Volume 8, Issue 2 Summer 2015

Welcome to the newsletter for CaPSNIG

(Canadian Association of Pediatric Surgical Nurses Interest Group)

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

It provides a forum to ask questions, share ideas, and discuss new initiatives via email.

Our annual meeting provides a forum for presentations offering educational opportunities and networking as we share ideas.

There is no cost to join CaPSNIG. To join our group, please send an email to monping.chiang@sickkids.ca. For more information about CaPSNIG, please check out the website at www.caps.ca

REMINDER:

11TH Annual CaPSNIG Meeting
Thursday September 17, 2015

47TH Annual CAPS Meeting
September 17-19, 2015
Both at the Marriott Gateway on the Falls
Niagara Falls, ON

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CONFERENCE INFORMATION:

The 11th Annual CaPSNIG Meeting is fast approaching. It will be held at the Marriott Gateway on the Falls, Niagara Falls, ON, Thursday September 17, 2015. There is NO FEE to attend. This is a great forum for nurses and allied health to get together to review latest pediatric surgical issues and advances in practice. See meeting agenda on next page.

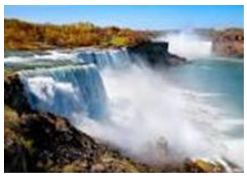
If you wish to register, please email Ping at monping.chiang@sickkids.ca.
Last day to register will be September 4, 2015. There will be a late fee of $50 if not registered.
Conference information and agenda to be available on CAPS website shortly.

SOCIAL EVENT – CaPSNIG Nursing Dinner

Wednesday September 16 (evening before CaPSNIG meeting)
Time and place TBD based on group size
Please RSVP to Ping

The 47th Annual CAPS Meeting be held September 17-19, 2015, also at the Marriott Gateway On The Falls.

General conference information and hotel registrations are open and are available through the website at www.caps.ca. Early bird is available until August 14.



SAVE THE DATE: International Congenital Diaphragmatic Hernia Workshop:

September 14-15, 2015 in Toronto (prior to CaPSNIG/CAPS meeting)
Visit the website provided for more information:

http://www.cvent.com/events/international-congenital-diaphragmatic-hernia-workshop-from-patient-to-bench-to-bedside-to-the-futur/event-summary-e3552025d9fd49f78829a876beffb593.aspx?i=4bd535c2-29ec-4b2c-8864-574bd839f001

11th Annual Meeting September 17, 2015

Niagara Falls Marriott Gateway on the Falls
6755 Fallsview Boulevard
Room TBA

7:00-7:45 am	CaPSNIG business meeting-*members only* *Breakfast will be served*
7:45 – 8:00 am	Registration
8:00 – 8:30 am	Welcome & Introduction of CAPS President - Dr. Peter Fitzgerald *Monping Chiang & Kimberly Colapinto – Chair CaPSNIG*
8:30 - 9:30 am	Education session-TEF/EA management: Toronto to Rotterdam *M. Chiang & N. van Beelen*
9:30 - 10:00 am	Coffee Break & Mingle
10:00 - 10:30 am	GIFT program introduction - *C. Kosar* Long-Term complications in the paediatrician intestinal failure population - *C. Kosar*
10:30 - 10:50 pm	Long term management challenges of intestinal failure patients - *K. Steinberg*
10:50 - 11:30 pm	Constipation Management - *K. Colapinto*
11:30- 12:30 pm	Lunch *Discussion of interesting cases*
12:30 - 1:30 pm	1. Growth retardation in patients with esophageal atresia - *N. van Beelen* 2. Blenderized table food: an alternative to traditional commercial formal for enteral tube feeding - *B. Haliburton* 3. Ins and outs of adolescent bariatric surgery - *S. Lira*
1:30-1:50 pm	1. Trials with Trials: Challenges faced in performing randomized trials in neonates - *E. Lapidus-Krol* 2. Advancing Knowledge and Practice in Pediatric Wound and Ostomy Care at a Tertiary Centre - *C. Bumanlag*
1:50-2:00 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

CLINICAL CORNER

CaPSNIG provides a great forum for pediatric surgical nurses and other allied health care members to share their knowledge, experience, and expertise. Over the last few months, we have had amazing success with our forum. Please continue to ask questions and seek ways to enhance the care that we provide to our patients and families.

