<table>
<thead>
<tr>
<th>Project ID</th>
<th>Uncertainty (PICO)</th>
<th>Original uncertainty</th>
<th>Evidence (reference, and weblink where available, to the most recent relevant systematic review identified by the PSP, plus a maximum of 2 other systematic reviews, including protocols for future systematic reviews, included in the PSP)</th>
<th>Source of Uncertainty (if there are multiple sources, a PSP may wish to consider additional information from the sources listed)</th>
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<tbody>
<tr>
<td>1</td>
<td>Are ongoing mental health assessments for patients admitted to a general paediatric inpatient unit beneficial?</td>
<td>What is the awareness of mental health in patients and any training to support the language/interactions they have with children to support their whole care mind, body and spirit while hospitalized? How does an admission to a general paediatric ward affect patients' overall mood and mental health? What is the impact of isolation precautions on clinical outcomes and child/family coping? Involving a mental health assessment with every pediatric patient admitted to hospital (and knowing how to do this)? What kind of psychological impact do hospital procedures have on kids post admission? What kind of psychological impact do hospital procedures have on kids post admission?</td>
<td><strong>CPS statement</strong>: A wide range of tools are available for screening. Nothing specific to general pediatric inpatient unit; <a href="https://www.cps.ca/en/mental-health-screening-tools">https://www.cps.ca/en/mental-health-screening-tools</a>; AAP guideline: List of tools available; not specific to inpatient unit; <a href="https://downoads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf">https://downoads.aap.org/AAP/PDF/Mental_Health_Tools_for_Pediatrics.pdf</a></td>
<td>2 x parent/caregiver, 1 x nurse, 1 x youth</td>
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<tr>
<td>2</td>
<td>What comfort care and pain management tactics are being used in pediatric care? What is the best way to care for patients with chronic pain? Or patients with chronic illness that have pain related to this?</td>
<td>Comfort care and pain management tactics are used in pediatric care. Is Tylenol and Advil alternated every 3 hours more effective for pain then giving Tylenol and Advil together? All types of procedural pain control and anxiety relief in the paediatric patient and underutilization Can we do everything to make these stressful painful procedures less so for kids? Effect of non-medical pain management. morphine seems to negatively affect teenage boys, aren't there other options for pain management? How to minimize the pain of hospital tests Pain relief in hospital pediatrics. Distractions that can be used to help minimize pain or anxiety. How can we improve patient care through the usage of language when discussing pain with children, what other methods are they compared to the 1-10 scale, what other options are available to teaching children about their pain or chronic condition? Education of patients how to assess pain and opioid</td>
<td><strong>CPS statement</strong>: Guidelines are available; Trottier ED, Doré-Bergeron MJ, Chauvin-Kimloff L, Baerg K, Ali S. Managing pain and distress in children undergoing brief diagnostic and therapeutic procedures. Paediatrics &amp; child health. 2019 Dec;9(4):509-21.</td>
<td>3 x parent/caregiver, 1 x physician, 1 x respiratory therapist, 1 x friend/family member, 1 x physical therapist</td>
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</table>
When can we go home? What role would a step down unit for a rehab unit play in the transition home for a family in which their child acquired a significant disability - ie prior to discharge being in a near by apartment like setting in which the parent take full responsibility for care and the acute rehab team simulate community therapy and support. Need research and O to minimize LOS and promote best practice in care and safe discharge. brain injury or spinal cord to ease the transition home. What issues do they encounter after discharge that we should be addressing better during the inpatient stay? waiting for family services to find a safe home for discharge etc… - All items above and communicating when rounds will be. follow up post release from hospital. What are the perceptions of patients and families of their inpatient experience after they have settled at home? What issues do they encounter after discharge that we should be addressing better during the inpatient stay? Readmission rates for respiratory illnesses like asthma, bronchiolitis. Are there barriers to discharge that can be improved? Optimal management of most common conditions, bronchiolitis, asthma, etc while maintaining efficiency, safety, patient satisfaction. It could have been better if they knew it was so urgent to get us a date when we were leaving so we could have planned as a family. When will the next follow up be? Transition to Home Discharge (Are patients really following our recommendations? Lack of discharge planning. Admission could have possibly been avoided had more education been provided to parents regarding intake/output/breastfeeding and topping up. My concerns on my childs stay after being discharged were recognizing the symptoms of an attack and knowing when to seek help again or when it was a CPS statement. CPS guidelines on educating parents prior to discharge for healthy infants; Lemyry B, Jefferies AL, O’Flythe P. Facilitating discharge from hospital of the healthy term infant. Paediatrics & child health. 2018 Nov 19;23(8):515-22. Jefferies AL, Canadian Paediatric Society, Fetus and Newborn Committee. Going home: facilitating discharge of the preterm infant. Paediatrics & child health. 2014 Jan 10;19(1):31-6. AAP guideline: Discusses the discharge process for high risk neonates only; Committee on Fetus and Newborn. Hospital discharge of the high-risk neonate. Pediatrics. 2008 Nov;122(5):1119-26. NICE guideline: Guideline on preparing for discharge for mental health practitioners for adults. No guidelines specific to children. NICE. Transition between inpatient mental health settings and community or, care home settings. Hall, K. K., Pestyak, H. L., Chang, A. B., & O'Grady, K. F. (2018). Caseworker assigned discharge plans to prevent hospital readmission for acute exacerbations in children with chronic respiratory illness. Cochrane Database of Systematic Reviews, (11). Ronan, S., Brown, M., & Marsh, L. (2020). Parents’ experiences of transition from hospital to home of a child with complex health needs: A systematic literature review. Journal of Clinical Nursing, 29(17-18), 3222-3235. Spittle, A., Orton, J., Anderson, P. J., Boyd, R., & Doyle, L. W. (2015). Early developmental intervention programmes provided post hospital discharge to prevent motor and cognitive impairment in preterm infants. Cochrane Database of Systematic Reviews, (11). Verdict: Importance of discharge preparation has been raised in the systematic reviews, but little evidence has been found on the effective methods specific to the GPIU. The CPS and AAP discuss discharge planning but related to specific pediatric populations (e.g. term or preterm newborn infants). This question has been partially addressed in the evidence base.

