

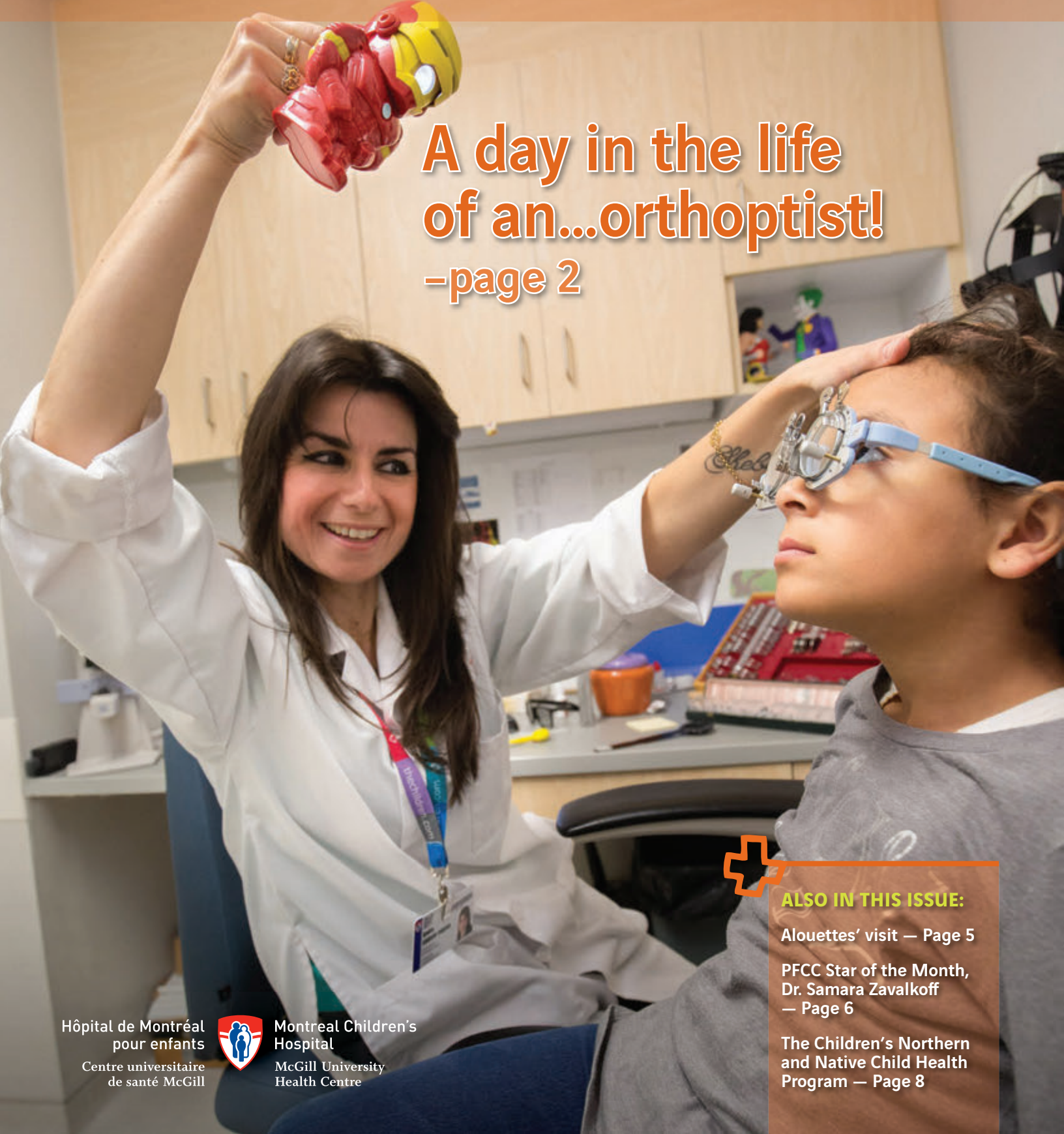
# Chez nous

MCH EMPLOYEE NEWSLETTER

Published by Public Relations and Communications | [www.thechildren.com](http://www.thechildren.com)

OCTOBER 25, 2017

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Montreal Children's  
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# A day in the life of an...orthoptist!



