a Canadian initiative supported by the Ontario Hospital Association, the network of the Canadian Association of Paediatric Health Centres and underwritten by The NRC+PickerGroup Canada. The objectives of the initiative include the following:

1. Develop a valid and reliable Paediatric Survey tool that measures patient and family experiences of care
2. Develop databases for benchmarking of best practices
3. Support care and service delivery improvement initiatives

Before this project began, there were many health centers and hospitals across Canada that were instituting patient satisfaction surveys, however there was no consistency in the use of tools, there was no sharing of data and no opportunity to benchmark nationally.

A Steering Group and supporting organizations guided the project and engaged health professionals from across Canada to measure the paediatric patient experience building

upon the paediatric Picker questionnaire developed in the United States.

Seven facilities from British Columbia, Manitoba, Ontario and Nova Scotia participated. Key dimensions measured through the survey tool include: coordination of care; information and education to the parent/guardian; information and education to the child; confidence and trust; partnership between family and clinicians; physical comfort; continuity and transition; and access to care. The poster will share the results of the validation initiative and discuss the value of benchmarking patient experience data with other paediatric facilities internationally.

#### **Research & Evaluation - 117**

##### **EXECUTIVE SAFETY WALKROUNDS IN CALGARY HEALTH REGION**

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Brenda Fischer RN, BN, MBA VP Child and Womens Health Portfolio, CalgaryHealth Region

In a health care system, patient safety needs to be a key focus of health care providers. The Calgary Health Region started a Patient Safety Collaborative in August 2003 to try to create a safety culture. As an action, the Child and Women's Health Portfolio piloted Executive Safety Walkrounds in clinical areas with frontline staff. An additional portfolio was added about 2 months later.

The Child and Women's Portfolio completed 22 rounds on 21 units from August 14th to March 1<sup>st</sup> while the North West Portfolio completed 11 walkrounds from November 5th to March 1st. Over 165 CHR staff participated with over 800 notes and suggestions made in 34 clinical sites. Each of the sites completed actions or have ongoing projects related to those suggestions. Overall feedback has been extremely positive. Staff were pleased to see that management wanted to understand safety issues that arise in clinical areas. In addition, they were not afraid to talk about some of the errors that they had witnessed or "near misses" that had taken place. They often had suggestions to improve their unit safety. The walkrounds provided a learning environment, new information and exposure to frontline reality. Two other portfolios are about to start with a third in the planning. Many identified opportunities still need action and follow-up. However, the small victories of engaging staff and senior executives in the safety process through walkrounds may be pivotal in helping to create a true "culture of safety".

#### **Research & Evaluation - 118**

##### **WRITING SAFER MEDICATION ORDERS IN A PAEDIATRIC HOSPITAL - A QI PROJECT**

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Cheri Nijssen-Jordan, Kyle Garrett, Child Health Patient Safety Team

Objective: To decrease the number of medication ordering errors within the teaching teams at Alberta Children's Hospital (ACH)

Methods: Order errors were defined as: illegibility, incompleteness, unclear abbreviations, or incorrect calculations. Patient order sheets were reviewed for order

errors by two reviewers between August 2003 and April 2004. A baseline review was done on 21 charts. Following an educational intervention on safe medication order writing for Paediatric Residents and Hospitalists at the ACH, additional rapid cycle interventions were trialed. Interventions included reminder posters, bright stickers attached to medication order sheets and handing out pocket laminated cards outlining safe medication ordering practices. Following each intervention, a chart review measured frequency of ordering errors: defined as an order, which is, illegible, incomplete, contained unclear abbreviations, or whose dosage was calculated incorrectly

Result: Error frequency (total errors/total orders) ranged from 49% - 82%. Although 5 charts were audited in each audit, the number of orders audited ranged from 34-93 with an average of 55 orders per audit.

Learnings: No single intervention has been shown to have a sustained effect on improving order accuracy. Involvement of residents in the next steps will be vital to moving forward as ownership of this as an issue is a key factor. Barriers to writing error free medication orders need to be explored and solutions need implementation.

#### **Research & Evaluation - 119**

##### **THE USE OF EVIDENCE-BASED PRACTICE TO CHANGE ENDOTRACHEAL SUCTIONING TECHNIQUE IN PICU**

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Vallée Dominique, Gauvin France

Endotracheal suctioning is performed frequently in PICU. A fixed schedule for ES was used in our unit, recent literature has recommended a different approach. The objective of this study was to revise the technique and to compare complications and patients' outcomes in groups of patients using different frequencies.

150 papers that addressed this issue were retained from an extensive computer search. We consulted international experts and formed a multidisciplinary committee to analyse the findings. Most articles were based on experts' consensus. The literature supports a non-invasive technique performed as needed. A pilot study was formulated with a surveillance sheet for all intubated patients during a six months period. All intubated patients admitted to the PICU were divided in three groups, according to pre-defined clinical criteria and different guidelines for ES frequency.

148 patients were included in the study. Length of ventilation was similar between the 3 groups ( $p=0.26$ ). The number of ES per day ( $8.2 \pm 2.1$ ) was not different between the groups ( $p=0.27$ ). Mean maximal delay between two ES was 4 hours in each group ( $p=0.64$ ). Overall, delay between two ES more than 4 hours occurred in 25% of the cases. Complications were rare and similar in all groups.

