POSTER #1

Active Living Alliance for Canadians with a Disability

The focus of the Active Living Alliance for Canadians with a Disability is on connecting individuals with a disability with physical activity opportunities and educating service providers about including persons with a disability in active living environments.

This display will provide an overview of the services and resources that the Alliance has available to help communities and organizations address the physical activity interests of children and young people with a disability. It will also provide insight to the barriers that people with a disability face with reference to an active lifestyle and how health care professionals can assume an important role in making physical activity a regular part of their lives.

Abstract submitted by:

Chris Bourne
National Partnerships Manager
Active Living Alliance for Canadians with a Disability

POSTER #2

Quality Counts–A Comprehensive Quality Survey in a Children's Hospital

This poster will discuss the development and administration of a quality improvement initiative across a Children's Hospital, Children's Mental Health Centre and a Children's Treatment Centre. The process includes patient, family, staff and community stakeholder input, and has been guiding the re-development of our services for the past 5 years. The poster will also discuss our innovative "Kids Count" instrument, a survey for children ages 3-12.

Abstract submitted by:

Don Buchanan
Facilitator, Community Education and Family Resource Centre
Children's Hospital at Hamilton Health Sciences

POSTER #3

The Canadian Association of Pediatric Haematology/Oncology Program Leaders– The Formation of a New Networking Group

In February 2002 the Operations Leaders from Paediatric Haematology/Oncology Centres across Canada met in Calgary. Issues discussed at this meeting included:

- Recruitment and Retention
- Strategies for supporting staff working in this area, with the goal of preventing and/or managing chronic fatigue and stress

- Education needs to support new staff who are often novice professionals
- Use of advanced practice nurses in the Paediatric
- Haematology/Oncology environment
- The need for clear outcome measures and workload indicators

The meeting provided an excellent forum for networking and joint problem solving of shared issues. A decision was made to formalize this group. Terms of reference were developed and a number of projects identified which would be appropriate for this group to work on together. Examples of these projects include:

- Development of consistent standards for orientation and education of Paediatric Haematology/Oncology nursing staff
- Development of guidelines for human resource planning within Paediatric Haematology/Oncology
- Development of retention strategies for staff working in Paediatric Haematology/Oncology

The operations leaders would provide the leadership for the completion of these projects and would involve staff from the Canadian centres with specific expertise in the project area.

Abstract submitted by:

Seonag Macrae
Director of Strategy, Haematology/Oncology/Immunology/Allergy
Hospital For Sick Children, Toronto Ontario

POSTER #4

An Overview of the Patient Safety Program at the Hospital for Sick Children

Poster Presentation will include:

- Review of the “systems” approach to medical error
- Components of our Patient Safety Program
- New policy for Management Critical Occurrences
- New policy for Disclosure of Adverse Events to Patients/Families

Abstract submitted by:

Polly Stevens
Director, Quality and Risk Management
The Hospital For Sick Children, Toronto, Ontario

POSTER #5

Neonatal/Pediatric Best Practice: A Work in Progress

Quality improvement initiatives that support professional and clinical practice have been longstanding goals at Kingston General Hospital (KGH). The challenge of making this a reality includes linking the right people to the right resources in the most effective way possible. Within the Women's and Children's Program at KGH, a beginning step was the creation of a formal multidisciplinary committee to promote and support the identification, development and implementation of quality improvement initiatives and research projects.

The Neonatal/Pediatric Best Practice Committee was established in May 2001 with members from hospital, university and community settings. The committee generates ideas for initial or further investigation, identifies appropriate experts or resources who can support projects, facilitates processes such as literature reviews, project design, and report writing, maintains an inventory of initiatives conducted, and receives updates from focus groups that are managing projects. Members communicate these initiatives to their clinical settings, fostering a supportive attitude toward quality improvement processes. This process allows a group of individuals, who possess unique skills and abilities, to come together as a collective whole opening an avenue for communication, collaboration, visioning, and enabling with a view to challenging and moving beyond the status quo. Results are measured with the advancements of projects that might not otherwise have occurred or progressed to the current degree or comprehensiveness. These wins have inspired the development of two other perinatal teams. It is anticipated that these two teams will link with and benefit from the strengths of the Neonatal/ Pediatric Best Practice Committee while enjoying an independent momentum of their own.

Our experience with the Best Practice Committee process will be of interest to those who promote excellence in professional and clinical practice and continually search for innovative ways to achieve this end within the realities of today's health care environment.

Abstract to be submitted by:

Lenora Duhn
Clinical Nurse Specialist, Women's & Children's Programs
Kingston General Hospital, Kingston, Ontario

POSTER #6

Canadian Institute of Child Health (CICH)

The "Rights of the Hospitalized Child", originally developed by CICH in 1980 is under review and revision through a partnership between CICH and CAPHC. This poster session will consist of an exhibit of the poster and accompanying flyer under review and includes the latest release of the Canadian Coalition on the Rights of Children handbook which demonstrates the impact of the UN Convention on the Rights of the Child to health care.

POSTER #7

Canadian Institute of Child Health (CICH); "The Health of Canada's Children, a CICH Profile, 3rd edition

After the release of The Health of Canada's Children: a CICH Profile, workshops have been held in all provinces to discuss emerging trends and issues. This poster session will provide an overview to the Profile, describe the results of the consultations with over 2,000 Canadians and put forward the plans for the future.

POSTER #8

Child and Youth Congress 2003

Following two Child Health Congresses in the 1990s, Child and Youth Health Congress 2003 will be hosted in Vancouver May 11 to 14, 2003. This Congress aims to bring together those interested and involved in child and youth health and well-being, including young people to define opportunities and establish priorities related to new knowledge development to the health of children for he next decade, within the context of the UN Special Session on Children. Learn about the program and identify gaps and opportunities for this major gathering next year.

Abstracts 6/7/8 submitted by:

Dawn Walker
Executive Director
Canadian Institute of Child Health
Ottawa, Ontario

POSTER #9

Building A Regional Approach to Neonatal Care: Focus on Professional Education

With the move towards regionalization for Maternal-Child Care as per the direction of the Ontario Ministry of Health and Long Term Care, the hospitals and CCAC's in our region (as members of the GTA Child Health Network) have begun to build relationships that will form the foundation for regional approach to care. This poster will focus on the process used to build a regional educational program that is focused on improving quality of care for our neonates and their families. Using the guiding principles of evidence-based practice, consistency, outcomes and evaluation, our group has developed a multi-disciplinary approach to professional education. The topics of Orientation, Skills, Family Centered Care and Pain Management are being addressed via a regional approach with participation from all levels of each organization. Other educational activities include regional rounds, development of a web-site and newsletter to impart information to all stakeholders and finally the collection of pertinent data that is available for decision making and planning.

