# Surgical Short Stay Integrated Care Pathway Guiding Document (CR3171)

**Purpose of the pathway**

The Surgical Short Stay Integrated Care Pathway is an agreed standardised pathway of documenting multidisciplinary care which also captures the essence of each child and whānau. The paediatric surgical short stay medication chart is used in conjunction with the pathway to document safe medication practice across the continuum of care.

**Scope of the pathway**

- Includes Infants, children or young person's receiving planned surgical or procedural care with a length of stay of 24 hours or less admitted to all areas of Starship Child Health
- Includes the period from admission to discharge

**Objectives of the pathway**

- Standardise documentation of multidisciplinary care from admission to discharge while also capturing the essence of the child and whānau
- Improve whānau information and preparation for planned pre-op and post-op care
- Optimise use of criteria led discharge
- Facilitate timely discharge
- Measure variance from standard practice
- Reduce post op complications

**Objectives of the paediatric surgical short stay medication chart (CR3168)**

- Reduce medication duplication errors
- Increase adherence to Paracetamol and Ametop Gel 4% standing orders

The Surgical Short Stay Integrated Care Pathway should never replace clinical judgement. Care outlined in the pathway should always be varied if it is not clinically appropriate for the individual infant, child, or young person.

**Documentation in the pathway document**

All members of the multidisciplinary team (MDT) are required to provide a sample signature and initial in the signature log located on page 1 of the document. Nursing staff caring for the child will document their shift, other MDT member's document the time of documentation within the pathway document.

Initials are utilised throughout the document to indicate whether care has been administered, is not applicable or if there is a variation from the pathway. There is no need to document additional nursing or clinical notes beyond this unless there is a variance to expected care which requires explanation. In this case, documentation is to occur in the variance section of the pathway document (pages 11-13).

All documentation is to occur in real time. Completion of any aspect of the pathway document in retrospect is not recommended. The pathway is intended to guide care and processes.

There are some aspects of care that apply to every care encounter (therefore NA column is blacked out). These actions can, however, be varied as per the variance column.

From Goal 4 onwards, there are aspects of care delivery that may require assessment on multiple shifts. For this reason, there are shift columns available for indicating when care has been administered.

**Capturing the essence of the child and whānau**

The essence of the child is assessed through use of specific questions about the child's whānau, routines, needs and abilities in association with care planning goals that are incorporated into the pathway document with opportunity to individualise as per the assessment questions. There is opportunity throughout the pathway for the child and whānau to verbalise any question or concerns indicated by regular check-in points throughout the pathway document. It is important that these check-in points are acknowledged with the child and whānau at every indication.

Clinical care reviews can be utilised at these points throughout the journey of care.

**Setting up the discussion**

- Interpreters are accessed if required *(need for interpreting services is often identified on the wellness check and booked in advance).*
- A suitable environment for information gathering is sought to maintain child and whānau confidentiality.

## Content of the pathway document

**Compulsory forms required for progression through to theatre are located at the front of the pathway document. These include:**

- Preoperative patient assessment and check in (CR4135)
- Anaesthetic screening questionnaire (CR4115)
- Agreement to treatment (CR0111)

Preoperative patient assessment and check-in.pdf

Every page must have a patient label affixed.

**Short Stay Medication Chart (CR3168)**
The paediatric surgical short stay medication Chart (with associated fluid balance chart) is to be used for all children on the Surgical Short Stay Integrated Care Pathway.

It includes standing orders approved for use by Registered Nurses in Day Stay Unit (DSU)and at Greenlane Surgical Unit (GSU). Please refer to the following standing orders for best practice guidance:
Standing Orders/Paracetamol DSU GSU.pdf
Standing Orders Ametop PAEDS PAIN.pdf

The fluid balance chart is a 24 hour chart and can be used for the entire 24 hours of the child's admission. It is not necessary to obtain a new fluid balance chart simply because the date has changed.

**Multidisplinary Whānau Assessment and Screening form (CR3165)**

guidelines/starship-nursing-care-plans

The multidisciplinary whānau assessment and screening form is utilised by the multidisciplinary team (MDT) and can be updated at any time.