This study shows no significant difference between the groups for the number of ES per day, despite pre-established criteria. This could reflect either old habit, the needs of patients, non-verbal orders or small sampling. Nevertheless, no complications were associated with longer delays between ES and these changes enhance the practice and ensure the quality of care.

## Research & Evaluation - 120

### **PICU HEALTH CARE WORKERS' EXPERIENCE WITH TREATMENT CESSATION DECISION**

Sophie Charland, CNS, Ste-Justine, Université de MTL, 3175 Cote-ste-Catherine, Montreal, Quebec, H3T1C5, sophie\_charland@ssss.gouv.qc.ca

Vallée Dominique

There is a paucity of research exploring health care professionals' experiences with treatment cessation involving pediatric intensive care patients. The objectives of this study were to understand the PICU health care professionals' experiences regarding treatment cessation, and to evaluate their satisfaction with the current approach, which consists of daily multidisciplinary meetings and specific meetings for more complex issues. A questionnaire containing 6 open questions was developed, validated by the PICU bereavement committee and administered by the unit coordinator and her assistants. In total, 103 questionnaires were distributed and 39 were returned. Overall, the treatment cessation experience was described as difficult. Certain elements were identified as particularly perturbing: a long and difficult death, feelings of guilt and failure, treatment cessation decision made by others, and emotionally overburdened parents. Doctors were afraid that they had made mistakes and nurses felt powerless and did not feel well prepared. Yet, both questioned their performance and rationalized the decision by a lack of quality of life for the child and felt in peace that everything possible had been done. The staff used a variety of emotional and cognitive strategies to deal with the experience. The emotional impact varies greatly amongst the staff even though most of them expressed the need for temporary emotional detachment. Several changes were recommended regarding the current approach such as acquiring more knowledge about cultural impact, death rituals and religions; more psychological assistance during the experience and pastoral involvement; improve interdisciplinary communication; and more debriefing using an interdisciplinary team approach.

## Research & Evaluation - 121

### **DEVELOPMENT OF A MEASURE OF PSYCHOLOGICAL DISTRESS IN CHILDREN FOLLOWING CRITICAL ILLNESS**

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Linda McHarg Nursing Consultant, The Montreal Children's Hospital of the McGill University Health Centre, Celeste Johnston Professor, McGill University, Melissa DellApi Staff Nurse, The McGill University Health Centre, Bonnie Stevens Signy Hildur Eaton Chair in Pediatric Nursing Research, The Hospital for Sick Children & Associate Professor, University of Toronto, Patrick McGrath Psychologist, The IWK Health Centre & Professor, Dalhousie University, Robert Platt Biostatistician, The Montreal Children's Hospital of the McGill University Health Centre & Associate Professor, McGill University

There is mounting evidence in the literature that severe childhood illnesses and the intensity of the treatment they require can have significant psychological repercussions for children. Attempts to measure psychological outcomes in children have been limited by instruments adapted primarily from adult measures and narrowly defined diagnostic frameworks. The purpose of this study was to develop a measure of psychological

distress for use with children following critical illness that would demonstrate content validity and specific relevance for this population of children. Data were collected in 3 Canadian paediatric hospitals. A developmental model of childhood traumatic stress provided the conceptual framework. Items were generated by interviewing 25 children (aged 6 to 12 years) following paediatric intensive care unit hospitalization, 26 parents, and 12 health care professionals. Interview data were transcribed, subjected to thematic analysis, and a preliminary instrument was developed. Items were assessed for readability, comprehension, and content validity by another 8 children, and based on their feedback the number of items was reduced. The measure consists of 25 items that fall into 7 domains, including sleep, fears, worries, memories, behaviours, friends & school, and sense of self. While the domains are consistent for children aged 6 to 12 years, it was determined that 6 and 7 year olds will require a simpler version of the scale. This presentation is targeted to health care professionals who care for critically ill children in hospital, and who provide follow-up care to this population in the community at large.

## **Research & Evaluation - 122**

### **PATIENT MEDICATION SAFETY COLLABORATIVE - THE CHILD HEALTH APPROACH**

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Margot Harvie QI Consultant Pediatrics

Objective: To create a culture of safety throughout the Child Health Portfolio

Methods: The child health quality council began working on projects related to patient safety in September of 2002. In September of 2003, a region wide collaborative was launched with a focus on medication safety. A multidisciplinary team from throughout the Child Health portfolio was brought together for this project. The team began working on projects related to medication ordering, delivery and dispensing, and administration as well as projects related to creating a culture of safety. The teams used a rapid cycle or Plan, Do, Study, Act methodology to introduce changes to improve patient safety. The system measure used for this collaborative was ADE chart reviews

Results: Various projects were undertaken during the collaborative. Frontline staff including RN's, Pharmacists, physicians, and pharmacy techs. Meetings were one hour in length every two weeks for 9 months. Over 30 PDSA cycles were attempted during the course of the collaborative on different areas within Child Health.