Abstract submitted by:

Kathryn Hayward-Murray
Regional Neonatal Education Coordinator
The Credit Valley, Trillium, William Osler, Halton Health Centre

POSTER #10

Critical Link Canada

Where there is no communication there is no care. However, it is not always easy for health care professionals to communicate effectively when they and their clients do not share a common language. At times like this, the community interpreter can be the Critical Link that makes equitable care possible. This bilingual poster will highlight the role played by interpreters in the health care setting.

Abstract submitted by:

Heather Clarke
Consultant, Services to Linguistic & Ethnocultural Communities
Montréal, Québec

Isabelle Hemlin
Interim Chief of Service, Services to Linguistic & Ethnocultural Communities
and Inter-regional Interpreter Bank
Montreal Quebec

POSTER #11

Injuries To The Abdomen and Thorax Caused by Bicycle Handlebars: Data From The Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP)

Problem under study: Head and upper extremity injuries are common in bicyclists. Abdomen and thorax injuries, although less common, are potentially serious. In the literature the handlebar of the bicycle has been implicated in serious and sometimes fatal injuries to the abdominal organs.

Objectives: To identify abdomen/thorax bicycle handlebar-related cases in the CHIRPP database and to study the circumstances and mechanisms of such injuries.

Methods: CHIRPP is a Health Canada-supported emergency room-based injury surveillance program at ten pediatric and five general hospitals operating across Canada since 1990. Information on circumstances is collected directly from patients or parents. The entire database (N=1,098,334) was searched for records involving the handlebars as the direct cause of injury and injury to abdomen or thorax recorded in any of three body region fields.

Results: A total of 650 cases (76.6% male), or about 1.5% of all bicyclist cases in the database, were identified. Almost half (47.9%) of all cases involved children aged 5-9 years, which proportion is larger than that for all bicyclist cases (38.1%) ($p<0.005$). Simple, bicycle-only events accounted for three-quarters (75.9%) of the incidents while a motor vehicle was involved in only 3.1% of cases. In half (50.5%) of the incidents loss of control or balance was the only circumstantial information provided. Of the remaining cases, where more detail was available, 33.8% involved a problem with the riding surface. The type of impacting mechanism was unspecified in three-quarters (74.5%) of the cases. In the events where the type of impact was known, the "spearing"mechanism (handlebar end) was involved in 39.8% of the events. Of the first (most serious) recorded injury, 15.7% were internal. The typical profile of a handlebar-related injury involves a child usually under the age of 10 years, in a single-party (bicycle-only) non-motor vehicle related event, losing control of the bicycle and falling on or progressing into the handlebars, suffering an injury to the abdomen. Overall, 24.8% of the

patients were admitted to hospital (about 2.5 times higher than the admission proportion for all bicycling injuries) and of these patients, 84.5% suffered abdomen and thorax injuries only.

Conclusions: Although infrequent, handlebar-related abdomino-thoracic injuries can be serious and thus present a significant hazard to children under 10 years of age. These types of injury events are often simple in nature, in that they don't involve collisions with a motor vehicle or stationary objects, yet the results can be severe. Due to the well-defined population and hazard, handlebar-related injuries are amenable to control solutions (which will be discussed).

Limits: CHIRPP data do not include all injuries in Canada but only those seen at the 15 participating hospitals. Certain groups are under-represented in the CHIRPP data because of the types and locations of the hospitals. For example, 10 of the hospitals are children's hospitals located in major cities, therefore, some of the under-represented groups are older teenagers and adults seen at general hospitals, native people, people who live in rural areas and fatalities. The CHIRPP numerical coding system allows the bicycle to be identified as the direct cause of the injury; handlebar involvement was determined by use of the text field. This process resulted in 79.5% of the cases being classified as 'definite' cases, with the remaining incidents deemed 'suspected' based on suggestive (but not explicit) text and/or a similar profile to the definite cases (and information in the literature).

Contribution of the project to the field: Data on handlebar injuries in the United States have been published. A detailed study of the Canadian experience has not been previously presented and the results of this study are similar to the American profile. The severity or potential severity of such injuries coupled with the young age of the victims makes this an important subgroup of all bicyclist-related injuries on which to concentrate preventive strategies. The narrow age range and bicycle characteristics identified could further focus preventive efforts.

Abstract submitted by:

Steven R. McFaull, Research Analyst
Injury Section, Health Surveillance and Epidemiology Division
Population and Public Health Branch, Health Canada, Ottawa

POSTER #12

Pediatric Injuries Resulting From Television Set Tip-Overs: Data From The Canadian Hospitals Injury Reporting And Prevention Program (CHIRPP)

Problem under study: Television sets (TVs) are part of most Canadian households and children spend considerable amounts of time in proximity to this product. Most of a TV set's mass is concentrated in the screen so that as the screen size increases, the center of mass shifts forward, making the set unstable unless compensated for by other design features. The mass of the set is not linearly related to the screen size; a 33% increase in screen size (27″ to 33″) results in a 55% increase in mass. With the average size of a television set becoming increasingly large, when they do topple the amount of energy released is larger–potentially leading to more severe injuries. There are some data in the U.S. suggesting that hospitalization and mortality rates among children struck by TV sets may be increasing. Many sets have sharp corners and edges making possible large amounts of mechanical stress to be imposed upon the body. These factors coupled with the possibility of the TV being used on supports not designed for such a load has serious implications. With the current move (albeit slowly) towards digital TVs, which are all large, the hazard potential may increase over time.

Objectives: To study the frequency, circumstances and injury mechanisms of TV tip-over injury events currently in the CHIRPP database.

Methods: CHIRPP is a Health Canada-supported emergency room-based injury surveillance program at ten pediatric and five general hospitals operating across Canada since 1990. Information on circumstances is collected directly from patients or parents. The CHIRPP database as of September 2001, ages 0-9 years (N=561,308) was searched for cases involving contact with a moving television set.

Results: Overall, 735 cases were identified of which 58.0% were male. Such cases represent 0.1% of all CHIRPP records aged 0-9 years. Children aged 1-3 years accounted for 71.7% of the incidents. Almost one-third (32.2%) of the cases involved the TV, electrical cords or the stand being pushed or pulled resulting in the TV falling. One-fifth (21.4%) of the tip-overs resulted from the child climbing or hanging on the TV or its stand. The type of support (stand) was known in about one-third of the cases. Of these, 50% were simple TV stands or carts while 20.4% were wall units or entertainment centres and 16.2% were dressers. The size of the TV was specified in only 86 (11.7%) of the records with 20-21 inch screens representing 37.2%. Overall, 340 (46.3%) of the children sustained a lower extremity injury including 93 (27.3%) fractures, 11 crushing injuries and 2 traumatic amputations. One-third (33.6%) of the toppling incidents involved the head, face and neck including 13 (5.3%) skull fractures and 11 concussions. Overall 7.2% were admitted to hospital compared to 5.8% of all cases aged 0-9 years.