Infection Screening, Allergies and Routine Enquiry must be completed at time of admission by nursing staff

**Situation/Procedure:**

Document the surgery or procedure the child will have/reason for admission.
For example: Tonsillectomy, Endoscopy; Hernia Repair; Metal ware removal

*Date and time of admission:* To be completed in real time

*Team:* Primary team caring for the child

**Background/Medical history:**

Provide a detailed overview of the infant, child or young person's medical history. This can include:

- Medical/surgical conditions
- Previous admissions to hospital
- Developmental needs
- Psychosocial components.

For detailed information regarding the child's infection status, immunisation history and allergies, please utilise the Multidisplinary Whānau Assessment and Screening form (CR3165) to avoid duplication of information.

**Goal 1.0:** *A welcoming environment is maintained for the child and whānau*

The objective of this goal is to encompass a welcoming experience for the infant, child or young person and whānau on admission by ensuring a detailed orientation to the environment and safety processes such as Kōrero Mai and application of the ID band occurs. Collaboration in getting to know the child and whānau is initiated and supported by the document from admission and guides the care delivered during their short stay.

**Nursing Care Planning:** *Knowing and caring for me and my whānau*

The nurse will explain to the child or young person and whānau the rationale for the discussion. Completion of the Knowing and caring for me and my whānau section with the child and whānau facilitates improved mutual understanding and ability of the health care team to better provide individualised care to the child.

The statements in these sections are written with the voice and the essence of the child in mind. It is importance to rephrase these into questions that are asked of the child or whānau depending on the age of the child or young parson and their ability to answer the questions.
Examples of how these questions may be asked in practice are outlined below.

| Knowing and caring for me and my whānau | | |
|---|---|---|
| **Question as written** | **Example of how you might choose to phrase the question** | **Example of potential responses you may receive** |
| **Cultural or spiritual considerations my whānau would like you to know include:** | Are there any cultural/spiritual considerations you would like us to know about and support you with?<br><br>Do you have any cultural or spiritual needs we can meet with support from our specialist teams (Kaiatawhai, Pacific support, Chaplains)? | No<br><br>Karakia prior to meals and family karakia prior to surgery. Child wears taonga at all times.<br><br>Would like contact with Kaiatawhai |
| **I express myself and communicate by:** | Baby is only 6 weeks old – Are there things you have picked up on that she does that helps you to interpret her needs?<br><br>How does your child communicate? | She is a quiet baby, only cries when hungry or needing her nappy changed. Not usual for her to cry otherwise. |
| **My nutritional routines are:** | What is baby's usual feeding routines/times?<br><br>What are your child's usual eating and drinking routines? | Bottle feeds 3-4 hourly with some breast feeds in-between for comfort.<br><br>At home will have breakfast, lunch and dinner. Needs encouragement with drinking fluids. |
| **Medical equipment or devices I use includes:** | Do you / your child use any medical equipment or devices? | Yes, I use a CPAP machine at night time.<br>Yes she has a Portacath that is accessed each time we come into hospital or monthly by the nurses at home.<br><br>Hearing aids. |

**Goal 2.0:** *Play specialist supports the child, young person and their whānau to cope with hospitalisation by minimising associated stress and anxiety, build coping strategies and create opportunities for participating in their health cares.*

[Supervision in the Play Room (hanz.health.nz)]

Hospital play specialists work closely with doctors and nurses to improve outcomes and the hospital experience for infants, children and young people. Documentation is an important but challenging aspect of their work, particularly in the short stay setting. For this reason, the WISE format [1] has been adopted into the pathway as a form of documentation for hospital play specialists.

**Wellbeing:**

- Child's condition or behaviour (physical, cognitive, psychosocial, emotional)
- Child's development stage
- Child's previous hospital or medical related experiences
- Concerns about the child
- Stressors for the child
- Parent/caregiver /whānau and child interactions (including whānau dynamics)

**Interest:**

Child or young person's interests. For example:

- Hobbies
- Play interests
- Sources of pleasure or distraction

**Strategies**

- Strategies applied by the play specialist to address the condition or needs of the child or young person
- For example: Use breathing relaxation exercises

**Evaluation:**

HPS and MDT members are able to evaluate the effectiveness of the above interventions/strategies
For example: Child provided with breathing exercises and techniques prior to going into theatre, anaesthetist reports in the evaluation that the child remained calm and relaxed during gas induction

Please refer to the Procedural-pain-management guideline

**Goal 3.0:** *Child and whānau are prepared for a safe transfer to theatre*

Safety throughout the pathway is paramount to child and whānau experience and outcomes. To facilitate safety, the following forms are required to be completed prior to transition to theatre.