By *Stephanie Tsirgiotis*

*There are so many different jobs in the healthcare industry, but not all of them are well known. Every month, Chez nous will shed some light on these important, but unfamiliar professions. Sure, we've heard about them, but what do they actually do?*



► There are three orthoptists at the Montreal Children's Hospital, Mona Hijazi, Stephanie Oglietti and Gaëla Cariou-Panier.

Gaëla Cariou-Panier always knew she wanted to work in health care. She even loved the smell of hospitals. After two years of medical school in France and some time working in research, she came across a job she had never heard of: orthoptist. "It was a hard word to say," she laughs. "But as soon as I learned more about it, I knew it was for me."

## WHAT'S AN ORTHOPTIST?

Orthoptists specialize in evaluating, diagnosing and treating patients who have crossed eyes, double vision or lazy eyes. The majority of these problems are congenital and are

due to a weakness or paralysis of an eye muscle. "Our goal is to find out which muscle or nerve is affected, how long has this been going on for, why, and how can we treat it?" explains Gaëla. "We work closely with the ophthalmologists. More often than not, we see patients with strabismus first, in order to give the diagnosis and determine if an operation is necessary."

Their main objective is to straighten the eye, strengthen the weaker eye, or refer to surgery if none of the treatments help and prescription glasses don't work. Most of their patients are

*continued >>*



treated by various non-surgical treatment options, like glasses and/or wearing a patch over the dominant eye in order to strengthen the weaker one. However, a quarter of their patients have a more complicated reason behind their visual impairment, like a brain tumor.

### SMALL TEAM, BIG RESULTS

There are three orthoptists at the Montreal Children's Hospital, Gaëla, Mona Hijazi and Stephanie Oglietti. They each see approximately 12 to 13 patients a day and a consultation can last between 20 to 45 minutes. During a regular appointment, Gaëla will observe, measure and use different techniques, like using a prism to determine the gravity of the problem. A prism is an optical device that can be placed on a patient's glasses to trick the brain into thinking that the eyes are straight. The strength of the prism can be easily adjusted until the eye is recentered and the prism is then removed.

During a consultation, Gaëla will check a patient's 3D vision, as well as the muscles around the eye. "We have six muscles in each eye that allow it to move and I can figure out which muscle is not working by simply looking at it," she says. The eye will drift outward, inward, upward or downward depending on which muscle is affected. If there is any deviation, she figures out which muscle is not working and then measures the angle of the deviation. "These measurements help the ophthalmologist with the surgery," she says. *continued >>*



► A prism is sometimes placed on a patient's glasses to trick the brain into thinking that the eyes are straight.






### **Chez nous is published by the MCH Public Relations and Communications office**

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Production of *Chez nous* is made possible thanks to funding from the Montreal Children's Hospital Foundation.

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*On the cover: Gaëla Cariou-Panier and a six-year-old MCH patient  
Cover photo: Owen Egan*

## A day in the life... (cont'd)

### TIME IS KEY

Time is crucial in a lot of these cases, because the younger the child, the better chance they have of solving the problem. "A patch will be more effective with children under six-and-a-half years old, because after that the visual function matures and recovery is more difficult," she explains. This tight time frame is important when explaining to parents why they have to be vigilant with this treatment option. "Even if it takes me five extra minutes, I always explain why it's important for their child to wear the patch," she says. "If they understand the 'why' then they will more likely go home and make sure their child wears it."

### CLOWNING AROUND

A lot of their patients don't speak yet so the orthoptists use special instruments, toys and techniques to try and figure out if these children can see properly or not, and each of them do it in a different way. For Gaëla, she likes to clown around. "I love being a clown and using my humour during consultations. I'll stick things on my nose so they can focus

on one thing or I'll let them watch TV to calm them down while I take a closer look at their eyes."

As a mother of two teenage girls, she understands what these parents are going through and tries to help them navigate these difficult times by making them laugh and smile. "If it's appropriate, I will ask the parents to participate in our little games and I even get the child's stuffed animal involved too," she laughs. "I'll either put drops in their eyes or send their teddy bear home with a patch!"

