Great Ormond Street **NHS**Hospital for Children

NHS Trust

Name		Ward
Hosp no		
DOB		
Aff	ix patient label	

Pyloric stenosis integrated care pathway (ICP)

Inclusion criteria

Patients suspected of having pyloric stenosis

Instructions for using this ICP

- The ICP incorporates the defail and information required for this patient journey/episode together with specific activities and variance tracking, which companies planned and actual care.
- When activities are completed the practition let hould initial in the "met" box and enter the date and time in the adjacent boxes.
- In the event of variance is om the plant or if an activity is not met, the practitioner should initial the "not met" box, enter the date and time and complete the variance tracking at the end of the document.

Important

- Cach are essional making an entry in this record must complete the signature sheet on page 2, after which the should use only initials when making an entry.
- In using this ICP the precitioner should refer to trust policies, clinical practice and procedure guidelines and protocols, vinich provide evidence and support the activities contained herein.
- This document complements rather than includes existing stand-alone documentation in use at GOSH.
- The integra 3d care pathway forms part of the legal record of care received so must be completed fully.

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Document development lead: Carole Irwin	Document status: PILOT				
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Signature sheet

Name	Designation	Signature	Initials	Date
		N		
		00		
		(5)	·	

Abbreviations and glossary of terms used in ICP

Abbreviation	Term in t "
PYE	Pylon stenosis
FBC	Full Chow count
U&E	Urea and electroly, is
G&S	Group and Eve
EP	Electronic, rescribing
CEWS	Childer warning score
NG	Nasc gas ric

Specific needs of child

Specific need	Solution required	Action taken, date and initials
EXAMPLE		
Child is hearing impaired and wears	Remove hearing aids for procedure but	Recovery staff informed
hearing aids	ensure put back in recovery	JB - 31/3/2010
		\
	N	

Discharge criteria

For this procedure, the child will be able to be discharged or transferred whan the following criteria have been met:

- Child is feeding on demand having there feeds with a womiting
- Wound healing satisfactorily

Documentation accomparying this integrated care pathway

- Family Form 2
- Patient Asses ment Forn.
- Consent form

On admission

			Day shift			Night shift			
		Date:	Date:			Date:			
ID	Activity	Met	Not	N/A	Met	Not	N/A		
			met			met			
		Ente	r initials	s/time	Ente	r initials	s/time		
0001	Confirm child and family understanding for reason for								
	admission						<u> </u>		
0002	Explain outline plan of stay to child and family								
0003	Inform surgical team (ST level) of admission								
0005	Complete assessment using Family Form 2, Patient								
	Assessment Form, Birth History and Immunisation History								
	forms								
0006	Confirm any allergies and document								
0007	Identify any specific needs (disability, cultural or language) of					1			
	child and make arrangements for those to be met during stay -								
	record on page 3		2						
8000	Check that details on PiMS are correct including next o kir and								
	parental responsibility								
0009	Admit child onto EP								
0010	Attach patient identification wristband to hind and explain i.s								
	importance to child and family								
0011	Ensure child is nil by mouth and document time of ast fear								
0012	Orientate child and family to wa. 1 or department ancl in 10 luce								
	members of staff								
0013	Ensure that family hav been given appropriate written								
	information at our the procedure if available								
0014	Record temp Lure pulse, resp ations, blood pressure and								
	oxyge rsaturation every four nource								
0015	Take L'ood te its (FBC, 'J&L oud G&S)								
0016	Take L'ood gases every 12 hou s until within normal limits								
0017	'leas' ie weight and record on growth chart								
	and EP								
CO18	Take nor a an throat swabs								
C019	Complete ressure area care and moving/handling assessment								
1020	C mplete paseline pain assessment								
0021	Insetsing 8 nasogastric tube if not already in situ and leave on								
	rree drainage								
0022	spirate NG tube every four hours, recording amount and								
	colour on fluid balance chart								
0023	Replace NG losses as prescribed								
0024	Consider abdominal ultrasound to confirm diagnosis								

		Day s			Night Date:		
ID	Activity	Met	Not	N/A	Met	Not	N/A
			met			met	
		Ente	r initials	/time	Ente	r initials	s/time
0025	Complete consent procedure with child and family ensuring that						
	person with parental responsibility has signed form						
0026	Check blood test results and transcribe onto pre-operative						
	checklist						
0027	Complete pre-operative checklist						
0028	Review by anaesthetist						
0029	Accompany child to theatre						
0030	Commence discharge planning using checklist on page 15						
0031	Enter discharge date on PiMS						

Outcomes for episode

		Di y s	shit		Night	shift	
ID	Activity	Mε.	Nc.	N/A	Met	Not	N/A
ן וט	Activity		met			met	
		Er	nter initi	als	En	ter initi	als
X0001	All records for child available and us to date						
X0002	All test results reviewed by \nsulta_''/team						
X0003	Child and family understand reas in for proce tire						
X0004	Family have given informed consent						
X0005	Child is fully prepared for an aesthetic and roccoure						