All items above and communicating when rounds will be. Best practices for providing patient education before discharge. Prior to being put on the general ward one time my son had been in the ICU and after no longer being sedated he was able to talk. Then after being put on a new med all of a sudden he couldn’t talk and he lost his ability to use the toilet and had to wear pull ups. I was concerned about it on the general ward and they said it was just a side effect and it should go away. He got a referral to an outpatient clinic at medical day treatment to get checked over a few days after being discharged but still couldn’t talk or use the toilet. They ended up diagnosing him with psychosis from the med through the neuro clinic but I had to deal with a brain injury or spinal cord to ease the transition home. When we can safely bring her home? CPS statement. CPS guidelines on educating parents prior to discharge for healthy infants; Lemyry B, Jefferies AL, O’Flythe P. Facilitating discharge from hospital of the healthy term infant. Paediatrics & child health. 2018 Nov 19;23(8):515-22. Jefferies AL, Canadian Paediatric Society, Fetus and Newborn Committee. Going home: facilitating discharge of the preterm infant. Paediatrics & child health. 2014 Jan 10;19(1):31-6. AAP guideline: Discusses the discharge process for high risk neonates only; Committee on Fetus and Newborn. Hospital discharge of the high-risk neonate. Pediatrics. 2008 Nov;122(5):1119-26. NICE guideline: Guideline on preparing for discharge for mental health practitioners for adults. No guidelines specific to children. NICE. Transition between inpatient mental health settings and community or, care home settings. Hall, K. K., Pestyak, H. L., Chang, A. B., & O'Grady, K. F. (2018). Caseworker assigned discharge plans to prevent hospital readmission for acute exacerbations in children with chronic respiratory illness. Cochrane Database of Systematic Reviews, (11). Ronan, S., Brown, M., & Marsh, L. (2020). Parents’ experiences of transition from hospital to home of a child with complex health needs: A systematic literature review. Journal of Clinical Nursing, 29(17-18), 3222-3235. Spittle, A., Orton, J., Anderson, P. J., Boyd, R., & Doyle, L. W. (2015). Early developmental intervention programmes provided post hospital discharge to prevent motor and cognitive impairment in preterm infants. Cochrane Database of Systematic Reviews, (11). Verdict: Importance of discharge preparation has been raised in the systematic reviews, but little evidence has been found on the effective methods specific to the GPIU. The CPS and AAP discuss discharge planning but related to specific pediatric populations (e.g. term or preterm newborn infants). This question has been partially addressed in the evidence base.
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<tr>
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<th>What best practices and/or care models exist for inpatient care for children and youth with medical complexity on the general paediatric inpatient unit?</th>
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<tr>
<td>5</td>
<td>For children with medical complexity (CMC), they should have an automatic pharmacist and dietician who reviews their care. For CMC, I would like to know if we can get feedback from parents on how we could have prevented or shortened the hospitalization stay; how we could have improved the stay (Patient/family oriented outcome measures). How can weekend care be improved for medically complex children? Does avoiding transfer out of NICU or PICU of medically complex children prevent medical errors or lead to better patient care? Children with complexity now comprise a significant proportion of inpatients - how has &quot;traditional acute care&quot; model been effectively modified to meet the needs of this acute/chronic cohort? What is the best model of care to support children with neurocomplexities where there is no rulebook to follow? Risks to infants and developmental care and management. How do we communicate better with families and caregivers of CMC, particularly with respect to minimizing medical error and increasing quality of care? How can we identify and bridge care for complex cases that combine mental and physical health concerns be best cared for? How can we improve the discharge of medically complex children? CPS statement: Guideline related to possible medication error and its prevention. Huth K, Vandenbos P, Orkin J, Patel H. Medication safety for children with medical complexity. Paediatrics &amp; child health. 2020 Nov 29(7):473-. AAP guideline: Recognizes CMC as a special population but does not outline best practices or care models. Kuo DZ, Houtrow AJ. Recognition and management of medical complexity. Pediatrics. 2016 Dec 1;138(6). NICE guideline: No relevant guidelines. Bradshaw, S., Bern, D., Shaw, K., Taylor, B., Chiawell, C., Salama, M., . . . &amp; Cummins, C. (2019). Improving health, wellbeing and parenting skills in parents of children with special health care needs and medical complexity—a scoping review. BMC pediatrics, 19(1), 1-11. Verdict: Lack of evidence on best practices for CMC. This question has not been addressed in the evidence base.</td>
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<th>What best practices and/or care models exist around discharge for children and youth with medical complexity on the general paediatric inpatient unit?</th>
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| What methods of communication are most effective between patients, caregivers, and health care providers on a general paediatric inpatient unit? | Every interaction was very quick. The information would be relayed so quickly that I couldn't think of a response until after the physician/nurse left the room. Why do I only see my child's doctor randomly when I sit by their bedside? It is hard to be there all the time. It would be great to do research that streamlines communication, or perhaps, enhance communication by being transparent with patients and families as to why you need to hear the same information over and over, and how the information is used to inform care. Would like to be told in advance about the risks of Botox with green tendon transfer. Also no one could explain why hair on the arm under the cast grew so long.  
How can we decrease hospital duration in medically complex children by coordinating care by multiple specialists in a more timely manner?  
I feel that there needs to be better communication between healthcare professionals in regards to their patients. What are the barriers and enablers to providing assessment, treatment planning and the communication is this to the patient +/- family in an integrated ways?  
Communication between HCPS and patients and families  
Would care be better and would families learn more from informal interactions with other families if children with similar conditions were grouped together—even if all on a general paediatrics unit?  
How does a community doctor know when their patient is hospitalized and how other families if children with similar conditions were grouped together—even if all on a general paediatrics unit?  
Would care be better and would families learn more from informal interactions with other families if children with similar conditions were grouped together—even if all on a general paediatrics unit?  
Miscommunication leading to longer hospital stays, incorrect treatments, unsafe information that was communicated wasn't trusted.  
How to communicate with families in a teaching environment that does not add to patient care, frustrated families and inefficient care.  
It would be great to do research that streamlines communication, or perhaps, enhance communication by being transparent with patients and families as to why you need to hear the same information over and over, and how the information is used to inform care.

| Do communication systems or tools that connect healthcare providers on the general paediatric inpatient unit with community providers improve care of patients? | Do communication systems or tools that connect healthcare providers on the general paediatric inpatient unit with community providers improve care of patients?  
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**CPS statement:** Guidelines are available (using interpreters for cross-cultural communication)  
**AAP guideline:** Guidelines are available.  
**NICE guideline:** No relevant guidelines.

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<tbody>
<tr>
<td>2 x physician</td>
<td>1 x occupational therapist</td>
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<tr>
<td>12 x friend/family</td>
<td>6 x parent/caregiver</td>
</tr>
<tr>
<td>5 x physician</td>
<td>3 x nurse</td>
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<tr>
<td>Question</td>
<td>CPS Statement</td>
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<td>-------------------------------------------------------------------------</td>
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<tr>
<td>What are the most effective communication methods (e.g., handover, rounds, etc.) between healthcare providers on a general paediatric inpatient unit?</td>
<td>No relevant guidelines.</td>
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<tr>
<td>Lack of communication between specialists</td>
<td></td>
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<tr>
<td>Lack of communication between nursing staff post surgery and specialist team</td>
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<td>Many! There is a very big lack of communication between doctors and nurses. Nurses at the same time don’t communicate effectively to parents and just give orders. When it comes to children, surgery and anesthesia it is extremely important to educate the parent and build a plan together as per meals including water and other drinks. Nurses don’t like to give information to parents and it’s cruel to ask a parent not to feed their children for days specially when they still breast feed and are in pain.</td>
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<td></td>
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<tr>
<td>CPS statement: No relevant guidelines.</td>
<td></td>
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<tr>
<td>AAP guideline: No relevant guidelines.</td>
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<tr>
<td>NICE guideline: No relevant guidelines.</td>
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<td>Verdict: Did not find evidence that looks at communication between provider teams in the GPIU. While there is some evidence related to the IPASS handover system, there are no systematic reviews that include this stool. This question has not been addressed in the evidence base.</td>
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<td>Lack of professional communication between staff RN to RN and also to other members of health care teams and disciplines</td>
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<td>The nurses were incredible. They obviously cared greatly for our child and what she was going through. They were the biggest source of information for us throughout the week we were staying in hospital, and made sure we understood everything they were doing, and why. They explained everything they were doing and WHY, often detailing different research information while explaining things to us.</td>
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<tr>
<td>How efficient is Epic compared to other systems used in hospitals?</td>
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<td>How can we utilize connect care for communication between teams?</td>
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<td>Since Covid, opportunities for interprofessional discussion at rounds is more difficult. Is there a way to improve this?</td>
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<td>How can we have better processes/structures to ensure better flow of information (between staff and families) throughout a hospital stay and beyond (after discharge)?</td>
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<td>Longitudinal discussion can help clarify what work/doesn't work in real life and help/incorporate new evidence where applicable</td>
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<td>MultiD handover and rounds how it is run and the best way to run to incorp family centered care</td>
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<td>Why do most centres claim to offer &quot;family centred care&quot; but spend most of their time speaking for and about patients on rounds?</td>
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<td>Most tests are not explained before they are done. What are they looking for?</td>
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<td>What could be the implications? An x-ray machine was wheeled into our room, but no one had told us it was coming, or why. When the results were received, we were only told it was “clear”, but never informed as to what they were looking for. Tests should be explained before they happen, in order to prepare the family ahead of time, especially those who have children who will have questions themselves. If our baby hadn’t been pre-verbal, explaining why the giant machine was there to look at her insides with no information would’ve been quite difficult, and possibly scary.</td>
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<td>Most of the doctors were very quickly in and out, with little time for explanation, except to tell us they’d ordered tests. Only one stayed to give us a more in-depth reason as to the testing they were requesting, and what it might mean for our baby’s health in future. This took all of five minutes, but was incredibly reassuring. Due to poor communication, there have been unnecessary tests ordered, delays in patient care and poor plan of care execution. Many! There is a very big lack of communication between doctors and nurses. Nurses at the same time don’t communicate effectively to parents and just give orders. When it comes to children, surgery and anesthesia it is extremely important to educate the parent and build a plan together as per meals including water and other drinks. Nurses don’t like to give information to parents and it’s cruel to ask a parent not to feed their children for days specially when they still breast feed and are in pain.</td>
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<tr>
<td>CPS statement: No relevant guidelines.</td>
<td></td>
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<td>AAP guideline: No relevant guidelines.</td>
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<td>NICE guideline: No relevant guidelines.</td>
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<td>Verdict: Evidence is limited to communication around testing. This question has not been addressed in the evidence base.</td>
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What is the most effective route (i.e. IV vs PO) and duration of antibiotic therapy for children and youth with bacteremia (of known origin e.g. UTI vs unknown source) on a general paediatric inpatient unit?