Conclusions: Children aged 1-3 years are especially at risk for serious injuries related to TV tip-overs. The lower extremities are disproportionately involved in TV tip-over cases and given the mass and fall height serious morbidity and long-term disability could result, especially from complex fractures or crushing injuries to the feet. The potential for fatal injuries resulting from the large amount of energy imparted to the head has obvious implications. This injury scenario will be monitored in the coming years.

Limits: CHIRPP data do not include all emergency department-treated injuries in Canada but only those seen in the 15 participating hospitals. Because of the types and locations of the hospitals certain groups are under-represented in the CHIRPP data (older teenagers and adults seen at general hospitals, native people, and people who live in rural areas). Also, fatalities are not often captured in the CHIRPP database.

Contribution of the project to the field: The circumstances and potential severity of TV toppling injuries points to the need for a proactive approach to increase awareness and education among parents, and possibly retailers, about the dangers of this common household product. Manufacturers should strive for increased stability and load handling in their designs.

Abstract submitted by:

Steven R. McFaull, Research Analyst
Injury Section, Health Surveillance and Epidemiology Division
Population and Public Health Branch
Health Canada, Ottawa

POSTER #13

The Hypothermia Pediatric Head Injury Trial

Head injury is a significant cause of mortality and morbidity in children and youth. We will describe our multi-site international clinical trial of moderate hypothermia for severe pediatric traumatic head injury. This trial represents a collaboration between pediatric intensivists, intensive care staff, neurosurgeons, and neuropsychologists in centres across Canada, the United Kingdom and Europe. The goal of the study is to test the effect of moderate hypothermic treatment on functional independence, and neurocognitive and neurobehavioural outcome after severe head injury. This type of clinical trial represents an important step in improving evidence-based therapy for children with serious head injuries.

Abstract submitted by:

The HyP-HIT Study Group
c/o Marcia A. Barnes, Ph.D.
Brain and Behaviour Program
The Hospital for Sick Children, Toronto, Ontario

POSTER #14

Child and Youth Health Network

The Southern Alberta Child & Youth Health Network is a fledgling cross sector collaboration supporting the health well being of children and youth in southern Alberta. This poster display will provide information about the form and structure of the network, and about some of its early activities.

Abstract submitted by:

Janice Popp
Project Manager
Southern Alberta Child & Youth Health Network
Alberta Children's Hospital, Calgary, Alberta

POSTER #15

A Three-Year Screening And Outcome Assessment Initiative

A three-year screening and outcome assessment initiative in the Ontario children's mental health system moves to an implementation phase in 2002. The goals of the initiative are to enable standardized screening and outcome measurement in 125 centres, promote community of practice interactions, improve practice, organizational and system-wide service delivery, promote the use of evidence-based mental health treatment.

The initiative represents a 'first" in Canada for the systematic measurement of mental health problems and outcomes for children across a provincial children's mental health system. Our team has trained approximately 3000 clinicians to be reliable raters of the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1997). Our partners at McMaster's Centre for the Study of Children at Risk have trained intake staff at 125 centres to use the Brief Child and Family Phone Interview (BCFPI; Cunningham, Pettingil, & Boyle, 2000) for intake screening. The harmonization of these measures with clinical practice and service delivery requires significant

organizational change and associated supports. We review the initiative to date, describe lessons learned from our training and implementation support activities, and describe our efforts to track the impact of the initiative. This is a 'groundbreaking' project involving inter-ministerial collaboration (MCSS and MOHLTC), large-scale clinician training, and organizational change at the level of clinical practice, inter-agency service delivery, and provincial accountability and tracking.

The application of this initiative province-wide affords us the unique opportunity to answer a multitude of questions about children's mental health, including but not limited to the extent to which level of functioning changes as a result of treatment. We anticipate that BCFPI data will provide a unique provincial perspective regarding the incidence of childhood mental disorders reported at the time of referral, comorbidity of mental disorder, barriers to service utilization, and readiness for service. CAFAS data will inform regarding level of functioning at intake and discharge, and provide important information about the state of the province's children and the success of individual treatment approaches.

Abstract submitted by:

Melanie Barwick,
Psychologist, Associate Scientist
Community Health Systems Resource Group
The Hospital for Sick Children

POSTER #16

Population Baselineof Meconium Fatty Acid Ethyl Esters Among Infants of Non-Drinking Women In Jerusalem And Toronto

Objectives: Early diagnosis and treatment are critical to the postnatal development of fetuses affected by Fetal Alcohol Spectrum Disorders. The presence of fatty acid ethyl esters (FAEE) in meconium has led to the development of a non-invasive neonatal screening method for the identification of intrauterine alcohol exposure. We report the results of the first population baseline study conducted to investigate basal FAEE levels in the meconium of alcohol non-exposed neonates.

Study design: One hundred and four non-drinking women and their neonates were recruited antepartum from each of the two teaching hospitals in Toronto and Jerusalem. Meconium samples collected were kept frozen at -80°C until analysis. A series of FAEE (ethyl laurate, myristate, palmitate, stearate, oleate, and linoleate) were extracted using a solid phase extraction method and analyzed by GC-FID. Results were expressed as Total ug FAEE/g dry meconium.

Results: Low concentrations of meconium FAEE were detected from both cohorts (Toronto: 0.434 ± 0.819 ug/g; Jerusalem: 1.035 ± 1.707 ug/g). Several trends were apparent in both populations: Ethyl stearate, oleate, and linoleate were below the limit of detection in > 90% of the samples; ethyl laurate and palmitate were detected in > 50% of the samples. Ethyl myristate was the FAEE most commonly detected (>80% of Jerusalem and >90% of Toronto population, respectively). Ethyl laurate, myristate, and palmitate were detected at much higher concentrations among all FAEE quantified. A secondary analysis will be conducted to generate a potential positive cut-off level for the FAEE screening test in clinical practice.

Conclusions: Whether the accumulation of FAEE in the meconium of alcohol non-exposed neonates is related to the diet, physiological status, and endogenous ethanol metabolism requires further investigation. It can be concluded that certain FAEE are present at basal levels in the meconium of alcohol non-exposed neonates. Supported by CIHR, HSC Translational Research Grant, and Brewers Association.

