Volume 3, Issue 1 June 2010

Welcome to the newsletter for the CaPSNIG (Canadian Pediatric Surgical Nurses Interest Group)

Purpose of the CaPSNIG is to network and exchange information.

There is no cost to join the CaPSNIG group. To join the list, please send a brief email to kimberly.colapinto@sickkids.ca and confirm whether or not you wish to remain a member.

Make sure to include your full name, hospital/employer, area of expertise,
and preferred email address.
Please let us know if it's okay to share your email address with the rest of the group, since each hospital in Canada have different communication channels and confidentiality rules.
Kimberly Colapinto RN(EC) MN, Nurse Practitioner General Surgery

Our new logo is presented in this newsletter. Lida Jones from MCH in Hamilton, ON won the design competition. From the original the graphic design was done by Karen Patel at Studio Five Three www.studiofivethree.com

September will soon be here!

September 23 ,2010

There is no fee to attend our one-day educational meeting. However, we still require **confirmation of your attendance for catering and space purposes.**

Nurses also have the option to register for The Canadian Association of Pediatric Surgeons (CAPS) Annual conference slated for CAPS Sept 23-26 2010 at the Delta Bessborough Hotel
For further details regarding registration fees and scientific agenda, please visit CAPS website at www.caps.ca.

Please note ……
We are meeting at Earl's Restaurant at 6:30pm on Wednesday September 22nd for dinner. It is located at 610 2nd Ave N. 306-664-4060.
RSVP kimberly.colapinto @sickkids.ca

Canadian Pediatric Surgical Nurses Interest Group
Annual Meeting September 23, 2010

Saskatoon City Hospital
701 Queen Street
Room 1932
Saskatoon, Saskatchewan

Agenda

9:00am – 10:00am *Business Meeting Breakfast* (members only)

10:00am – 10:30am *Welcome*
Kimberly Colapinto – Chair CaPSNIG

10:30am – 11:00am *Coffee and Icebreaker*

11:00am – 11:30am *Bowel Management in Hirschsprung's Disease*
Kimberly Colapinto

11:30am – 12:00am *Finding the Evidence: An Introductory Guide to the Medical Literature*
Julia Pemberton

12:00pm – 1:00pm *Lunch*

1:00pm – 1:30pm *The Kasai Procedure*
Bela Dharia

1:30pm – 2:00pm *How to Develop and Use Clinical Pathways in the Workplace*
Monping Chiang

2:00pm – 2:15pm *Coffee Break*

2:15pm - 2:30pm *Does 2% Chlorhexidine Decrease the Rate of Post Pyloromyotomy Wound Infection? A Nurse Led Quality Initiative*
Kimberly Colapinto

2:30pm – 3:00pm *Establishing Guidelines to Streamline Care of the Infant/Child with Intestinal Failure*
Karen Lang and Christina Kosar

3:00pm - 3:30pm *Family Centered Care and Consumer Expectations: Where are the Boundaries?*
Deb McKeown

3:30pm-4:00pm Evaluation & Closing Remarks

Clinical Connect

Question
I am starting up a project for improving teaching to patients/families & nurse in our hospital for the "Low Profile Gastrostomy Devices"
Who does teaching re care and insertion to families /patients in your hospital? (units and clinics) and how many are responsible? What kind of device do you mostly use? Which clinic is responsible for initial insertion of device? What kind of teaching material i.e. policy & procedures pamphlets is available? What do you find work best for teaching families? What do you find works best for teaching of nurses? Is there a person/department responsible for creating material? Is there a plan for keeping up skill i.e. insertion? Who handles initial funding for families? Who gets consulted for GT issues (ie peristomal site leakage, sizing etc.)
Lise Beadow RN
Ottawa, Ontario

Answers
This is a very brave project! It sounds like you are having all the same issues that we are. I will try to answer your questions in sequence but will include initial tubes as well as low profile devices. We, too, are trying to formalize the whole "Enteral Program" but with budget cuts, shortage of staff, crossing different care teams, etc, etc we seem to be spinning our tires so I would be very interested to follow along with you.
Gail Creelman
Halifax, Nova Scotia

