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

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

Upcoming Events:

12TH Annual CaPSNIG Meeting
Thursday September 22, 2016
Vancouver, BC
The Westin Bayshore Hotel

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48TH Annual CAPS Meeting
September 22-24, 2016
Vancouver, BC
The Westin Bayshore Hotel

CONFERENCE INFORMATION:

The 12th Annual CaPSNIG meeting is quickly approaching. It will be held on September 22, 2016. There is NO FEE to attend. This is a great forum for surgical nurses and allied health to get together to review latest pediatric surgical issues and advances in practice.

To register, please complete registration form on Caps website and email to Ping at monping.chiang@sickkids.ca. Registration is due by **September 2, 2016** to avoid late fee of $50. Please see agenda on following page.

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The 48th Annual CAPS Meeting be held September 22-24, 2016.

General conference information and hotel registrations are open and are available through the website at www.caps.ca. Early bird is available until **August 19, 2016**.

12th Annual Meeting September 22, 2016

The Westin Bayshore
Vancouver, BC

7:30 - 8:00 am	CaPSNIG business meeting-*members only* *Breakfast will be served*
8:00 – 9:00 am	Introductions & Welcome *Dr. Erik Skarsgard Surgeon in Chief, Dept of Peds Surgery, BC Children's* *Monping Chiang & Kimberly Colapinto – Chair CaPSNIG* *Coffee will be served*
9:00 – 10:00 am	1st annual CaPSNIG motivation presentation (*Kim Colapinto, Sick Kids*)
10:00 – 10:30 am	Midgut presentation (*Monping Chiang, Sick Kids*)
10:30 - 11:00 am	**Quality & Practice innovations** Giant Omphalocele: Growing and Healing (*Amie Nowak, BC Children's*)
11:00 - 12:00 pm	**Education Session** (*Dr. Rodrigo Romao, IWK*) *Lunch will be served*
12:00 – 12:30 pm	**Case study #1** "Take a Chanse on me…" A case study of collaboration, Innovation and Determination (*Hazel Pleasants, Sick Kids*)
12:30 - 1:00 pm	**Case Study #2** Innovative Surgical Approach in the Management of Intestinal Pseudo-obstruction (*Karen Steinberg, Sick Kids*)
1:00 - 1:30 pm	**Case Study #3** The sky is the limit: improving quality of life in children with complex medical needs (*Christina Kosar, Sick Kids*)
1:30 - 2:00 pm	Evaluations Closing remarks- *Monping Chiang*
	CAPS conference to follow at 2:30 pm

CANADIAN ASSOCIATION OF PAEDIATRIC SURGEONS
ASSOCIATION CANADIENNE DE CHIRURGIE PÉDIATRIQUE

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

CLINICAL CORNER

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

Question 1:
I am wondering if most pediatric inpatient med-surg units require a secure access or if they are accessible to public?

Answers:

1) Our paediatric unit is within a general hospital. We have the ability to lock our unit down fully and access via swipe cards in and out; however, we do not do this unless there is a known risk to a patient/family or a patient flight risk/apprehension risk, 80-85% of the time our unit doors are open.
2) Our pediatric ward is within a general hospital. We have the ability to lock down, and this is done every night. Parents are given wrist bands in order to access the unit after hours and staff have cards to swipe. There is only one way in or out for the public.
3) We lock down every night.
4) We don't have a locked pediatric surgical ward. However, there is one entrance to the ward area.
5) Our pediatric med-surg inpatient units are open to the public. We have a visiting policy that outlines public hours, but it is not enforced by having secure access to the unit. After visiting hours, the main doors to the hospital are locked and all visitors are expected to pass through one entrance where there is a security desk.
6) Our NICU is locked (with a "doorbell" for parents); staff need ID cards to enter. However, our PICU, surgical, and medical units are not locked. All med rooms, CSR rooms, etc. are only accessible via ID card.
7) We have recently gone to secure units. Parents get an access card on admission. Others have to be buzzed in.
8) Our unit is locked and requires security tag access of which many staff does not have. The clerk lets us in as we approach the glass door. The NICU and PICU are also locked. The general wards are not locked but you must buzz in for the oncology ward to triage for illness. Very rarely a general ward is temporarily locked.
9) Our PICU, L&D, NICU units are all locked. We require badges with permissions to enter. Doors are monitored with security cameras and parents enter on the permission of the Business Clerk monitoring traffic through the door (portable phone, monitors showing security footage at our main desks).
10) At our hospital the only locked unit is NICU, we need to ask permission and access is allowed by ID card.

Question 2:
I am wondering what is common practice for a continuous furosemide infusion in other pediatric hospitals. Would a pediatric patient receive a continuous infusion of furosemide on an inpatient unit with regular surveillance or would the patient require a higher level of surveillance or ICU?