### IN HIGH DEMAND

It is very evident that Gaëla's job is not just a job – it's her passion; a passion that she also gets to share with adult patients as well. Orthoptists are in very high demand so they often work in pediatric and adult settings. In fact, the *Programme d'Intégration Francophone des Orthoptistes* (PIFO) was put into place in order to allow francophone orthoptists, like Gaëla, to work in Canadian hospitals. "We have over 2,000 orthoptists in France, but only 20 to 30 in Quebec," she says.

"It was a no brainer to move here for a job I love."

"I always tell my daughters it's important to wake up in the morning and love what you do. I love my job because it varies enormously every day. Even if the pathology looks similar, the patient is always different. Orthoptists don't treat the cause; we solve the problem." ■



► Gaëla often sticks things on her nose so that the patient can focus on one thing while she looks at their eyes.







# The Alouettes visit the MCH

Players and coaches from the Montreal Alouettes visited the MCH on October 2 to hand out gifts to their young fans. Patients, families and staff on the wards, in the clinics and even those in the waiting areas had a chance to chat and take pictures with the pros. Every year, we are happy to have the Als and always look forward to welcoming them again!



# Dr. Samara Zavalkoff, PFCC Star of the Month

By Maureen McCarthy



Sandra Filopoulos watched her newborn son Emmanuel undergo surgery and treatments for a heart condition. During Emmanuel's stay in the Children's pediatric intensive care unit (PICU), Dr. Samara Zavalkoff was part of his care team. Sandra and her husband Thierry nominated Dr. Zavalkoff for this month's PFCC Star Award for her dedication and professionalism, and her understanding of the family's central role in their child's care.

When Emmanuel was born at the Royal Victoria Hospital, he weighed only four pounds. Sandra, who had worked as a nurse coordinator in cardiovascular research at the MUHC, had an understanding of what was wrong. "He was totally blue," says Sandra, "and at first they couldn't intubate him." Within 24 hours, Emmanuel was transferred to the Montreal Children's Hospital. He was immediately seen by cardiologist Dr. Adrian Dancea, and one week later, had heart surgery. Emmanuel was admitted to the PICU after his surgery; Sandra remembers an encounter with Dr. Zavalkoff at a moment when she was feeling very vulnerable. For one *continued >>*



**Our PFCC Stars are featured on the Children's Facebook page. Here's what people had to say about our previous award recipient, Kathy Kehoe.**

**Jo-Anne Desjardins**  
*You so deserve it Kathy!  
Congratulations ❤️*

**Adeline Noel**

*You are a wonderful nurse, Kathy. Congratulations on your star—you deserve more than one for sure.*

Like Comment Share





week, Emmanuel's chest was kept open, with the risk that his lungs might collapse. "At one point, Dr. Zavalkoff went to his bedside while they put the chest tubing back in," says Sandra. "Afterwards, she came to see me and asked how I was doing. She touched my hand and said, 'It's going to be ok.' That was when I realized what a connection she has with patients and families." Emmanuel eventually went home, and returned to the Children's every two months for follow-up. "I'd sometimes see Dr. Zavalkoff in the hallway, walking with a family as their child was being taken for tests," says Sandra. "She was never stressed, always calm. That's a real gift to parents."

### BRINGING FAMILIES TO THE TABLE

Dr. Zavalkoff is a pediatric intensivist. "Growing up, everything I did outside school always revolved around children," she says. "When I finished medical school and started to focus on a specialty, I was drawn to critical care because I liked the pace, but also because you can accompany a family through one of the most difficult times in their lives. It's really an honour."

The PICU team has long practiced patient- and family-centered care, having included families in bedside rounds for many years. "What's happening in the PICU now, though, is almost a 'next' level of PFCC, with more situations where the family is truly engaged in the process," she says. "It's now almost an everyday occurrence that a family tells us something we otherwise wouldn't have known, and it ends up having an important effect on how we deliver care to their child."