- Duration of treatment for neonatal UTI
  - Treatment of neonatal febrile UTI: IV vs PO and duration of treatment
  - Treatment for infants with bacteremic UTI
  - Duration of intravenous antibiotics for infant under 30 days of age with urinary tract infection.
  - UTI prophylaxis - still wide variation in practice especially between urology and pediatrics - who needs prophylaxis?
  - Use of oral antibiotics in neonates with urinary tract infections
  - Treatment of neonatal febrile UTI: IV vs PO and duration of treatment
  - Duration of IV vs total Rx for pyelo

CPS statement: Management guidelines focused on optimum antibiotic use


AAP guideline: Specific instructions suggesting oral IV antibiotic therapy (for CAP)


NICE guideline: No relevant guidelines.

Verdict: Evidence is limited to specific clinical conditions; the overall evidence is unclear. Systematic review by Havey et al., is the best available evidence. This question has been partially addressed in the evidence base.

What is the most effective route (i.e. IV vs PO) and duration of antibiotic therapy for urinary tract infections (UTIs) with and without a negative blood culture?

- Duration of treatment for neonatal UTI
  - Treatment of neonatal febrile UTI: IV vs PO and duration of treatment
  - Use of oral antibiotics in neonates with urinary tract infections
  - Treatment for infants with bacteremic UTI
  - Duration of intravenous antibiotics for infant under 30 days of age with urinary tract infection.
  - UTI prophylaxis - still wide variation in practice especially between urology and pediatrics - who needs prophylaxis?
  - Use of oral antibiotics in neonates with urinary tract infections
  - Treatment of neonatal febrile UTI: IV vs PO and duration of treatment
  - Duration of IV vs total Rx for pyelo

CPS statement: No significant difference between IV and PO antibiotics; no difference between short and along-course antibiotics (> 2 months of age)


NICE guideline: Recommends Vf for <3 months; PO as first line for > 3 months, if vomiting exists then IV. Recommends 7-10-day antibiotic course also identifies that no difference between IV and PO routes.

Verdict: Evidence is limited to specific clinical conditions; the overall evidence is unclear. Systematic review by Havey et al., is the best available evidence. This question has been partially addressed in the evidence base.
What is the most effective way to use oxygen monitoring (e.g. intermittent, continuous) for hospitalized children with common respiratory illnesses (e.g. bronchiolitis) on the general paediatric inpatient unit?

Continuous oximetry monitoring has become commonplace on the pediatric ward. Kids move around a lot and there can be a lot of false ‘desats’ and these can lead to alarm fatigue and missed real desats.” I’m curious about whether routine continuous oximetry is overused on the general pediatric ward. We know from ICU experience that it can lead to alarm fatigue (especially evidence in NICU.) Should this target be different on admission, during signs of significant respiratory distress, and later, when hospital discharge is considered? Is it 95%, 92%, 90%? Also there is a huge discrepancy in SpO2 monitoring with the current patient room monitors vs the model used for overnight oximetries. This was brought to Respirp's attention. Look at the procurement of hospital equipment...does it involve the right professions for feedback at purchase time. An example...new ventilators just recently purchased...is cheaper always better? Are there adverse events related to alarm fatigue where we would be better off using continuous SpO2 monitoring more judiciously? What is the oxygen saturation to aim for in the case of acute respiratory failure (acute viral bronchiolitis in infants, pneumonia, asthma attack...) Are we intervening before adverse events because of this monitoring? Do the monitors get over used? Intermitent vs continuous oxygen use When does a child really need to be given oxygen as an intervention for breathing which may decrease the likelihood that they will manage well on room air. Could I test weaning with and without the prongs on a see if it makes a difference?

AAP statement: Topic of continuous versus intermittent monitoring of oxygen saturation is controversial, with lack of clear recommendations.

CPS statement: Topic of continuous versus intermittent monitoring of oxygen saturation is controversial, with lack of clear recommendations.

Verdict: Could not find any relevant systematic reviews that address this query. Checked references from CPS statement and AAP guideline, but references are either outdated or inconclusive. Also checked a recently published clinical trial (Mahant et al. 2021) but no systematic review.

How many resources (1x respiratory therapist, 1x physical therapist, 1x nurse) does it take to manage a respiratory patient on the general paediatric ward?

Verdict: The evidence available is based on ICU level care and not the GIPU or inpatient ward; limited evidence to answer the question. This question has NOT been addressed in the evidence base.

What is the most effective way (i.e. population, illness, initiation, weaning) to utilize heated high flow nasal cannula (HHFNC) in hospitalized children and youth on the general paediatric inpatient unit?

High Flow Nasal Cannula needs a closer look as there is belief that due to a lack of RT resources able to attend rounds, there is a delay in weaning of O2 to transition to Nasal prongs to room air...again not cost effective and delay in weaning for who benefits from high flow

CPS statement: Topic of continuous versus intermittent monitoring of oxygen saturation is controversial, with lack of clear recommendations.

Verdict: Studies identified focused on effectiveness of HHFNC and not on why it is effective, or which way is most effective. Evidence is present but not sufficient to answer the question. This question has NOT been addressed in the evidence base.

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AAP statement: Discussed weaning from continuous positive airway pressure (CPAP) to heated high flow nasal cannula (HHFNC) but no specific recommendations on weaning from HHFNC.

CPS statement: Topic of continuous versus intermittent monitoring of oxygen saturation is controversial, with lack of clear recommendations.

Verdict: Could not find any relevant systematic reviews that address this query. Checked references from CPS statement and AAP guideline, but references are either outdated or inconclusive. Also checked a recently published clinical trial (Mahant et al. 2021) but no systematic review.

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16. What is the most appropriate way to provide fluid therapy (e.g., IV, nasogastric tube) to children and youth hospitalized with bronchiolitis in a general paediatric inpatient unit?

How long should an infant with bronchiolitis have sxs >= 90 on room air prior to discharge, to prevent readmission - one night, one nap, 4 hours, 12 hours?

What is the most appropriate way to provide fluids to hospitalized children with bronchiolitis?

1. Bronchiolitis care: Is NG hydration superior to IV hydration? Seems plausible that it may be generally fewer attempts, less hypotension, no need to do daily tyes and provides calories. But is it better, or at least non-inferior to IV? (in terms of clinical outcomes, LOS, weight loss during hospital stay, etc)

2. The effectiveness of hypertonic saline in secretin clearance of bronchiolitis. Is this an unnecessary step?

Are there negative outcomes associated with the use of nasogastric bronchodilators in treatment of children admitted for acute bronchiolitis?

Also there is a huge discrepancy in SpO2 monitoring with the current patient room monitors vs the model used for overnight oximetry. This was brought to Respiriology's attention. Look at the procurement of hospital equipment...does it involve the right professions for feedback at purchase time. An example...new ventilators just recently purchased...is cheaper always better? ????

CPS: Bronchiolitis guideline available which states that both routes of fluid therapy equally effective.


AAP: Guideline available, but does not clarify which route is superior.


NICE: Guideline suggests using enteral tube fluid, but if not possible then parenteral fluids.

https://www.nice.org.uk/guidance/eng9


Verdict: There are no systematic reviews, only 1 published protocol. This question has NOT been addressed in the evidence base.

17. What is the most effective route (i.e., IV vs PO) optimal indications, duration of antibiotic therapy for children and youth hospitalized with cellulitis on a general paediatric inpatient unit?

Early step down to oral in cellulitis.

How long should children with orbital cellulitis treated with IV antibiotics?

2) Duration of antibiotics for almost every infection we commonly treat (e.g. pneumonia, osteomyelitis/septic arthritis, UTI, mastoiditis, orbital/periorbital cellulitis, other skin/soft tissue infections (e.g. adenitis))

Prolonged courses of antibiotics when there is no evidence to the contrary. Broadly, under what circumstances can antibiotics safely be minimized or withheld?

Optimal treatment durations.

CPS: Guideline focused on management of methicillin resistant Staph aureus (MRSA)


AAP: No relevant guidelines. The one found is specific to orbital cellulitis


NICE: No relevant guidelines.

Verdict: There are no systematic reviews. The only relevant evidence found was a guideline specific to orbital cellulitis. The guideline also doesn’t clarify if IV or PO is the effective route. The question has NOT been addressed in the evidence base.

18. What are effective treatments for children and youth hospitalized with an acute asthma exacerbation on a general paediatric inpatient unit?

More efficacious medications for asthma relief:

Duration of oral corticosteroids for patients admitted for acute asthma exacerbation

Withdrawal protocol for administration of ventolin during asthma exacerbation attacks.

