ACCURACY OF CHILDREN’S PERIOPERATIVE MEMORIES

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PURPOSE
To examine the accuracy of children’s declarative memories of contextual details and emotional aspects (ie, fear, pain) of perioperative events and to determine if recall accuracy differs across perioperative time points (ie, preoperative holding, transfer to the OR, induction in the OR).

METHODS
• Standardized the contextual details of the preoperative period, transfer to the OR, and anesthesia induction.
• Measured preoperative fear and preoperative pain using validated rating scales.
• Measured memory of contextual details, fear, and pain two weeks postoperatively to determine participants’ accuracy of recall for contextual details and whether the children accurately recalled pain and fear or minimized or exaggerated their preoperative fear and preoperative pain postoperatively.

RESULTS
• On average, children accurately remembered 64.5% of contextual details across perioperative time periods.
• Memory recall accuracy was significantly lower during the transfer to the OR than during the preoperative holding or induction in the OR time periods.
• Recall accuracy for contextual details had a significant positive correlation with age (ie, as age increased, recall accuracy increased).
• No significant difference for recalled pain and fear. A majority (62.1%, n = 29) of children accurately reported their preoperative fear level postoperatively; 36.4% (n = 22) exaggerated their preoperative pain level postoperatively.

KEY TAKEAWAYS
Children are generally accurate in their recall of contextual details before surgery. Health care providers should be aware that children can accurately remember health care experiences, and that negative experiences could affect their willingness to seek care later in life.
RADIOACTIVE SEED LOCALIZATION PROGRAM FOR PATIENTS WITH NONPALPABLE BREAST LESIONS

Judy Burroughs, MSN, RN, CNOR; Jennifer L. Fencl, DNP, RN, CNS, CNOR; Matthew C. Wakefield, MD

Relevant Specialties
General surgery

Procedures
RSL lumpectomy for nonpalpable breast lesions, surgical excision of the breast

Perioperative Roles
Perioperative nurse, anesthesia care provider, surgical technologist, surgeon, radiation safety committee members

Patient Population
Patients with nonpalpable breast lesions

KEY RESOURCES
Full-Text Article
AORN Guideline for Radiation Safety

PURPOSE
To describe the care needed when patients undergo radioactive seed localization (RSL) lumpectomy for nonpalpable breast lesions.

BACKGROUND
• Early diagnosis and treatment of breast cancer saves lives.
• Increased breast cancer awareness has facilitated research to guide health care providers toward improving patient outcomes.
• RSL patients have the potential for decreased tumor re-excision for positive margins near the surgical site, a lower volume of excised breast tissue, decreased operative time, convenient surgical scheduling, and less pain.
• RSL lumpectomy can improve patient and staff member satisfaction.

IMPLICATIONS
• Improve patient care with knowledge of new diagnostic and treatment modalities.
• Understand and comply with regulatory requirements when dealing with radioactive material.
• Coordinate care with all involved personnel.
• Understand how to handle radioactive seeds.
• Provide perioperative nursing care that includes radiation safety, deep vein thrombosis prevention, and infection prevention.
• Provide accurate information to patients about potential postoperative radiation exposure to others.

KEY TAKEAWAYS
New treatment modalities, such as RSL, provide better outcomes for patients with nonpalpable breast lesions. Nurses must familiarize themselves with these technologies and understand how to collaborate with other involved personnel and how to comply with regulatory requirements.
IMPLEMENTING SKIN-TO-SKIN CONTACT FOR CESAREAN BIRTH

Margaret M. Boyd, DNP, CNM

**PURPOSE**
To discuss the benefits of initiating skin-to-skin (STS) contact between mother and newborn in the OR after cesarean birth and to describe a quality improvement project to increase the number of mother-infant dyads who experience STS contact after cesarean birth.

**METHODS**
- Developed a standard of practice for initiating STS contact (ie, positioning the naked newborn prone on the mother’s bare chest covered with a blanket within the first hour after birth) in the OR and in the postanesthesia care unit (PACU), rather than separating the mother and newborn after cesarean birth.
- Developed an informational handout for parents regarding STS contact and placed this handout in the admission packet given to all mothers.
- Collected data on the number of mother-infant dyads who experienced STS contact in the OR or in the PACU according to the updated standard of practice.

**RESULTS**
- 37 out of 50 mothers and newborns experienced STS contact either in the OR or in the PACU; 25 mothers and newborns experienced STS contact on the OR bed.
- The median time newborns spent skin to skin with their mothers was 42.5 minutes, exceeding the author’s goal of 15 to 30 minutes.
- The author assessed reasons why STS contact was not initiated for the 13 mothers who did not experience it (eg, staffing issues, equipment problems) and initiated practice changes to decrease the occurrence of these obstacles in the future (eg, creating a neonatal assessment nurse position, revising the warming methods used).

**KEY TAKEAWAYS**
STS contact has been shown to have many benefits for the mother and the newborn, including improving breastfeeding rates and duration, increasing mothering behaviors, decreasing maternal anxiety, and reducing the risk of postpartum depression. To uphold the values of family-centered maternity care, it is beneficial to facilitate this practice in the OR for cesarean birth.
CLINICAL ISSUES

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PURPOSE
To provide answers to AORN members’ clinical questions based on current evidence.

What are the documentation requirements for electrosurgery?

• Document the electrosurgical unit’s device identification (ie, serial or biomedical number), the location (ie, site and laterality) of the dispersive electrode, the patient’s skin condition before application and after removal of the dispersive electrode, and the person performing the intervention.

• Optional requirements according to facility policy: document the accessories used, the cut and coagulation settings, jewelry left in place, and the safety and warning alarm settings.

Key Resources: Guideline for Safe Use of Energy-Generating Devices

Many patients request the return of their orthopedic hardware at the end of a procedure. We do not have a policy regarding this. Does AORN have a guideline about this practice?

• The “Guideline for specimen management” indicates that explanted medical devices should be collected, handled, decontaminated, labeled, packaged, and documented according to facility policy before being returned to the patient.

• Personnel should verify that the orthopedic hardware does not need to be returned to the manufacturer or has not been recalled before returning to the patient.

• Pathology personnel in the facility can identify whether an explant is considered a specimen and may dictate the process for returning the explant to the patient.

• A multidisciplinary team should develop policies for decontamination, labeling, and packaging an explant before returning it to the patient.

• Disposition of explanted hardware should be documented in the patient’s health record, including the patient’s request for the return of the hardware and the personnel returning the explanted hardware.

Key Resources: Guideline for Specimen Management; Guideline for Sterilization

For more details and to find the answers to the questions below, read the full column.

• When can we use wall suction to evacuate a small amount of surgical smoke?

• How do we comply with the Occupational Safety and Health Administration’s (OSHA’s) hazard communication standard regarding medications?