We have our G-tube resource nurse do the button teaching and insertion. The NP is available to put in buttons when covering for Julia. Mickey button. Smallest size is 12 Fr. GI Clinic is the main clinic and the GT nurse has her own G-tube Issues Clinic within this where she puts in buttons. There is limited written material on the button that we give to parent's. The nurse teaches the family for ~45 minutes about care of the button after she puts it in. We have a G-tube booklet that each family get's at the time of the primary insertion (Mac-loc style tube). It covers a small amount of information on the button. One to one teaching after the button has been inserted. Allowing the family to touch the button, attach the adapter, and play around with filling the balloon. We generally don't teach the nurses to insert buttons as they don't have the medical directive to do so. The GT nurse will do education with nurses around skin care and granulation tissues etc. Material is created by the nurse and NP re: G-tubes and G-tube care. The nurse does more teaching about buttons and mentoring the new NP through technique, skin care and treating infections. The nurse or NP will be consulted. If there are ongoing issues, we will involve the radiology department as they put in the initial G-tube.
Kim Milbury
Toronto, Ontario

I see them in the surgical clinic or as inpatients on the units. Unit nurses then reinforce the information. Mickeys, and there is 1 surgeon who inserts PEGs. Surgeons will do most of them. Sometimes radiology will insert tubes if surgery is not the best option or will be too delayed. They usually start off with a Cook Catheter type of tube and then convert it to a Mickey later. There is a manual for families as well as a website. There are also some policies and procedures available for staff. I also prepare a patient teaching flowsheet for the patient which the unit nurses then expand

upon and reinforce. A DVD is also in the midst of being finished. I have a kit with the various different tubes and I do a show and tell with the families and demonstrate things like tube reinsertion etc. They seem to like this hands on approach. The manual is also great but is quite lengthy. Also repetition of the information is great. I have done inservices in the past and attended teaching days. However turnover of nurses tends to be quite quick. I have pondered doing a travelling road show but have not started it yet. I also do some internship days with nurses. I will admit that sometimes it is hard to convince staff that teaching re. GTs is a joint responsibility. We have a manual that was created long ago and it is updated as needed. I am sometimes asked for information- developing policies and procedures, but another department actually creates them. It is mostly myself that does them so I have a constant opportunity for practice. Most of the families I see are already covered by a funding source when I see them. If they are not they are directed to the Social Worker of the department or program the child is followed by (eg. Renal, Oncology etc.) I get consulted for GT issues.
Christine Adamson
Vancouver, BC

Question
We are looking at the way we decide on whether or not a child will be placed in a bed, a crib, or a crib with a dome upon admission. I wonder if any of the members have specific criteria for their sites that they might share. I know that Safe Kids Canada recommends that a healthy child move to a low bed when they are about 90cm tall or appoximately 2 years old. We use this as a general guideline but the child's developmental stage plays a significant role as well so we are looking to elaborate.
Debbie Meldrum
Quebec, Canada

Answers
Here in Ste-justine's Hospital we use these recommendations from UCSF Children's Hospital. They recommend a crib for children <3 years old.
You'll find in attachment a poster who explains their strategy to prevent falls in pediatric settings (please contact Stephanie for copy of the poster).
Stéphanie Duval
Montréal, Québec

I just did a search for our sleeping guidelines and nothing formal exist. Sick Kids in currently reviewing the data and will be coming out with a policy/guidelines for patients and their sleeping arrangements, however there is no time line of when this will get approved.
Monping Chiang
Ontario, Canada

Please be advised that CHEO has developed a Safe Sleep Policy (please contact Brenda for a copy)
Brenda Martelli
Ottawa, Ontario

Question
Has anyone ever heard of using, or actually used, Preparation H for hypergranulation tissue?
Gail Creelman
Halifax, Nova Scotia

Answer
I have never heard of this. I would think the
preparation H would keep it moist which causes
hypergranultaion
Theresa Allan
Toronto, Ontario
I do not have any experience with this either.
Christine Adamson
Vancouver, BC