Three projects included practice changes to be implemented, 4 projects have been spread to areas throughout the portfolio and the Calgary Health Region. Two projects will be carried on for the next year

Learnings: To impact patient safety, there needs to be an increase in awareness of the issues around safety. The very strong team commitment and energy was invaluable as the team was working on many projects at one time and everyone took a lead position in their area. Significant changes of staff priorities required to ensure safety is incorporated into daily practice

## Research & Evaluation - 123

### **UNCOVERING THE ART OF COMMUNITY PAEDIATRIC NURSING PRACTICE: NURSES SHARE THEIR STORIES**

Helene Lacroix, Clinical Services Expert, Saint Elizabeth Health Care, 90 Allstate Parkway, Suite 300, Markham, Ontario, L3R 6H4, hlacroix@saintelizabeth.com

Karen Spalding Associate Director - Research and Graduate Studies, School of Nursing, Ryerson University, Jasmin Earle Manager, Child and Family Program, Saint Elizabeth Health Care

Our children are exposed to the powerful nature of stories and storytelling at a very early age. Parents use stories to teach such important lessons as respect for others. In health care, stories and storytelling are often used to inform children about procedures or complex topics such as death and dying. We are undertaking a qualitative research study that will use nurses' stories as the data source to describe the art of community paediatric nursing in our community health agency.

Objective of the session: The objective of this poster is to provide a view into the often hidden world of the community paediatric nurse. This will be achieved through the sharing of critical nursing stories from the data collected and the beginning analysis of their meaning.

Conclusions: Story telling is a powerful medium that can enable depth of understanding. Through analysis of nursing stories, it is possible to gain insight into common elements of community paediatric nursing practice without losing the contextual elements that are so critical to full understanding.

Target Audience: This poster will have broad appeal. For the professional working in the community setting, the poster will validate the importance, challenges, and rewards of practice. For professionals working in institutions, this poster will increase understanding of the community sector, including the synergies that are possible.

## Research & Evaluation - 124

### **REDUCING THE RISK OF ENTANGLEMENT IN MEDICAL TUBING – EVALUATION OF POLICY**

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Cheri Nijssen-Jordan, Cindy LaFrance, MTS HFMEA Team

Objective:

To evaluate the policy changes and new product adopted as strategies to reduce the risk of children becoming entangled in medical tubing.

Method: In 2003 a policy was introduced within the Child Health portfolio of the Calgary Health region to decrease the possibility of entanglement of children in medical tubing. The policy was developed including a medical failure mode analysis on a new piece of equipment that makes medical tubing more rigid and less likely to entangle called a medical tubing stabilizer (MTS). When the policy was developed, there was also an evaluation of the policy planned. When the policy was introduced, there were

problem identification sheets placed on each unit to identify specific issues with the MTS. In Feb. 2004, in-patient units were visited by one reviewer who identified all children on any type of medical tubing. Pertinent documentation was reviewed and reviewer spoke to RN's about the entanglement reduction strategies being utilized for at risk patients. In March and July, patient areas were visited and RN's were asked questions to test their knowledge of the medical tubing entanglement policy. RN's were also asked about their experiences with the MTS.

Results: There were no reported instances of entanglement of medical tubing reported during evaluation period. Staff had good knowledge of the policy and entanglement reduction strategies. There was variable use of the medical tubing stabilizers related to nursing practice as well as issues with the MTS that were felt to increase risk of harm to the child.

## **Research & Evaluation - 125**

### **NEAR MISS TO GOOD CATCH – IMPROVING REPORTING IN CHILD HEALTH**

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Cheri Nijssen-Jordan, Janet Cohen, Child Health Patient Safety Team

Objective: To improve the culture of safety and increase the reporting of Near Misses within the Calgary Health Region.

Methods: In 2002, the Child Health Quality Council began working on projects related to patient safety. One of the first projects launched was a "Near Miss Trial" within the inpatient areas throughout Child Health. The trial consisted of a two week time period in each clinical area where the staff filled out forms developed for the trial to report near misses. A near miss was defined as anything that would have been considered an error or problem with patient care or unit process that was caught before it reached the patient. The forms required no signature and no follow up or further investigation was done on specific incidents. During the 2003/04 Regional Medication Safety collaborative, further PDSA cycles were done involving near miss reporting.

Results: A total of 15 clinical areas participated in the two week near miss trial. Several of the projects worked on in the medication safety collaborative were at least in part identified through the near miss project. A major reorganization of the IV storage carts and stocking procedures were a direct result of the choosing of the wrong IV solution identified as a near miss. The name of near miss has been changed to "Good Catch" within the Child Health portfolio as identified as a more positive way to have incidents and almost incidents reported.

Conclusions: Introduction of the near miss trial within the Child Health portfolio has identified areas to focus on with projects related to patient safety. Staff felt comfortable in reporting good catches and some are now being reported on the regional Incident Reporting Form where they rarely were before

**CARE OF CHILDREN WITH CHRONIC HEALTH CONDITIONS: VIEWS OF PEDIATRICIANS IN BRITISH COLUMBIA, CANADA**

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Magdalena Recsky, Robert W Armstrong

