

Name
Hosp no
DOB
Affix patient label

Ward
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## Pyloric stenosis integrated care pathway (ICP)

### Inclusion criteria

- Patients suspected of having pyloric stenosis

### Instructions for using this ICP

- The ICP incorporates the detail and information required for this patient journey/episode together with specific activities and variance tracking, which compares planned and actual care.
- When activities are completed the practitioner should initial in the "met" box and enter the date and time in the adjacent boxes.
- In the event of variance from the plan 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

- Each professional making an entry in this record must complete the signature sheet on page 2, after which they should use only initials when making an entry.
- In using this ICP the practitioner should refer to trust policies, clinical practice and procedure guidelines and protocols, which provide evidence and support the activities contained herein.
- This document complements rather than includes existing stand-alone documentation in use at GOSH.
- The integrated 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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## Specific needs of child

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

### Discharge criteria

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

- Child is feeding on demand having tolerated three feeds without vomiting
- Wound healing satisfactorily

### Documentation accompanying this integrated care pathway

- Family Form 2
- Patient Assessment Form
- Consent form

The sequence of events, prompts and recommendations contained in this ICP are not intended to replace the professional judgement of individual clinicians. Staff should use their knowledge, experience and assessment of the child as a basis for variance from this plan.

## On admission

ID	Activity	Day shift			Night shift		
		Date:			Date:		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials/time			Enter initials/time		
0001	Confirm child and family understanding for reason for admission						
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 child and make arrangements for those to be met during stay - record on page 3						
0008	Check that details on PiMS are correct including next of kin and parental responsibility						
0009	Admit child onto EP						
0010	Attach patient identification wristband to child and explain its importance to child and family						
0011	Ensure child is nil by mouth and document time of last feed						
0012	Orientate child and family to ward or department and introduce members of staff						
0013	Ensure that family have been given appropriate written information about the procedure if available						
0014	Record temperature, pulse, respirations, blood pressure and oxygen saturation every four hours						
0015	Take blood tests (FBC, U&E and G&S)						
0016	Take blood gases every 12 hours until within normal limits						
0017	Measure weight and height/length and record on growth chart and EP						
0018	Take nose and throat swabs						
0019	Complete pressure area care and moving/handling assessment						
0020	Complete baseline pain assessment						
0021	Insert size 8 nasogastric tube if not already in situ and leave on free drainage						
0022	Aspirate 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						

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### Pre-procedure day 1 (if applicable)

ID	Activity	Day shift			Night shift		
		Date:			Date:		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials/time			Enter initials/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						
0038	Record temperature, pulse, respirations and oxygen saturation (blood pressure as required) 4 hourly						
0037	Take blood gases 12 hourly						
0039	Take blood tests (U&E) if required						
0040	Record strict fluid intake and output on fluid balance chart						
0041	Review and attend to pressure area care and moving/handling as per assessment						
0042	Assist with basic hygiene needs						
0043	Medical handover sheet updated as necessary						
0044	Nursing handover sheet updated as necessary						
0045	Support patient and family						
0046	Continue discharge planning using checklist on page 15						

### Outcomes for episode

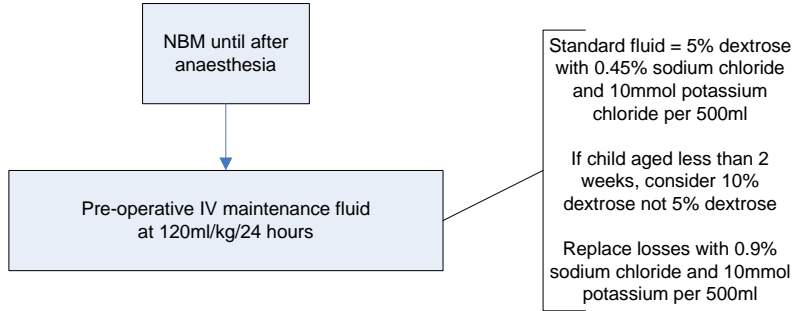
ID	Activity	Day shift			Night shift		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials			Enter initials		
X0006	Observations within CFWs acceptable ranges						
X0007	Pain adequately controlled						
X0008	Review by surgical team completed						