Abstract submitted by:

D. Chan; PhD Student
Clinical Pharmacology and Toxicology,
Hospital for Sick Children
Toronto Ontario

Co-authors: B. Bar-oz*; B. Pellerin; C. Paciorek; J. Klein; D. Farine**; G. Koren. Division of Clinical Pharmacology/Toxicology, The Hospital for Sick Children, Toronto, Canada; *Hadassah University Hospital, Jerusalem, Israel; **Mount Sinai Hospital, Toronto, Canada.

POSTER #17

The Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP): An example of Emergency Department Injury Surveillance Description

This poster addresses three related aspects of injury surveillance in Canada. First it gives an overview of sources of data on injury occurrence: data on fatal injuries, hospitalizations due to injury and emergency department visits for treatment of injuries. Next it introduces the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) and describes it operation. CHIRPP collects information on injuries treated in the emergency departments of fifteen hospitals across Canada, including 10 paediatric emergency departments.

Injury surveillance in emergency settings offers a unique opportunity to collect information not only on the injury and treatment, but also on the circumstances that led to injury. This information is important for those developing prevention programs. The poster then highlights some of important contributions that CHIRPP has made to the understanding of the types of injuries occurring in Canada, their circumstances and approaches to their prevention.

Abstract submitted by:

Margaret Herbert
Health Surveillance and Epidemiology Division
Centre for Healthy Human Development
Population and Public Health Branch, Health Canada

POSTER #18

Child and Youth Health Network for Eastern Ontario

The 'Child and Youth Health Network for Eastern Ontario' brings over 100 representatives from across Eastern Ontario and from the sectors which impact on health and well-being (health, social services, education, recreation). The goal of improving health service delivery and health status is implemented through a series of action oriented Working Groups which model vertical and horizontal integration. These Working Groups have tackled issues from positive life skills for children to rural outreach services and education; 20 hospital wide telehealth to county specific report cards on poverty.

Abstract submitted by:

Dennise Albrecht
Director, External Development
Children's Hospital of Eastern Ontario

POSTER #19

The electronic Child Health Network (eCHN)

The electronic Child Health Network (eCHN) has developed practical applications that are designed to share knowledge among professionals within Canada's publicly funded and administered health care system. Those who benefit from eCHN include paediatric healthcare providers, children, parents and others who need to know something about children's health and wellness. The poster presentation provides a brief visual introduction to eCHN.

Abstract submitted by:

Andrew Szende
Chief Executive Officer
electronic Child Health Network
Hospital For Sick Children
Toronto Ontario

POSTER #20

The Pediatric Acquired Brain Injury (PABI) Consortium

PABI is comprised of researchers and clinicians interested in promoting and participating in the study of pediatric brain injury. It is the only Canadian research and advocacy group specifically for children with acquired brain injury, e.g. traumatic brain injury, stroke, and/or injury arising from infectious disease.

This poster will highlight key issues identified by PABI representatives, as well as provide information regarding ongoing hospital-based research projects focusing on pediatric acquired brain injury. For example, the efficacy of rehabilitation and school transition services following brain injury has been identified as a key issue for Canadian children. A subcommittee during the March 2001 PABI consortium focused on assessing how school transition programs help to bridge the gap between rehabilitation programs and school re-entry. This issue is now beginning to be assessed in research projects in Canada.

Abstract submitted by:

Adrienne D. Witol Psy.D.
Glenrose Rehabilitation Hospital, University of Alberta
Project Leader, Pediatric Acquired Brain Injury (PABI) Consortium

POSTER #21

Poverty Makes Me Sick!

We all know that poverty is a major determinant of ill-health for children and youth. As colleagues in the hospital and health care sector, we face a new challenge and role for our health centres: recognizing the impact of poverty on the health and well-being of children, youth and families in the communities we serve. The need to look at issues beyond our institutional walls is a new but critical aspect of our shared responsibilities. The Canadian Association of Paediatric Health Centres (CAPHC) is taking a leadership role in bringing our collective voice to this critical issue at provincial and national levels.

The Children's Hospital of Eastern Ontario Advocacy Committee of the Board of Trustees has developed a unique package to help all health care professionals and organizations address this issue. This poster session and exhibit will launch a national poverty initiative and introduce conference delegates to a brief video and information kit that provides helpful statistics and resources, as well as ideas for action to assist in developing new programs, research initiatives and education strategies at regional and national levels. The video and information kit will be offered to all conference delegates as an effective tool for use within our respective communities, in various disciplines and sectors from health, education, and social services to research, policy and advocacy.

Abstract submitted by:

Charlotte Gray
Chair, CHEO Advocacy Committee
Board Member, Canadian Association of Paediatric Health Centres

POSTER #22

Pulmonary Artery Hypertension (PAH) in the Paediatric Population

Pulmonary hypertension presents a clinical challenge to both health care professionals and affected families alike. This poster presentation will review the disease process of pulmonary artery hypertension in children. Key elements of this progressively crippling disease will be discussed. Pulmonary hypertension will be defined along with a review of causative factors, incidence and prevalence. Clinical signs and symptoms will be highlighted as well as those complications that are potentially life threatening. Since there is no cure, management is primarily aimed at treating the symptoms. This can be achieved via two routes: heart/lung transplantation or medications. The role of oxygen, anticoagulants, calcium channel blockers, and aerosolized Flolan (prostacyclin, epoprostenol) in the management of pulmonary hypertension, will be reviewed. Essential to the management of these patients is understanding specialized equipment such as the CADD pump and Legacy pump.

Exciting research is underway at the Hospital for Sick Children wit the use of drugs such as Sildenafil (Viagra) and Flolan + Sildenafil, in an effort to manage this debilitating disease. This presentation will review both the progression and outcome of pulmonary artery hypertension.

The Pulmonary Hypertension Clinic at the Hospital for Sick Children does much to provide the necessary supports to children and their families. The clinic provides the health care team members both in the acute care setting and within the community.

Abstract submitted by:

Janette T. Reyes, RN, BScN, Master's Candidate
Pulmonary Hypertension Program, Division of Cardiology
The Hospital for Sick Children. Toronto, Ontario

Co-author: Ian Adatia, MBChB, MRCP(UK), FRCP(C)

POSTER #23

Sildenafil (Viagra) in Childhood and Neonatal Pulmonary Hypertension

Background: Cyclic guanosine monosphate (cGMP) mediates vasodilation induced by nitric oxide (NO). Inhibition of type 5 phosphodiesterase (present in high concentration in pulmonary vasculature) elevates cGMP and promotes vasodilation. Therefore, we investigated the effect of oral sildenafil in pulmonary hypertension.