Limited attention has been paid to the adequacy of healthcare services for children with chronic health conditions (ChrHC) in Canada. We conducted a postal survey of pediatricians in British Columbia (BC) to ascertain their views on healthcare services to children with ChrHC, and explore whether views differed in relation to chronic medical (Chr-Med) vs. chronic developmental, behavioural and mental health conditions (Chr-DBM). Full data were obtained from 119 of 197 eligible pediatricians across BC (60.4% response rate). Pediatricians rated the ability of the BC health care system to provide safe, high quality care to children with acute or life threatening illnesses/injuries highly (mean rating [ $\pm$  SD] on 7-point scale was  $6.0 \pm 1.0$ ), lower for Chr-Med ( $4.9 \pm 1.0$ ) and well-child/preventive care ( $4.46 \pm 1.3$ ), and lowest for Chr-DBM ( $3.1 \pm 1.2$ ;  $P < 0.01$  for all comparisons). The most highly rated suggestions for improvement were improving access to community-based assessment, treatment and supportive services/ resources (rated  $6.1 \pm 0.9$ ), improving access to medical specialists and facilities ( $5.5 \pm 0.1$ ) and alternative care models, such as interdisciplinary community-based care teams ( $5.4 \pm 0.1$ ). Amongst options for various aspects of care for children with ChrHC, some differences were observed between Chr-M and Chr-DBM, but pediatricians almost universally rated existing arrangements, such as fee-for-services remuneration, and their participation as solo clinicians rather than part of a team, least favorably. This survey highlights shortcomings in healthcare services for children with ChrHC, and especially ChrDBM, as perceived by practising pediatricians. Further analysis are in progress to assess for consensus on what changes might be most helpful.

**ENHANCING CLINICAL RESEARCH CAPACITY IN CHILD AND YOUTH HEALTH: PRELIMINARY SURVEY RESULTS**

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Janet Olds

The contributions of clinical health researchers have been important in developing knowledge of health care outcomes. Their role has grown along with the demand for evidence-based practice; clinician scientists are among those best equipped to gather and critically analyze these findings. They also help to ensure the translation of research findings into clinically useful applications, a key priority for Canadian Health Care Research. Despite these contributions, there are several significant concerns regarding the future of clinician scientists working within hospital or health care settings. Some of these concerns were identified at a CIHR-funded workshop held in Edmonton in January 2003.

This workshop, "Enhancing Clinical Research Capacity in Child and Youth Health", was attended by child and youth researchers in the clinical health sciences across health



disciplines, research trainees, administrative, clinical and academic leaders from paediatric health centres, universities, and granting agencies. During the workshop, issues that facilitate or impede clinical research were identified, and action plans were developed to enhance clinical research capacity.

Successful implementation of these action plans is partly dependent upon a greater understanding of common obstacles and facilitators to clinical health research in pediatric health centers. From the Edmonton workshop, a survey was developed to provide data about these issues from a national perspective. In this poster, we present preliminary data about facilitators and barriers to enhancing clinical research in child and youth health, based on responses of those representatives at the workshop. Future directions, including a broad-based sampling of Canadian clinician researchers, will be discussed.

### **Transition & Alternate Models of Care - 128**

#### **PAEDIATRIC ACUTE CARE TRANSPORT: A COLLABORATIVE PRACTICE MODEL**

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Alison Quigley, Director, Acute Care Transport Services, Hospital for Sick Children, Hilary Whyte, Medical Director, Acute Care Transport Services, Hospital for Sick Children, Annette Martens, Transport Clinician, Acute Care Transport Services, Hospital for Sick Children

The Acute Care Transport Service (ACTS) Team is responsible for the stabilization and transport of over nine hundred critically ill pediatric patients annually to tertiary care centres in central east and regionalized northern areas of the province. ACTS is a dedicated neonatal/pediatric transport service; its staff members consist of specialized nurses, respiratory therapists and transport physicians. ACTS team members operate in an enhanced practice role with the utilization of medical directives and the support of a transport physician by phone. The success of the ACTS team is based on the philosophy of collaborative practice.

This interdisciplinary practice model promotes autonomy, capitalizes on the collective knowledge base of its professionals and strives to continuously improve clinical outcomes. A key component of collaborative practice is sharing of knowledge. ACTS provides an interdisciplinary, competency based education program for team members. This comprehensive program encourages staff to value the uniqueness of its respective professions, thus fostering a complementary approach to patient and family centred care within the transport environment.

The ACTS team is faced with many challenges in the highly unpredictable and at times very unstable transport environment. Patient stability, transportation issues, long hours and dealing with families in crisis are only a few of the challenges the team face. It is the expertise of varried health care professionals from transport nurses, transport RTs to EMTs and physicians who make the stabilization and transport process run smoothly and efficiently. The uniqueness of this collaborative practice model profiles the specialties of various health care professionals while positively impacting patient outcomes.

## **Transition & Alternate Models of Care - 129**

### **TRANSITION PROGRAM: A TRIP TO INDEPENDENCE**

Joanne Ruck-Gibis, Head of Physiotherapy, Transition Coordinator, Shriners Hospital for Children, 1529 Cedar Ave., Montreal, Quebec, H3G 1A6, kthorstad@shrinenet.org

K Thorstad

Care Coordination/ Transition is the health care delivery model of the Shriners Hospital for Children Canada. The transition program is designed to help guide patients through their own "trip to independence." The Transition Coordinator ensures that patients' needs are identified and addressed through the Transition Referral process. Healthy life skills, friends and relationships, school, work, and adult health care issues are all addressed throughout the transition phase. The ultimate goal of the transition program is that all Shriners patients are successfully transitioned into the adult health care system and their own communities with as much functional autonomy as possible.

