Volume 6 , Issue 1 Feb, 2013

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 monping.chiang@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.

Monping Chiang RN (EC) MN, Nurse Practitioner General Surgery
Hospital for Sick Children
monping.chiang@sickkids.ca

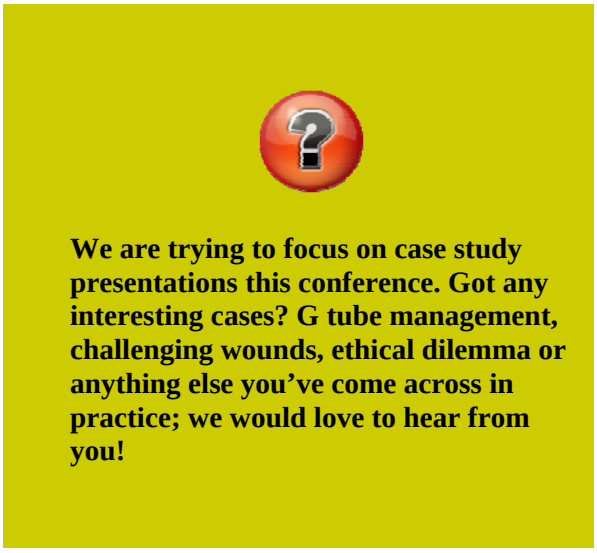
Annual Meeting September 25, 2013

Charlottetown, PEI

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

Please confirm attendance by **August 31st, 2013** to monping.chiang@sickkids.ca

Nurses also have the option to register for The Canadian Association of Pediatric Surgeons (CAPS) Annual Meeting www.caps.ca
September 26-28
Charlottetown, PEI



We are trying to focus on case study presentations this conference. Got any interesting cases? G tube management, challenging wounds, ethical dilemma or anything else you've come across in practice; we would love to hear from you!

Call for Oral or Poster Presentations
9th Annual CaPSNIG Conference

This is the call for abstracts for the 9th annual meeting of the Canadian Pediatric Surgical Nurses Interest Group (CaPSNIG) to be held **Wednesday, September 25, 2013 in PEI**.

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. **We are trying to focus on case study presentations this conference. Got any interesting cases? G tube management, challenging wounds, ethical dilemma or anything else you've come across in practice; we would love to hear from you!**

Deadline
April 12th, 2013

Criteria for Abstracts:
1) Length is limited to 300 words, single-spaced, 10 pt, Arial font. (separate word document)
2) Include authors name and credentials, title of position and institution, contact information, and a brief biography. (attached form, separate from abstract document)
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 13th, 2013.

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 Christina Kosar on CD or memory stick on September 25, 2013.

Presenters are responsible for conference fees, lodging and travel. Please go to the CAPS website for further information (www.caps.ca)

Please fill out demographic form (available online at www.caps.ca) and submit abstract by April 12th, 2013 to:
Monping Chiang (monping.chiang@sickkids.ca)

CLINICAL CORNER

Question:
I was wondering about medication administration on the medicine/surgery units. Once a nurse has transcribed an order and the second nurse verifies, do nurses from then on, use the medication administration record (MAR) to give meds or do they go back to the original order each time??
This is our practice and I am wondering if it is beyond what is necessary??
Also if nurses do use the MAR for med admin once the transcription has been confirmed, do they check the orders at the beginning of the shift, or rely on the MAR only. Our adult counterparts use MAR only and this is their recommendation to us, but I wanted to see what other pediatric facilities are doing.

A: At Sick Kids, all our orders are computerized on the med/surg units. NO more transcriptions and no more MARS sheets

A: I too work at SickKids...the NICU and CCU/PICU are a bit behind regarding computerized medication orders and we still have order sheets and a MAR. The RN's are responsible to check the medication order in the chart/doctors orders, and sign on the MAR. All medications are double checked in the NICU against the medical order in the chart and not against the MAR each time. The quality management team promotes checking with the primary source only (the doctor's order) and avoid secondary sources (e.g. MAR) as there is a risk of transcription error. THis step forces the RN to go back to the chart to determine if any changes have been made (particulary if she has hot been made aware of the changes by the physician/delegate). The electronic system removes much of this risk.

A: At Winnipeg Children's we still have written orders and paper MARS. The nurse uses the MAR for creating their work list of drugs for the shift, giving the med and signing the med. When an order is written the clerk transcribes the order on the MAR. A nurse must check the transcription and co-sign the MAR. At the beginning of each shift the nurse checks the MAR with the orders to ensure they are all inclusive and correct (nothing has been missed). There should be no need to use the chart order each time a med is given. This isn't really practical when the chart could be with anyone and difficult to find. (students, therapists, residents, myself…use the chart). This would lead to delays in administration not to mention frustration of the nurse. The MARS on the sx floor are kept in a wall file holder in a locked med room. It's always quick and easy to find the MAR. If the order is double checked for accuracy it doesn't make sense to use the orders again. Can't imagine having to run through pages and pages of orders looking for something! Anyway, that's my 2 cents.

Question:
I am writing to ask about your practice in caring for post operative adenotonsillectomy patients. This is in relation to the evidence of risks with the use of codeine.
Do your physicians prescribe codeine?
If so what is the usual dose?

If so, what are your monitoring criteria?
If not (ie Sick Kids where apparently it has been removed from the formulary), what is prescribed to replace codeine?
If codeine has been removed and NSAIDS used instead, have there been any noted increases in complications?
I would greatly appreciate any information on this from anyone involved with this patient population.

A: Victoria General Hospital has moved away from the use of Codeine for all post-op tonsils and adenoids patients.

A: I used to work on the ENT surgical floor at SickKids. All of our post op T&A patients would be prescribed PRN Tylenol and PRN morphine (if the Tylenol wasn't enough). If they were OSA patient's, they would only have a half-dose morhine PRN order.

We would have special monitoring guidelines if using IV morphine, but for oral, liquid morphine, no special monitoring used (although would generally keep a closer eye on the patients for the first dose). OSA patients would be in a constant observation room anyways with continuous O2 sat monitoring. We generally would use oral, liquid morphine, not IV.

We would generally avoid NSAIDS due to risk of bleeding.

From my experience, the Tylenol would work pretty well, and the kids would usually only need a couple PRN doses of the morphine.

I left this unit in June for the CCCU so I am not sure if anything has changed. Morphine seemed to be a great alternative (we never use codiene), and is safe to use when dosed appropriately.

A: IWK DOES NOT USE Codeine for T&A OR Ads . Tylenol and Morphine

A: Up until a few years ago, all out patients having a Tonsillectomy would be ordered Tylenol with codeine elixir post-op. While there is still some ENT surgeons who order this, some are starting to order plain Tylenol. We have found the children often do just as well as those receiving the codeine, without the side effects. We do not see morphine orally used for Tonsillectomies.

A: I'm sorry I don't know what we do for T&A's – I've forwarded this to our surgical nurses. As for General Surgery, we have not yet removed codeine from our surgical floor and we still often order T 3's. I'm wondering what the other gen sx people doing on the floor? What are you sending them home with? Most of our surgeons don't have a triplicate script for narcotics. T3s was easy as it required a generic script form. Thank you in advance.

2007 St John's NFLD

2008, Toronto, ON

Halifax, NS. 2009

Saskatoon, SK. 2010

Ottawa, ON. 2011

Victoria B.C. 2012