### Notes

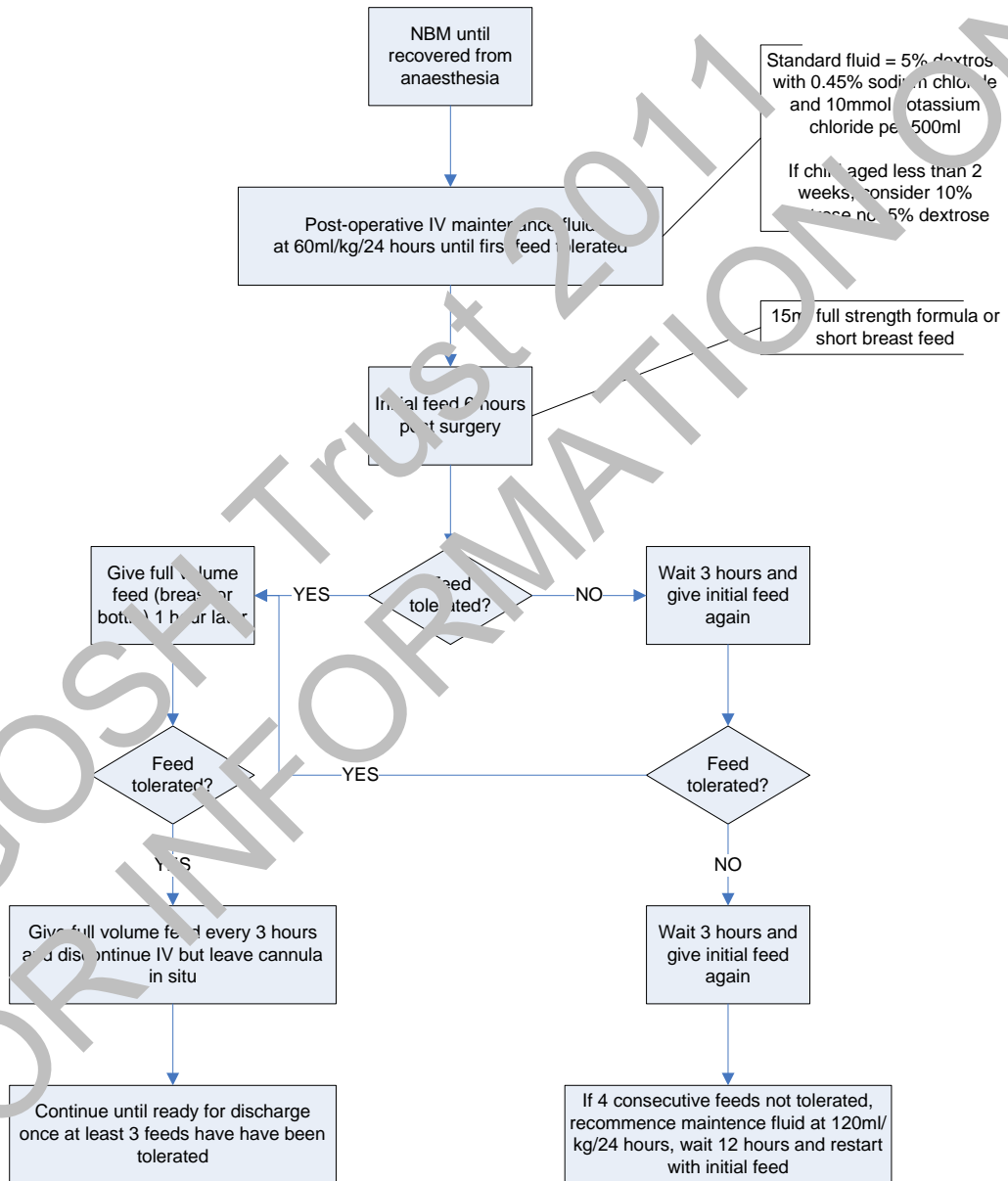

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## Pre-pyloromyotomy feeding regime