Answers:

1) The only IV infusions we run on the med/surg units are insulin for DKA (and this only after stabilization in critical care area such as ED or PICU), and narcotics such as fentanyl or morphine in a "background rate" on our PCAs. We have run milrinone on the wards in exceptional cases.
2) At our hospital we are able to do this on the general floor but it would depend on patient status. Our monitoring would include: BP, heart rate, postural hypotension, urine output, fluid balance, serum electrolytes, creatinine, and urea.

Question 3:
We are looking at what other centers are doing to ambulate their patients who have chest tubes. For patients without an air leak, it usually is not an issue and we get an order from the physician to discontinue the suction for the duration of ambulation. The concern is for patients with air leaks. We are wondering how to ambulate these patients? Do other centers put the patient on portable suction?

Answers:

1) At our hospital, if the patients have air leaks with a chest tube, we don't ambulate them. We keep them on wall suction to prevent further pneumothorax. We will extend the suctions tubing, so the patients can walk around in their room and get to the bathrooms, otherwise, they stay on suctions until the pneumothorax or air leak resolves
2) We find the portable suctions don't last long and are only used on transportations.
3) We ambulate them merely off wall suction (without adding portable suction). The tube is to straight drain for the time they walk laps. In theory the pneumo should remain decompressed as the air can still escape. We have not had any difficulty as of yet doing this.

Question 4:
We are in the process of revising our Tunneled Central Venous Catheter policy and would like a general idea of what other pediatric hospitals are practicing with regards to the care and maintenance of the catheter. What is the frequency of locking the catheter when not in use? Is the catheter double clamped when locked? i.e clamped with the manufacturers clamp only, or is there an additional clamp added, such as a bulldog clamp?

Answers:

1) We lock these devices 2 x per week. We utilize the clamp on the tube and have a bulldog clamp with the patient at all times for emergency care.
2) Our PICCs are heplocked q12 and CVL's are heplocked every 24 hours when not in use and port-a-caths once a month (30 days). The catheter is not double clamped. We use the manufacturers clamped. We also at times wrap in gauze to protect the clamp and maybe tape around the clamp to ensure the clamp doesn't undo.

3) We lock our PICCs and CVADs twice a week when not in use and ports are once a month.

Question 5:

We have recently had a few kids who have such sensitive skin that they seem to react to the chlorhexidine, alcohol, and even the Tegaderm. We have had to resort to Primipore or Mepilex Border (silicone), but they are dry gauze type dressings which need to be changed at least q48hrs. Does anyone use an alternative dressing to Tegaderm that is occlusive, clear and can stay on for 7 days?

Answers:

1) Our IV team uses IV 3000 for the kids who react to the tegaderm. I believe it has a better MVTR than the tegaderm.
2) For children who have bad reactions to Tegaderm, we have used IV 3000 with good effect.
3) We use IV 3000 for children who do not tolerate Tegaderm.
4) Our standard dressing is the IV 3000, we change it every 7 days. We evaluated Tegaderm advanced last year but had issues with babies or patients for who the standard size was too large.
5) We have a patient using 'BIOCLUSIVE' Transparent dressing, by 'Systagenix'.
6) We also use IV 3000 if kids react to the tegaderm. We have also had kids react to the chlorhexidine therefore we still clean the skin with it and wait for it to dry to disinfect the area and then we wipe the area one final time with normal saline and let it dry before applying the dressing.
7) For kids who react to tegaderm and IV 3000, we use mepitel film (Molnlycke), a silicone transparent film dressing. It's not made for IV fixation so we need to make sure the catheter is secured with stiches or steristrip, or another dressing (like hypafix, outside of the CVC dressing). There is also mepitel Film IV AM (Molnlycke), made for IV site but more expensive.
8) Our standard dressing is Tegaderm advance. Our go to dressing if the patient is sensitive to the Tegaderm is Mepitel film, same company as Mepitel border.
9) We use 3M's Tegaderm Advance or Sorbaview.
10) We have kids that react to the chlorhexidine where we need to make sure the nurses are letting it dry for at least 2 min and also use Cavilon after. Sometimes we have to resort to using iodine that usually takes care of the dermatitis within a week or two.
11) Our nurses sometimes have used iodine to cleanse when everything else is irritating. They have also used the mepilex border but agree, it needs to be changed more often.

Question 6:

What kind of medical adhesive do you use in neonatal population to fix the stitches on endotracheal tube? In our facility, we use Benzoin tincture or Mastisol.

Answers:

1) We use the Neobar to attach the ETT to the infants face. The ETT is attached to the Neobar with white zinc tape.
2) We use the Neobar as well, but our tube is also sutured in place (sutures through the tube) and the sutures are taped down with pink tape. The RTs use mastisol as well under the pink tape. For preemies, we may use mepitac but it usually doesn't last long as the humidity gets to it.