CaPSNIG
CANADIAN PEDIATRIC SURGICAL NURSES INTEREST GROUP
EST. 2005

Volume 8, Issue 1 Winter 2015

In Memoriam

We dedicate this issue of the CaPSNIG newsletter in honour of Dr. Sigmund Ein and his contributions to Pediatric Surgery and his endless support for surgical nurses.

Dr. Sigmund H. Ein (Siggie) passed away on January 25, 205. Dr. Ein began his career at SickKids on July 1, 1969 in the Division of General Surgery where he remained until his retirement in 2004. During his 35 years at the University of Toronto, he held many leadership positions within Sick Kids and was President of the Canadian Association of Paediatric Surgeons. After retirement he remained an Honorary member of staff at SickKids and an Associate Professor of Surgery at the University of Toronto.

Dr. Ein was also a HUGE supporter for our CaPSNIG group in the infancy stage and throughout the past 10 years. He was always encouraging us with our growth of CaPSNIG. He looked at our meeting agendas and was proud of what we had accomplished. We have lost an icon in pediatric surgery and a great supporter for surgical nursing.

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

IN THIS ISSUE:	
1	In Memoriam
2	Save the dates/Call for Abstracts
3	CaPSNIG 2014/Call for new ideas
4-7	Clinical Corner

SAVE THE DATE:

11TH Annual CaPSNIG Meeting
Thursday September 17, 2015
Marriott Gateway on the Falls
Niagara Falls, ON

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

CALL FOR ABSTRACTS:

CAPS – Due: March 20, 2015
CaPSNIG – April 3, 2015

WORKSHOP SAVE THE DATE:

International Congenital Diaphragmatic Hernia Workshop
September 14-15, 2015 in Toronto
(prior to CaPSNIG/CAPS meeting)

For more information, email:
cdhworkshop2015@gmail.com

CaPSNIG Annual Meeting – Montreal 2014

Our 10th annual CaPSNIG meeting held September 18, 2014 in Montreal, Quebec, was a huge success! We had several participants join us from across Canada. Ping presented a wonderful presentation at the CAPS annual meeting, outlining the evolution of our interest group and the amazing things we have accomplished throughout the years. We were also very fortunate to hear that the CAPS executive committee will continue to financially support our annual CaPSNIG meetings!

CALL FOR IDEAS:

If you have any ideas, suggestions, or comments for future newletters or the CaPSNIG meeting, please send an email to monping.chiang@sickkids.ca

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:
Do your ORs have procedure rooms that are utilized to provide patients with sedation/GA? If so how are these rooms utilized, booked and who is responsible for recovery?

Answers:

- We have a procedure room which has an anesthetist assigned to it generally (sometimes the on call anesthetist) and bookings are made through the OR as all OR bookings are made.
- We have 1 OR that is set up primarily for pediatric use but pediatric procedures may be done in any of our rooms. Our pediatric cases are booked through the surgeon offices on a booked and planned slate or may be booked as an added case (emergency or urgent) and placed on an add board. If a procedure is deemed emergent, the surgeon can bump into the slate. The pediatric procedures done in the OR are with GA with very few exceptions, eg. Flexible esophagoscopy may be done with sedation depending on the pt. Procedures such as bronchoscopy, placement of central lines, etc. (which are done under sedation in PICU or NICU) are not usually done in the OR unless they are part of a procedure requiring a GA. The pts may be recovered in our general recovery room, PICU or NICU depending on acuity, type of surgery, age, etc. This is determined by anesthesiologist and surgeon.
- We have program specific procedure room which is staffed by an anesthetist for sedation and GA procedures. Other services can request time slots but the "home" program have preference. The booking is done through our main OR and the individual programs may have to recover their own kids, depending on procedure and sedation.

Question:
I am interested in what successes you have had for chronically leaking tubes. Specifically I am interested in leaking cecostomy tubes, but really solutions to any leaky tubes would be helpful. Also, when referring an overage patient on to adult care – do you refer to an adult colorectal surgeon, or to GI?

Answers:

- I'm wondering if the flushes are not effective enough? I find the kids leak more when they are constipated. As for overage people, we refer to an adult GI physician.
- We find when chronic leakage occurs, that it is likely due to constipation. We will either use an oral cleansing product if the xray indicates severe constipation (ie Pico Salax) or recommend increased flushes.(either volume or frequency). Many of our patients are on daily Laxaday. We use various skin protection techniques, Cavilon, Zinc Oxide cream, which we blot dry (like lipstick) such as Calmoseptine or TRIAD. We utilize a dressing such as Mepilex Lite to wick the drainage off the skin and change it prn. We have had difficulty passing on issues with our adult population to the adult surgeons or GI doctors.

Question:
Does anyone have an algorithm for choosing therapeutic (pressure-reducing) surfaces in peds? Would love to see what others have to help them decide which bed/mattress type to choose for pressure ulcer prevention in kids.

