Translating Emergency Knowledge for Kids (TREKK), a knowledge mobilization initiative to improve emergency care for all children in Canada

Presented by: Dr. Terry Klassen
September 10th, 2015
Objectives

Learn how TREKK has:

- Determined the needs of end users
- Designed and created resources
- Connected with stakeholders across the country
Why TREKK?

85% of Canadian children who need emergency care are treated in general EDs that are not part of a children’s hospital.

40% do not get treatments for which clear evidence exists

1 in 5 get treatment which is of no benefit or even harmful
Why TREKK?

• Barriers exist in providing pediatric emergency care in EDs that do not have a pediatric focus
  • Difficulty in accessing appropriate training
  • Difficulty in accessing resources
• The result is an “extremely variable” level of pediatric emergency care within Canada

VISION

That every child receives the highest standard of care, whether they seek treatment in a pediatric or general emergency department.

Three Phase Plan

1. Needs Assessment
2. Map current evidence
3. Share knowledge and practical tools
Pediatric Emergency Research Canada (PERC)

Established in 1995 to improve the quality of research and clinical care in pediatric emergency medicine across Canada

• Made important advances in croup, gastroenteritis, bronchiolitis
• Substantial number of quality publications and highly valued research
• 2007: ongoing collaboration with KT Canada
• 2009: brought together pediatric emergency research networks from North America, Europe, Middle East, Australasia to form the Pediatric Emergency Research Network (PERN)
• Put Canada at the forefront of pediatric emergency research
Pediatric Emergency Research Network (PERN)

A global network established in 2009 to improve the production and dissemination of high quality research to improve the emergency care provided to children across the world

Consists of 5 Pediatric Emergency Networks

• PERC, PECARN, PEMCRC, REPEM, PREDICT (3 million ED visits)

Annual international meetings

• 2009 in Amsterdam
• 2010 in Vancouver
• 2011 in Denver
• 2012 Dublin

Published Project

• BMJ Publication 2013
• Goal: to determine risk factors for the development of severe H1N1 disease in children(265 cases)
• Includes participation from 75 institutions across 12 countries and 5 networks
Pediatric Emergency Research Networks

<table>
<thead>
<tr>
<th>Organisation</th>
<th>PEMCRC</th>
<th>PECARN</th>
<th>PERC</th>
<th>PREDICT</th>
<th>REPEM</th>
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<td>Australia &amp; New Zealand</td>
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<td>EMSC/ HRSA/ MCHB</td>
<td>CIHR</td>
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<td>Paediatric Population Accessible</td>
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<td><a href="http://www.pecarn.org">www.pecarn.org</a></td>
<td><a href="http://www.perc-canada.ca">www.perc-canada.ca</a></td>
<td><a href="http://www.pemCRC.org">Link</a></td>
<td><a href="http://www.pecarn.org">Link</a></td>
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*PEMCRC and PECARN have substantial overlap in populations accessed (up to 2/3)*
37 GENERAL EDs
~80% SICK KIDS

TREKK Clinicians

PRIORITIZE HEALTH PROBLEMS

PERC Researchers & Clinicians

Child Family Community

ENSURE KNOWLEDGE IS USED

CREATE NEW KNOWLEDGE

15 PEDIATRIC EDs
~20% SICK KIDS

trekk Translating Emergency Knowledge for Kids

perc Pediatric Emergency Research Canada
PERC & PERN

Continue to have an important role in improving research and clinical care within the pediatric emergency department (ED) setting
Lancet

CMAJ

Decision rules for head injuries
The TREKK Team

**Director**
- Dr. Terry Klassen
  - University of Manitoba
  - Children’s Hospital Research Institute of Manitoba

**Co-Directors**
- Dr. Shannon Scott, *Needs Assessment*
  - University of Alberta
- Dr. Lisa Hartling, *Knowledge Synthesis*
  - University of Alberta & ARCHE
- Dr. David Johnson, *Implementation*
  - University of Calgary
- Dr. Mona Jabbour, *Implementation*
  - University of Ottawa
Long history of working together
A Randomized Controlled Trial of Storytelling as a Communication Tool

Lisa Hartling¹, Shannon D. Scott², David W. Johnson², Ted Bishop³, Terry P. Klassen⁴

¹ Alberta Research Centre for Health Evidence, Department of Pediatrics, University of Alberta, Edmonton, Alberta, Canada, 2 Faculty of Nursing, University of Alberta, Edmonton, Alberta, Canada, 3 Departments of Pediatrics and Physiology & Pharmacology, University of Calgary, Calgary, Alberta, Canada, 4 Department of English and Film Studies, University of Alberta, Edmonton, Alberta, Canada, 5 Manitoba Institute for Child Health, Winnipeg, Manitoba, Canada

Abstract

Introduction: Stories may be an effective tool to communicate with patients because of their ability to engage the reader. Our objective was to evaluate the effectiveness of story booklets compared to standard information sheets for parents of children attending the emergency department (ED) with a child with croup.