## Post-pyloromyotomy feeding regime



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

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## Day of operation – Post-procedural care

ID	Activity	Day shift			Night shift		
		Date:			Date:		
		Met	Not met	N/A	Met	Not met	N/A
Enter initials/time			Enter 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						
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 oxygen saturation (blood pressure if required) half hourly for 2 hours then 4 hourly						
0060	Record strict fluid intake and output on fluid balance chart						
0061	Review and attend to pressure area care and moving/handling as per assessment						
0062	Assist with basic hygiene needs						
0063	Medical handover sheet updated as necessary						
0064	Nursing handover sheet updated as necessary						
0065	Support patient and family						
0066	Continue discharge planning using checklist on page 15						

## Outcomes for episode

ID	Activity	Day shift			Night shift		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials			Enter initials		
X0009	Observations within CEWS acceptable ranges						
X0010	Pain adequately controlled						
X0011	No signs of immediate wound complications						
X0012	Child and family updated on procedure						

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## Post-procedure day 1

ID	Activity	Day shift			Night shift		
		Date:			Date:		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials/time			Enter 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 duration of stay						
0075	Record strict fluid intake and output on fluid balance chart						
0076	Review and attend to pressure area care and moving/handling as per assessment						
0077	Assist with basic hygiene needs						
0078	Medical handover sheet updated as necessary						
0079	Nursing handover sheet updated as necessary						
0080	Support patient and family						
0081	Continue discharge planning using checklist on page 15 if not ready for discharge						
0082	Complete discharge planning using checklist on page 15						
0083	Ensure cannula removed						
0084	Complete discharge notification and send to all relevant parties						

## Outcomes for episode

ID	Activity	Day shift			Night shift		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials			Enter initials		
X0013	Observations within CEWS acceptable ranges						
X0014	Pain adequately controlled						
X0015	Discharge criteria on page 3 have been met						
X0016	Family understanding of aftercare confirmed						
X0017	Child is safely discharged						

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## Post-procedure day 2

ID	Activity	Day shift			Night shift			
		Date:			Date:			
		Met	Not met	N/A	Met	Not met	N/A	
Enter initials/time			Enter initials/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 balance chart							
0094	Review and attend to pressure area care and moving/handling as per assessment							
0095	Assist with basic hygiene needs							
0096	Medical handover sheet updated as necessary							
0097	Nursing handover sheet updated as necessary							
0098	Support patient and family							
0099	Continue discharge planning using checklist on page 15 if not ready for discharge							
0100	Complete discharge planning using checklist on page 15							
0101	Ensure cannula removed							
0102	Complete discharge notification and send to all relevant parties							

### Outcomes for episode

ID	Activity	Day shift			Night shift		
		Met	Not met	N/A	Met	Not met	N/A
		Enter initials			Enter initials		
X0018	Observations within CEWS acceptable ranges						
X0019	Pain adequately controlled						
X0020	Discharge criteria on page 3 have been met						
X0021	Family understanding of aftercare confirmed						
X0022	Child is safely discharged						

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## Discharge checklist

Predicted date of discharge			Discharged to	
	Yes	No	Details	Initials
<b>Transport</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Medication</b> <ul style="list-style-type: none"> <li>▪ Prescribed</li> <li>▪ Collected</li> <li>▪ Explained</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Equipment</b> <ul style="list-style-type: none"> <li>▪ Ordered</li> <li>▪ Delivered</li> <li>▪ Explained</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Teaching</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Follow up arrangements</b>	<input type="checkbox"/>	<input type="checkbox"/>		
<b>Discharge contact made</b> <ul style="list-style-type: none"> <li>▪ Other GOSH clinicians</li> <li>▪ Family doctor (GP)</li> <li>▪ Local paediatrician</li> <li>▪ Community team</li> <li>▪ Social worker</li> <li>▪ Other</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>		

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