## **Transition & Alternate Models of Care - 130**

### **TRANSITIONS: DEVELOPING A PATH FOR CHANGE**

Susan Lindsay, Transition Co-ordinator, The Ottawa Children's Treatment Centre, 395 Smyth Road, Ottawa, Ontario, K1H 8L2, slindsay@octc.ca

Transitions, including the transition to adult services, high school and elementary school have been identified as stressful periods for young people with disabilities and their families. The Ottawa Children's Treatment Centre has recognized these concerns by supporting the development of transition services and creating a position of Transition Co-ordinator.

This poster presentation will document the development of our transition services, report on our environmental scan of "best practice", and highlight our current work in creating a program that provides a philosophical framework and model of practice to address transition points from birth to 18 years.

Specifically, our work in developing individualized transition plans, group life skills/programming, information for families and our community collaborations will be demonstrated. Tools that we have created to help families track their son/daughter's independent life skills will be displayed.

Our objective is to present our work to date in creating a transition program so that it may assist others in the development of their own programs and provide a forum for further discussion or collaboration on the topic. The poster presentation will be relevant to health professionals working with young people with disabilities, parents and young adults.

## **Transition & Alternate Models of Care - 131**

### **THE PEDIATRIC SEDATION SERVICE**

Alida Bowman, RN, BScN, MScN, Program Manager, McMaster Children's Hospital, 1200 Main St West, 3d2, Hamilton, Ontario, L8N3Z5, bowmana@hhsc.ca

Kathy Coskey RN, Educator, Dr Desi Reddy Anesthetist, Dr Mike Parish Anesthetist, Ruth Lee Chief of Nursing Practise

Pediatric sedation is a high-risk procedure and a patient safety issue. Sedation care and needs for infants and children are different from adults. Hospitals across North America

struggle with logistics, resources and medical manpower associated with pediatric sedation. Best practice supported by literature indicates that skilled pediatric personnel are required, equipment and up to date medication procedures. Access to health care and diagnostic testing for children is compromised due to sedation needs. This poster presents the development of a new Pediatric Sedation Service in a Children's Hospital within a hospital. Despite the strong evidence for change in practice, a potential patient safety issue resulted in a "buy in" for a new model of care. A Pediatric Sedation Service is a team of pediatric nurses and health professionals who provide sedation for painful and non-painful procedures throughout the hospital. The program development included a change in hospital committee structure, a business case and a review of research and best practice to standardize practice, procedures, education, and evaluate outcomes for pediatric sedation throughout the hospital. The guiding principles included children have a right to effective sedation for pain control, reduction of anxiety and to enable procedures that require stillness; efficacy and safety of sedation is necessary; equal access to procedures/care for children; the MRP for sedation cannot assist with the procedure and pediatric staff educated in sedation management are required.

#### **Transition & Alternate Models of Care - 132**

##### **THE IMPLEMENTATION OF ADVANCED POST OPERATIVE CARE ON A NEUROSURGICAL UNIT**

Josie Barbita, Child Health Services Director, Hospital for Sick Children, 555 University Ave., Toronto, Ontario, M5G 1X8, josie.barbita@sickkids.ca

Mary Douglas Nurse Educator The Hospital for Sick Children

The post operative phase of any neurosurgical patient is a critical time. Historically, certain Neurosurgical patients such as large craniotomies, many types of tumors and other more complex cases, have been nursed post operatively in the ICU setting for an overnight stay, prior to transfer to our Neurosurgical floor. At the Hospital for Sick Children, due to the previous challenges faced with access to ICU beds, this practice was re-examined.

A set of inclusion and exclusion criteria were developed in order to identify which post operative patients were appropriate to come directly to the Neurosurgical unit immediately following their post anesthetic care recovery. The criteria were based upon patient diagnosis and condition pre operatively, patient status, the surgical procedure being done, intraoperative complications, and post operative status and condition. A detailed process was then set out which would allow for the right patients to be selected for this process to ensure patient safety and outcome. Included in this process was also a post operative protocol including details such as standard physician orders, level of monitoring, etc. Once the planning and education stages were completed, this new protocol was implemented in June 2002.

This poster presentation will outline the inclusion criteria and post operative protocol. A flow diagram will illustrate the process from preoperative selection this process through to discharge. As well, data representing the number of surgeries completed through this process will demonstrate that more than 50% of activity that previously had gone to the ICU is now being successfully managed on the Neurosurgical unit.

## **Transition & Alternate Models of Care - 133**

### **A DUCHENNE MUSCULAR DYSTROPHY CRITICAL PATHWAY**

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Ms Louise Martin RN, BN, Critical Pathway Coordinator, The Childrens Hospital of Eastern Ontario, The Neuromuscular Team of the Childrens Hospital of Eastern Ontario

Critical pathways are becoming more common within pediatric health care centers. They provide important structure and assist to ensure a high quality standard of care for the children and families we serve. As well, they provide important information for resource planning and research data bases.

In a progressive, multi-system disease such as Duchenne Muscular Dystrophy (DMD), complications can be life threatening and timely interventions life saving. There are also significant equipment needs, families need to plan carefully and family stress is enormous. Comprehensive, coordinated, efficient and effective multidisciplinary care is therefore required throughout the child's life. Provision of this care is extremely challenging.

To address these concerns, an experienced multidisciplinary neuromuscular team has developed a unique, comprehensive critical pathway for individuals with DMD spanning ages 0-18 years. This was developed through consensus and an up-to-date literature review. The pathway subdivides the clinical condition into four functional stages. The aspects of care required and expected outcomes for each stage are defined to ensure that team goals are achieved.