- Pre-operative checklist (CR4048)
- Anaesthetic screening questionnaire (CR4115)
- Agreement to treatment (CR0111)
- Standing orders and pre-medications – these must be signed for

For best practice, please refer to the Preoperative-preparation-and-postoperative-recovery-for-a-child nursing guideline

**Additional pre-operative note**

This section is available for any required pre-operative documentation by the MDT.
For example: An anaesthetic assessment note.

**Procedure note**

This section is for the documentation of the operation/procedure by the surgeon. This is a structured form to ensure clear and concise documentation of findings and post-operative or post-procedure plans of care.

**Goal 4.0:** *Handover and clinical review*

This goal ensures safe handover of care and transfer to the post-operative area. Safety is ensured through use of:

- PACU scores
- PEWS score documentation and appropriate escalation
- SBARR handover
- Handover of documents and post procedure plan of care

It is important that all aspects of this goal are actioned prior to transfer of the child to the post-operative area.

Post Anaesthesia Care Unit (PACU) Care and Discharge-Transfer.pdf

**Goal 5.0:** *Observations, including PEWS are monitored to ensure they are maintained within acceptable parameters for age and condition*.

Monitoring of the post-operative child is a critical aspect of care. PEWS documentation should be completed as per the Observation and Monitoring of an infant, child or young person guideline.

For any additional monitoring requirements, please indicate what these are and obtain the appropriate documentation tools for these requirements. It is important to specify what the additional monitoring may be. This may include but are not limited to:

- Neurovascular observations
- Neurological observations

Escalation of concerns shall remain as per the PEWS chart and area specific escalation pathways.

**Goal 6.0:** *Operation site and drains are monitored for signs of bleeding and infection*

Monitoring for bleeding and wound union are important aspects of post-operative assessment and monitoring. For bleeding or concerns with wounds, these can be documented in the variance section of the pathway followed by any actions taken.

**Goal 7.0:** *Pain and anxiety are recognised, responded to and reassessed. Child and whānau comfort are supported through negotiation of care; maintaining child's normal routines and planning caregiver breaks*

Completion of and reference to the knowing and caring for me and my whānau section are essential to achieving this goal.

- Pain scores are to be documented with observations using the PEWS chart.
- Pain relief is given regularly post operatively – the importance of this is discussed with the child and whānau.
- Non pharmacological strategies are considered – reference to the knowing me and caring for me sections support this.
- Reference to section 2.0 Play specialist progress note for interests and strategies that can be used.
- Check in with the child and whānau for any questions or concerns.
- Please refer to paediatric-pain-assessment and pain-analgesia-overview guidelines

**Goal 8.0:** *Maintenance or re-establishment of an acceptable nutrition and hydration status for age and clinical condition is achieved*

It is important that the child is supported to resume their usual nutritional routines.

- Oral intake is supported by ensuring appropriate formula/food is available for the infant or child
- Updating TrendCare diet will ensure appropriate meal delivery
- Allergies must be considered as documented on the multidisciplinary whānau assessment and screening form.
- Medications to manage any anticipated nausea and vomiting should be administered as required. These are to be prescribed on the Short Stay Medication Chart.
- Please refer to the paediatric-postoperative-vomiting-prophylaxis-and-treatment guideline

**Goal 9.0:** *Child's intravenous access device / central venous catheter remain patent and secure and are monitored for phlebitis and infection. Child is supported through procedural experiences to minimise anxiety and distress.*

For children who may have a CVL please ensure the forms associated with this (CR4030: Central Line Associated Bacteremia (CLAB) Insertion Bundle Checklist) are utilised as per the Central venous catheter (CVC) care for an infant, child, or young person guideline.