Methods: We administered oral sildenafil (0.25 -0.5 mg/kg) to 16 patients (median age 6 years, range 3 days to 18 years, gender 7M,9F). All patients had pulmonary hypertension defined by echocardiography or catheter measurement. During cardiac catheterisation (n=6) we measured hemodynamics before and 20 minutes after administration of sildenafil. We administered sildenafil to 5 patients with refractory suprasystemic pulmonary hypertension after gradual withdrawal of inhaled NO, despite alkalinisation, (diagnoses included repair of congenital diaphragmatic hernia n=3, and pulmonary vein stenosis n=2). Five patients received chronic sildenafil therapy, given 4 times a day (primary pulmonary hypertension n=3, secondary pulmonary hypertension n=2). Subsequent evaluation was by echocardiography and distance walked in 6 minutes .

Results: During cardiac catheterisation mean pulmonary artery pressure decreased from 50±8 to 38±12 mmHg ($p<0.05$) and indexed pulmonary vascular resistance decreased from10.5±4.9 to 7.6±4.6 Wood Units m2 ($p<0.05$). There were no changes in mean systemic pressure 64±4 to 65±8 mmHg, systemic vascular resistance 17.1±4.6 to 17.6±5.2 Wood Units m2 or cardiac index 4.0±1.2 to 4.0 ±1.2 l/min/m2. In 5 patients sildenafil attenuated the rise in pulmonary artery pressure and permitted discontinuation of NO without hemodynamic instability 4-6 hours after oral sildenafil. In the chronic therapy group 3/ 5 patients followed for a median of 12 weeks had improvements in 6 minute walk distance of 200%.

Conclusion: Our results suggest that oral sildenafil selectively decreases pulmonary vascular resistance, attenuates rebound pulmonary hypertension and facilitates weaning of prolonged inhaled NO therapy and improves distance walked in 6 minutes. Sildenafil offers promise in the treatment of acute and chronic pulmonary hypertension.

Abstract submitted by:

Simon Erickson, Janette Reyes, Des Bohn, Ian Adatia
Hospital for Sick Children, Toronto, Ontario, Canada

POSTER #24

The Rural Perspective on Continuity of Care: Pathways and Barriers to Care for Children with Emotional and Behavioural Disorders

The Canadian Health Services Research Foundation has recently funded a two-year study examining the issue of access to care for children and youth with emotional and behavioural disorders in rural areas, from the perspectives of both service providers and families. Conducted by Dr. Katherine Boydell, The Hospital for Sick Children, and Dr. Raymond Pong, Centre for Rural and Northern Health Research, the research aims to identify and discuss the facilitators and barriers to care in rural and remote areas in order to support the development and delivery of effective mental health services for children. Qualitative methods are being used to obtain the voice of families and service providers regarding access issues in the children's mental health service system in rural areas. This proposed poster will outline the research objectives and methodology for the study and provide preliminary results of key community consultations held in the project's two study sites, Owen Sound and Sudbury.

Abstract submitted by:

Tiziana Volpe
Research Coordinator
Community Health Systems Resource Group
The Hospital for Sick Children

Co-authors:

Boydell, K.M.; Pong, T.; Tilleczek, K.

POSTER #25

Safe Kids Canada

Safe Kids Canada is the national injury prevention program of the Hospital for Sick Children in Toronto. Our activities focus on raising awareness about injury prevention for children, educating people on how to prevent child injuries, and advocating safer environments for children. A national expert advisory committee of leading injury prevention specialists provides direction on program priorities and positions on safety issues. Our success is based on the unique collaboration and efforts of almost 1,400 community partners across the country.

À propos de SécuriJeunes Canada

SécuriJeunes Canada est le programme national de prévention des blessures du Hospital for Sick Children de Toronto. Nos activités sont axées sur la promotion de la prévention des blessures chez les enfants, la transmission des mesures préventives au public et l'action sociale en vue de créer des milieux plus sécuritaires pour les enfants. Un comité consultatif d'experts national, composé des principaux spécialistes en prévention des blessures, nous aide à établir la priorité des programmes et notre positionnement par rapport aux questions liées à la sécurité. Notre succès repose principalement sur les grands efforts que déploient près de 1,400 partenaires communautaires à travers le pays et sur leur extraordinaire collaboration.

Abstract submitted by:

Jennifer Hall
Coordinator, Partners and Programs
Safe Kids Canada

Poster will be presented by:

Pamela Fuselli, Safe Kids Canada

POSTER #26

I Promise Program: Formative Evaluation

Over 350 youth between 15 and 19 years of age were killed in automobile crashes in Canada in 2000 and 30,000 were injured. Plan-it Safe at CHEO is conducting a formative evaluation and pilot study of the I Promise Program, a primary injury-prevention program targeting new young drivers and their parents. Acceptability of the IPP and its components (driving contract, rear-window decal, brochure, FAQs) to the target groups it impacted (new young drivers, parents of new young drivers, community members) were assessed through focus groups. Content analyses indicated the need to review the driving contract's language-level, comprehensiveness, length, format and content, as well as the decal's visual acuity, memory issues, anonymity of reporting, and general feasibility. Results were shared with the program founder, who has subsequently made several positive changes to the program.

POSTER #27

Suicidality, Risk-Taking Behaviours, and Psychological Adjustment of Homeless Adolescent Males

Professionals working with homeless adolescent males do not have a clear understanding of the association between homeless adolescent males' suicidality, risk-taking behaviours, and psychological adjustment. This study was a preliminary step to improving that situation. Data were collected over a 12-month period, through a semi-structured interview and standardized measures, from 100 homeless male youth (16-19 years) accessing an Ottawa emergency shelter and 70 non-homeless youth (16-19 years) accessing various Ottawa drop-in centres. Results confirmed that homeless youth are at high risk for poor psychosocial outcomes, such as suicidality, substance abuse, depression, behaviour problems, cigarette use, legal problems, academic difficulties, and family dysfunction. Results suggest that homeless youth would benefit from intervention-programs that are designed to decrease the incidence of risk-taking behaviours, suicidality, and psychosocial difficulties.

POSTER #28

Protective Equipment Use and Skill Level Among In-Line Skaters over a 2-Year Period

Critical to the prevention of injury among in-line skaters is the use of protective equipment, particularly helmets. An observational study of child, youth, and adult in-line skaters in Ottawa, over a two-year period explored trends in the association between protective equipment use and skill level. In-line skaters (N = 5476) were observed for eight consecutive weekends in July and August of 1998 and 2000 at various locations in Ottawa. A decline in use of all pieces of safety equipment, particularly helmet use among youth, were observed. With respect to age, skill level, and equipment, youth were least likely to wear safety equipment, females wore safety equipment more than males, wrist guards were the most frequently worn piece of safety equipment, and the likelihood of wearing each piece of safety equipment decreased as skating skill increased.