This poster will review the entire pathway as it is now utilized. It will also outline how this pathway was developed and the future plans for evaluation and database development. The information will be pertinent to multidisciplinary healthcare professionals who provide health services for children, youth and families, especially facilities that provide care for individuals with Duchenne Muscular Dystrophy or other complex multisystem diseases that require organized multidisciplinary care.

## **Transition & Alternate Models of Care - 134**

### **A COLLABORATIVE APPROACH TO IMPROVING ACCESS TO CRITICAL CARE BEDS**

Judy Burns, Child Health Services Director, Critical Care, Hospital for Sick Children, 555 University Avenue, Toronto, Ontario, M5G 1X8, judy.burns@sickkids.ca

J Barbita, A Haslehurst

Access for scheduled surgical patients into the Critical Care Unit (CCU) at the Hospital for Sick Children has been negatively impacted by several factors over the past 5 years. The shortage of qualified nurses coupled with increasing volume and acuity in CCU forced frequent rescheduling of surgery. In order to address this growing problem, CCU worked with Neurosurgery, Orthopaedics, Plastic and Craniofacial Surgery to develop a different model of care. Patients from each of these services had been cared for in the CCU overnight. The new model of care facilitated patients moving directly from the Recovery Room to an observation room on the ward. We also utilized nurses from the

floors to care for patients in CCU where an observation room was not available or for surgical patients who medically required a CCU stay, but were not intubated.

This new model of care required extensive collaboration between different services to obtain agreement to provide care differently and to provide nurses with the skills, expertise and confidence to look after these patients. The model represented a shift in the culture of caring for surgical patients.

The outcome of this new model of care is significant. In the presence of increasing volume of medical/surgical patients in CCU we have dramatically reduced the cancellation of surgery and deferrals to other centres. There is also greater continuity of care for surgical patients.

This target audience for this poster includes anyone who is involved in the operations of critical care and surgical programs.

#### **Transition & Alternate Models of Care - 135**

##### **NEW WAYS OF DELIVERING CARE: FROM THE TERTIARY CARE PEDIATRIC CENTRE TO THE GENERAL HOSPITALS.**

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Ms Johanne Desrochers, Dr Michael Westwook, Dr Michael Malus, Dr Richard Haber, Ms Diane Sommerville

Objective: To deliver care to the patient and the family as close to home as possible, thus improving access and continuity of care for specialised pediatric services.

Summary: This poster will describe a new Pediatric venture between the Montreal Children's Hospital and the Lakeshore General Hospital with the goal of offering specialised pediatric care as close to the patient's home as possible. A second venture with the Herzl family practice unit at The Jewish General Hospital will provide Montreal children without Family Physicians or Pediatricians quick access to the new MCH/JGH Pediatric Primary Care Centre.

The role of the Child, Youth and Family Health Network of the MUHC in facilitating these partnerships will be described.

#### **Transition & Alternate Models of Care - 136**

##### **COLLABORATION: A WORK IN PROGRESS**

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Dr Susan Blatz, Dr Bosco Paes

Collaborative practice is the hallmark of health care today. As patients become more complex the need for specialized health care practitioners (HCP) increases. As a result there are times when scopes of practice overlap and confusion about who should do what tasks related to patient care and why one profession should do it versus another profession.

The Neonatal Nurseries at McMaster Children's Hospital recently encountered this

situation with mechanical ventilation. There are two highly skilled professional groups, Acute Care Nurse Practitioner (ACNP) and the Registered Respiratory Therapist (RRT), with different knowledge bases and focus who can provide excellent care with respect to mechanical ventilation. Traditionally the ACNP group looked after mechanical ventilation leaving the RRT group feeling under valued and under utilized. With the increase in beds and workload it became more apparent everyone's scope of practice needed to be fully utilized. As a result the neonatal nursery decided to explore medical directives as a way to capitalize on the RRT's scope of practice.

A multidisciplinary group was organized to begin writing a medical directive. The group consisted of physicians, Registered Nurses (RNs), RRTs, and a medical directive consultant. The Chiefs of Respiratory

Therapy and Nursing practice was also involved with the process. It was a timely project since much of the province of Ontario. The group started out by collecting current data from the NICU, the most current evidence on mechanical ventilation of the neonatal patient and asking other NICUs to share their protocols. With all this information, draft one was developed and the group started meeting on a weekly basis. Each profession had the opportunity to provide input and feedback. The document was sent out twice to the staff neonatologists for feedback. Each member of the group was also responsible for giving feedback to their respective profession. Ten months and eleven drafts later the protocol was complete as well as the new process for creating a medical directive. Built into the protocol are points of team discussion to ensure everyone is aware of the plan of care. The directive also includes a quality monitoring process to ensure the directive's criteria is followed. When the directive was finished it was sent for Medical Advisory Committee approval.

While waiting for approval, education began on the content of the medical directive, consisting of two hours of education for the RRTs plus a certification test, two one hour sessions for the staff neonatologists and fellows. RNs received in-services at the bedside due to the scheduling difficulties of 180 RNs.

The communication plan consisted of posters, updates in the nursery's monthly newsletter and a special edition newsletter conveying how staff would see changes in the nursery. This process has been a valuable learning experience, providing an incredible example of how groups work better than the individual. The directive is progressive, will improve efficiency for patients to be weaned from mechanical ventilation and will improve team work in the nursery.