Methods: Parents were randomized to receive story booklets (n=208) or standard information sheets (n=205) during their ED visit. The primary outcome was change in anxiety during triage to ED discharge as measured by the State-Trait Anxiety Inventory. Follow-up telephone interviews were conducted at 1 and 3 days after discharge, then every other day until 5 days (or until resolution of symptoms), and at 1 year. Secondary outcomes included: expected future anxiety, event impact, parental knowledge, satisfaction, decision regret, healthcare utilization, time to symptom resolution.

Results: There was no significant difference in the primary outcome of change in parental anxiety between recruitment and ED discharge (change of 5 points for the story group vs. 6 points for the comparison group, p=0.78). The story group showed significantly greater decision regret regarding their decision to go to the ED (p<0.001). 6.7% of the story group vs. 1.5% of the comparison group strongly disagreed with the statement “I would go for the same choice if I had to do it over again”. The story group reported shorter time to resolution of symptoms (mean 3.7 days story group vs. 4.0 days comparison group, median 3 days both groups; log rank test, p=0.04). No other outcomes were different between study groups.

Conclusions: Stories about parent experiences managing a child with croup did not reduce parental anxiety. The story group showed significantly greater decision regret and quicker time to resolution of symptoms. Further research is needed to better understand whether stories can be effective in improving patient-important outcomes.

Trial Registration: Current Controlled Trials, ISRCTN39642997 (http://www.controlled-trials.com/ISRCTN39642997)


Editor: Gemma Elizabeth Derrick, Brunel University, United Kingdom

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Competing Interests: Dr. Hartling is an Academic Editor with PLoS ONE. This does not alter the authors' adherence to all the PLOS ONE policies on sharing data and materials.

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Protocol for a systematic review of the use of narrative storytelling and visual-arts-based approaches as knowledge translation tools in healthcare

Shannon D Scott1*, Pamela Brett-MacLean2, Mandy Archibald1 and Lisa Hartling3

Abstract
Background: The arts are powerful, accessible forms of communication that have the potential to impart knowledge by attracting interest and developing meaningful connections. Knowledge translation aims to reduce the ‘evidence-practice’ gap by developing, implementing and evaluating strategies designed to enhance awareness and promote behavior change congruent with research evidence. Increasingly, innovative approaches such as narrative storytelling and other arts-based interventions are being investigated to bridge the growing gap between practice and research. This study is the first to systematically identify and synthesize current research on narrative storytelling and visual art to translate and disseminate health research.

Methods: A health research librarian will develop and implement search strategies designed to identify relevant evidence. Studies will be included if they are primary research employing narrative storytelling and/or visual art as a knowledge translation strategy in healthcare. Two reviewers will independently perform study selection, quality assessment, and data extraction using standard forms. Disagreements will be resolved through discussion or third party adjudication. Data will be grouped and analyzed by research design, type of knowledge translation strategy (that is, a narrative or visual arts-based approach), and target audience. An overall synthesis across all studies will be conducted.

Discussion: The findings from this research project will describe the ‘state of the science’ regarding the use of narrative storytelling and visual art as knowledge translation strategies. This systematic review will provide critical information for (1) researchers conducting knowledge translation intervention studies; (2) nursing, medicine, and allied healthcare professionals; (3) healthcare consumers, including patients and families; and (4) decision makers and knowledge users who are charged to increase use of the latest research in healthcare settings.