POSTER #29

CHEO: Reaching Out to Prevent Injuries

Injuries among children and youth under the age of 20 are a major health problem: they are the leading cause of death and second leading cause of hospitalization in this age group. As part of a comprehensive strategy to address this problem in the area served by the Children's Hospital of Eastern Ontario's (CHEO), a new position has been established in conjunction with the hospital's Injury Prevention Centre (Plan-it Safe) and Trauma Program. Targeting staff at CHEO and its 17 referral hospitals, the Injury Prevention/Trauma Liaison works to enhance hospital based injury prevention education for patients and their families by increasing hospital staffs' injury prevention knowledge and the educational tools and resources at their disposal. This poster will provide an overview of the injury problem in Eastern Ontario and Canada and describe the activities implemented to date including in-house and outreach programming; injury prevention educational display boards; involvement in regional campaigns (ERIN) and an environmental scan and appraisal of educational videos with injury prevention content.

Abstracts 26/27/28/29 submitted by:

Morag MacKay
Director, Plan-it-Safe
Children's Hospital of Eastern Ontario Research Institute

POSTER #30

A Path to Best Practice for Gastroenteritis: The Road to Critical Pathway

Gastroenteritis is one of the top diagnoses in our pediatric emergency department. In year 2001, 3,366 children and youth were seen and treated for gastroenteritis. Maintaining the welfare of the children and youth we serve is the most important aspect in pediatrics. The presenter will describe current practice and assessment of children. An overview of the new triage guidelines and the treatment of dehydration will be described. Emphasis of the presentation will be on practice change (e.g. the demise of the BRAT diet to oral rehydration therapy when required), and the development and implementation of a critical pathway for gastroenteritis in the emergency department. The critical pathway provides a comprehensive multidisciplinary tool that benefits patient, families and all disciplines providing care. It also provides a written plan with evidence-based practice to plan, deliver, monitor, report and review care. Diminished intravenous therapy and blood work to children who could tolerate oral rehydration therapy was initiated with success. Length of stay has shown to decrease with the initiation of this mode of treatment. The four phases of the project will be discussed as well as the design and the educational methodologies. Ensuring the physician's buy-in in this change of practice and the organizational support was shown to be getting this critical pathway working effectively in this setting. Strategies used such as, program education to emergency nurses and support from physicians will be reviewed. Evaluation, barriers, lessons learned and success will be illustrated in order to understand the implementation of this critical pathway in a very busy emergency, To conclude, this critical pathway has help promote evidenced-based practice and change in practice through research utilization. Delivering quality care supports our organization's mission and values in order to provide continuous quality improvement to the children and youth we serve.

POSTER #31

Integrating Best Practice Guidelines for the Care of Bronchiolitis

This presentation describes the process and implementation of a bronchiolitis critical pathway using evidence-based practice: and RNAO fellowship program experience. In the past two-decade, many initiatives have been introduced to improve clinical effectiveness and patient care. They are key issues in our current health care delivery in the hospital settings and the community. The presenter describes how one critical pathway was implemented into the hospital settings in-patient units. In February 2001, the bronchiolitis critical pathway was piloted on 4 in-patient units at the Children's Hospital of Eastern Ontario. The goals of the critical pathway were: to provide a comprehensive multidisciplinary tool that would benefit the patients, families and all the disciplines providing the care; improve the quality of care; standardize care by reducing variation and to improve documentation. The critical pathway served as a written treatment form that acted as a vehicle for evidence-based practice to assess, plan, deliver, monitor and report by evaluation. Planning and implementing a critical pathway into an organization demands full support from management. The change process, benefits and lessons learned will be described. Emphasis will be place on change practice by using best practice guidelines such as assessment, treatment, medication and discharge planning to improve the care of theses children. Nursing leadership, energy, good communication and time were all crucial to implement change. Physician buy-in and participation were critical to promote change and standardize practice. The evaluation process and results will be discussed. The critical pathway can be a useful multidisciplinary tool for the management of quality pediatric care to help ensure evidence-based practice and used as a vehicle to implement care.

Abstracts 30/31 submitted by:

Louise Martin RN, BN
Clinical Educator
Children's Hospital of Eastern Ontario
Ottawa Ontario

POSTER #32

The Child and Youth Homecare Network

The poster will summarize the history and accomplishments to date of the Child and Youth Homecare Network (CYHN). Emphasis will be placed on the lessons learned from the 2001 CYHN forum held in October, 2001 in Toronto.

Abstract submitted by:

Marilyn Booth
Director, Child Health Systems
The Hospital for Sick Children

POSTER #33

Supporting the Opportunity for Tissue Donation in the Palliative Care Setting

Background: The impetus for the development of the initiative was being unable to fulfill the wishes of a family that chose to have their child die at home. The lack of a coordinated approach resulted in frustration, anger and intensified anguish for a family who was already grieving. Key stakeholders were consulted, the policy was developed by a multi-disciplinary team and unanimously endorsed by Senior Management. The policy addresses the identification and management of issues that are unique to this patient population, as well as the implementation of the standards requisite to tissue donation. Much has been written about the benefits to families when they have consented to organ/tissue donation. Until this time this opportunity has been denied to those parents whose have chosen to have their children die at home. Feedback from parents has supported the role of tissue donation in end of life decisions, as an important step in their "journey".

Abstract submitted by:

Eleanor Holmgren, Donor Coordinator
The Ottawa Hospital Organ and Tissue Donation Program
Ottawa, Ontario

Marion Rattray, Palliative Care Coordinator
Children's Hospital of Eastern Ontario
Ottawa, Ontario

POSTER #34

Canadian Institutes of Health Research

1. Institute of Gender and Health (IGH)

The mandate of the Institute of Gender and Health is to support research that addresses how sex (biological-genetic dimensions), and gender (social-cultural dimensions of gender identity), interact with other socio-cultural, bio-physical, and political-economic factors to influence health, and create conditions that differ with respect to risk factors or effective interventions for women and girls, men and boys. The objectives of the Institute for Gender and Health are to:

- generate evidence regarding the impact of sex and gender on health status, health behaviour, and health services use throughout the life span;
- to enhance understanding of how gender and sex interact with other health determinants;
- to provide evidence to inform the design of programs, policies and practices;
- to build the capacity of gender and health researchers in Canada; and
- to advance the gender and health perspective nationally and internationally.