See treatment of asthma - Best Treatments for Asthma Screening

new asthma guidelines

Some patient care pathways (ex. asthma pathway used at CHEO) can be difficult to understand and follow, especially for new nurses, and sometimes this leads to improper treatment and increased time for recovery/discharge.

My son has asthma and has been hospitalized many times with a need for steroids and oxygen. There are many exercises that staff try to get him to do to open his lungs. The most I have ever seen him improve though, due to laughter, and opening his lungs, was when child life specialists or the clown have come and played in a silly way. Are there studies that support the use of these programs? I firmly believe that they had a large impact on the speed of my son's recovery.

CPS statement: Available, but no specific recommendations focused on inpatient management; mainly focuses on ED care.


AAP guideline: No relevant guideline.

NICE guideline: People admitted to hospital with an acute exacerbation of asthma should have a structured review by a member of a specialist respiratory team before discharge. No other details have been provided.


19 Are additional doses of corticosteroids effective in hospitalized children and youth with croup on a general paediatric unit?

**Treatment of a patient with croup hospitalized in general pediatrics (after first dose of steroid)?**

CPS: Guideline discussed first dose of corticosteroid (ED based management)


AAP: Guideline discussed only single dose of corticosteroid.


NICE: No relevant guidelines.


Roked F, Atkinson M, Hartshorn S. G95 (P) Best practice: one or two doses of dexamethasone for the treatment of croup?


Verdict: Evidence exists on the use of corticosteroid on croup focused on the initial dose. It does not suggest if an additional dose is effective. The question has NOT been addressed in the evidence base.

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20 What are the most appropriate IV maintenance fluid?

**Use of plasmalyte in DKA or more broadly in Pediatrics, Diabetes Guidelines regarding IV fluids.**

Guidelines are present

CPS: Guidelines are present


AAP: Guidelines is present


NICE: Guideline does recommend use of IV fluid but does not specify the type that is appropriate.

National Institute for Health and Care Excellence. Intravenous fluid therapy in children and young people in hospital. NICE. www.nice.org.uk/guidance/ng29

Verdict: In the ICU, hypotonic fluid leads to increased rates of hyponatremia compared to isotonic. For the GPIU, there is some evidence of similar increases in hyponatremia. Although there is no single IV fluid composition that is ideal for all children, an isotonic saline solution does appear to be the safer choice when maintenance IV fluid therapy is used in the general pediatric inpatient unit.

---

21 What is the utility of routine blood cultures in children and youth hospitalized with common condition on a general paediatric unit?

**The yield, and thus the usefulness of blood culture in different context, like urinary tract infection, pneumonia, fever,**

CPS: No relevant guidelines.

AAP: No relevant guidelines.

NICE: No relevant guidelines.

Verdict: Evidence on benefits of routine blood culture is limited. The only evidence found was focused on community acquired pneumonia (CAP). The question has NOT been addressed in the evidence base.

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22 What is the most effective way to obtain and maintain IV access in children and youth hospitalized on the general paediatric unit?

**Do patient/families prefer blood work/IV starts to be done in their rooms or in a separate treatment room? Or why they didn’t use NICU butterfly iv?**

CPS: Guideline makes recommendations on positioning of child, but is limited overall.


AAP: No relevant guidelines.

NICE: The question has NOT been addressed in the evidence base.

Verdict: There was insufficient evidence to support the use of ultrasound, infrared light or transillumination. Interventions to reduce children’s pain did not decrease first attempt success. The question has NOT been addressed in the evidence base.
What are potential uses of point of care ultrasound in the general paediatric inpatient unit?

Potential uses of point of care ultrasound in the general paediatric inpatient unit are to monitor and manage patients with specific conditions such as ventilator weaning, sepsis, and shock. Ultrasound can be used to visualize the heart, vascular structures, and other anatomical features. It can also be used for procedural guidance, such as central line placement, and to assess for complications like intravascular catheter placement and monitor hemodynamic status. Ultrasound can help in making real-time diagnostic decisions and improving patient outcomes.

What are effective strategies to mitigate the impacts of prolonged hospitalization on general paediatric inpatients?

Effective strategies to mitigate the impacts of prolonged hospitalization on general paediatric inpatients include providing adequate support and resources, such as access to social workers, psychologists, and rehabilitation services. Communication with the family is crucial to keep them informed and involved in the patient's care. Early discharge planning and transition planning are also important to ensure a smooth transition from hospital to home. The use of telemedicine and telehealth services can also help in reducing the duration of hospitalization.

What are the experiences and needs of hospitalized families, especially those who experience multiple hospitalizations?

The experiences and needs of hospitalized families, especially those who experience multiple hospitalizations, are complex and multifaceted. Families may face challenges related to financial strain, lack of information, and uncertainty about the patient's condition. They may also experience stress, anxiety, and depression. Hospital staff can support families by providing clear information, emotional support, and resources like financial assistance and counseling. Early intervention and involvement of family members in the patient's care can help in reducing these challenges.

What are the potential uses of point of care ultrasound in the pediatric inpatient setting?

Potential uses of point of care ultrasound in the pediatric inpatient setting include monitoring hemodynamic status, assessing for complications like intravascular catheter placement, and guiding procedures like central line placement. Ultrasound can also be used for procedural guidance, such as central line placement, and to assess for complications like intravascular catheter placement. Ultrasound can help in making real-time diagnostic decisions and improving patient outcomes.

What are effective strategies to mitigate the impacts of prolonged hospitalization on general paediatric inpatients units? Understanding the impact of prolonged hospitalization of inpatient child and youth from Nunavut on their families and especially on the caregivers. Issues included: family separation due to the 1 escort policy, isolation, mental health challenges, emotional breakdown due to displacement and lack of support etc... What we need do long term patients/families have. What are the perceptions of patients and families of their inpatient experience after they have settled at home? What are the experiences and needs of hospitalized families, especially those who experience multiple hospitalizations?

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What are effective interventions for children and youth hospitalized with cyclic vomiting on the general paediatric inpatient unit?

Severe, refractory cyclic vomiting syndrome: establish a national network/database to help inform care decisions for this challenging patient population.

CPS: No guideline found
AAP: No guideline found
NICE: No guideline found


Verdict: Studies found are based on findings in acute care setting or ED. While ondansetron is an effective pharmacotherapy, overall, the question has NOT been addressed in the evidence base.

What are the most effective interventions in infants, children and youth with gastrooesophageal reflux disease (GERD) on the general paediatric inpatient unit?

Typical practices for the assessment of swallowing and GERD as well as management of GERD and 'silent aspiration' in preterm neonates. Indication to repeat the dose, etc. / Assessment and treatment of reflux

CPS: No guideline found
AAP: Practice guideline identified but the evidence is unclear.
NICE: Guideline available

Gastro-oesophageal reflux disease in children and young people: diagnosis and management
[https://www.nice.org.uk/guidance/ng1/chapter/1-Recommendations#enteral-tube-feeding-for-gord]

Verdict: No studies identified.

What is the most effective way to standardize care and reduce unnecessary variation in care delivered to hospitalized children and youth on the general paediatric inpatient unit?

No consistent evidence-based care provided. Poor clinical evidence informed practice

CPS: No guideline found
AAP: No guideline found
NICE: No guideline found


NICE: Guideline available


Verdict: Studies identified but they focus on surgical interventions only. The question has NOT been addressed in the evidence base.

What is the most effective strategy for hospitalized children and youth with neurologic impairment who suffer from chronic respiratory illness on the general paediatric inpatient unit?

Sharing order sets for common pediatric conditions (i.e. Kawasaki Disease, Sickle Cell, Sepsis, etc.).

CPS: No guideline found
AAP: No guideline found
NICE: No guideline found


Verdict: The only article found reports that standardized care reduces cost, but does not specify the most effective way. The question has NOT been addressed in the evidence base.

What are the best management strategies for respiratory symptoms / salivormia in children with neurological impairment?