#### **Transition & Alternate Models of Care - 137**

### **OUTCOMES EVALUATION OF AN INTER-DISCIPLINARY HOSPITAL-BASED SCHOOL PROGRAM FOR ELEMENTARY SCHOOL CHILDREN WITH TERTIARY COMPLEX LEARNING DIFFICULTIES: THE FIRST YEAR PILOT STUDY**

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B Stoesz

Objective: Children with learning problems use significant amounts of health resources, and care is complicated by its interface with the education system. There are few published studies of effective interdisciplinary treatment programs. We used two standardised measures of family-centred care and program-specific outcome measures to evaluate an inter-disciplinary, hospital-based day school program recently redesigned to improve access. Methods: All children, aged 4.5 to 8 years (n = 95) with complex learning difficulties attending the program, recruited on admission. Parent outcomes, including Measure of Processes of Care-20 (MPOC-20) and a parent program-specific questionnaire (PPSQ), obtained 8 wks after transition back to community schools. Staff outcomes, including Measure of Processes of Care for Service Providers (MPOC-SP) and staff program-specific questionnaire (SPSQ) obtained at program end. Results: Mean total MPOC-20 score (1-7 pt scale, 7 = exemplary care) was 4.90+/-1.90SD. PPSQ scores (1-5 pt scale, 5 = high satisfaction/success) were advocacy 4.14+/-1.04SD, knowledge of child's needs 4.19+/-1.30SD, ability to use strategies 4.28+/-0.85SD, and transition satisfaction 4.03+/-1.38SD. Staff mean score on the MPOC-SP was 5.34+/-1.43SD. Mean staff score on SPSQ was 4.03+/-0.97SD. Discussion: Both parent and staff MPOC scores indicated redesigned program met needs for family-centred care. Parent MPOC scores were in keeping with the literature (range 4-6) for children with other disabilities, suggesting that MPOC-20 may be a valid assessment tool in this population. Staff MPOC scores were similar to parent scores. Results serve as a baseline against which outcomes of future program redesign can be assessed.

#### **Transition & Alternate Models of Care - 138**

##### **DEVELOPMENT OF AN OUTREACH MENTAL HEALTH PROGRAM FOR CHILDREN, YOUTH AND THEIR FAMILIES IN SOUTH CENTRAL ONTARIO**

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Anita McGowan McMaster Children's Hospital

The South Central Ontario region of Ontario covers approximately 7,000 square kilometers and contains a population of 263,184 under the age of 18 years. There are estimated to be nine Child Psychiatrist's serving the South Central region for a ratio of 1:29,243. The Canadian Psychiatric Association recommends a ratio of 1:3,800. Dubois et al. (1991) recommended that rural centers have child psychiatry consultation provided through Outreach rather than allocating one physician to a region (population less than 25,000).

The newly developed Child and Adolescent Mental Health – Mobile Outreach Team will use an innovative interdisciplinary, collaborative care model to provide effective consultation-liaison services for the patients and families in the South Central Ontario communities. The Mobile Outreach Team will consist of Child Psychiatrist(s) and Nurse Practitioner(s) leadership with additional clinical roles to support existing services in the rural communities. The service will offer consultation and assessment to both first line and intensive service providers with an emphasis on working collaboratively to build sustainable capacity into the mental health system. The Mobile Outreach team will compliment additional services being planned with the Inpatient Child and Adolescent unit. These include an Urgent Assessment clinic, Telepsychiatry, Day Hospital and telephone consultation.

The intention of this service is multi-fold and includes the following;

- Improved access to specialists and community-based care.
- Improved liaison between specialists and primary care practitioners.
- Improved patient and family satisfaction.
- Improved financial outcomes due to lowering of psychiatric admission rates.
- Ensuring communities have access to scarce resources.

#### **Transition & Alternate Models of Care - 139**

##### **EVALUATION OF REGIONAL PHOTOTHERAPY PROGRAM WITHIN THE CALGARY HEALTH REGION**

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Janet Cohen, Irene Anderson, Cheri Nijssen-Jordan, Regional Phototherapy Team

Objective: To establish a regional phototherapy program and centralize newborn readmissions for phototherapy to the Peter Lougheed Hospital (PLC).

Methods: The regional phototherapy program and routine admission to the PLC for all children needing phototherapy began in May 2002. The target population was all infants 0-7 days requiring phototherapy treatment of jaundice. Health Records data from Jan – March 2002 and 2003 were compared. Family questionnaires and a nurse administered admission questionnaire were given to all families of babies admitted for phototherapy in the second evaluation period. Data from Healthy Communities was also reviewed to assess drawing of blood work by Public Health Nurses (PHN's) in the home.

Results: There were 64 patients evaluated in 2002 compared to 68 following the introduction of the Regional Phototherapy program in 2003. 25 % of these babes were able to have their blood work drawn at home by PHN's. PLC admissions increased from 53% in 2002 to 96% in 2003. The mean total hours of phototherapy decreased from 23 hours in 2002 to 19 hours in 2003. Families were overall very satisfied with readmission to the PLC.

Conclusions: Introduction of a regional phototherapy program within the Calgary Health Region was achieved with increased centralization of hospital therapy taking place at the PLC. The Child Health Portfolio is currently looking for other patient populations that would be appropriate for a regional admission program at non-tertiary care sites.