The PICU's efforts to continually build on their PFCC approach include a move towards bringing more parents onto committees—and that's how Sandra became reacquainted with Dr. Zavalkoff. Like many parents, Sandra feels her perspective really changed after living through Emmanuel's illness. "Everything is still very vivid, and I'll never forget any of it," she says. Being so grateful to the PICU team is one of the reasons Sandra agreed to join the unit's Quality Improvement Patient Safety Committee (PQUIPS).

"Sandra is amazing, and perfect for the role," says Dr. Zavalkoff. "With her professional background and personal experience, she brings suggestions and a perspective that might have been totally overlooked." Dr. Zavalkoff points out that family representation is now standard for the PICU's committees, and they're even looking ahead to ask young adults who were treated in the PICU as teenagers if they'd consider joining a committee. "We've seen that family members really feel grateful to have a way to give back in a substantial way," she says. "They see the concrete ways that their involvement changes things for the next child." ■

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# The Children's Northern and Native Child Health Program

By Maureen McCarthy



► Dr. Aisling O’Gorman examines Samuel during his admission to the Children’s for a respiratory infection.

The Northern and Native Child Health Program at the Montreal Children’s Hospital is a team that works closely together, yet sometimes very far apart. The program covers a territory within the *McGill Réseau universitaire intégré de santé* (RUIS) that includes the Montreal region as well as Northern Quebec, the Cree territory and Nunavik.

The first initiatives of what eventually became the Northern Program began in the 1960s when pediatricians from the Children’s started visiting Baffin Island. “At the time, the program did not serve Northern Quebec which is now our base,” says Dr. Gary Pekeles, who until recently was the program’s director. When the James Bay and Northern Quebec Agreement was signed in 1975, First Nations and Inuit communities gained responsibility for their own

healthcare delivery and eventually formed their own health boards. “Montreal became the go-to place for all these communities,” says Dr. Pekeles.

## WORKING WITH OVER 20 COMMUNITIES

Dr. Johanne Morel was recently named program director. At the start of her career, when she had just finished medical school, she accepted a short-term position in Chisasibi hospital on the advice of a friend. Within months, she knew she’d found her calling.

Today, the Northern and Native Child Health Program provides consultation and services to more than 20 First Nations and Inuit communities. The program’s pediatricians—Dr. Morel, Dr. Pekeles, Dr. Margaret Berry, Dr. Chi-Minh (Chip)

*continued >>*





Phi, Dr. Aisling O’Gorman, and Dr. Kent Saylor—provide much of their consultation at a distance but each of them also visits and works in the communities 12 weeks a year. The team also includes H  l  ne Caron, a nurse clinician, Sue Gennerelli, executive secretary, and Dr. Jos  e Chouinard who, although not based at the Children’s, serves as a part-time member of the team.

Last year, the pediatricians saw approximately 2,300 patients in their own communities, and admissions to the Children’s were stable at around 300 patients. “The northern communities are fast growing with a higher-than-average birth-rate, so the number of patients we see is increasing,” says Dr. Pekeles. “But the fact that admission rates are stable is a good sign that the efforts to build capacity in the community are working.”

Dr. Morel and Dr. Pekeles say that along with building knowledge and capacity, one of the program’s strategic goals is to build stronger partnerships in the communities. “The number of First Nations and Inuit doctors, nurses, therapists, lab techs, and other healthcare professionals hasn’t increased significantly over time,” says Dr. Pekeles. It’s a fact that

Dr. Kent Saylor is working to change. Dr. Saylor is co-founder of the Indigenous Health Professions Program in McGill’s Faculty of Medicine to help First Nations, Inuit and M  tis students enroll in the health professional schools at McGill. He is also responsible for the Indigenous Health Curriculum, designed to give all medical students a starting point from which to understand health issues of indigenous people. Dr. Pekeles has also worked to develop a distance education program for nurse practitioners in the northern communities to provide greater support to them over the long term.

### **CONTINUITY OF CARE FROM HOME TO THE CHILDREN’S**

For some children, the treatments and procedures they need are only available at the Children’s. Given that travel distances are so great, the Northern program team works hard to group appointments for the same visit, and if possible, find ways to reduce the number of required visits to Montreal by conducting follow-up appointments where the patients live. At the Children’s, H  l  ne Caron organizes the sometimes complex care for children coming to the hospital, and when a specialist from the Children’s makes a trip up north, she works with them ahead of time to ensure that as much as possible, diagnostic tests are done in advance.