Notes

Pre-procedure day 1 (if applicable)

		Day s	shift		Night Date:	shift	
ID	Activity	Met	Not met	N/A	Met	Not met	N/A
		Ente	r initials	s/time	Ente	rinitials	/time
0032	Child assessed at beginning of shift with bedside handover						
0033	Bedside oxygen and suction checked and functioning						
0034	Explain plan of care to family and negotiate care requirements						
0035	Review by surgical team including medications and fluids						
0036	Patient prescribed and receiving fluids as per pre-operative						
	protocol on page 8						\mathbf{Y}
0038	Record temperature, pulse, respirations and oxygen saturation						
	(blood pressure as required) 4 hourly						
0037	Take blood gases 12 hourly		Ť				
0039	Take blood tests (U&E) if required						
0040	Record strict fluid intake and output on fluid balance crust		7				
0041	Review and attend to pressure area care and moving/h uncling						
	as per assessment						
0042	Assist with basic hygiene needs						
0043	Medical handover sheet updated as nec ssarv						
0044	Nursing handover sheet updated as nices; ary						
0045	Support patient and family						
0046	Continue discharge planning using checklist on page in						

Outcomes for episode

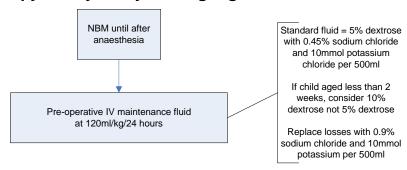
		Day shift			Night shift		
ID	Activ ty	Met	Not	N/A	Met	Not	N/A
	Activity		met			met	
		Er	ter initi	als	En	ter initi	als
X0006	Observations within CLWS acceptable ranges						
X0627	Pain adequately controlled						
70008	Review 'y su sical team completed						

Notes

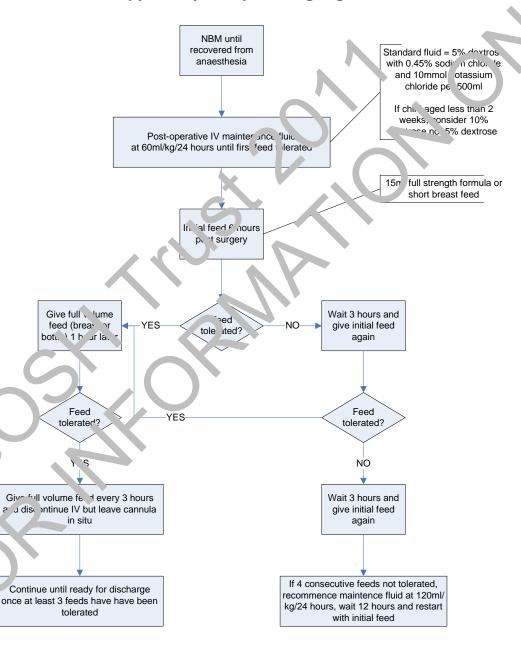
Operation report

Nature of operation		
Date and time carried out/ at		
	·	Deint
Surgeon	Sign	Print
Assistant		
Anaesthetist		
Borrowt		
Report	4 daga sa amayialay	2 dagge og amayialay
Prophylactic antibiotics prescribed: None	1 dose co-amoxiclav	3 doses co-amoxiclav
8, ()		

Pre-pyloromyotomy feeding regime



Post-pyloromyotomy feeding regime



Note: Feeds are considered not tolerated if significant vomit of at least half volume given

Day of operation - Post-procedural care

		Day s	hift		Night	shift	
		Date:	Ī	1	Date:		
ID	Activity	Met	Not	N/A	Met	Not	N/A
			met			met	
		Ente	rinitials	time	Ente	initials	/time
0047	Handover received from recovery nurse						
0048	Bedside oxygen and suction checked and functioning						
0049	Explain plan of care to family and negotiate care requirements						
0050	Meet child and family to update on procedure						
0051	Review by team including medications and fluids						
0052	Prescribe and give pain relief as required						
0053	Record pain scores as per protocol	A					
0054	Check intravenous sites hourly						
0055	Check operation site hourly for 4 hours then 4 hourly		•				
0056	Prescribe and give fluids as per flowchart on page 8						
0057	Commence oral feeds as per flowchart on page 8						
0058	Ensure regular medications and analgesics commence						
	enterally as per post-operative protocol						
0059	Record temperature, pulse, respirations and Jaxy jen satura'.o.						
	(blood pressure if required) half hourly for bours then 4 hourly						
0060	Record strict fluid intake and rutpu on haid balance chart						
0061	Review and attend to pressure area care and movil garanting						
	as per assessment						
0062	Assist with basic hygien , needs						
0063	Medical handon r smet updated as necessary						
0064	Nursing han or set updated as nec ssary						
0065	Support pations family						
0066	Continue discuarge planning using checklist on page 15						