Use of Domase/pulmozyme for patients with hypotonia to help with respiratory secretion clearance

CPS: No guideline found
AAP: No guideline found
NICE: No guideline found

No studies identified

Verdict: No studies identified. The question has NOT been addressed in the evidence base.
### 50

How can we ensure that healthcare delivery in hospital meets the needs of children and youth with developmental disabilities on the general paediatric inpatient unit? (or is there evidence that healthcare delivery needs to be different, unique for this population - needs presuming evidence)

<table>
<thead>
<tr>
<th>My daughter had a rare genetic condition at birth. During her 67-day stay at the paediatric hospital, she was seen by many doctors and received many types of tests, the medical team was not able to give a precise medical diagnosis, let alone an effective treatment plan. For us (parents), everyday our question was - what would be the effective treatment plan for our daughter? My largest concern is around the assumptions that healthcare workers make with non-neurotypical children. I feel that these incorrect assumptions have impacted the quality of my child's care. Our other concern is our child is diagnosed with ASD. When he was younger getting him to take the inhalers while it was still manageable a challenge and I found not everyone was equipped with the knowledge to help with those challenges.</th>
</tr>
</thead>
</table>

### 31

What is effective support strategies for parents, families and children/youth hospitalized on the general paediatric inpatient unit? E.g. support groups, private rooms/sleeping arrangements, breastfeeding support, physical activity, making the ward more adolescent-friendly, screen time, Indigenous communities and spiritual care

<table>
<thead>
<tr>
<th>Support strategies for parents with a child with a recent acquired disability: No where to sleep. Interested in more research about day/night cycles and the impact of disturbing these in inpatient settings. Parent education/comfort in caring for children is a huge area requiring more investigation. The impact of the parent-partner to reduce the length of hospitalization recommendations for discharge and rehospitalization in the following mont...</th>
</tr>
</thead>
</table>

### Resources

Can the nutritional needs of children/youth and their families be addressed as an essential part of the therapeutic care plan on a general paediatric inpatient unit and what are effective methods to support children and families’ nutritional needs?

Not provided food.

Assessment of nutritional status. What are the benefits of a nutrition screening tool upon admission? Food is not appropriate to the MEDICAL COMPLAINT that the youth is admitted for. Who are the efficient tools to standardize length measurements? There is better ways we can assess if’s that have issues with feeding tolerance and we can create some sort of pathway for having MD support nurses in addressing/supporting parents who are ++ resistant to advance feeds. Seems to be a repeat issue leading to ++sick admissions on 7d. How well do we support the recommendations of good health with admitted patients (e.g. electronic time, nutrition, physical activity, etc.)? We should not just ask about medications but care and nutrition that is specific to the care of the child.

We should not just ask about medications but care and nutrition that is specific to the care of the child. Mothers who are breastfeeding their child in hospital have 0 support. Are there any specific coping mechanisms that healthcare professionals can help chronically ill children/families develop? What are interventions to reduce food insecurity for families during the inpatient stay? Food choice and support for those who are experiencing food insecurity as a family during the stay? Food was such a high issue we have to request 4 times to only send chicken or vegetables and finally I told them to not to get food we will get it from outside or I will leave my daughter in hospital to go home to cook. I did not like wasting so much food someone else could have eaten it. Not very good menu. Food is not appropriate to the MEDICAL COMPLAINT that the youth is admitted for!! Not provided food.

Also, I should be allowed to get a coffee when I have not eaten for 24 hours.

CSF: No guidelines were found
AAP: No guidelines were found
NICE: No guidelines were found


Verdict: Some studies were identified but many aspects of the questions remain unanswered. The question has NOT been addressed in the evidence base

52

When it is appropriate to involve allied health care professionals (e.g. OT, PT, child life specialists) in the care of hospitalized children/youth on the general paediatric inpatient unit?

Increase in the number of resources available for patients such as child life specialists and OT/PT support. Access to Child Therapist during hospitalization and family overall experience on the general paediatric ward.

Are there any specific coping mechanisms that healthcare professionals can help chronically ill children/families develop? BC Children’s Hospital does not have a Speech-Language Pathologist for its inpatient patients, is it affecting that outcomes or patient stay? Should acute care patients have access to Speech Language Pathologist? Respiratory ward: Respiratory Physiotherapy should be a very major part of this ward which is NO WHERE TO BE SEEN!! It’s a real disgrace example can we reduce the workload of the doctor by giving more latitude to the respiratory therapist?

Poor RT resource availability on wards that can improve patient outcomes better than NP and PA... we are the experts in airway and ventilation...especially in chronic care of trach ventilated patients. Unbalance use of RT resources that can improve patient outcomes and D/C dates.

CSF: No guidelines were found
AAP: No guidelines were found
NICE: No guidelines were found


Verdict: The only systematic review includes mainly adult studies, with only 3 on infants, and 1 in the NICU. There is very little pediatric specific evidence. The question has NOT been addressed in the evidence base

54

What are best practices and support strategies for Indigenous patients and their families on the general paediatric inpatient unit?

Understanding the impact of prolonged hospitalization of Inuit children and youth from Nunavut on their families and especially on the caregivers. Issues include: family separation due to the 1 escort policy, isolation, mental health challenges, emotional breakdown due to displacement and lack of support etc... What is the impact of medical transport to a pediatric center on children youth and families from Nunavut. What is the average length of stay. What are the factors that impact the longer length of stay? How can we better take care of our Indigenous patients/families, barriers to giving care to this population. What are the experiences of Inuit children, youth and their families from Nunavut who require hospitalization at CHEO? What are the factors that cause a medically complex child to be placed into foster care instead returning back home to Nunavut?

CSF: There are relevant guidelines but not focused on GPUI care.


Verdict: Some of the identified articles studied interventions directed to indigenous children, but they were not systematic reviews and were not relevant to GPUI care. The question has NOT been addressed in the evidence base
1. What % of babies, admitted for diagnoses of failure to thrive or cows milk protein allergy and admitted on breastfeeding or EBM are still receiving breast milk a month after discharge and what can we do to improve this rate?

Mothers who are breastfeeding their child in hospital have 0 support. Breastfeeding friendly hospitals- babies admitted with dehydration/feeding top up since hospital isn’t in Mon are not encouraged to use formula on post-partum unit (in some cases the moms don’t even want to breastfeed).

What are the barriers to breastfeeding mothers being supported when their breastfed infant is hospitalized?

Admission could have possibly been avoided had more education been provided to parents regarding intake/output/breastfeeding and topping up.

2. What are effective ways to support breastfeeding mothers when their breastfed infant is hospitalized on the general paediatric inpatient unit?

Security for patients and staff with potentially violent patients

Appropriate assignment of roommates in shared rooms

The benefits of private rooms vs shared rooms

and staff?

The question has been partially addressed in the evidence base. Noise, light, shared room, presence of window, etc. Overall, given the small number of patients available, there are several areas that warrant future research. The question has been partially addressed in the evidence base.

3. What is the impact of the patient’s rooming-in on health outcomes on the general paediatric inpatient unit?

| What is the evidence for environmental interventions to reduce stress for families and staff? |
| What are the benefits of private rooms vs shared rooms |
| Window vs no window bed - effects on recovery and mental health |
| Appropriate assignment of roommates in shared rooms |
| Security for patients and staff with potentially violent patients |
| Cleanness and disinfecting rooms at the time of patient turn over |
| The effect of noise/lights in a general pediatric ward on the healing and wellbeing of children admitted to the ward |
| Effect of noise/lights at night on the pediatric ward for children admitted to the ward |

AAP: No guidelines were found

No studies identified

Verdict: No studies identified. The question has NOT been addressed in the evidence base.

3 x physician

3 x friend/family member

1 x physical therapist

3 x dietician


Donovan TJ, Buchanan K. Medications for increasing milk supply in mothers expressing breastmilk for their preterm infants. Cochrane Database of Systematic Reviews. 2012(3).

CPS: The Baby-Friendly Hospital Initiative (BFHI)
38 What are ways to structure multiple clinical assessments and consultations to minimize discomfort and reduce unnecessary tests or treatments on children hospitalized on the general paediatric inpatient unit?

Sometimes I recognize that many visits were necessary because my child was acutely sick. But sometimes a resident or other would come, wake my son, in the middle of the night, 20 minutes after the last exam, done by someone else. Is there a way to put these exams together so that once kids fall asleep, they are able to get some quality sleep?

Unnecessary investigations for certain patients

Unnecessary monitoring of patients rather than clinical observations.

Unnecessary admissions, tests and treatments.

Overuse of X-Ray in Bronchiolitis and Asthma

can we reduce orders for vital signs. In stable patients with a small education intervention or order set?

Looking at how often investigations are actually changing management

When an innocent child strays onto the hospital ward they are at risk for many interventions...many possibly most non evidence based. The longer a child is in an inpatient the greater odds of being jabbed with a sharp implement to expensively generate a number that will have no bearing on anything or... her or his thorax imaged for chest Xray with zero impact. So, I’d love a list of top ten non evidence-based things we do all the time that we don’t need to strict ins and outs, vital sighs, electrolytes. CBC because a child is hospitalized doesn’t mean we have to get to assault them with our technology plus, many in patient can probably go home 12-36 hrs sooner than they do now with no increased risk.

people are driven by theoretical catastrophes that are in the vast majority of cases, non existent so, a hard look at what we do in house... and doing nothing perfectly acceptable... and impact of discharging earlier... have been giving my cell number to parents as they head out the door for as long as I’ve had one and 0 readmits... clearly not discharging soon enough!