► (l. to r.) Dr. Aisling O’Gorman, Sue Gennerelli, Dr. Margaret Berry, and Dr. Gary Pekeles (absent from photo: Dr. Kent Saylor)

*continued >>*

## The Children's Northern and Native... (cont'd)



► (l. to r.) H el ene Caron, Dr. Chi-Minh Phi, and Dr. Johanne Morel.

Six-month-old Samuel has been treated both at the Children's and in his home community of Chisasibi. When Samuel's mother Marlene was pregnant, she and her husband learned that Samuel had a congenital syndrome called trisomy 18 which affects his vision, hearing, musculoskeletal function, development and growth. Samuel was born prematurely at 33 weeks and spent the first months of his life in the Children's neonatal intensive care unit before going home. In late August, during a visit to Montreal for follow-up tests and appointments, Samuel developed a respiratory infection and was admitted to the Children's. Dr. Aisling O'Gorman is Samuel's pediatrician. "One of Samuel's challenges has been to gain weight, so when he was admitted for the respiratory infection, we took the opportunity to try to further investigate and address his feeding difficulties while he was in close proximity to subspecialists who are not available in their community," she says.

Dr. O'Gorman is the newest member of the program. "My first exposure to northern communities was during a family medicine rotation in Puvirnituk as a medical student. I loved it," she says. "It was only later as a pediatrics resident on elective that I met Dr. Saylor, and saw what the

Northern Program pediatricians do for their patients, who are so far from home."

### EXPANDING THE DEFINITION OF PEDIATRIC CARE

Building capacity within the communities also happens outside the hospitals and clinics. Dr. Morel is part of a team which has developed a social pediatrics centre in Whapmagoostui/Kuujuarapik, the only mixed Cree/Inuit community in the north. "This is an initiative that brings everyone to the table to bring about change," she says.

"So far, we've seen 30 children and their families, which often include not just parents but grandparents, aunts and uncles too. It's an approach within pediatrics that encourages family members to learn how to support their child's health and well-being." The project is independent of the health boards and is privately funded. "This type of program requires a community that is open to the idea," says Dr. Morel. "Part of its success is that it takes into consideration the community's strengths and values. So far we've seen some fairly positive outcomes from it."

Serving the communities better can also take on other social and cultural components such as Dr. Morel's decision to approach Paris-based Inalco (*Institut national des langues et civilisations orientales*) about making their course in Inuktituk, the language of Nunavik, available by video-conference. The Institute agreed and the course is now available through telehealth in all 14 Inuit communities. Dr. Morel is one of a handful of people in Quebec enrolled in the course. "Inalco is very interested in protecting languages that are at risk of extinction so their decision to make their Inuktituk course more accessible was something we were very happy about," she says. ■







# B8 scores high marks on hand hygiene initiative

By Maureen McCarthy



► Christiane Martel, Donna Murray, Kelly Goudreau and Stéphanie Lepage review weekly hand hygiene data posted on the unit's white board.

The team on B8 at the Montreal Children's Hospital has recently addressed one of the most important patient safety issues—hand hygiene—with some outstanding results. “We were aware that not washing your hands is often unintentional, but our compliance rate was less than 50%, so we needed a plan to increase that number,” says Kelly Goudreau, Assistant Nurse Manager on B8.

Kelly led the effort along with Donna Murray, Nurse Manager, Christina Duperreault, Assistant Nurse Manager, Stéphanie Lepage, Nursing Educator, and Christiane Martel, Nurse, who is also the unit's Infection Control delegate. As a starting point, they adopted the Controlling Specific Infection Successful Strategies (CSISS) program, which incorporates a “Quality Station”—a white board to display relevant data that all staff can refer to.

The five nurses were trained on how to audit team members' hand hygiene compliance on a daily basis; they enter data on an app, which sends information to the Quality Improvement department, which then produces weekly reports. They also employed a key tactic with the team:

talking about hand hygiene on a constant basis at every possible opportunity. “During morning rounds, we go through patient lists and discuss messages for the day so every single morning for the first few months, we talked hand hygiene,” says Kelly.