Question 1:
We are looking to streamline and standardize our vital sign monitoring for all post-operative patients. I am curious what other facilities are doing. Currently once the patient is transferred back to the ward from PACU, we are doing Q1h x4 vital sign monitoring and then Q 4h until discharge.

Answers:

- Our vital sign monitoring goes as follows: In our PACU patients are assessed on arrival and then every 5-15 minutes depending on the surgery and airways status. On arrival to the unit, they are assessed with the PACU nurse and receiving nurse and then, if patient is stable, then monitor vital signs: hourly x 4, then every 2 hours x 2, then as per physicians order thereafter or as per unit routine (routine is Q4 hourly)
- ***Please contact Ping for Policies that were included in this email train***

Question 2:
Does anyone have a protocol and or written guide for transferring patients to the ward post op from recovery in regards to refraining transfers around the time of nursing sign over?

Answers:

- We have no guideline/protocol regarding transfer times. However in that past it was discussed by management and there are no transfers 30 minutes before or after shift change.
- We have nothing in a written policy but it is practice to try to minimize transfer during changes of shifts. This is more applicable for admissions from the ER department. Most elective post-op transfers are transferred before change of shift however on occasion with unscheduled surgeries, again the recovery room does try to avoid change of shift times when it is possible.
- We don't have a formal policy but the nurses are excellent at communicating with each other. Once report is given, then an agreed upon time for the transfer takes places whether it's an ER, PACU or ICU transfer. If the transfer is around the time shift change occurs, they negotiate for a safe transfer time.
- We have had many discussions with our PACU unit on proper patient transfer times that will benefit both units and ultimately the patient. We do not have a written policy, but have been trying out a system where there are no patient transfers during the last half hour of the shift.

- We have no written policy, but an understanding that for patient safety and avoidance of over time, transfers do not occur during shift change.

Question 3:
Do other centers have a policy or guideline on rectal irrigations? Is this a task that bedside nurses would perform? Or is this done only by physicians?

Answers:

- We don't tend to do enemas on the ward – this is usually taught to out-patient families as part of a new bowel regime program. Some nurses have been trained and know what they are doing. I had educated all the surgical nurses last year at their mandatory education day. We don't have a formal written guideline.
- We have no formal guideline for irrigations. We do have a handout we give to families, as well as provide hands on demonstration and have the family repeat the steps to us to ensure competency. If it is a new diagnosis, either our surgery fellow or staff surgeon does the first few irrigations, and the nurses continue. If it is a patient on the general pediatric surgery ward, then we ensure it is an experienced nurse doing the irrigations.
- Generally, the nurses from our Surgery Clinic do the teaching with the family, however, we have had some NICU and staff nurses that have done teaching.
- At our institution the bedside nurses will perform the irrigations and teach the families.
- ***please contact Ping for Policies related to this email train***

Question 4:
Here are my questions for anyone who works with negative pressure wound therapy in pediatrics. Which centres use negative pressure wound therapy in pediatrics? Do bedside RNs independently do the NPWT (negative pressure wound therapy) dressing changes? Do you prefill your drainage canisters? Would you be willing to share your policy with me?

Answers:

- We use NPWT pretty regularly. The bedside nurses can do dressing changes; often the educators will give a hand/guide the nurses if they are less familiar.
- We do use NWPT as required. To my knowledge, we have never prefilled the canisters.
- The dressings are done by the bedside nurses. If someone is unfamiliar with the procedure they are guided by their co-workers who are proficient, or myself, or the educator. The wound care nurse also has step by step instructions made available to staff .
- Since we don't have a lot of NPWT, the ET nurse always do the dressings, except for the OR, were it's the resident, surgeon of OR nurse who do it.
- We have a step by step procedure with pictures.
- We use NPWT, however we don't prefill the canister. The bedside nurses do the changes.
- ***please contact Ping for Policies related to this email train***