Extensive cross-Canada consultations with stakeholders representing the full spectrum of research, and practice, program, policy and public domains led to the identification of five research priority themes for the Institute:

- access and equity for vulnerable populations;
- promoting health in the context of chronic conditions and disabilities;
- gender and health across the lifespan, including healthy child development;
- promoting positive health behaviours and preventing addictions; and
- gender and the environment.

Abstract submitted by:
Miriam Stewart, Scientific Director
Kathleen Lewis, Executive Assistant
CIHR Institute of Gender and Health

2. Institute of Human Development, Child and Youth Health

The CIHR Institute of Human Development, Child and Youth Health will support research to enhance maternal, child, and youth health and to address causes, prevention, screening, diagnosis, treatment, short- and long-term support systems, and palliation for a wide range of health concerns associated with reproduction, early development, childhood, and adolescence.

Research areas include but are not limited to:

- health promotion policies and strategies–individual, community, and population levels (e.g. for healthy pregnancy and optimal birth outcomes, for parenting and child development, for interventions in adolescent populations)
- health determinants–to elucidate the multi-dimensional factors that affect the health of populations and lead to a differential prevalence of health concerns
- identification of health advantage and health risk factors related to the interaction of environments (cultural, social, psychological, behavioural, physical, genetic)
- targeted disease and disability prevention strategies at the individual and population levels
- reproductive health of men and women: contraception, abortion, fertility and infertility
- reproduction: conception, fetal development, maternal health and pre-term care, maternal influences on fetal development, birthing methods
- prevention and treatment of low birth weight infants, research into congenital anomalies and their management,
- child development: conditions for optimizing child development; prevention, treatment and strategies for support of children with physical, mental and behavioural health challenges
- adolescent health including physical, mental, and social development; sexuality; sexually transmitted diseases; youth and violence; suicide prevention; drug and alcohol abuse; nutrition; pregnancy

- family research and child-care, health impacts and outcomes; parenting; attachment patterns; family structure; impact of poverty; abuse
- specific childhood and youth-related conditions: causal factors, prevention, early identification, treatment and long term management including school-related issues
- application of clinical interventions in the child and adolescent populations
- impacts of health status in early life on adult health outcomes
- development: molecular, genetic, cellular, tissue, organ, systems, and whole organism approaches
- development and implementation of health technologies and tools (e.g. imaging, diagnostics, medical devices)
- ethics issues related to research, care strategies, and access to care (e.g. embryo research, informed consent for minors, economic impacts of pre-term birth)

Abstract submitted by:

John Challis, Scientific Director
Loretta Wong, Institute Liaison
CIHR Institute of Human Development, Child and Youth Health

3. Institute of Nutrition, Metabolism and Diabetes

The CIHR Institute of Nutrition, Metabolism and Diabetes will support research to enhance health in relation to diet, digestion, excretion, and metabolism; and to address causes, prevention, screening, diagnosis, treatment, support systems, and palliation for a wide range conditions and problems associated with hormone, digestive system, kidney, and liver function.

Research areas include but are not limited to:

- health promotion policies and strategies (individual, community, and population based); understanding motivations for healthy living practices (e.g. eating habits)
- health determinants–to elucidate the multi-dimensional factors that affect the health of populations and lead to a differential prevalence of health concerns
- identification of health advantage and health risk factors related to the interaction of environments (cultural, social, psychological, behavioural, physical, genetic)
- disease and disability prevention strategies at the individual and population levels
- nutrition, food and health: population and life-cycle nutrient use and requirements; pathogenesis of nutrient imbalance; non-oral feeding strategies; food production techniques and food handling
- clinical research and health outcomes research into diagnostic technologies and methods; therapies (e.g. drug therapies, surgical or behavioural interventions); treatment, care, and rehabilitation strategies (long and short-term)
- conditions related to hormone, digestive, kidney, liver or basic metabolic function (e.g. diabetes, stomach ulcers, Crohn's disease, kidney failure, hepatitis, obesity)
- design and implementation of health services delivery–from prevention, to screening, to diagnosis, to intervention or treatment, to rehabilitation, to palliation

- development and implementation of health technologies and tools (e.g. non-oral feeding devices, sterilization techniques, dialysis tools)
- development, regulation, function, and dysfunction of metabolism, hormone systems, digestion, the kidney, and the liver at the genetic, molecular, cellular, tissue, and systems levels
- basic biochemistry
- basic pharmacology
- ethics issues related to research, care strategies, and access to care (e.g. poverty and food access, costs of infant screening for inborn errors of metabolism)

Abstract submitted by:
Diane Finegood, Scientific Director
Hope Kubryn, Operations Coordinator
CIHR Institute of Nutrition, Metabolism and Diabetes

POSTER #35

The Canadian Child Health Clinician Scientist Program

The newly created Canadian Child Health Clinician Scientist Program aims to develop a transdisciplinary training program for the next generation of clinician-scientists in child and youth health research in Canada. We created this program because Canada is deficient in child health researchers and because child health research would greatly benefit from an integrated interdisciplinary approach. We have established a national network of 13 Canadian Child and Youth Health Research Centres in partnership with CIHR, The Hospital for Sick Children Foundation and the B.C. Research Institute for Children's and Women's Health. Our objectives and plans for implementation are:

1. Recruit child and youth health clinicians who aspire to be career scientists. Most clinician-scientist trainees develop an interest in science during clinical training. Our team of mentors will identify, recruit, and mentor trainees in clinical child health programs across disciplines including, but not limited to, medicine, communication disorders, nursing, psychology, and rehabilitation.
2. Train towards transdisciplinary research. We have assembled a cadre of expert mentors in the four CIHR pillars to supervise training within interdisciplinary programs. The following strategies will be pursued:
   - Doctoral or post-doctoral training. A highly qualified mentor will supervise research training for pre- and post-doctoral level recruits. Each trainee will gain interdisciplinary scientific expertise, and receive mandatory exposure to the concepts, perspectives, and languages of scientists across the four CIHR pillars.
   - Participation in multidisciplinary/interdisciplinary symposia. Our program will establish regional and national workshops and interactive long-distance multimedia programs. These will engage both trainees and mentors in interdisciplinary debates on major questions in child and youth health through participation in problem-solving exercises. We will model interdisciplinary research by demonstrating current research within our partner centres, and with our partners in the Canadian Language and Literacy Research Network and the CanChild Centre for Childhood Disability Research.

- Core curriculum. A common language in clinical research, population health, and health services disciplines will be developed through seminars, courses, and interactive exercises in research design, statistics, research ethics, and knowledge transfer. We will use web-based tools and feature mini-symposia on these issues at annual research symposia.

