



**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

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SAVE THE DATE:

**12TH Annual CaPSNIG Meeting
Thursday September 22, 2016
Vancouver, BC
Venue TBD**

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

CALL FOR ABSTRACTS:

**CAPS – Due: March 18, 2016
CaPSNIG – Due: April 8, 2016**



CaPSNIG Annual Meeting – Niagara Falls 2015

The 11th annual CaPSNIG meeting was well attended. We had allied health members attend and also had the privilege of having an international speaker. We look forward to continuing those relationships and look forward to their attendance in future meetings.





CaPSNIG Meeting 2016:

The next CaPSNIG meeting will be held in Vancouver on September 22, 2016. We are working with the CAPS executives on the venue for our meeting.

CaPSNIG - Call for Abstracts:

Formal Announcement coming February 2016

Due: April 8, 2016

Based on the evaluations from our 2015 meeting, we would like to focus on case studies for submission. Please start thinking of interesting cases you've encountered in your practice!

CAPS – Call for Abstracts:

Due: March 18, 2016

Please see CAPS website for details





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:

How do other hospitals communicate the patient's plan of care to their team members, from admission to discharge, so that the teams are all proactively advancing the patient through the anticipated trajectory of care? What communications tools do other teams use?

Answers:

- We have a very old paper kardex that identifies all aspects of care. The clerks transfer orders with a pencil so it allows changes. It's tossed in the garbage upon discharge. We now also use a white board in each room that identifies the stage they are in yellow green red stating the stage of care and closeness to discharge. Issues, plans and team member names are written on it.
- We use the following: Interdisciplinary Rounds every morning (Monday thru Friday), Interdisciplinary Care Plan, White Board in the patient room for family and all interdisciplinary team members to communicate: goals / questions / and list of team members caring for patient and family.
- We use the following: Interdisciplinary morning rounds (6:30-7:00) every day, Interdisciplinary Rounds with surgical team twice weekly (Tuesday and Friday), White Board in the patient room

Question 2:

Is anyone collecting pressure ulcer incidence/prevalence data? Who does it and how do they do it?

Answers:

- We are meant to capture this in our patient safety event reporting system and this data would go to our quality and safety leaders. That said, we don't have a formal grading system that we have put into place and many events do not get reported early so we have limited data on stage 1 ulcers.
- We have an AEMS reporting system that is as good as the people who report. The intent is that all hospital acquired pressure ulcers are reported and tracked by this system.
- We did our first prevalence in 2010. We created a team of nurses, OT and PT who looked at all the patient, head to toe. We'd like to do it once a year but we don't have the resources for it.
- Last year, my ET nurse colleague and I did the prevalence in PICU and readaptation center, we had the help of an orderly to mobilize the patient. We will do this once every year. It is part of the pressure ulcer prevention program that was created to meet the goal of Agreement Canada.

We also try to educate the nurses to report all new pressure ulcers (stage 2 and up) through an accident and incident form.

- We do a prevalence survey every year, looking at pressure ulcers, pain, falls - basically the BPGs we have implemented over the years.

Question 3:

I attended a webinar last week that showed a lot of evidence to suggest that elevating the head of the bed for infants during feeding can actually increase the incidence of GERD as opposed to decrease it. I am wondering what other centers have policies around enteral feeding that suggest patients to be positioned flat (obviously unless otherwise contraindicated) and if they would be willing to share? (Contact Ping for handouts/attachments)

Answer:

- It is actually a big debate at our hospital lately. There is some literature out suggesting that raising the HOB does not improve reflux. As a result, last year, the physician hospitalist group tried to mandate HOB flat as an essential component of safe sleep, regardless if running enteral feeds. It's under physician discretion to order HOB up while feeding. However some GI physicians are in disagreement and believe there needs to be a greater literature search done. Home Nutrition Services still teaches raising the HOB when their child is feeding at home.

Question 4:

I'd like to know what needless connector do you use and is it a clear needless connector?

Answers:

- We use the smart-site and max plus connectors.
- We use the One-Link by Baxter. It is clear.
- We use clearlink by Baxter.
- We use the MicoClave Clear by ICU medical.
- We have just recently moved towards extension sets with bonded caps (MicroClave Clear) also from ICU medical.
- We also use Microclave Clear.

Question 5:

I am wondering if there are any pediatric facilities that have designated step down beds on their inpatient units. If they do what services do they cover and do they have any tool used to determine what type of patient requires the step down beds.

Answers:

- We have step down observation beds for each unit. It's usually 4-6 bed rooms with constant 24 hr. nursing. Since we have them on each unit and they are for their own service, it's hard to comment on what services they cover.
- In general, patients transferring out of the PICU & NICU, with airway issue or with CPAP, nasal trumpets, Tracheostomy; long OR times that do not need ICU, major electrolyte imbalances in infants. Anyone who needs closer monitoring (change in statuses) or is requiring more nursing

intervention and care may also be moved in for staffing purposes. Staffing ratio is mostly 2:1 but some kids do require 1:1 while in obs.

- We have no designated step down unit. We do place our acutely ill patients or T/F from PICU/ER in a monitored room with nurse in the room as required for close observation.
- We have a two-bed monitored room with 1:2 nursing. 1:1 if they are heavy. No designated step down.

Question 6:

I would be grateful for policies/program info on transitioning complex NICU patients to Peds. Often these kids are surgical patients (Short gut, unrepaired omphaloceles, shunts, etc.) who either transfer straight to Peds or show up in the ED with no introduction or formal preparation. I am looking for guidance as we put a program in place (Contact Ping for handouts/attachments).

Answers:

- Most of the time, complex NICU transfers to our peds unit are put in our special care room/constant care with a nurse for the first few weeks (and sometimes for their whole hospital stay until discharge) depending on their needs. We do not have a formal policy that guides this though.
- We have a lot of complex neonates in our ICU who transition to both peds/general surgery and intestinal failure programs. Because their transitions are often complex we now try to engage the receiving service/team in transitional care rounds before they move. We have variable success but our Gen Peds teams come to our weekly meetings now. Always interested to hear what works for others.
- We have developed the attached algorithm for transfers between NICU and Paeds/PICU. Our complex NICU babes generally transfer to PICU due to high acuity needs. If the babe is coming to PICU due to post-op needs that cannot be met in NICU, then they generally come for the post-op period and return to NICU until discharge home.
- If babe is feeding and growing, then transferred NICU to Paeds. Once transferred to Paeds, babe never returns to NICU but will go to PICU if more intensive care needs.
- Essential is communication in transfer between all areas.
- We have a discharge coordinator who organizes these transfers (we have had trouble getting them transferred in the past, which led to the development of this position). She ensures all consultants are on board, makes sure there is a long-term bed available on the medical or surgical unit (few and far between, but she will help determine which baby should get priority), gives a tour to the families, and generally helps the families mentally prepare for the change in environment/level of surveillance. She is also responsible for organizing direct discharges of these patients if more appropriate. The bedside nurses are still responsible for any teaching that needs to be done prior to transfer/discharge.
- We also have a discharge planning nurse/coordinator for NICU and they provide all information to the accepting team. We also have a transfer tool/checklist that provides the accepting team with history and important information on the patient to help with the transition.