Chez nous

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Hôpital de Montréal pour enfants
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Montreal Children's Hospital
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The Alouettes are back at the MCH!

By Christine Bouthillier

For the first time since the beginning of the pandemic, the Montreal Alouettes were able to visit patients at the Montreal Children's Hospital (MCH) on October 5, to the delight of children and adults alike!

▶ Above: Delphine Beauchemin got to celebrate her birthday with very special guests!

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The welcome speech opening the tour was marked with cheers of joy from the players, a sign that they were eager to meet the patients. With a certain excitement, the athletes set off down the hospital corridors, accompanied by two cheerleaders and members of the team's administration.

They met patients in the day hospital, complex care, hemodialysis, neonatal intensive care unit, pediatric intensive care unit, hematology-oncology day centre and care unit, psychiatry unit, and the B8 and B9 units.

"I've been doing this for several years. Prior to the pandemic, I would sometimes go to pediatric hospitals with a few other players on our own initiative," says Eugene Lewis, number 87. "It's important for me to meet these children, who are going through a difficult time, and to try to put a smile on their face for a moment. I'm glad we can do it again."

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▶ The players spent over an hour with MCH patients, taking pictures and signing autographs.

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On the cover:
Players from the Alouettes visiting patients at the Montreal Children's Hospital

Cover photo: Frank Pavan

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GENUINE INTEREST

The joy was shared by the MCH patients, who welcomed the team with wide eyes and contagious smiles. One teen celebrated her birthday with these special visitors, another marked the end of his treatment in a beautiful way, and everyone had a great time.

The players were attentive and thoughtful with these often very sick patients, taking an interest in their lives. There were interesting exchanges about Spiderman or the speed of wheelchairs…

The visit also brought a moment of respite to the parents, who often need it after stressful moments at their child's bedside. Fans talked about the end of the "Als" season, while others warmly thanked the players for their time. ❇

▶ Patients received tuques with the Alouettes logo and a signed picture of the team.

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▶ The players visited the vast majority of the units.

A day in the life of a... spiritual care professional

By Maureen McCarthy

When a child is admitted to the Montreal Children's Hospital (MCH), their family is introduced to many different healthcare professionals that make up the care team. The multidisciplinary approach at the MCH means that families are meeting not only nurses and doctors, but also a number of other professionals involved in their child's care.

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▶ Above: Spritual care professional Doreen Shalla meets with Sirahi Virgini Reyes Avendano and her baby Liam in the hospital's PICU. Doreen has been following the family for almost nine months.

Doreen Shalla is one of these people. She is a spiritual care professional working in the Pediatric Intensive Care Unit (PICU), and is also the coordinator of Spiritual Care services at the Montreal Children's Hospital. The Spiritual Care team offers emotional, spiritual, and religious support to patients, families and sometimes staff.

Doreen and her colleagues accompany patients and family members as they deal with the spiritual questions that surround illness and hospitalization, questions that deal with meaning, hope, faith and values. "Our goal is to try to help families reduce their emotional and spiritual suffering when they come face to face with illness, suffering and sometimes death," she says.

"As human beings, we have a tendency to stress over the unknown, but the unknown is something we find a lot of when a family member is ill and in hospital," she says. The spiritual care professional's role is to help parents as they work through their feelings, thoughts, and emotions. "We go into the deep questioning with them and try to help them reach higher ground."

AN INTEGRAL PART OF THE CARE TEAM

The start of each day finds Doreen in psychosocial rounds in the PICU with her colleagues from Psychology, Social Services, Child Life Services, Music Therapy, and the PICU nurse manager. Some mornings they meet virtually on Teams, but twice a week they're on the unit, which allows them to hear directly from the nurses how each child and their family are doing.

"We have a very good relationship in the PICU, and work so well as a team," says Doreen.

After rounds, she usually plans to see six to seven patients and their families but sometimes her day is spent with just one family.

Doreen's initial contact with a family can vary. Sometimes it's right at the beginning of their hospital stay, other times, it can be weeks or months later. "We try to let all families know we're available and what we can offer," she says. When she begins working with a family,

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▶ The spiritual care professionals at the MCH include (seated, l. to r.) Susan Buell and Joëlle Anna St-Arnaud, (standing, l. to r.) Nathalie Tremblay, Doreen Shalla, and Catherine Rioux-Crochetière.

she focuses on determining their needs, and stresses the importance of listening to the family first to know what exactly those needs are.

The multidisciplinary approach is integral to her work and often guides her decisions. "There can sometimes be a situation where a person's needs go above or beyond what I can offer, so I'll refer them to Psychology, Social Work or Child Life," says Doreen. "And my colleagues in these services will refer to me if they see the need."