Attention needs to be paid to treatment options that families want explored, whether conventional, complementary, or traditional in origin.

multiD handover and rounds how it is run and the best way to run to incorp family centered care.

Do rounds that genuinely include parents shorten stays, increase the knowledge and confidence of parents at discharge, or help families participate more competently and confidence in the child’s care?

Involving children and youth in decision making about their health and treatment, Parental involvement with care while in hospital effects on outcomes.

Parental involvement with care while in hospital effects on outcomes.

Involving children and youth in decision making about their health and treatment, Parental involvement with care while in hospital effects on outcomes.

How can we better partner with families/caregivers for optimal and effective shared decision making?

How can parents and caregivers be better engaged in the process of discharge? How much did patients understand about their hospitalization/discharge?

40 What is the most effective way to conduct medical rounds, including how to involve caregivers and patients in the decision making while on the general paediatric inpatient unit?

How do we evaluate if bedside rounds are actually working for patient nurses/ learner multiD handover and rounds how it is run and the best way to run to incorp family centered care.

Why do most centres claim to offer “family centered care” but spend most of their time speaking for and about patients on rounds?

Verdict: Most of the research identified focuses on specific populations, and not on those on GPIU. The one systematic review implemented bedside rounds to improve patient-centred outcomes: a systematic review. BMJ quality & safety, 28(4), 317-326.

Verdict: Available evidence does not address the specific question. The question has NOT been addressed in the evidence base.
41 How does the integration of virtual care on the general paediatric inpatient unit help to limit communication barriers affecting the outcome in patient and family experience?

Looking towards virtual and innovative ways to provide this I would love to know the 1) cost-effectiveness of the increased shift to virtual health. 2) the impact on children and their families of conducting healthcare in this manner. How to even further safely reduce LOS (least amount of treatment, supporting patients with FU clinic/ virtual care. Communication between disciplines in patient care - virtual supports to keep kids in regional sites rather than use tertiary beds that are in short supply - expanding the reach of tertiary resources using Virtual health (evaluating a program for this now but it has been very challenging to develop) communication barriers to communication

42 Does collecting and assessing patient-reported and patient-important outcomes for all hospitalized children/youth on a general paediatric inpatient unit improve outcomes?

Defining patient important outcomes from the get go

43 What are best practices when using intravenous immune globulin (IVIG) in hospitalized children/youth on the general paediatric inpatient unit?

Is it really necessary to flush the iv tubing line between ivig with different lot numbers? Since delayed infusion reactions can happen and you wouldn't be able to tell if it was a delayed reaction from the first lot number or a reaction from the second.

44 Does the implementation of quality indicators lead to improved safety and reduced medical errors in the general paediatric inpatient unit?

Best practice safety team 3. What quality & safety indicators should paediatric units across Canada be measuring regularly? Readmission rates? Medication errors? Compliance with follow-up? Communication with the community physician? Delay to obtain certain diagnostic testing? etc. Are there any common illnesses/complications that arise in young people being treated on a general paediatric unit? What can be done to ensure the most appropriate safety measures are maintained while providing safe medical care? Regarding the care of children in hospital on the general paediatric ward, I believe research should focus on the area of Paediatric Patient Safety and in particular: a) Best practices for eliminating hospital acquired conditions (HACs) How to reduce medical errors, lack of quality assurance work how can rural hospitals ensure they are providing adequate care is there a way to measure the quality of the communication between disciplines in patient care?
45 What are effective alternatives to shorten length of stay for hospitalized children/youth?

How can we shorten LOS in a safe way? Could we try home hospitalization in paediatric as it is done in adult? Which interventions could be safely and effectively cared for as outpatients with very close (up to daily) follow up care? Does length of stay affect functional and rehabilitation outcomes?

CPS: no guidelines found
AAP: no guidelines found
NICE: no guidelines found


Verdict: Some evidence was identified to support transitional care for neonates, but the studies focus on NICU or PICU. The question has NOT been addressed in the evidence base.

46 What is the most effective way to perform vital sign measurements while ensuring patient and family comfort on the general paediatric inpatient unit?

During one of my admissions, my vitals had to be checked every half hour by a nurse. This made it difficult to for both me and my parent to sleep. Is there a way to perform these checks at night without waking up the patient and parent?

FREQUENCY OF VITALS MONITORING, ESPECIALLY OVERNIGHT: how can we minimize resources utilized for inpatients without sacrificing safety when checking vital signs at night, weighing diapers, use of cardiospore monitors?

What should be the reasoning for putting a patient on a cardiac monitor?

CPS: no guidelines found
AAP: no guidelines found
NICE: no guidelines found


Verdict: The only identified systematic review identifies limited evidence, and that further research is needed on this topic. The question has NOT been addressed in the evidence base.

47 What mental health supports can be provided to parents, families and children/youth while hospitalized on the general paediatric inpatient unit?

can we improve comfort for baby/ anxiety for parents in bronchiolitis? How can we meet mental health needs of children and youth admitted to hospital? What mental health supports can we put in place for kids before they need it? Overall support of parent and mental health of child. It can be very isolating, especially if infection procedures in place. What help can we provide for parent for their mental health during this stressful time?

I wonder how we can reduce the stress of parents when a child is admitted with a complex formula (mix of powdered formula, modular +) +/- treated with medication (example of Kayexalate to remove potassium)

How are we socially supporting children and youth during this difficult period? I encourage social groups or friendship formation?

Model of care whereby we get infants out of their cribs to play & move rather than providing screen time for which psychologists recommend, observe screen time under the age of 2 years (we could measure how much screen time they were getting before and after the intervention)

Deconditioning is a reality of patients during their hospital stay. At one point during my treatment, I was convinced that the “hospital smell” was choking me whenever I entered the building. What are some strategies that nurses, doctors, child life specialists and therapists can use to help kids with hospital anxiety or imaginary fears?

CPS: no guidelines found
AAP: no guidelines found
NICE: no guidelines found


Verdict: The identified systematic review identifies limited evidence, and that further research is needed on this topic. The question has NOT been addressed in the evidence base.

48 What are evidence-based protocols for the safe management and discharge of hospitalized infants with jaundice on the general paediatric inpatient unit?

When can babies with jaundice be discharged without concern for rebound (a lot of American data in this area but few use it... could be KT study)?

Management of the infant who is admitted for physiologic jaundice - level to treat, discharge of management of physiologic jaundice in the newborn infant - appropriate level to treat, risk factors, frequency of testing, follow up care and testing

CPS: no guidelines found
AAP: no guidelines found
NICE: no guidelines found


Verdict: Some evidence was identified to support the management of physiologic jaundice in the newborn infant - appropriate level to treat, but the studies focus on NICU or PICU. The question has NOT been addressed in the evidence base.

49 What are evidence-based protocols for the safe management and discharge of hospitalized infants with jaundice on the general paediatric inpatient unit?


AAP: guideline available


NICE: guideline available


CPS: no guidelines found

Verdict: The guidelines clearly outline management and discharge strategies. The systematic reviews identified in the search were from before 2010. The question has NOT been addressed in the evidence base.

50 What are evidence-based protocols for the safe management and discharge of hospitalized infants with jaundice on the general paediatric inpatient unit?

1 x nurse
1 x physician
1 x speech language pathologist
1 x youth
1 x nurse practitioner
1 x friend/family member
1 x dietician
1 x parent
1 x physical therapist
1 x kinesiologist
1 x youth
50 What are effective uses of albumin infusions in hospitalized children/youth hospitalized on the general paediatric inpatient unit? 

When is the use of albumin indicated for inpatients with low albumin, or generalized edema? 

CPS: no guidelines identified 
AAP: no guidelines identified 
NICE: no guidelines identified 
No studies identified 
Verdict: No evidence was found relevant to the question. The question has NOT been addressed in the evidence base 

50 What are best practices during respiratory viral season to reduce spread of nosocomial infections amongst and prevent outbreaks hospitalized children/youth on the general paediatric inpatient unit? 

During viral season is it OK to make patients share rooms if they are hospitalized with different viral infections? And if so, what tests or screening could be used to prevent outbreaks? 