Question
We are updating our pyloric policy and wondering if anyone has a current one they are willing to share. There is a lot of discussion around feeding of post-op pylorics and wondering what everyone else in doing.
Gail

Answer
We have a clinical practice guideline at the Hospital for Sick Children (please contact Ping for a copy)
Monping Chiang
Toronto, Ontario

Question
1. What is your patient – staff ratio for patient with epidurals for post-op pain control?
2. What is your patient – staff ratio for patients with ketamine and fentanyl infusions or ketamine and morphine infusions?
Lyn Seward
Winnipeg, Manitoba

Answer
The response for McMaster Children's are the same 3:1 post op PCA/epidural question two patients requiring those meds would most likely be in the PCCU.
Deb McKeown
Hamilton, Ontario

All of these patients would usually be immediately post-op so there acuity may vary. As far as I know we do not have any P&P or guidelines related to these infusions and staff ratio, however we do have monitoring guidelines related to the medications.
1. What is your patient – staff ratio for patient with epidurals for post-op pain control? Usually 3-1
2. What is your patient – staff ratio for patients with ketamine and fentanyl infusions or ketamine and morphine infusions? Usually patients on Ketamine and fentanyl infusions have high needs anyhow so would be on a 2-1 or 1-1, however these medications are rarely run on the floor. Morphine infusions we use quite frequently and patients are on a 3-1 assignment.
Kim Colapinto
Toronto, Ontario

Our ratio at the IWK would be post op (new) infusion 3-4 patients to 1 .This being said the other 3 patients would be in the same area and would be stable more predictable patients.. Our assignments

totally depend on the acuity of the patients if need be because of patient condition we would be 2-1 or 1-1, if this is what was needed. This would be the same for morphine infusions. There has been a few times where a nurse has had 2 morphine infusions these would have been post op a few days and because this was the best we could do at the time.
Jayne Fryday
Halifax, Nova Scotia

Question:

I was hoping you may be able to assist me in either providing me with your facility practice for spinal precautions or connect me with an appropriate person. I am presently revising our current standard physician order sheet for spinal precautions. I am interested in what your practice is. We have always been "all or nothing" (bed flat, no pillow, cervical collar, turn q2h). I have great difficulty with adult residents wanting to let children walk around with a c-collar because they cannot clear them clinically (although cleared radiologically), or ER sending kids up in a wheelchair. Could you tell me what your practice is for admitting children who have a suspected spine injury / not yet cleared. I have attached our present sheet for interest.

Cindy Holland, Winnipeg

Answers:

These are the general principles NOT a detailed algorithm. If the mechanism of injury doesn't involve the face or chest we use the following for c-spines:
1) Radiographically clear with AP/lat films
2) Remove cervical collar and check a) by palpation for spasm/tenderness b) by active ROM for spasm/pain If normal, then flexion and extension views. If these are normal, then considered clear. Some may not do flexion/ext views if no other symptoms.
3) If there is pain or spasm, they are left in collar until a later date, when pain settles then flexion and extension views would be done.
VARIABLES: If pt. is unconscious, has decreased LOC or is unreliable pt.
Mostly done in ER as well except if they come back with a collar to outpatient clinic or are admitted to ward

Cory Savitsky British Columbia

I have attached our ACH Spinal Immobilization Guidelines that we developed here and also the TAC Sub-Pediatric Groups' DRAFT Spinal Clearance Pathways for both reliable and unreliable patients. I have also attached our Regional Logrolling policy that we use here at the ACH as well as the aspen collar guideline. The TAC group is publishing this draft pathway in conjunction with most of the pediatric centers across Canada. If you are interested in trialing it at your center as well, let me know and I will give you the contact person in Toronto that is heading it up. There is no start date yet as we are just waiting to get these algorithms back from graphics. We have been working on this pathway since TAC meeting in Ottawa in 2007 so it has been around the bush with every center ortho/neurosurgery/ED etc many times.

Sherry MacGillivray, Alberta

2007 St John's NFLD

2008, Toronto, ON

Halifax, NS. 2009

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CANADIAN PEDIATRIC SURGICAL NURSES INTEREST GROUP
EST. 2005