Outcomes for episode

		Day s	Night				
IL	Activity	Met	Not	N/A	Met	Not met	N/A
	. ()		met	ala	Г.,		
		Er	ter initi	ais	⊨r	als	
X000.	Observations within CEWS acceptable ranges						
X0010	ain adequately controlled						
X0011	No signs of immediate wound complications						
X0012	Child and family updated on procedure						

Notes

Post-procedure day 1

		Day s	shift		Night	shift	
		Date:			Date:		
ID	Activity	Met	Not	N/A	Met	Not	N/A
			met			met	
		Ente	r initials	/time	Ente	r initials	/time
0067	Child assessed at beginning of shift with bedside handover						
0068	Bedside oxygen and suction checked and functioning						
0069	Explain plan of care to family and negotiate care requirements						
0070	Review by surgical team including medications and fluids						
0071	Record pain scores as per protocol						
0072	Increase feeds as per flowchart on page 8						
0073	Ensure regular medications and analgesics commence						
	enterally as per post-operative protocol						
0074	Record temperature, pulse and respirations 4 hourly for					ĺ	
	duration of stay						
0075	Record strict fluid intake and output on fluid balanc a chart						
0076	Review and attend to pressure area care and moving/h and ling						
	as per assessment						
0077	Assist with basic hygiene needs						
0078	Medical handover sheet updated as necessary						
0079	Nursing handover sheet updated a necessary						
0800	Support patient and family						
0081	Continue discharge planning usin, checklist cage 15 f not						
	ready for discharge						
0082	Complete discharge nanning using the kline, age 15						
0083	Ensure canrula r aved						
0084	Complete Cocharge notification and serveto all relevant parties						
	Outcomes for episode						

		Day shift				Night shift		
15	Activity	Met	Not	N/A	Met	Not	N/A	
	Activity		met			met		
		En	ter initi	als	En	ter initi	als	
⊼2913	O servations within CEWS acceptable ranges							
X001 +	Fain adequately controlled							
X0015	Discharge criteria on page 3 have been met							
X0016	Family understanding of aftercare confirmed							
X0017	Child is safely discharged							

Notes

Post-procedure day 2

		Day s	hift		Night Date:	shift	
ID	Activity	Met	Not	N/A	Met	Not	N/A
			met			met	
		Ente	r initials	s/time	Ente	rinitials	/time
0085	Child assessed at beginning of shift with bedside handover						
0086	Bedside oxygen and suction checked and functioning						
0087	Explain plan of care to family and negotiate care requirements						
0088	Review by surgical team including medications and fluids						
0089	Record pain scores as per protocol						
0090	Increase feeds as per flowchart on page 8						
0091	Ensure regular medications and analgesics commence						
	enterally as per post-operative protocol			(
0092	Record temperature, pulse and respirations 4 hourly for						
	duration of stay	•					
0093	Record strict fluid intake and output on fluid balanc ; ch art						
0094	Review and attend to pressure area care and moving/h and ing						
	as per assessment	1					
0095	Assist with basic hygiene needs						
0096	Medical handover sheet updated as necessary						
0097	Nursing handover sheet updated at necessary						
0098	Support patient and family						
0099	Continue discharge planning using checklist capage 15 if not						
	ready for discharge						
0100	Complete discharge hanning using the klig. on, age 15						
0101	Ensure canr ıla r nved						
0102	Complete Cachard notification and send to all relevant parties						

Outcomes for episode

		Day shift				Night shift		
15	Activity	Met	Not	N/A	Met	Not	N/A	
	Addition		met			met		
		Enter initials			Enter initials			
⊼2918	O servations within CEWS acceptable ranges							
X001	Fain adequately controlled							
X0020	Discharge criteria on page 3 have been met							
X0021	Family understanding of aftercare confirmed							
X0022	Child is safely discharged							

Notes

Discharge checklist

Predicted date of discharg	je			Discharged to		
	Yes	No	Details			Initials
Transport						
Medication Prescribed Collected Explained						
EquipmentOrderedDeliveredExplained					7	
Teaching						
Follow up arrangements			O			
Discharg cor act made Other GOSH linicians Family docto (GF Local paed atrician Community team Social worker Other						

Variance tracking record

Instructions for use

- Each time a task is not met, the variance should be recorded in the table below.
- This page should be photocopied and used for variance analysis

Name		
Hosp no	4	
DOB		
		Affix patient label

Date	Time	ID	What occurred?	Why?	What did you do about it?	Outc. me	Initials
Example	111110	110	What occurred:	, 	What are you do about it:	Juliot III	minuas
					-/10		
31/11/08	10am	0013	Parents not given written	Computer network down	Fil's copy requested	Parents given written	JB
			information			information	
				•			
			•	\			
		4		+			
				<u> </u>			