

Practice Update

The Center for Professional Development & Practice

May 20, 2014

Tampon Use in the Operating Room

The question of whether the use of tampons for patients undergoing general anesthesia was raised following an incident where a tampon was left in patient greater than 24 hours who had undergone a neurological procedure and was in the PICU. Currently we do not have a standard of care. This sparked a discussion with professional staff to assist in determining the best practice. Dr. Rachel Miller, Children's pediatric and adolescent gynecologist, recommends that **tampons**, **menstrual cups or sponges are removed prior to anesthesia**. This recommendation is supported by the anesthesia medical directors, Dr Reiner, Dr. McCormick, and our chief of surgery, Dr. Schmeling.

Here are the changes in practice effective May 20th, 2014.

Preoperative:

- Ask the question for menstruating females whether they are currently using a tampon, menstrual cup or sponge.
- Explain it is for their safety that they remove the tampon prior to surgery.
- Provide the patient with mesh underwear and a sanitary pad to use during surgery.
- Document the information in the preop assessment record under Patient Safety/ Checks found in the Screening segment. The documentation will flow to the preop QV and the Periop Handoff tab (see attached "On the Record").

OR:

• If you notice a tampon in please remove and fill out a Safety Learning Report.

Preop Assessment Powerform Changes: Re. Feminine Hygiene Products.

There is a change to both the **Preop Assessment Record** and the **Preop Assessment Record**-**Inpatient** to document the removal of feminine hygiene products before surgery. This information will flow to the Preop QV and the Periop Handoff.

	Day of Surgery			1						
	Detailed Skin Ass	RN RN	∐ Parent/L	Guardian	🗹 Patie	ent			Other:	
	Vital Signs (NEW)									
	Pain Assessment						No	N/A		Comment
*	Screenings	Current H&P (v Patient ID On				××				
	Devices	Meds sent to (DR					X		
	Directives	Loose Teeth/0 Oral Appliance					××			
	Pregnancy Status		maker/AICD Ve Jewelry Remov				×	X		
	Safe Pt. Handling	Smokes	-					X		
	Functional Assess	Alcohol/Drug Glasses/Conta						XX		
	Education-Periop	Nail Polisn Re	noved		-	X				
	A shart Tasa star	Tampons, Mer	strual Cups, Sp	onges R	emoved	<u>×</u>				
	Actual Transfer of	Tuebs/Curren			_			X		
			ant Medications	Held				X		
		Other Safety C	oncerns					<u>^</u>		>
										-
			Remove all scalp g on them. Need g							or if
		Pre-op Skin Prep								
		CHG bath		•	e hairwas	h 🗆] N/	•••		
		CHG wipe	E Be	efused] 01	her:		

Preop Assessment Record: Day of Surgery Section: Patient Safety/Checks

Inpatient Preop Assessment Record

Paste (Ctrl	Day of Surgery Checklist					
to the		Yes	No	N/A		
	Current H&P (within 30days)					
	Allergies Verified					
	Labs Drawn					
	Pregnancy test completed					
	Pre- Meds Administered & Documented					
10 days)	All Anticoagulant Medications Held					
10 4493)	Head to Toe Assessment Documented					
	VS Documented Within 1 Hour of OR					
	Pre-Op Education Documented					
	Interpreter Available					
	Patient Specific Prep Completed					
	Patient ID On and Verified					
	First, Middle, and Last Name Verified					
	Patient in Gown & Undergarments Removed					
	Hair Ties/ Clips/ Braids Removed					
	Glasses/Contacts Removed					
	Null Folish Removed					
· · · · · · · · · · · · · · · · · · ·	Tampons, Menstrual Cups, Sponges Removed					
	Oral Appliance					
	Loose Teeth/Lapped					
	Implants/Pacemaker/AICD Verified					
	Body Piercing/Jewelry Removed					
	Transport Equipment Available & Ready					
	Meds sent to OR					
	Family Available/ Contact Info in EMR					
	Patient Chart/Paper Work					
	Void Before Transport					
	Trachs/ Obturator/ Emergency Equipment					
	<					

Preop QV

< 🔹 🔹 🛉 PreOp QV	
This grid contains all data documented in the past 7	
	06
05/08 Other Medical History No 05/08 Problems with prior anesthetics No	05
05/08 Problems with prior anesthetics No 05/08 History of Malignant Hyperthermia No	
05/08 History of excessive bleeding No	
05/08 Respiratory support No	
05/08 Communicable disease exposure No	05
05/08 Patient History of Diabetes No	05
05/08 Developmental needs No	↓ 06
Flowsheet: Peri-Op QV Clinical Information	Level: Peri-Op QV Clinical Information V More Fl
• 01 May 2014 12:15 - 09	May 2014 12:15 (Posting Range)
Peri-Op QV Clinical Information	05/08/2014 12:13
NPO Status- last time consumed	a la
NPO Time - Solids	05/07/2014 23:00
NPO Time - Clears	05/08/2014 6:00
Pument Ulinical Data	
Tampons, Menstrual Cups, Sponges Removed	Yes
Tampons, Menstrual Cups, Sponges Removed	Yes
Integementary Assessment	
	RN, Patient
Integementary Assessment Skin Assessment Verified By Skin Within Defined Limits	
Integementary Assessment Skin Assessment Verified By	RN, Patient
Integementary Assessment Skin Assessment Verified By Skin Within Defined Limits Pre-op Miscellaneous	RN, Patient Skin warm, dry & i

Periop Handoff

Flowsheet: Periop Hand Off	💌 Level: Periop Hand Off	× (
		01 May 2014 12:29) - 1	
Periop Hand Off				
Past/Current Medical History	Pre-op Assessment Record			
05/08/2014 12:13	Pre-Op Accessment Record			
Current Clinical Data 🥂 🧹	Tampons, Menstrual Cups, Sponges Removed	Communicable Disease		
05/08/2014 12:13	Noc	No		
Current Clinical Data	Respiratory Support	Developmental needs		
05/08/2014 12:13	No	No		
NPO Information	NPO Time - Solids	NPO Time - Clears		
05/08/2014 12:13	05/07/2014 23:00	05/08/2014 6:00		
Integumentary Assessment	Skin Assessment Verified By	Skin Within Defined Limits		
05/08/2014 12:13	RN, Patient	Skin warm, dry & intact		