Keywords: Knowledge translation, Narrative, Research use, Storytelling, Systematic review, Visual art

Introduction
Storytelling [1] and visual art are powerful, ancient means of embodying and reinforcing socially shared significances [2], that can cut across age, culture, language, literacy, and gender barriers. Independently and together, storytelling and visual art have the potential to create shared, embodied understandings through imparting knowledge. One mechanism through which they may work is by attracting and sustaining interest, and engaging recipients in making meaningful connections [3]. More importantly, storytelling and visual art are highly accessible modalities that do not require specialized knowledge and skills to connect with or derive meaning from. Although recognized as an effective and engaging means of communication [4-6], storytelling and visual art have not been utilized to their full potential in the healthcare environment [6]; however, there is increasing interest in their power to motivate, communicate, heal [7-11], and engage with multiple audiences [12-15].
Best strategies to implement clinical pathways in an emergency department setting: study protocol for a cluster randomized controlled trial

Mona Jabbour¹,²,³*, Janet Curran⁴, Shannon D Scott⁵, Astrid Guttmann⁶,⁷,⁸, Thomas Rotter⁹, Francine M Ducharme¹⁰,¹¹, M Diane Lougheed¹²,¹³, M Louise McNaughton-Filion¹⁴,¹⁵,¹⁶, Amanda Newton¹⁷, Mark Shafir¹⁸,¹⁹, Alison Paprica²⁰, Terry Klassen²¹,²², Monica Taljaard²³,²⁴, Jeremy Grimshaw²⁵,²⁶ and David W Johnson²⁷,²⁸,²⁹

Abstract

Background: The clinical pathway is a tool that operationalizes best evidence recommendations and clinical practice guidelines in an accessible format for ‘point of care’ management by multidisciplinary health teams in hospital settings. While high-quality, expert-developed clinical pathways have many potential benefits, their impact has been limited by variable implementation strategies and suboptimal research designs. Best strategies for implementing pathways into hospital settings remain unknown. This study will seek to develop and comprehensively evaluate best strategies for effective local implementation of externally developed expert clinical pathways.
Discharge instructions for caregivers in the context of pediatric emergency care: a narrative synthesis protocol

Janet A Curran, Andrea Murphy, Mandi Newton, Roger Zemek, Lisa Hartling, Amy Plint, Jill Chorney, Shannon MacPhee, Samuel G Campbell, Mona Jabbour, Darlene Boliver, David Petrie, Randy Colwell, Kate MacWilliams and Alicia Nolan

Abstract

**Background:** The period following discharge from a pediatric emergency department (ED) can be a time of significant vulnerability for caregivers who provide ongoing care to their child when they return home. Discharge communication practice varies widely at the individual practitioner and departmental level. At present, there are no nationally accepted guidelines for discharge communication for children and/or their caregivers in the ED. The primary objective of this knowledge synthesis is to understand how and why discharge instructions work and under what conditions. We will also examine the contextual factors and barriers and facilitators associated with discharge communication across varied ED settings.
1 Needs Assessment

Goal:
Determine the needs & preferences for knowledge mobilization among our receptor communities:

• emergency healthcare professionals; and

• health consumers
Survey Data Collection (32 sites)

- 1,471 surveys of health professionals (57% response)
- 897 Healthcare consumers surveys
- Focus group data from 7 TREKK sites
Healthcare professionals (HCP): Who they are & their info sources

- **Physician**: 70%
- **Nurse**: 20%
- **Allied health professional**: 6%

HCPs’ device use at work to find new information:
- **Desktop computer**: 91%
- **Smartphone**: 51% (100% of residents)

# Healthcare Professionals – Info sources

<table>
<thead>
<tr>
<th>Source</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Talking to colleagues</td>
<td>82%</td>
</tr>
<tr>
<td>Specific medical/health websites</td>
<td>68%</td>
</tr>
<tr>
<td>Professional development opportunities</td>
<td>64%</td>
</tr>
<tr>
<td>Internet search engine</td>
<td>63%</td>
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<tr>
<td>Printed resources</td>
<td>61%</td>
</tr>
<tr>
<td>Academic journals</td>
<td>51%</td>
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<tr>
<td>Social media</td>
<td>13%</td>
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</table>

What They Need

Resources needed

- Protocols and treatments for common conditions
- Evidence-based info on new diagnoses & treatments

Clinical Conditions

- Multi-system trauma
- Severe head injury
- Meningitis
- CHD
- Sepsis
- Status Epilepticus
- Diabetic ketoacidosis
- Croup
- etc.