CPS: Guideline found is limited to physician’s office. 
AAP: no guidelines found 
NICE: no guidelines found 
Verdict: There are several systematic reviews which focus on the prevention and spread of nosocomial infection (bacterial and fungal), but none of them are specifically to virus or viral season. Hence, the evidence was not found to address this query. The question has NOT been addressed in the evidence base 

51 When should physicians complete nasopharyngeal swabs for respiratory viral infections in children/youth hospitalized on a general paediatric inpatient unit? 

When is the use of a nasopharyngeal swab indicated on hospitalized children? 

CPS: Guidelines related to COVID-19 were identified. 
Michael Narvey, Canadian Paediatric Society, Fetus and Newborn Committee; NICU care for infants born to mothers with suspected or confirmed COVID-19; https://www.cps.ca/documents/position/nicu-care-for-infants-born-to-mothers-with-suspected-or-proven-covid-19 
AAP: no guidelines found 
NICE: no guidelines found 
Verdict: COVID-19 related guidelines were constantly changing and left to the discretion of each province. according to one guideline, "obtain a nasopharyngeal swab within 2 h of birth if SARS-CoV-2 has been confirmed in the mother, regardless of infant symptomatology." No evidence found for other viral infections. The question has NOT been addressed in the evidence base 

52 Can a national EMR system improve care on a general paediatric ward? 

PROVINCIAL/NATIONAL EMR please :) 
The trajectory of care prior to hospitalization (how often were they seen - by whom) I wonder a lot about the trajectory of patients, before and especially after hospitalization, in terms of efficiency and quality of follow-up Sharing order sets for common pediatric conditions (i.e. Kawasaki Disease, Sickle Cell, Sepsis, etc). 

CPS: no guidelines identified 
NICE: no guidelines identified 
Verdict: The review by Despin, does attempt to address the question to some extent, but the results are inconclusive. The focus is also limited to sepsis care and does not employ a national EMR. The question has NOT been addressed in the evidence base 

53 Does ensuring continuity of care of healthcare professionals improve the care and outcomes of hospitalized children/youth on the general paediatric inpatient unit? 

9) How can we have better processes/structures to ensure the continuity of care beyond hospitalization? There was very little continuity in the nurses who looked after our child? 

AAP: no guidelines identified 
NICE: no guidelines identified 
https://doi.org/10.1007/s11606-019-5497-8 [ABSTRACT] 
Verdict: Evidences identified does not focus on the GPIU. The question has NOT been addressed in the evidence base.
54 What are the adverse effects of sedation on children/youth hospitalized on a general paediatric ward?

Do the risks of sedation for a procedure outweigh the risks of developing trauma from a procedure in Pediatrics? How does one know?

CPS: Relevant position statement
AAP: no guidelines identified
NICE: guideline present but does not discuss adverse effects.
National Institute of health and excellence. Sedation in under 19s: using sedation for diagnostic and therapeutic procedures; www.nice.org.uk/guidance/cg112

Verdict: Both systematic reviews are based on ICU population; none addressed the GPIU. The question has NOT been addressed in the evidence base.

55 What are the most effective diagnostic tests to diagnose meningitis in children/youth hospitalized on a general paediatric inpatient unit?

Use of MRI in meningitis - review of practices across the country. How do findings impact outcomes (in our centre many treatment alterations due to findings but are they clinically relevant? If they are more children use MRI routinely in meningitis)

CPS: Diagnosis guideline available
AAP: no guidelines identified
NICE: no guidelines identified

Heeyeon Kim, Yoon Ho No, Seo Hee Yoon. Blood procalcitonin level as a diagnostic marker of pediatric bacterial meningitis: a systematic review and meta-analysis. PROSPERO 2021 CRD42021186913 Available from: https://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42021186913
Monisha R, Sourabh Dutta, Praveen Kumar, Ashutosh Agarwal. Diagnostic accuracy of cerebrospinal fluid c-reactive protein, procalcitonin and interleukin-6 for meningitis in neonates and young infants < 90 days old: a systematic review and meta-analysis. PROSPERO 2019 CRD42019126957 Available from: https://www.crd.york.ac.uk/PROSPERO/display_record.php?ID=CRD42019126957

Verdict: Other than the CPS guideline, there is a lack of strong evidence to identify the most effective diagnostic test. No systematic review was found that could support the question but several studies appear to be in progress. The question has NOT been addressed in the evidence base.

56 What are effective treatments for children/youth with acute kidney disease hospitalized on a general paediatric inpatient unit?

We see many children with acute kidney injuries, nephrotic syndrome, pyelonephritis and other. I would like to see more research and treatment options for renal disease.

CPS: no guidelines identified
AAP: no guidelines identified
NICE: no guidelines identified

Verdict: No guidelines or systematic review addressed this question. The question has NOT been addressed in the evidence base.
57 What is the most effective treatment for children/youth with complicated pneumonia hospitalized on a general paediatric inpatient unit?

Management of large but minimally symptomatological complicated effusions

What is the appropriate post-pleurocentesis management for complicated children/youth with complicated pneumonia (when and how to). Efficacy and safety of azithromycin combined with glucocorticoid on refractory Mycoplasma pneumoniae pneumonia in children: A PRISMA-compliant systematic review and meta-analysis (image, clamp, go to straight drainage).

CPS: One guideline was identified focused on empyema


AAP: no guidelines identified

NICE: no guidelines identified


Zhongguo Dang dai er ke za zhi= Chinese Journal of Contemporary Pediatrics, 22(2), 124-129.[In Chinese]


Qu, J. L., Huang, L., Shao, M. Y., Chai, Y. N., Zhang, H. J., Li, X. F., ... & Zhai, W. S. (2020). Efficacy and safety of azithromycin combined with glucocorticoid on refractory Mycoplasma pneumoniae pneumonia in children: A PRISMA-compliant systematic review and meta-analysis. Medicine, 99(22), e20121. (In English)


58 What is the most effective treatment for children/youth with aspiration pneumonia hospitalized on a general paediatric inpatient unit?

What is the appropriate treatment for aspiration pneumonia (if any) including choice of antibiotics and length of therapy.

CPS: no guidelines identified

AAP: no guidelines identified

NICE: no guidelines identified


Verdict: The identified studies focus primarily on ventilator induced pneumonia, which focuses on the ICU. None are relevant to GP/UI and aspiration pneumonia. The question has NOT been addressed in the evidence base

59 Does including interpreters for all communications between healthcare professionals and families/patients improve care for hospitalized children on the general paediatric inpatient unit?

One of the most challenging aspects of my work is communicating with people who do not speak either English or French. Ottawa has a big immigrant population and yes the interpreters are present for admission procedures but day to day care communication, directions and support are difficult to provide. Availability of care in the preferred language of family (ex: French speaking staff for French speaking families).

CPS: Guideline present on crosscultural communication


AAP: no guidelines identified

NICE: no guidelines identified


Verdict: There is evidence that use of ad hoc interpreters or no interpreter is inferior to use of professional interpreters of any mode. The question has been addressed in the evidence base
60 What are adverse effects of nebulized epinephrine on patients, caregivers and healthcare professionals on the general paediatric inpatient unit?

Verdict: The second hand effect of inhalation epinephrine on the Nurse or parent holding the nebulizer mask. Is it safe in pregnancy? Does it increase caregivers HR? Cause headaches? Cause sleeplessness later in day? How can these risks be minimized?

CPS: Guideline available that suggests epinephrine has no adverse effects on patients (it is rather indicated for croup management).

AAP: no guidelines identified
NICE: no guidelines identified

Baggott, C., Hardy, J., Sparks, J., Sabbagh, D., Beasley, R., Weatherall, M., & Fingleton, J. (2020). Systematic review of the comparison between adrenaline (epinephrine) and selective β2-agonists in the setting of adults or children with acute asthma. [Full article not found]


Verdict: There have been several systematic reviews focused on the use of nebulised epinephrine. In terms of adverse effect the review by Bjornson et al. suggests there were no adverse effect to report. But that evidence is limited to children suffering from croup. There is limited evidence on the safety for healthcare professionals and caregivers. The question has been PARTIALLY addressed in the evidence base.

61 How are ethical principles and guidelines influencing the care of hospitalized children on the general paediatric inpatient unit?

Verdict: More research on ethical dilemmas in pediatrics (quality of life, etc).

CPS: no guidelines identified
AAP: no guidelines identified
NICE: no guidelines identified


Verdict: All the current studies are focused on PICU patients, none on children in GPIU. The question has NOT been addressed in the evidence base.

62 What is the effectiveness of oseltamivir for hospitalized children/youth with influenza on a general paediatric ward? Which hospitalized children with influenza benefit from oseltamivir?

