Don't Let Pressure In The Operating Room Leave a Mark!

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INTRODUCTION

Positioning patients during surgical procedures poses the potential for nerve injuries and pressure ulcers. These injuries are at greatest risk of developing during procedures lasting over 2-3 hours. Our facility enlisted the knowledge of our Surgical Service Practice Council to conduct a comprehensive review of the existing positioning protocol. This, in turn, prompted a reassessment of our health system's policy. Although pressure injuries may not manifest at once, their prevention remains critical in this costly and debilitating complication.

Purpose/Framework

Following the Iowa Model of Evidence-Based Practice we concentrated on interprofessional collaboration and organizational support. Upon reviewing our patient positioning policy, we identified a significant gap: the absence of a standardized assessment tool tailored to the perioperative population. Four tools were then identified relevant to perioperative criteria. These tools were presented to the multidisciplinary team for review.

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OBJECTIVES

After viewing the poster, perioperative staff will be able to name evidence-based practices for preventing pressure injuries as well as the importance of reassessment throughout the surgery.

The learner will incorporate using evidence-based hand off to post anesthesia care unit (PACU) staff about risk factors, intraoperative patient position, and length of procedure.

METHOD

The Surgical Services Council formed a multidisciplinary team to review the current policy on patient positioning during surgical procedures. This included an evaluation of the existing tool used for pressure injury (PI) risk assessment. After careful organizational consideration, the decision was made to continue using the current assessment tool.

- Revise policy where needed
  - Define characteristics of a long procedures
  - Identify risk factors
  - Modify pacu handoff to address intraoperative position concerns

RESULTS

Evidence-based resources enhance and improve ongoing initiatives to prevent pressure injuries in surgical patients.

Key Takeaways

1. Application and use of foam dressings, gel pads, and other positioning aids.
2. Continuous intraoperative patient reassessment ensuring proper positioning is maintained.
3. The importance of pacu handoff including pre-op skin assessment, length of procedure and intraoperative position.

Collaboration with leadership has resulted in a revised updated policy. Upon ratification, educational initiatives were implemented alongside randomized audits. This revealed strong overall performance, with solid compliance in most key areas. Evidence of improvement show a few manageable gaps such as the consistent use of foam dressings. By focusing on this area, we can continue building on the positive momentum and move even closer to full compliance.

CONCLUSION

Attendance at the AORN National Conference has further guided our strategy, equipping us with up-to-date best practices and reinforcing the importance of system-wide awareness. These strategies will serve as foundational components in our comprehensive efforts to mitigate pressure injuries within the operating room environment. While results are forthcoming, our commitment to preventing intraoperative PI marks an important initiative in the quality of care for our surgical patients.

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