Preferred sources

- Professional development opportunities
- Printed summaries

Legend:

- 60-80%
- 40-59%
- 20-39%

Health Consumers

4 in 10 LOOKED FOR INFO BEFORE COMING TO THE ED

70% LOOKED FOR INFO ON SYMPTOMS

43% LOOKED FOR INDICATION OF SEVERITY

Talking To Trusted Professionals (68.7%)

Internet Search Engines (52.5%)

Talking To Family & Friends (50.3%)

Smartphones/apps (8.6%)

### Inputs from the needs assessment

#### Inputs led to the identification of 14 priority conditions

(% of healthcare professionals surveyed who wanted clinical information on each condition)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisystem Trauma</td>
<td>48.6%</td>
</tr>
<tr>
<td>Severe Head Injury</td>
<td>43.2%</td>
</tr>
<tr>
<td>Meningitis</td>
<td>39.2%</td>
</tr>
<tr>
<td>Congenital Heart Disease (1st presentation)</td>
<td>38.6%</td>
</tr>
<tr>
<td>Status Epilepticus</td>
<td>35.4%</td>
</tr>
<tr>
<td>Sepsis</td>
<td>31.5%</td>
</tr>
<tr>
<td>Diabetes Ketoacidosis</td>
<td>30.2%</td>
</tr>
<tr>
<td>Croup</td>
<td>27.4%</td>
</tr>
<tr>
<td>Asthma</td>
<td>27.1%</td>
</tr>
<tr>
<td>Intussusception</td>
<td>25.3%</td>
</tr>
<tr>
<td>Fractures</td>
<td>24.9%</td>
</tr>
<tr>
<td>Bronchiolitis</td>
<td>21.4%</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>17.9%</td>
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</tbody>
</table>

**Procedural Sedation** (focus group and network meeting input)

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Silhouettes designed by Flaticon.com
Sharing Needs Assessment Findings

How long have you worked in this profession?

TREKK site (N= 24)
Average: 15.3 years

All TREKK sites (n=1471)
Average: 12.9 years

Number of participants in this site = 24

Number of participants across Canada = 1471

May 2014
Prioritization

• Prioritization Committee
• Unperceived needs review

- Canadian Medical Protective Association
- Ontario Paediatric Death Review Committee and Deaths Under Five Committee Annual Reports
- AB province-wide system for facilitating consultation and transfer of patients to specialized centers
2 Mapping current evidence

Goals:
• Synthesize evidence for online resources on trekk.ca
• Develop user-friendly summaries
• Overview of SR – procedural sedation

Don’t re-invent the wheel!
Evidence Repository

- Bottom line recommendations
- Clinical practice guidelines, pathways, decision rules
- Systematic reviews and network analyses of primary studies
- Primary research: RCT, diagnostic and prognostic studies
TREKK Content Advisors....

Gastroenteritis

Sepsis

Croup & Asthma

DKA

Bronchiolitis
Status Epilepticus

Congenital Heart Defect (1st presentation)

Fractures

Concussion

Trauma & Severe Head Injury
Sharing Knowledge & Tools

Goals:
• Address priority needs identified
• Develop strategies adaptable to local context
• Learn from early work to adapt processes
Professional development

• Simulation-based training sessions – 4 provinces
• Face to face education sessions – 7 provinces
• Webinars
• Podcasts

95% of education session attendees plan to visit trekk.ca or contact TREKK for resources
Resource Repository: trekk.ca

- 24/7 access to evidence-based information vetted by TREKK team
- Responsive web design
- Extensive site audit and redesign over past year
- Have adapted look, content and usability features to meet needs of end-users
Diabetic ketoacidosis

Diabetic Ketoacidosis is a complication of new or existing Type 1 Diabetes. Pediatric DKA may be complicated by cerebral edema and due to this risk, is treated differently than adult DKA. Healthcare providers must follow a published pediatric-specific protocol when treating pediatric DKA. We have chosen 3 examples of such protocols: a general treatment algorithm from the Canadian Diabetes Association, a detailed treatment algorithm from BC Children's Hospital (English) and a detailed treatment algorithm from Centre hospitalier universitaire Sainte-Justine (French). Each pediatric hospital in Canada will have a protocol that they follow, thus early communication with the diabetes specialist at your pediatric referral site is a key element of the management of these patients.

