bioequivalent in the fasted and semi-fed states, with 90% confidence intervals (0.80-1.25). In the semi-fed state, PPS had a significantly higher early exposure ($AUC_{0-30min}$ and $AUC_{0-60min}$, all P -values < 0.05), and T_{max} was shorter (by 30 minutes; P < 0.0001) compared with PBIS. Food increased early PPS absorption significantly, while decreasing total absorption (AUC_{0-inf} and $AUC_{0-10hrs}$). Time to reach therapeutic level (4 mg/ml) was significantly shorter for PPS than comparators. In the first 10 minutes after semi-fed dosing, 50% of subjects treated with PPS, 32% with CP and 7% with PBIS reached therapeutic level.

Conclusions: In fasted and semi-fed states, PPS is bioequivalent and showed some superior PK parameters of early absorption for 4 hours to CP and PBIS. PPS is safe and well-tolerated with no adverse events.

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PEDIATRIC TEAM: FAMILIES BECOMING INTEGRAL MEMBERS!

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Studies have found that family presence at the bedside of critically ill and injured patients during invasive procedures and resuscitation can positively affect patient outcomes and satisfaction. Despite this evidence, many critical care units do not permit family presence at these crucial times and limit visitation throughout the patient's ICU stay.

Purpose: To equip the participant with tools to integrate families as requisite members of the healthcare team in both adult and pediatric transplant patients in the critical care units.

Strategies to achieve this goal include case studies and scenario exploration with small group audience participation. Key components of this session include the concepts of family-centered care and how to create and utilize evidence-based family presence policies. The pros and cons of creating and supporting family presence from a nursing perspective will be explored.

Finally, small groups will examine scripted resuscitation/invasive procedure scenarios from the perspective of the nurse, the healthcare team, the family, and the patient. The groups will explore their feelings and insights gained through the exercise, and will share the findings with the entire group. The

target audience is the acute and critical care nurse that desires to be a catalyst for the integration of family-centered care and desires to include families as integral members of the team. No prerequisite knowledge is necessary.

Outcomes for the participant include an enhanced understanding of family-centered care, including the unique perspectives of others attending the session. Participants will leave the session with diverse strategies to take back to their workplace.

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ENTERAL NUTRITION NURSING PROTOCOL

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Purpose: Ensure an adequate enteral nutrition monitoring signs and symptoms of potential adverse events. Standardize the nursing monitoring of pediatric patients receiving enteral nutrition. Provide accurate problem solving guidelines to follow when administering continuous enteral nutrition.

Description: The protocol, the result of a collaboration between the medical and nursing staff, identifies appropriate guidelines to follow before starting enteral nutrition by NG tube: check if tube is placed correctly and the quality/quantity of gastric residual.

The protocol:

Ø Provides guidelines to administer the nutrition.

Ø Defines physiological gastric residual, and outlines the relevant guidelines.

Ø Defines monitoring times of gastric residual, every 3 hours.

Ø Defines what non-physiological gastric residual is, and outlines the relevant guidelines.

Ø Gives indications on sentinel signs/symptoms to consider before putting on hold or discontinuing enteral nutrition.

Evaluation: The pediatric population requiring continuous enteral nutrition by NG tube includes seriously-underweight children with growth and absorption disorders.

Under this specific protocol no nutrition-related complications occurred, and families were educated