Answers:

- We do not have a specific algorithm for choosing mattresses. If they are at risk for developing pressure ulcers according to our Pediatric Braden Q scale, they will often be placed on one of our Skryker pressure reduction mattresses
- *please contact CaPSNIG chair for policies/tools related to this question

Question:
How is procedural sedation managed in your centers outside of ED, PICU and OR?
What policies/procedures are in place to guide procedural sedation being administered on inpatient units (it at all)?
What guidelines exist re: transport of the patient post sedation?

Answers:

- We manage procedural sedation on our inpatient units and vary in the degree of sedation (light to deep). We also run an outpatient burn treatment program on our inpatient unit where we do anesthesia led procedural sedation. If a patient receives any sedation by an anesthetist they are transferred by that anesthetist to PACU till they are appropriate to come to the units.
- *please contact CaPSNIG chair for policies/tools related to this question

Question:
I have been asked to revisit how procedures are managed outside of the OR where anesthesia is consulted to provide sedation. Is this something that happens at other pediatric sites? If so how is this managed? How are the procedures booked? Who is present for the procedures? Where do these procedures happen? Who provides recovery? What is your hospital policy on monitoring post procedures that require sedation?

Answers:

- In our facility the admitting service books these cases as emerg cases (prioritized and placed on the emerg list) in the usual way (we call adult OR to book an emerg case, they call peds OR to give the DPC code). These cases would have anesthesia going to the CT and possibly the MRI departments for sedation, or the burn ward for a burn dressing. Anesthesia delivers the sedation and they recover in the Peds recovery room before going back to the ward. For an elective MRI certain physicians are allowed to deliver the sedation and a nurse is present for the procedure and recovery in the MRI area. For a CT there is usually a Physician from the service and a nurse with the patient. We also have a CT tech and CT nurse. In regards to ERCPs using sedation – the GI MD doing the procedure and giving the sedation is responsible for the child. They are transported by a PACU nurse to PACU for recovery. Procedures that occur in the emerg have sedation delivered by the EMO and an emerg nurse recovers them in the ED.
- If the child/youth meets the correct guidelines, then the Procedural Sedation is done by the PICU Intensivist and team. MRI's are one procedure done by the team which consists of: PICU Intensivist, PICU RN, Respiratory Therapist for airway management. This team accompanies the child/youth to MRI and recovery is done by the Paeds Daycare RN's who have taken and are current in PALS. Dependent on how deeply the child/youth is sedated, the PICU RN or RT may also remain with the patient for a while. Procedural Sedation is also done for other children for a multitude of issues (Botox injections, Incision and Drainage, etc). In this case the requesting physician/paediatrician completed a Procedural Sedation Booking Form which is sent to and reviewed by the PICU Intensivist. If acceptable, the procedural sedation is done by PICU Intensivist + PICU RN +/- RT…dependent on sedation to be given.
- We would do procedural sedations in the clinic. The nurses to do a complete assessment (review old chart, nursing history, ask about airway/cardiac issues, ask about cough cold fever) and determine whether the child is fit for sedation. In the event that the child is not, anaesthesia would be consulted and book the child under GA in the operating room. The nurses have a medical directive to administer the sedation (oral) in the clinic. The nurses require additional training regarding pre sedation assessment and post sedation recovery care. There is a sedation room that is equipped with emergency safety equipment (O2 masks code chart, and the code blue bottom). Nurses in the clinic monitor the child after the sedation.

Question:
What are pediatric hospitals teaching parents in regards to nasogastric tube insertion/placement for feeds out in the community and at home?

Answers:

- We don't have anything in place for our surgical patients. We are trying to development some guidelines. Our surgeons are hesitant until we come up with a definite plan so that patients don't get lost to follow up.
- Our medical teams have been sending patients home with NG tube. They are teaching parents but the challenge is the follow up. We have found a few patients who are orally averted and now 9-11 months old in the community and getting lost of follow up.

- Our patients with NGs are followed by their respective specialty services. Those who don't require specialized follow-up are followed by the "home enteral feeding program" nurse and nutritionist. We have a standardized teaching manual for patients to take home that is used by all services in the hospital.
- We have a liaison nurse who does all the teaching for nasogastric tubes. She shows them how to manage and reinstall the tube.
- We have a nurse who does all the education and tracking of kids going home with NG feeds. She will be the go to person for families with questions or issues. We also have a feeding specialist and a nurse clinician who follow all the tube feeders where there is a dietitian. They also monitor progression/safety of oral feeds. They also follow kids in hospital and directs feeding issues/regimes.
- *please contact CaPSNIG chair for policies/tools related to this question

Question:
What are your current practices for sucrose administration? Policy? Where is the supply located? What is the process for nurses to administer, chart etc.

Answers:

- We use the Natus TootSweet twist tip vial, and keep it with our stock oral medications. Nurses are supposed to initiate the collective order by sending it to pharmacy and chart administration as they would for any other PRN med. (Elissa Remmer, Nurse Educator – Montreal Children's)
- *please contact CaPSNIG chair for policies/tools related to this question