Verdict: There seems sufficient work has been done in this field and oseltamivir is effective in children hospitalized with influenza. But, the strong evidence (e.g. RCTs) are based on outpatient setting, and the inpatient setting is based on low quality observational, mainly retrospective studies. The question has NOT been addressed in the evidence base.
What are effective tools to increase adherence with recommended therapies for hospitalized children/youth on a general paediatric ward?

How to improve compliance with treatment?

CPS: no guideline identified
AAP: no guideline identified
NICE: no guideline identified


Verdict: The available evidence does not provide any direction to which tools increase adherence. The question has NOT been addressed in the evidence base.

What is the effectiveness of procalcitonin in diagnosing a serious bacterial infection in children/youth hospitalized in a general paediatric inpatient unit?

Is procalcitonin effective to diagnose serious bacterial infections?

CPS: procalcitonin does diagnose early onset of bacterial sepsis.

NICE: guideline found but limited to ED and ICU


Ritchie, B., Pomrit, K., Marin, T., & Williams, N. (2020). Diagnostic test accuracy of serum measurement of procalcitonin and C-reactive protein for bone and joint infection in children and adolescents: a systematic review protocol. JBI evidence synthesis, 18(3), 564-570. [protocol]

Schuetz, P., Muller, B., Christ Grain, M., Stolz, D., Tamm, M., Bouadina, L., ... & Briel, M. (2013). Procalcitonin to initiate or discontinue antibiotics in acute respiratory tract infections. Evidence Based Child Health: A Cochrane Review Journal, 8(4), 1297-1371. [does not cover inpatient care]

Verdict: For certain infections (meningitis) evidence has been found that suggests procalcitonin is effective in the initial diagnosis stage. There is some evidence for meningitis, procalcitonin can be helpful, but evidence is limited for other conditions, and regarding its use in the GPU. The question has been PARTIALLY addressed in the evidence base.

What are medication-related information management system or tool improves outcomes of children/youth hospitalized in a general paediatric inpatient unit?

Pharmacokinetics of drugs in children. Who can we contact if we have a question about meds?

CPS: no guidelines identified
AAP: no guidelines identified
NICE: no guidelines identified

No studies identified

Verdict: No studies identified. The question has NOT been addressed in the evidence base.

Can a national network improve care for children/youth on the general paediatric inpatient unit?

A national collaborative could help to improve quality care of hospitalized children nationwide.

CPS: no guidelines identified
AAP: no guidelines identified
NICE: no guidelines identified

No studies identified

Verdict: No studies identified. The question has NOT been addressed in the evidence base.

What are the most effective methods for oral and nasal suctioning (i.e aggressive vs minimalist, cough assist vs deep suctioning) of hospitalized children/youth on a general paediatric inpatient unit?

could cough assist (in/exsulflator) be used more instead of deep suctioning to help clear secretions? In particular, what is the value of aggressive vs. minimalist approaches to suctioning.

CPS: suction during resuscitation and Bronchiolitis management


Verdict: The question has NOT been addressed in the evidence base.
What are non-antimicrobial therapies for hospitalized children/youth with chronic otitis media on the general paediatric inpatient unit?

Effectiveness of ultrasound-assisted lumbar puncture (or ‘ultrasound-LP’) for children: A systematic review

Predictors of difficult LP and/or use of POCUS to optimize LP success rates

Verdict: Only one systematic review found that looked at use of antiseptics. But the evidence is limited and are based on outpatient care. The question has NOT been addressed in the evidence base.
<table>
<thead>
<tr>
<th>Page</th>
<th>Question</th>
<th>CPS</th>
<th>AAP</th>
<th>NICE</th>
<th>References</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>71</td>
<td>What are risk factors for serious underlying illnesses in children who are hospitalized with a brief resolved unexplained event (BRUE) on the general paediatric inpatient unit?</td>
<td>No guideline identified</td>
<td>Relevant guideline identified which outlines some risk factors, but based on limited evidence</td>
<td>No guideline identified</td>
<td>Tieder JS, Binkowsky JL, Etzel RA, Franklin WH, Gremse DA, Herman B, Katz ES, Krivol LR, Merritt JL, Nordin C, Perozlay J. Brief resolved unexplained events (formerly apparent life-threatening events) and evaluation of lower-risk infants. Pediatrics. 2016 May 1;137(5).</td>
<td>The question has NOT been addressed in the evidence base</td>
</tr>
<tr>
<td></td>
<td>How can we differentiate between children who will have a one time BRUE and kids who have larger medical issues?</td>
<td>No guideline identified</td>
<td>Relevance identified which outlines some risk factors, but based on limited evidence</td>
<td>Management of apparent life-threatening events in infants: a systematic review. Pediatria Polaka, 89(3), T15-T29.</td>
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<tr>
<td>74</td>
<td>What are evidence-based guidelines on the management of infants under 1 month / 3 months with fever without a source?</td>
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<tr>
<td>1.</td>
<td>Febrile infants under 30 days old: can LOS be reduced from the traditional 48h if certain clinical and biologic criteria met?</td>
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<td>2.</td>
<td>After how long are cultures (blood, CSF, urine) positive if pathogenic? (some research on this but little in Canada)</td>
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<td>Q2</td>
<td>Can there be a CPG for infants with fever without source (age &lt;90 days)?</td>
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<td>CPS:</td>
<td>No guideline identified</td>
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<td>AAP:</td>
<td>No guideline identified</td>
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<tr>
<td>NICE:</td>
<td>Guideline available on diagnosis and treatment but limited evidence referenced. National Institute of Health and Care Excellence, Fever in under 5s: assessment and initial management; <a href="http://www.nice.org.uk/guidance/ng143">www.nice.org.uk/guidance/ng143</a></td>
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<td>Watts, R., &amp; Robertson, J. (2012). Non-pharmacological management of fever in otherwise healthy children. JBI Evidence Synthesis, 10(28), 1634-1687. [3 months to 18 yrs]</td>
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<td>Verdict:</td>
<td>No evidence-based guidelines available. NICE guideline only suggests what symptoms to observe, what diagnostics to carry and to provide parenteral antibiotics based on certain criteria. The question has NOT been addressed in the evidence base.</td>
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<table>
<thead>
<tr>
<th>75</th>
<th>What are effective non-sedate (e.g. feed and sleep) diagnostic tests (e.g. CT scans) for children and youth admitted on a general paediatric inpatient unit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the success rate of non-sedate (e.g. feed and sleep) diagnostic tests (e.g. CT scans) in children at different ages?</td>
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<td>Are there non-invasive interventions which increase this success rate?</td>
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<td>CPS:</td>
<td>No guideline identified</td>
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<td>AAP:</td>
<td>No guideline identified</td>
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<tr>
<td>NICE:</td>
<td>No guideline identified</td>
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<tr>
<td>Verdict:</td>
<td>Only evidence found is focused on non-sedated MRI for a particular cohort of cases based on a review that was not a systematic review. The question has NOT been addressed in the evidence base.</td>
</tr>
</tbody>
</table>
Paediatric Hospital Care

5 J

Children with medical complexity may have unique needs, as such it is important that these are understood and managed appropriately. (PICO)

Aug 18-19

3

Reflections of parents in the support to the ill child (reference not found)


Kwok, Y., Sze, L., & Siu, E. (2019). Communication in the support to the ill child (reference not found)


Paediatric Hospital Care

A

Are ongoing mental health assessments for children hospitalized on a general paediatric inpatient unit beneficial?

Paediatric hospitalization is important for children, especially while they are hospitalized, as such, it is important to understand whether ongoing mental health assessments are required for children hospitalized on a general paediatric inpatient unit.

Aug 18-19 2021

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Paediatric Hospital Care

K

What is the impact of the patient’s hospital environment on health outcomes on the general paediatric inpatient unit (e.g. noise, light, private/shared room, window/no window)?

Reducing IV access is a common procedure and can cause distress in children hospitalized on the general paediatric inpatient unit, as such it is important to understand how the patient’s room can impact their health outcomes.

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Paediatric Hospital Care

M

When is it appropriate to involve allied health care professionals (e.g. occupational therapy (OT), physiotherapy (PT), child life specialist) in the care of children hospitalized on the general paediatric inpatient unit?

Obtaining IV access is a common procedure and can cause distress in children hospitalized on the general paediatric inpatient unit, as such it is important to understand the most effective ways to perform this procedure.

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Paediatric Hospital Care

P

What is the most effective way to obtain and maintain intravenous (IV) access in children and youth hospitalized on the general paediatric inpatient unit?

Discharge can be a daunting time for children and their families hospitalized on a general paediatric inpatient unit, as such it is important to understand the most effective methods to facilitate discharge.

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