Volume 4, Issue 1 January 2011

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 logo presented in this newsletter was selected from entries and converted to a graphic design by Karen Patel at Studio Five Three www.studiofivethree.com

Ping Chiang has volunteered to be co-chair, along with Kimberly Colapinto. Ping will need a partner in for September 2011 when Kimberly's term is completed. Please consider serving with as co chair. Contact Kim for more details.

Call for Oral or Poster Presentations
2011 CaPSNIG Conference

This is the call for abstracts for the 7th annual meeting of the Canadian Pediatric Surgical Nurses Interest Group (CaPSNIG) to be held September 22, 11 in Ottawa, Ontario.

Everyone submitting an abstract must complete all information requested. After the form is completed and sent, you will receive confirmation via email that you submission has been received.

Eligibility
Abstracts for presentation are welcome in any subject in clinical and experimental pediatric general surgery including interesting cases, research outcomes, and tips in management of challenging cases.

Deadline
April 15th, 2011

Criteria for Abstracts:
1) Length is limited to 300 words, single-spaced, 10 pt, Arial font.
2) Include authors name and credentials, title of position and institution, contact information, and a brief biography.
3) Specify if you are applying for oral or poster presentation.
4) Specify the abstract category you are applying for (i.e., Practice abstract, Case study abstract, or Research abstract)
5) The format outlined below should be utilized

For Practice Abstracts

1. Background: Include a description that identifies the problem and need for the practice change or innovation.
2. Objective: Clearly state the objective for the practice innovation.
3. Outcomes: Describe the outcomes. Indicate the key measures or indicators used to evaluate the outcomes.
4. Conclusion

For Case Study Abstracts

1. Statement of Clinical Problem: Articulate clearly the clinical problem relevant to pediatric surgical nursing. Include relevant clinical data such as age, gender, primary related diagnosis, and relevant comorbidities.
2. Description of Past Management: Include a description of the duration of the clinical problem, past management approaches, and patient response.
3. Current Clinical Approach: Describe the changes made to the management plan along with a rationale.
4. Patient Outcomes: Describe the patient response including time frame for response, objective and subjective data.
5. Conclusions: Identify clinical implications along with limitations.

For Research Abstracts
1. Background: Provide context/background to the need for the study and the significance of the problem
2. Research Question/Purpose

3. Methods: Describe the study design and data collection, including number and characteristics of subjects studied and the strategies used to recruit them. What are the outcomes measures?
4. Results
5. Implications for practice and conclusion

Notification
The authors will be informed of the status of their submission by May 16th, 2011.

Categories
Oral presentations will be 20 minutes in length.
Poster authors or designees must be present with the poster during meeting and prepared to give a 5-10 minute oral presentation of the poster.

Format
Presentations must be in Powerpoint format.
Presentations must be submitted to Monping Chiang on CD or memory stick on September 22, 2011.

Presenters are responsible for conference fees, lodging and travel.

Please submit abstract by April 15th, 2011 to:
Monping Chiang
monping.chiang@sickkids.ca

Clinical Corner

Question:

What solutions are you using to irrigate PICC lines? If heparin is not available what else would you use? How often does irrigation occur? Our hospital is presently using normal saline because of a backorder on heparin.

Answer:

“Our policy is heparin daily for line maintenance when locked for PICC line. You could try NS but TID would be recommended frequency since it’s what we use for locked PIV’s. Another thing to remember is to lock while still flushing to give you some negative pressure, to prevent the line from backing up and having blood in the lumen.”

“We have been locking peripheral lines with NS q 8hrs successfully for many years. Only when the line is accessed q 24 hrs do we use Heparin. I think the key is the turbulent flush with NS prior and the proper manual technique of positive pressure locking. It is important to clamp as the last 0.5ml is being infused to ensure positive pressure at the distal end of the catheter. For all other types of lines, we use Heparin at the same concentration but in different amounts and frequency of flushing.”

Question:

Perry and Potter suggests a "sterile Petrolatum impregnated occlusive dressing" to cover a chest tube site in emergency if tube was accidently removed. Is there such a dressing and what are other folks using? In this population waterproof tape is not a good option.

Answer:

“Our practice is a vaseline gauze over the site and Tegaderm dressing on top. Stays on for 72hrs then regular band aid is fine over the site. We have chest tube 'kit' that has emergency supplies with the patient at all times.”

“We use jelonet 2x2 or 4x4 then hypafix and remove 72 hrs later.”

Question:

What type of ID do your student nurses need when they come to your facility? If they need card access to areas such as the med room do they all get picture ID's when they come or do you have access cards that you use specifically for the students?

Answer:

“Any student or visitor we have has to have a photo ID badge. Their names and titles with the department they are affiliated with are visible. They get access to areas as per their status and needs during their time with our institution”

“We have the same policy requiring ID for the hospital access relevant to their clinical area.”

“The students here get a photo ID as well. As far as access is concerned, we have the numbered button door locks on our med rooms etc.”

“At our institution the students wear their college/university ID as identification.”

Question:

Our cecostomy population is aging, and I am interested in how other centers are either managing, or wanting to manage this patient population as they are ready to be transitioned to adult care. Currently we have a surgeon in the adult population who will follow the adult patients with cecostomy tubes, but there is no nurse attached to the clinic, and therefore no assistance for common complaints and concerns with leakage, long flushing times etc.
I would like to have a sense as to who else I can brainstorm with for other challenges I have as well. And if you are successfully transitioning adult patients with cecostomy tubes, I would love to hear what steps you took!

Answer:

“We do all the initial cecostomies here and most of the trapdoor replacements. The Spina Bifida population is gradually being transitioned and having their trapdoors replaced by a radiologist in the adult hospital. This is facilitated by the Adult Urology Clinic Nurse. As far as I know there is no surgeon attached to this process. As for the other Cecostomy patients who are adults now transition is not happening, although we are in negotiations with a GI physician and a surgeon. As of yet there is no surgeon willing to take on the initial process.”

“I follow all of our patients with cecostomies, and am responsible for their teaching and ‘trouble-shooting’ etc. We too are facing the transition to the adult ‘world’. There is a surgeon in the adult population who has agreed to take them on. We have actually transitioned 4 or 5 patients over the past 2 years. I don’t think there is a specific nurse attached to the adult clinic here, either. I did send some information on to the Patient Care Coordinator for the Outpatient Clinic when we first transitioned a patient.”

Question:

Could you please advise what your various institutions suggest for treatment of hypergranulation tissue around g-tubes? We are currently looking at revising our practice.

Answer:

“We use silver nitrate application- usually once a day as needed for no longer than 14 days. Alternatively we use Triamcinolone 0.1 % cream applied TID for 7 days.”

“We use silver as well. Or if it is a circumferential flap with a narrow base I ligate it with a suture/tie as it cuts off bloodflow & falls off. “

2007 St John's NFLD

2008, Toronto, ON

Halifax, NS. 2009

Saskatoon ,SK. 2010