

PROTOCOL FOR: Blanketrol II: Hypo/Hyperthermia Blanket

DESIRED PATIENT

OUTCOMES:

1. Patient will achieve normothermia.
2. Patient's skin will remain free from injury while receiving this therapy.

CLINICAL
ASSESSMENT

AND CARE:

1. Prior to placing the patient on the mat, assess patient for the following:
 - a. Presence of any skin lesions, decubiti or pressure areas
 - b. Temperature, vital signs, level of consciousness
 - c. Color of skin, as well as warmth or coolness of extremities
2. The patient's vital signs and temperature should be taken every 2-4 hours or more frequently as condition warrants or as ordered.
3. For Cooling: Blanket temperature should be set between 65-75°F. The temperature should not be set below 65°F. If patient exhibits evidence of shivering, blanket temperature should be increased.
For Warming: Blanket should be set at 1° to 2° higher than patient's body temperature, then increased based on patient response.
4. A dry sheet should be placed over the disposable pad, between the pad and the patient.
5. Turn and position the patient q 2 hours. Inspect the skin for any changes in color, lesions, etc. If any change/injury is noted on the patient's skin, remove the blanket and provide appropriate skin care.
6. If a low pressure/air therapy bed is being used the blanket should be placed on top of the patient.
7. Notify the MD/licensed independent practitioner (LIP) for any of the following:
 - a. No response/change in temperature
 - b. Excessive rise or fall in temperature
 - c. Areas of skin breakdown or suspected burn areas
 - d. Low urine output, change in skin turgor.

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APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 2/94

REVISION DATES: 9/96, 10/97, 12/99, 11/02, 2/06

REVIEWED DATES: 1/09