#### **Transition & Alternate Models of Care - 140**

##### **IMPLEMENTATION OF A NURSE PRACTITIONER/CLINICAL NURSE SPECIALIST ROLE**

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Margaret Steele

The Nurse Practitioner/Clinical Nurse Specialist (NP/CNS) is a self-directed advanced practice nurse prepared at the graduate level, who functions in an expanded nursing role



in a collaborative practice model. In Child and Adolescent Psychiatry the demands for the implementation of the NP/CNS role are two fold. First, there is an ongoing shortage of Child Psychiatrists in Ontario and nationally and secondly, there is a growing recognition that an advanced nursing role may be an appropriate blending of both advanced nursing knowledge with an expanded scope of practice to facilitate the comprehensive assessment and treatment of children and adolescents with mental health needs.

In a tertiary care centre in Ontario, The London Health Sciences Centre/The Children's Hospital of Western Ontario, an NP/CNS role has been implemented in the Child and Adolescent Psychiatry Service. This paper presentation will outline the competencies of the role and the innovations that have evolved. Role development continues and the authors will reflect on the strategies used to implement the role, obstacles and facilitators of the role and plans for the role in future years. Additionally, preliminary qualitative feedback from professionals and patients/families will be presented in the context of role evaluation.

As advanced nursing role are implemented the innovations and learning need to be evaluated and disseminated. Strengths and weaknesses of these dynamic roles can be utilized for future planning of advanced nursing roles in child mental health.

#### **Transition & Alternate Models of Care - 141**

##### **SPECIALIZED RESPITE FOR FAMILIES OF CHILDREN WITH LIFE-THREATENING ILLNESS: THE LIGHTHOUSE**

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Michele Viau-Chagnon

Children with complex medical needs require constant care while living at home. Due to advances in technology there are increasing numbers of these children every year. Once these children are sent home from the hospital the burden of care most often falls to their parents. Due to the complexity of their medical needs (e.g. tracheotomies, ventilators, multiple medications) there is a lack of respite services for these families.

The Lighthouse: Children & Families is a non-profit organization founded to provide support to families of children with life-threatening illness during a child's life as well as for their end-of-life and into bereavement. The Lighthouse currently has an active in-home respite program providing respite to families in the Montreal area. Elsewhere in Canada, the USA, and in the UK medically complex children have the opportunity for regular respite in specialized pediatric respite/hospice facilities that currently do not exist in Quebec. In 2005 a pediatric respite/hospice facility will be built to provide short-term respite to the most medically fragile and complex children in Quebec. This facility will serve as a bridge between in-hospital care and the home while providing respite for medically complex children in a supportive and home-like environment.

This poster will describe the results of a needs assessment for the respite needs of medically complex children as well as the operational plan for the pediatric respite/hospice facility to be built in Montreal in 2005.

**OPTIMIZING QUALITY AND EFFICIENCY IN PROVIDING  
MATERNAL/NEWBORN AND PAEDIATRIC HOSPITAL CARE: A NETWORK  
APPROACH TO CHANGE**

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The Child Health Network for the Greater Toronto Area is a partnership of 19 hospitals and 9 Community Care Access Centres that deliver maternal/newborn and paediatric services in the Greater Toronto Area. Established in 2000, the CHN has a mandate to develop and implement a high quality, family-centred, regional model of care for mothers, newborns and children based on level of care designations with a defined scope of service for each care level.

The CHN has recently undertaken a collaborative process to redefine the regionalized model of care and scope of services to provide enhanced distinction between levels of care and to define the critical mass and volumes for community and regional paediatric and maternal/newborn units.

The unit sizing/critical mass model was developed using a formula that supported both efficiency/economic and quality of care and was facilitated through a multidisciplinary participatory and consultation process amongst the membership. This presentation may assist those regions dealing with small volume inpatient and ambulatory services where human resource constraints and fiscal challenges impact the ability to provide an optimal level of service to mothers, newborns and children.

**Booth 7**

**Category- Family Centred Care (abstract 143)**

**« A MAGICAL DREAM » : A PROGRAM IN ANIMAL-ASSISTED  
THERAPY IN PEDIATRIC ONCOLOGY**

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For children with cancer, being hospitalized represents a great source of stress. Hospitalized children are not only deprived of their familiar world, but they must also face various and often painful treatments, in the context of a life threatening illness. They must quickly adapt to new people and to an environment that is very different from that of their homes. They have greater security needs. Thus, it is important to offer these children concrete ways to better adapt to the stresses of hospitalization. With this preoccupation in mind, the animal-assisted therapy program, « A magical dream » was conceived and implanted in October of 1999, on the pediatric oncology unit of the Centre hospitalier universitaire de Québec. This program is considered a novel approach, as it

allows for the child in treatment, a complete day with a dog. Its application on a tertiary unit, for a vulnerable population, requires many safety rules. In association with a veterinarian and a specialist in dog behavior assessment, a protocol for control of selected dogs was elaborated. The dogs are chosen after rigorous laboratory analysis and strict behavioral assessment. Medical criteria have been established by hemato-oncology and immuno-allergy teams. A summary evaluation of the program showed many positive effects on the children, and a high level of satisfaction of parents and nurses. There were no infectious or allergic problems nor was any other incident reported. A study is currently underway for a more thorough evaluation of the program.