Bottom Line Recommendations (5)

Clinical pathways or guidelines (3)  Overviews or summaries of systematic reviews (0)  Systematic reviews (4)  Key studies (9)

All (21)  Twitter 2  Google+  Facebook

Bottom Line Recommendations: Diabetic Ketoacidosis (2014)

Reid, S & TREKK Network

Recommendations de Base: Acido-cétose Diabétique (ACD) (2014)

Reid, S & TREKK Network

Bottom Line: Immediate Assessment and Management of Diabetic Ketoacidosis (DKA) in Children (2013)

Wherrett, D; Huot, C; Mitchell, B; Pachaud, D
**Recommandations de base : Commotion cérébrale**

La commotion cérébrale est un processus physiopathologique complexe qui affecte le cerveau et est provoqué par des forces biomecaniques traumatiques. La commotion cérébrale est le résultat de fortes accélérations et de décelerences qui peuvent être causées par un coup à la tête, au visage, au cou ou ailleurs sur le corps et dont la force impulsive est transmise à la tête. La perte de conscience et l’amnésie ne sont pas nécessairement les diagnostics de commotion cérébrale. La commotion cérébrale chez l’enfant est considérée comme une épidémie silencieuse. Plus de 3,8 millions de commotions cérébrales surviennent chaque année. On fait état de plus de 700 000 visites aux services d’urgence aux É.-U., rien que pour les commotions cérébrales chez l’enfant.

**Symptômes**
- Symptômes somatiques communs : maux de tête, nausées, perte d’équilibre et étourdissements
- Symptômes cognitifs communs : l’expression d’être somnolent, difficiles à se concentrer, confusion et distraction
- Des changements au niveau des émotions, l’émotion du comportement, ainsi que des troubles du sommeil, sont aussi possibles

**Évaluation de l’enfant qui présente une blessure traumatique légère au cerveau**

**Histoire**
- Evénement antérieur
- Symptômes
- Médicaments
- Histoire de la famille
- Histoire médicale
- Interventions précédentes : AINS, PGJ, SCAT3 (sauf documenté à la page 49, 51 et 52 du GDMPCH-C)

**Examen physique**
- Évaluation générale (humeur, pâle, comportement)
- Tests de démarche & Romberg
- Évaluation de l’équilibre avec le Balance Error Scoring System
- Évaluation ophtalmologique
- Évaluation neurologique

**Déterminer le besoin d’un examen par tomodensitométrie**
- Tomodensitométrie (TD) de la tête lorsque l’on soupçonne une blessure intracrânienne d’importance clinique (hématome épidural ou sous-dural)
- On peut systématiquement éliminer l’examen de la TD en utilisant le test PECAR
- Il ne faut pas utiliser une TD de la tête pour poser un diagnostic de commotion cérébrale car les symptômes d’une commotion cérébrale sévère sont causées par des perturbations fonctionnelles plutôt qu’une blessure structurelle évidente.

**Critères pour le retour à la maison en toute sécurité**
- Patients et parents/encourants devraient évaluer les symptômes les 24 heures
- En coordination avec l’avis clinique, il est suggéré que l’enfant ou l’adolescent soit à toutes visites à la maison si les conditions suivantes sont remplies :
  - État mental normal avec amélioration des symptômes
  - Pas de facteurs de risque qui indiquent le besoin d’une TD ou TD normale si déjà effectuée
  - Aucunes indications pour une observation prolongée à l’hôpital, y compris aggravation des symptômes, persistance des symptômes cliniques (nausée, maux de tête, etc.), troubles de sommeil, problèmes psychologiques ou symptômes cosmétiques

**Critères pour une hospitalisation ou une observation prolongée**
- Considérer une hospitalisation ou une observation prolongée si l’enfant ou l’adolescent présente des symptômes « alarmants » tels que :
  - Aggravation des maux de tête
  - Somnolence malgré un repos
  - Ne reconnaît pas les gens ou les endroits
  - Modification de l’état de conscience
  - Modification inhabituelle du comportement
  - Confusion ou irrationnel
  - Atteintes neurologiques focales
  - Faiblesse ou perte de sensibilité dans les bras ou les jambes

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In pediatric patients with Type 1 Diabetes, up to 5% of them may have Cerebral edema is associated with significant morbidity and mortality in response to trauma when compared to assessment and management of pediatric trauma.

**PEDIATRIC CONSIDERATIONS**

**ANATOMIC**
- Small body mass with large surface area, results in increased heat loss
- Proportionately larger and less protected solid organs

**PHYSIOLOGICAL**
- Increased metabolic rate leads to increased oxygen and glucose consumption
- Compensated shock is prevalent and often unrecognized in children under stress.

**DEVELOPMENTAL**
- Normal curiosity in young children and increased risk of head injuries
- Children are often fearful of trauma assessments and young, preverbal children.