## CREATIVE WAYS TO COMMUNICATE

One of their challenges was how to reach everyone on the unit on a regular basis. At the beginning they held short weekly meetings at the white board to review the data, but with nurses at bedside, and surgeons in the OR, they had

to come up with a more creative way to communicate news.

“Both Donna and I are here very early in the morning so we talk to the surgeons before their morning huddles and discuss data as a group,” says Kelly. “We give them feedback, tell them how they're doing, where they can improve as a team, etc. We've found the group meeting is much more effective than seeing people individually.”

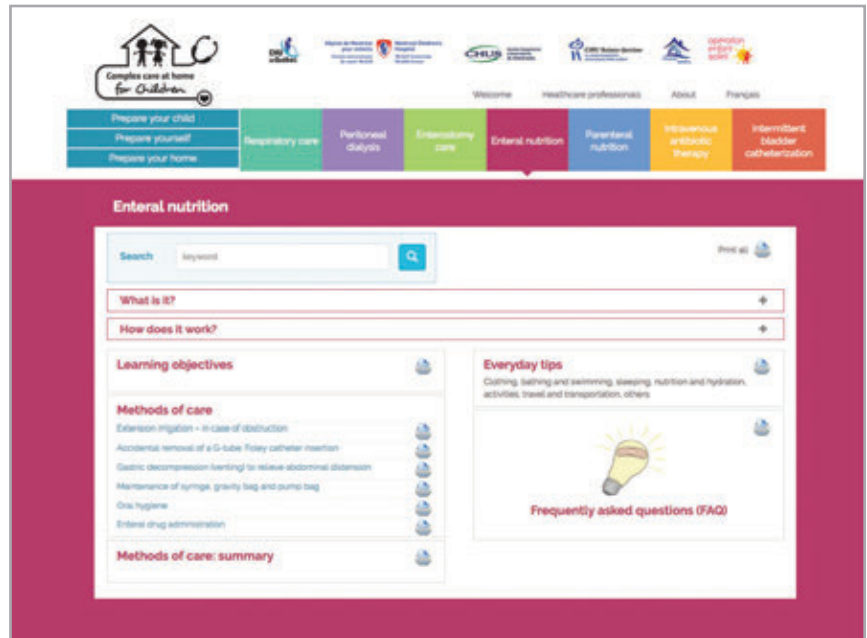
When they started the initiative, their goal was to reach an 80% hand hygiene rate, which is the level set by the Ministère de la santé et des services sociaux, as well as the requirement for Qmentum accreditation. “We're now consistently above that figure and even reached 91% one week this summer,” says Kelly.

Dr. Marie-Astrid Lefebvre, Medical Director of Infection Prevention and Control at the Children's, worked with the B8 team. “There is good communication on the unit, and they're very open to discussing hand hygiene and reminding each other of its importance,” she says. “I think it's a key reason that they've been so successful in their efforts.” ■

# New complex care website now up and running!

Thanks to Opération Enfant Soleil, Dr. Hema Patel and her team officially launched a new website on October 21 with collaboration from families, community partners, as well as CHU Sainte Justine, CHU de Sherbrooke, CHU de Québec-Université Laval and the National Program for Home Ventilatory Assistance (NPHVA).


A first of its kind, the site is meant for parents and caregivers of children living with complex medical conditions, and the tools can also be used by healthcare providers for educational or training purposes. The information is meant to facilitate daily care, all while ensuring a safe environment for the child and family. ■



► Check it out at [complexcareathomeforchildren.com](http://complexcareathomeforchildren.com)

## Flu season is right around the corner: don't forget to get vaccinated!

The Montreal Children's Hospital will not be holding its annual flu vaccination clinic for patients and families this year. For more information on where to go and how to book an appointment, check out your local CLSC or visit [sante.gouv.qc.ca](http://sante.gouv.qc.ca)

- Click on
-  Vaccination
  -  Flu
  -  Protection and prevention
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We also strongly encourage our staff to take part in the annual employee flu vaccine campaign starting in November. ■

