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ASPAN

Clinical Exemplar

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Double Banding Procedure

Patients coming for surgery at our busy, urban hospital begin their journey in the Surgical Patient Processing unit where nurses admit and assess patients of all ages, ranging in age from newborn to elderly. Imagine a young mother reporting to the receptionist's window of our pre-op unit with her two-week old newborn baby boy who requires bilateral inguinal herniorrhaphies. Our pediatric surgeon operates on his patients with the youngest going first. Our new mother and her infant would be checking in around 0630 for 0730 surgery.

Surgical Patient Processing is bustling with activity at 0630. We are filling between 13 and 16 operating rooms, so the nurses are busy performing assessments, doing patient teaching, starting IV's, and charting with large computers on wheels that are parked all over our unit. The families of our patients are everywhere in our unit. Sometimes four or five people accompany one patient, and they end up standing around outside our admission bays due to the limited seating we have for them. Our anesthesiologists start arriving next, often accompanied by anesthesia aides and large trays of equipment used to perform femoral nerve blocks on patients about to undergo knee replacement surgery. Our anesthesiologists often greet each other loudly, talking about the sporting events from the night before. It is a congenial atmosphere that often resembles a cocktail party (coffee cups sit everywhere in our unit, hidden, of course, from our poor fasting patients!) Surgeons arrive last by 0725. Estimating 13 to 16 first patients, multiple family members, anesthesiologists, operating room staff, and surgeons, it would not be unusual to count 100 people in our unit, many in blue OR garb, many with name identification badges, but some without.

This is the environment that our new mother and her newborn enter when our Patient Care Assistant escorts them to the bay where the baby will be prepared for surgery. The mother and her newborn have never been separated. Just two weeks earlier, her baby was a patient in the Newborn Nursery, safely dwelling in a secure environment where public access is limited and security precautions abound. Our mother wore two bracelets during her stay in maternity, one

identifying her as a patient, and one identifying her as the mother of her new infant.

I, as a pre-op RN, introduce myself to our new mother, explaining that I will be asking her some questions to get her baby ready for surgery. We go over NPO status, allergies and the plan for surgery. I explain to her that her baby's surgeon will talk to her afterwards, and that the baby will have an IV when she sees him post-operatively. I place an identification bracelet around her baby's ankle after spelling out his name and confirming his birth date. Our mother looks very scared, like "a deer in headlights". Chaos surrounds her, but she is all alone, now facing her newborn leaving her for his surgery. She asks me if she can have a bracelet, so she can be clearly identified as her baby's mother, just as she had been just two weeks ago. She needs a link to her newborn, a visible symbol of her status as mother to her baby.

For me as the caregiver, the "the light bulb goes on".	For me as the caregiver, the "the light bulb goes on". I have never had a request from a parent to have an identification bracelet. It seems so appropriate. I explain to her that we, in SPPU, do not provide a bracelet for parents, but I also tell her that I believe that it is an outstanding idea to offer such a bracelet to parents of young babies and children who are patients in our unit. I promise her that this is an idea that I will pursue so that other parents may feel slightly more secure in our unit, knowing that they are wearing identification bracelets that match those of their children.
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Thus, began my pursuit of a double-banding identification system for young children and their parents/caretakers in Surgical Patient Processing. It is a journey that has taken some time. Evidenced based research on double-banding processes was very limited. (1) At a pediatric perianesthesia conference, I was able to poll participants who represented several different states. Out of the group of approximately 25, 4 participants stated that they used a double-banding process. More validation was received from the national ASPAN (American Society of Perianesthesia Nurses) organization. Nurses from eight different states responded through their "Ask an Expert" network, with helpful suggestions about double banding and its implementation. I also asked the advice of our pediatric ophthalmologist who sends his patients to our unit. He could think of no negatives to double identification banding. As chairman of our unit's Clinical Practice Council, I started by asking fellow council members for their validation of the idea. From there, the hospital safety office gave affirmation, and unit policy and procedure documentation were updated for our outpatient children. Our pediatric unit did not opt to be included in double-banding implementation. Their unit is more secure, with limited accessibility, and far less busy and chaotic.

Pre-op staff recently started double banding parents of patients under the age of seven. Two adult caregivers who may be parents, guardians, or

grandparents or significant others, may be given bracelets identical to our patient. Post-operatively, when the parents/caretakers are invited to PACU (post anesthesia care unit), the staff now confirms that the bracelets match that of the patient. Again, in the discharge unit, the bracelets are checked and confirmed to be identical. The staff removes the parents'/caretakers' bracelets before discharge, so there is no risk of the bracelet being reused.

As expected, parents are happy to have more validation of their relationship to their young patients. In addition, because pediatric patients often arrive with multiple adults prior to surgery, the purposeful identification of the parents or caretakers by pre-op staff makes it simpler to know who receives pre-operative teaching and discharge instructions. Social workers or other non-family primary caregivers are more easily identified if they are to be part of the child's care.

I am sure that the new mother, with her two-week-old newborn, has no idea that the seed that she planted, has led to enhanced pediatric security for our outpatient surgical patients. The promise that I made to her that day came to fruition as a positive safety initiative for our surgical processing unit.

(1) Pediatric Emergency Care20 (7) 487-492, July, 2004

