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

The purpose of CaPSNIG is to network and exchange information among pediatric surgical nurse and allied health.

There is no cost to join the CaPSNIG group. To join our group, please send an email to monping.chiang@sickkids.ca

Make sure to include your full name, hospital/employer, area of expertise, and preferred email address.et us know if it's okay to share your email address with the rest of the group, since each hospital in Canada has different communication channels and confidentiality rules. For more information about CaPSNIG, email Monping or Kim. You can also visit the CAPS website https://www.caps.ca

10th Annual CaPSNIG Meeting
September 18, 2014

CHU Ste. Justine
Room-Marcelle Lacoste, 9th Floor
Montreal, Quebec

Please email Monping if you are planning on attending the CaPSNIG meeting by August 29, 2014. See meeting agenda below. There will be a fee of $25 for late registration.

Nurses attending CaPSNIG's annual meeting also have the option to register for The Canadian Association of Pediatric Surgeons (CAPS) annual meeting September 18-20, 2014 at Montréal Marriott Château Champlain.

Meeting and hotel registration are open! Please visit the website menu links under Annual Meeting for online registration and the link to the hotel reservation. https://www.caps.ca

Annual Nursing Dinner

Those attending the annual meeting are invited to join the nursing group for dinner the on Sept 17th at 6:30pm at **Modavie**
1 Rue Paul, Vieux-Montreal
Please email monping.chiang@sickkids.ca if you can attend so reservations can be made.

CLINICAL CORNER

Question:

How does your program deal with direct admissions vs. patients going to the emergency department?

Answer:

- At our hospital if a patient is in a community office and stable and there has been MD to MD communication then they will come to our unit as a direct admission. If the patient is being seen in another emergency room outside of our hospital then they will most likely come to our emergency for assessment/diagnosis, then will be admitted to our unit. If the patient has been admitted to another hospital and must come to our hospital, our emergency wants these patients to go direct to the unit. However our unit wants them to go to emergency and then be admitted for there.
- We will only do direct to our surgical unit if the patient is admitted as an inpatient at another institution. All other patients get assessed in the ER first and then consulted as appropriate.
- Direct to the unit occurs if the patient is an inpatient at a different institution. However, if the child is at a different ER and they have a confirmed surgical problem, the ER will consult our surgeon and the patient will be transferred to the ER direct to us. We will see them in the ER and devise a care plan from there. All other patients have to come to ER and be assessed by the ER physician, and then consultation occurs as appropriate.
- We transfer between hospitals as a direct to the admitting unit. If the patient is coming from a community office these children always go to the emergency department. Children from our hospital outpatient clinic can be admitted to the unit as direct.
- Our surgical unit takes patients directly from other inpatient units and from our own surgical outpatient clinics, otherwise the patient must go through emergency.
- Direct admissions from pediatrician's offices can only occur once the pediatrician has faxed in physician orders as the on-call pediatrician and residents/clerks are not always able to see and assess the direct admissions in a timely manner. Admissions from community hospitals for higher level of care are not admissions but transfers, and are admitted directly to the pediatric unit. ER patients at other hospitals may be transferred to our emergency for further assessment to see if admission is needed or not.

Question:

What is your practice for providing enteral feeding after tracheostomy?

Answer:

- We orally feed babies with tracheostomies whenever possible. We make our decisions to orally feed based on the reason why the baby required a tracheostomy. If medically and developmentally appropriate we will start a baby on oral/bottle feeds before a feeding study in an effort to prepare them for the study. We start very slowly, and have on rare occasions used dye/purple juice tinged milk in an effort to see if milk is being suctioned from the ET tube. We generally only feed babies who do not require ventilation.

Question:

I am working on overhauling our tube feeding at home manual. I am wondering if other centres would be willing to share copies of the patient/family education resources they are currently using for gastrostomy/jejunostomy feeds?

Answer:

- If you Google "Home Enteral Feeding Guidebook" http://infotheque.muhc.ca/Files/22/2226en.pdf you will find the new guide we are using.
- Attached are our latest teaching booklets from our hospital (please email Monping for a copy).
- Our enteral feeding program is accessible through our public website www.iwk.nshealth.ca, choose Children's Health on the top bar, then resources on the drop down menu, and search for enteral feeding. The first on the list should be Home Care Tube Feeding Learning Package: Enteral Feeding.

10th Annual Meeting September 18, 2014

CHU Ste. Justine, Montreal
Room-Marcelle Lacoste, 9th Floor

7:00-7:45 am	CaPSNIG business meeting-*members only* *Breakfast will be served*
7:45 – 8:00 am	Welcome & Introductions CAPS President-Dr. Jack Langer *Monping Chiang & Kimberly Colapinto – Chair CaPSNIG*
8:00 – 9:00 am	Intestinal Atresias (*Dr. Pavan Brahmamdam*)
9:00 - 9:30 am	Coffee Break
9:30 - 10:15 am	Is Another's Breast still the Best? The experience of Using Donor Breast Milk in Surgical Infants (*Hazel Pleasants*)
10:15 - 10:30 am	Promoting Safe Administration of Expressed Breast Milk: Systematic Exploration of Errors in EBM Administration and Strategies for Prevention (*Maria Manalo*)
10:30 - 10:50 pm	Case Study for the implementation of a protocol for managing GT dislodgement (*Cindy Holland*)
10:50 - 11:50 pm	Lunch-*open discussion for interesting cases*
11:50- 12:50 pm	1.Doing Research. Ethics, Quality & Reality met in Pediatric Clinical Research *(Eveline Lapidus-Krol)* 2. SHiKT: Integrated knowledge translation used to identify confidence in management of challenges faced by caregivers of Hirschsprung's Disease *(Kendall Hobbs-Murison)* 3. Family Health Literacy Levels and Patient In-Briefs: How Pediatric Surgery Nurse Practitioners can Communicate More Effectively in a Clinic Setting *(Julia Pond)* 4. Pregnancy urinary screening policy development and implementation in CHU Sainte-Justine *(Stephanie Duval)*
12:50 - 1:00 pm	Closing remarks **CAPS conference**

This meeting was made possible by the generous donation of CAPS. Please thank your surgeons!

CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
ASSOCIATION CANADIENNE DE CHIRURGIE PÉDIATRIQUE

Charlottetown, PEI 2013.