HEALING FROM THE INSIDE

Families who are coping with their child's illness do the work themselves, Doreen emphasizes. "We look at the whole person — mind, body and spirit — to guide them through their suffering," she says, "but we also help them understand that their feelings and emotions must come out for them to heal." Doreen also points out that while not everyone identifies as being religious, people generally feel some sense of spirituality. "We're here for people of every denomination and for those who don't have a particular faith tradition."

Family members sometimes ask Doreen to lead or take part in rituals like prayers, blessings and other services. She recommends different reading and listening resources to parents and also encourages them to journal as a way to understand their feelings and emotions, especially if they find it difficult to talk about what's bothering them.

Doreen and her colleagues also do bereavement counseling with families who have lost a child, and create memory boxes for them, which can hold handprints or footprints or some of the child's clothing. "We're helping to build the child's legacy and support their siblings and parents as they deal with their loss."

▶ Doreen Shalla (r.) talks to Pamela Naggessar, PICU nurse.

The spiritual care professionals also provide bereavement counseling to staff members when they experience the loss of a child who they came to know well.

CHALLENGES OF THE PANDEMIC

In addition to Doreen, the Spiritual Care team includes Susan Buell (Oncology), Catherine Rioux Crochetière (Neonatal Intensive Care Unit), Joëlle Anna St-Arnaud (Surgical ward), and Nathalie Tremblay (Medical ward). They all additionally provide services to Trauma and Women's Health, as well as ensuring 24/7 on-call service within the hospital. The team members have university training in religious studies, as well as courses in Clinical Pastoral Education.

Most of the team continued to work on the front lines throughout the pandemic but they all experienced burnout. "Thankfully, we were recently able to hire three other spiritual care professionals for on-call needs," says Doreen.

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Having started at the MCH 13 years ago, Doreen has worked in every area except Psychiatry, and has a knowledge of almost every aspect of the hospital.

"Although the work can be emotionally and physically draining, it's also so rewarding," she mentions. "I get up every morning and I'm happy to come to work." One of her greatest joys is to see a child head home after a hospital stay. And sometimes years later, a parent and child will knock on her office door to say hello. "Those are very special moments," she says. ❇

▶ (l. to r.) Emily DiLauro (administrative technician, Spiritual Care), Joëlle Anna St-Arnaud, Susan Buell, Doreen Shalla and Catherine Rioux-Crochetière.

▶ (l. to r.) Pascal Comeau, music therapist, Doreen Shalla, Pamela Naggessar, PICU nurse, and Bernard Groleau, PICU nurse, take part in psychosocial rounds on the PICU.

ENFit:
Teamwork benefits patients receiving enteral nutrition

By Christine Bouthillier

Replacing all enteral nutrition equipment throughout a hospital is not an easy undertaking. It requires multiple teams and a lot of planning and training for staff and patients. This summer, however, the Montreal Children's Hospital (MCH) rose to the challenge.

In the healthcare environment, there are many different syringes, tubes and connections. A safety issue arises if it is possible to mistakenly connect equipment designed for enteral nutrition to any other medical equipment such as IVs, oxygen, epidural, catheters, etc. For example, if the same type of syringe can be used for nutrition and for IVs, there is a risk of someone making a mistake and giving the right thing in the wrong place.

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▶ From l. to r.: Michael Marino, section manager, Logistics, Loïca Ducheine, interim nursing advisor, Products, Kim Tanguay, nursing practice consultant, Products, Yogita Patel, administrative technician, Materials Management, Barbara Izzard, retired nurse assisting with the project, clinical activities specialist, and Marie-Eve Besner, professional coordinator, Clinical Nutrition.

Missing from the photo: Eren Alexander, nursing coordinator, Alexandra Black, senior advisor for Quality Improvement, Jesse Eletto, project manager, Planning, Ines Houssou, contract specialist, Purchasing, Stephanie Mardakis, nursing professional development educator, NICU, Jordan Stanbury, nursing advisor, Products, Thanh Thao Ngo, interim assistant manager, Pharmacy, and Patricia Vandecruys, project manager, Pharmacy.

That's why, at the recommendation of the Global Enteral Device Supplier Association, the MCH has different systems that cannot be used together. This is the standard of care regarding enteral feeding devices.

A LONG PROCESS

In 2019, the hospital's enteral nutrition equipment supplier announced it was switching to ENFit equipment and would no longer produce its older devices. As a result, all of the MCH's equipment was scheduled to be changed in 2020. This was delayed due to the pandemic, but planning for this major change finally began in 2021.

Many professionals from several departments were engaged in the process: Nursing, Pharmacy, Nutrition, Purchasing, Materials Management, Logistics, Equipment Planning, etc.