**PEDIATRIC ATLS ASSESSMENT (KEY POINTS FROM AIRWAY WITH CERVICAL SPINE CONTROL)**
- Have pediatric equipment available (1/2 size higher)
- Blocks or sandbags with tape across the forehead are used

**BREATHING**
- Children have short breaths and are often intubated too early

**CIRCULATION**
- Be wary of tachycardia and signs of peripheral vasodilation
- DO NOT wait for the blood pressure to fall
- Warm isotonic fluids (NS or LR) should be administered uncorrected before shock should be assessed if hemodynamic stability
- Consider placing intravenous lines early after 90 seconds

**DISABILITY**
- In preverbal children, the Pediatric Glasgow Coma Scale (P-GCS) is used
- Check blood glucose in infants and young children to avoid hypoglycemia
- Address pain (appropriate analgesia) and anxiety (family presence)

**EXPOSURE**
- Keeping children warm after trauma is of critical importance
- Standard in pediatric trauma centers across North America
- Evidence demonstrates reduced stress on the family and patient.
Patient/Family Health Resources

• Work with parent advisory group to identify collaborative opportunities with community/parent organizations
• Links to useful websites
• Croup & asthma interactive storybooks
CROUP

Croup is an infection that is caused by a virus. It can cause swelling of the upper airway, including the windpipe (trachea), voice box (larynx) and vocal cords. This swelling can lead to a hoarse voice, barking cough and sometimes difficulty breathing. It occurs most often in babies and children up to 3 years of age because their airways are smaller, but older children can also get it.

Croup most often happens in the fall and winter months, but it can happen in any season.

Read a Croup Interactive Story  Find out more about Croup

SIGNS & SYMPTOMS

You might hear a high-pitched sound (sometimes as a harsh, vibrating sound) when your child breathes in – this is called stridor. Stridor can get worse when a child cries or coughs. If croup gets worse, your child may also have stridor while resting, and may have

- hoarse voice;

Classic symptoms of croup include:
COPING WITH CROUP

Start
All of a sudden Diane heard a strange cough and crying coming from her son's room. Every once in a while, three-year old Michael would awaken after a bad dream, but this time it seemed different. Diane could sense real fear in her son's voice.

Croup

Croup is an illness that affects a child's breathing. It is caused by many different viruses. It most often occurs in the fall and winter months but can happen in any season.

Croup symptoms most often happen in late evening and at night – it starts quite suddenly.
Michael's chest was sucking in deeply with each breath. Diane became scared but didn't want to show it.
Diane picked up the phone and dialed the health information number she had put on her fridge for health advice.

Health Links is a 24-hour, 7-days a week telephone information service that is staffed by registered nurses.

Call anytime
(204) 788-8200
or toll-free
1-888-315-9257
A nurse answered and asked questions to check if Michael needed emergency care.

- Has he stopped breathing?
- Has he fainted or passed out (unconscious)?
- Does he have bluish lips or fingernails?
- Does he appear very tired?
- If any of the above happens then you should call 911 immediately.
I learned so much during the visit. The nurse made sure we were using the inhalers properly and gave us tips on how to avoid Sammy’s triggers. She helped us create a step-by-step action plan to follow at home and gave me a bunch of information to read. Best of all, she used a model of the lungs to show us how the airways work and what happens during an asthma attack. It’s going to take time to process all of this information!

We’re going to keep in touch by phone. If all goes well, we will have our next appointment in six months.
Uptake

• Standards Committee reviews: NWT and MB
• Trekk.ca on ED desktops – AB and MB
• Curricula: BCIT
• Local conferences
• CAEP Review Course
• System changes: equipment, medicines
• Downloads
• Partnerships
2014: Social Network Analysis
17 isolated sites

2014
2015

3 isolated sites
Keys to Success

Context

• **Culture** – value learning, innovation, patient-centred approaches, face-to-face methods

• **Supportive leadership** – clear roles, organizational structure, management, communications

• **Evaluation** – routine evaluation and feedback (e.g. focus groups, meetings, surveys, web metrics)
Keys to Success

Facilitation

• Knowledge broker
• Local coordinators
• Clinical champions
• Content advisors
• Management team
• Strong partnerships
Impacts

Only national network addressing emergency care for children in general EDs

Rich data set of knowledge needs & preferences

Improved pediatric emergency care in Canada
Questions?