3. Train in professional knowledge, values, and skills. The curriculum will address integrity in research practice, skills in grant and manuscript writing, time management, teaching and mentoring skills, and research ethics.

4. Support Career Development. Limited early career support for clinician-scientists undermines the success of new 'faculty' appointees by failing to provide mentoring and protected research time. Our program will address this critical gap in career development by providing two to three years of mentoring after completion of the training phase and by providing salary support to newly appointed clinician-scientists.

Abstract submitted by:

Norman Rosenbloom
Principal Investigator
Canadian Child Health Clinician Scientist Program
Department of Paediatrics, University of Toronto
Hospital for Sick Children, Toronto

POSTER #36

Knowledge and Attitudes about Routine Childhood Immunization among Peadiatric Nurses in a Tertiary Care Centre

Introduction: Surveys have shown that the public prefers to receive health information from health care professionals. Our assumption is that paediatric nurses in a tertiary care centre are viewed as a source of information about childhood immunization.

Questions:
1. Are paediatric nurses in a tertiary care centre asked for immunization information by the public?
2. Do they feel prepared to give this kind of information? 3. Do they support routine childhood immunization?

Methods: We implemented a survey to answer these questions in order to identify learning needs. In a point-prevalence study, all nurses working during a 24 hour period on June 12, 2001 at The Hospital for Sick Children, Toronto, were given a self-administered 13 point questionnaire, which was returned the same day.

Results: Of the 499 who received the questionnaire, 421 (84%) responded. The majority (74%) are asked for immunization information. Of these, 54% do not feel adequately prepared. The current recommended immunization schedule for children in Ontario is either known or somewhat known by 73% of respondents. When asked if they would recommend individual vaccines in normal healthy children, 94% "always" recommend DTaP-IPV-Hib; 92% MMR; 65% Hep B; 42% influenza and 47% varicella vaccines. A general working knowledge about immunization is viewed as important by 98%. Of the 65 who chose to include a comment, a majority request educational sessions.

Conclusions: Our survey indicates that nurses at the Hospital for Sick Children are viewed by the public as a source of information yet 54% do not feel adequately prepared for this role. The percent of nurses who do not fully support routine immunization recommendations is concerning and indicates a need for education about current vaccines and the diseases which they prevent. We need to provide educational support so that HSC nurses can be informed advocates for childhood immunization.

Abstract submitted by:

Helen Heurter RN BScN
Research Nurse, Division of Infectious Diseases
Hospital For Sick Children, Toronto

POSTER #37

Maximizing Our Resources: An International Collaboration

The Mutual Assistance Agreement between CHEO and the Hospital of the Niñez Oaxaqueña, Oaxaca, Mexico, is an example of a collaborative relationship that has established an initial step towards the development and implementation of cultural competent international standards in paediatric health care. Through strengthening our partnerships with other hospitals not only at a national level but globally as well, resources for the health of children and youth can be optimized and all involved can benefit from the relationship.

This Poster will:

- Exhibit the importance of promoting and maintaining collaborative international networks.
- Identify the need for open dialogue, aimed at establishing equitable care for all children and youth.
- Share skills and experiences in cross cultural paediatric health care from an international level.
- Demonstrate the benefits of knowledge transfer, as an essential part for establishing cultural competent standards in paediatric health care and strengthening international relationships.

Abstract submitted by:

Fanny Zegarra,
Manager, Multiculturalism Programming
Children's Hospital of Eastern Ontario

Hector Tenorio Rodriguez
Vice-President of La Sociedad de Pediatria de Oaxaca
Oaxaca, Mexico

Blanca Delia Palacios
Pediatric Intensivist, Hospital de la Niñez Oaxaqueña
Oaxaca, Mexico

Carlos Garcia Rosado
Pediatrician, Centro Médico de Cozumel
Cozumel, Quintana Roo, Mexico

POSTER #38

Creative Options and Value

MEDBUY is a not for profit, national group purchasing organization (GPO) owned by leading healthcare providers, dedicated to providing economic and other value-add benefits to its members enabling them to further their individual areas of excellence.

MEDBUY is a member driven organization. Through innovative contracting strategies members enjoy invoice savings along with access to value-add benefits such as certified continuing education programs, national networking with peers, research/project grants and national problem reporting and resolution for clinical issues and supply chain concerns.

Abstract submitted by:

Ann Kelterborn
Director, Pharmacy
MEDBUYCorporation

Cyndy Donnell, R.N.
Director, O.R. & Medical Imaging
MEDBUY Corporation

POSTER #39

Family Centered Care: Putting Theory into Practice

In September 2001, Winnipeg Children's Hospital embarked on a new initiative, when together with the Family Advisory Committee, developed a proposal, applied for funding and hired a Family Centered Care Advisor (FCC Advisor). The role of the FCC Advisor is threefold: to support families whose children are hospitalized, provide education for families and staff regarding family centered care, and ensuring that the policies and procedures that exist within the hospital reflect family centered care. Children's Hospital has supported the principles of family centered care in the past, but are now more fully embracing the implementation of family centered care throughout the hospital. The process, development and planning for the expansion of FCC will be displayed.

Abstract submitted by:

Joanne van Dyck, M.Sc.
FAMILY CENTERED CARE ADVISOR
Winnipeg Children's Hospital
Winnipeg, Manitoba

POSTER #40

Four Stages Involved in Safely Transporting Children Aged 12 and Under

Seat belts are one of the most cost efficient and effective ways to protect motor vehicle passengers involved in a collision. The device is already fitted into the vehicle and use by passengers increases the survivability of the crash quite substantially. The device can prevent a secondary collision within the vehicle and reduces the likelihood of ejection from the vehicle. Since 1989, the National Occupant Restraint Program (NORP) of the Canadian Council of Motor Transport Administrators (CCMTA) has set a target for seat belt usage. Surveys by Transport Canada have monitored the usage rate. Seat belt usage rates in Canada for adult users are very high. However, with systems designed for children usage is high, but correct and appropriate usage is much lower. Incorrect usage refers to how the restraint is installed in the vehicle and how the child is secured in the seat. Inappropriate usage refers to using the wrong restraint system for the size of the child. There are four stages involved in safely transporting children aged 12 and under. This poster presentation provides information on each of the four stages. While many people actively seek information on how to use the restraint system, many more do not realize that a problem exists. Information delivery channels are being explored to provide this much needed information to parents and caregivers in the context of regularly scheduled activities. Other road safety material will also be available.

Abstract Submitted By:

Paul Boase
Chief, Road Users
Road Safety Programs
Transport Canada
Ottawa, Canada