This involved determining needs, establishing quotas, finding out what accessories were needed, translating clinical needs into equipment inventory, calling to tender, transition planning, testing new equipment, preparing medication, and ensuring the MCH had enough equipment.

"We started changing supplies in June 2022, and it took a few weeks. It's a big change in the equipment we use, but it's not a huge clinical change. Everything went pretty well," says Alexandra Black, senior advisor for Quality Improvement at the MCH.

A LEARNING EXPERIENCE

The team also developed videos, training programs and demonstration packages for staff, particularly those in Nursing and Pharmacy, as well as for families of patients who receive enteral nutrition at home, especially those in Complex Care.

"Families were able to view the videos before they picked up the new equipment. So they had their questions ready when they arrived at the hospital," says Alexandra.

Now that the MCH has completed this huge transition, the rest of the McGill University Health Centre is following suit and will soon make the same change. ❇

Responding to critical situations more quickly

By Sandrine Pelletier

The Pediatric Intensive Care Unit (PICU) at the Montreal Children's Hospital (MCH) is currently working on a pilot project with the Pediatric Medicine Unit (B9) involving early detection of patients at risk of deteriorating. Preliminary results are so promising, it could be scaled up to the rest of the MCH.

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▶ Above: Andrée-Anne Matte, a nursing professional development educator at the MCH, has been involved in the pilot project since its creation.

A deteriorating clinical condition is a major concern in the medical field. To better help staff face these situations, members of the B9 team have implemented, in collaboration with the PICU, a system specifically adapted to the reality of their unit.

Implemented in June 2022, the new B9 Rapid Response System (RRS) has been tailored to fit the pediatric reality. The project began in January 2021, following a review of the protocols and in an effort for continuous improvement. RRSs are frequently used in adult care and were developed in the 1990s, following numerous observations made in certain hospitals in the United States. Studies show a strong link between rapid patient deterioration, lack of management and cardiopulmonary arrest.

"Implementing the pilot project in B9 allows us to perform tighter cardiovascular monitoring," explains Andrée-Anne Matte, a nursing professional development educator at the MCH.

THE IMPORTANCE OF NUMBERS

The RRS consists of two main elements: the implementation of the Pediatric Early Warning Signs (PEWS) and the creation of a Critical Care Response Team (CCRT).

The PEWS rate the stability of patients using a chart. On a scale of one to 13, they quantify the patient's state of cardiorespiratory instability. The care staff then checks cardiovascular parameters, such as breathing, heart rate and the patient's general condition and looks at how they relate to other vital signs and observations to determine the patient's chart rank.

"Based on the score, the nurse decides on an action plan," says Andrée-Anne. "If it's too high, the second part of the pilot project is activated, and the Critical Care Response Team goes into action."

A 24-HOUR MOBILE TEAM

The second key to the success of the new program is its 24-hour mobile team. When called, the Critical Care Response Team has 30 minutes to get to the patient's bedside and decide on a care plan. The group consists of a PICU resident doctor, a PICU nurse and a respiratory therapist.

The involvement of respiratory therapists in this unique project is critical, according to Marisa Leone, respiratory assistant manager at the MCH.

"By focusing our expertise on the patient, the mobile team can work collaboratively with the ward group," explains Marisa. The collaboration benefits not only the patient being treated but all future patients as well, thanks to the sharing of knowledge."

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▶ A B9 nurse looks at the pediatric early warning signs criteria chart.

A SUPPORT SYSTEM FOR NEW NURSES

The Rapid Response System also benefits the many new nurses entering the Quebec medical field.

"They will have a whole system in place to help them discern deterioration," explains Catherine Bouchard, manager of clinical operations and access to care at the MCH. "If a nurse notes a score going from two to six out of 10 in a few hours, they don't have to wonder what to do. All these measures prevent misinterpretation of the patient's condition."

A POSITIVE OUTCOME

Overall, the initiative has been well received, according to Dr. Joshua Feder, a PICU fellow at the MCH.

"The most concrete change I've noticed has been the presence of the CCRT in the ward at the time of consult and the simultaneous multidisciplinary assessment of the patient," he says. "This translates directly to faster implementation of stabilization."

The project will soon enter its second phase: to see how the rapid response system can be gradually adapted to other units and departments in the hospital. ❇

▶ The corridor of the MCH Pediatric Medicine Unit.

PROMISING DATA

35 - The number of times the CCRT has gone to see a patient since the project was implemented in June 2022.

10 - The average number of minutes before the mobile team arrives at the bedside. The goal is 30 minutes.

27 - The average number of minutes it takes to see the patient.

67 - Percentage of cases analyzed that were in respiratory distress.