Documentation of phlebitis and infiltration scores can be documented on the Fluid Balance Chart found in the CR3168 Paediatric surgical short stay chart

Please refer to 2.0 play specialist progress notes to see if anxieties or coping strategies have been identified.

**Goal 10:** *Discharge assessment and planning*

**10.1 Criteria Led discharge (CLD):**

starship.org.nz/guidelines/criteria-led-discharge

If suitable for CLD, the SMO/surgeon is to sign as indicated:

*"I agree for this child to be discharge by a CLD validated staff member providing the criteria below are met:* ***SMO or Delegated Authority signature:***________________________________________

Once the pre prescribed criteria have been met, the child is able to be discharged by a validated staff member. Additional criteria can be added by the SMO/surgeon as required.

All signed criteria must be met prior to a safe discharge. Should the child undergo a procedure that does not require a particular criteria to be met, the consultant should cross off the specific criteria and initial this change. **Crossing off of criteria must be a clinical decision made by the surgeon or SMO and should not be crossed off by nursing staff discharging the child.**

**10.2 Medical led discharge:**

For children who are not suitable for CLD, a medical led discharge must occur. Two Medical Led discharge pages are available for documentation of medical review, assessment and plan.

A child may go from medical review to criteria led discharge if deemed appropriate to do so by the medical team. This must be clearly documented, and the above CLD process is then followed.

## Allied Health Assessments:

**Physiotherapist Clinical Note:**

The aim of the physiotherapist is to provide whānau-centred, culturally sensitive, safe, effective and comprehensive assessment and outcome-focused physiotherapy care to children.

Respiratory Assessment-Paediatric.pdf

**Social Work Assessment:**

The focus of health social work is to undertake an assessment based on an awareness of the social, emotional, cultural/spiritual, and psychological elements of a person's world and their impact on the child and whānau's overall health and wellbeing. This includes the assessment of service need, psychosocial strengths and barriers to treatment, and the identification of situations involving vulnerability and risk.

Social Work Initial Assessment.pdf

Oranga Tamariki Background Information Request Guideline for Health Social Workers.pdf

## Clinical events/variances

An important aspect of pathway development is measuring outcomes for the child on the pathway. The purpose of this section is to measure variance from the expected pathway of care.

Examples of variances associated with this pathway:

- Surgery cancelled
- Child not seen by play specialist
- Unplanned day stay to overnight stay
- Primary bleeding
- Variance to criteria led discharge
- Delayed discharge due to post op nausea and vomiting
- Delayed discharge due to poorly controlled pain

Where a variance occurs at any stage along the pathway, initial the variance column where the variance occurs. Document on the clinical events/variances pages the details of this variance including the date, time of variance, section number from pathway, action taken and outcome of interventions delivered. If the child requires clinical review, this is documented in the clinical events section.

A variance may mean that the child is no longer suitable to continue on the Surgical Short Stay Integrated Care Pathway. In this case, usual documentation processes will be followed. Documentation of why the child was not suitable to continue along the pathway should be documented in the clinical events and variances section of the pathway document.

**Goal 11:** *Ready to go home: Interventions towards daily goals for discharge are implemented and evaluated with child and whānau.*

Discharge planning should always commence from admission. Going home as prepared and as soon as possible will likely always be on the child and whānau's mind on admission. This section is conveniently placed on the final page so that it can be easily accessed by all members of the MDT at any point along the pathway for the following:

- Commencing referrals
- Arranging transport home
- Completing required certificates for school or work
- Discharge education
- Follow up appointment
- Completion of electronic discharge summary
- Discharge medicines

Utilise dedicated discharge and education resources to support discharge education. For example: Tonsillectomy and adenoidectomy discharge information booklet. This ensures that information and education provided to children and whānau on discharge is consistent and thorough.

**Measuring outcomes:**

*Individual disciplines or services may wish to have a process or system where variance and outcome measure data is collected.*

Indicate if the child has experienced a variance to the standard pathway of care in the outcome measures section on Page 14.

**References:**

1. Development and evaluation of play specialist documentation in a New Zealand hospital Nursing Children and Young People (2014+); London Vol. 31, Issue. 2, (Mar 2019): 32-36