

PROTOCOL FOR: Skin Care: Perioperative Care of the Patient at Risk for or with Skin Breakdown

- POLICY:**
1. The Braden scale will be used to assess all admit day of surgery and ambulatory surgery/procedure patients upon admission to the perioperative areas.
 2. Patients also will be screened for the following conditions:
 - a. Rash
 - b. reddened areas
 - c. bruises
 - d. scratches
 - e. sores
 - f. itching
 3. A head to toe physical assessment of skin condition will be performed on all patients who are scheduled to be admitted following their procedure. A head to toe physical assessment will be performed for all ambulatory patients with any of the following conditions:
 - a. 70 years or older
 - b. wheelchair dependent
 - c. steroid dependent
 - d. sent from an outside facility (non-DOC)
 - e. Braden score 18 or less
 - f. positive for any of the screened conditions from #2 above
 4. Patients deemed at risk for or with pressure ulcers will have individualized prevention and treatment interventions initiated based on physical assessment findings, the Braden Scale value, and specific patient needs.
 5. Notify the admitting service and the Wound Ostomy Continence Nurse (WOCN)CNS of any patient with a pre-existing Stage 3 or Stage 4 pressure ulcer, any ulcer that cannot be staged, or any suspected deep tissue injury. File a *patient safety net* report for any pre-existing Stage 3 or Stage 4 pressure ulcer, any ulcer that cannot be staged, or any suspected deep tissue injury.
 6. Any skin breakdown/wound, dressings, and associated care will be documented in the perioperative record prior to transfer within or discharge from the perioperative area.
 7. Ambulatory patients will be instructed regarding incision/wound care prior to discharge, as appropriate.
 8. To reduce the risk of thermal injury to skin, warmed blankets and irrigation solutions will not exceed 110 degrees Fahrenheit in temperature.

DESIRED PATIENT

- OUTCOMES:**
1. Patients will maintain optimal skin integrity.

- ASSESSMENT:**
1. All admit day of surgery and ambulatory patients and will be assessed on admission as follows:
 - a. completed Braden scale to determine risk status, and
 - b. head to toe skin assessment per policy and risk status

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- c. presence of factors that increase risk of skin breakdown and pressure sore development, including altered level of consciousness, diabetes, decreased circulation, age > 70 years, previous history of skin breakdown, chronic skin condition (eg, psoriasis, eczema), obesity/cachexia.
2. Perform head to toe skin assessment by inspecting bony prominences and weight bearing locations, including occiput, ears, shoulders, sacrum/coccyx, buttocks/perineum, trochanters, ischia, ankles, and heels.
3. Document overall skin assessment and any pressure ulcers or wounds in the perioperative nursing record. Documentation of pressure ulcer wound assessment will address:
 - a. location;
 - b. stage;
 - c. size in centimeters (longitudinal (head to toe) and horizontal (side to side) axes of the ulceration), including depth;
 - d. location and extent of any undermining or tunneling sinus or track;
 - e. wound bed, including color and type of tissue as well as evidence of healing or necrosis;
 - f. exudates - type, color, odor, amount;
 - g. pain - quality, type, intensity; and
 - h. description of surrounding skin

Refer to NPM Procedure for Pressure Ulcer Prevention and Management: Care of the Adult Inpatient for staging of skin breakdown and mattress selection, as needed.

4. Inspect dressings present on admission; collaborate with admitting service, as needed, to determine if dressings must be removed prior to surgery and discarded so that complete assessment may be accomplished.

GENERAL NURSING

CARE: PREOPERATIVE

1. Complete Braden risk assessment tool and inspect patient, as appropriate.
2. Any patient who has developed or is assessed to be at risk for developing skin breakdown/pressure ulcers and cannot adjust their position should be repositioned periodically, at least every 2 hours. Positioning devices such as pillows should be used to keep bony prominences from direct contact with one another.
3. To avoid shearing and/or friction injuries, use lifting devices such as a trapeze, bed linen or patient lift to move or reposition patients who cannot assist during transfers and position change.

INTRAOPERATIVE

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1. Verify preoperative nursing assessment.
2. Hair removal
 - a. Collaborate with surgeon regarding safest method of hair removal; assess skin before and after hair removal for redness, clipper nicks, or skin abrasions. Follow manufacturer's documented instructions regarding skin testing and use of chemical depilatories when removing hair, if that method used.
3. Antimicrobial prepping agents
 - a. Select antimicrobial agents based on patient's allergies and sensitivities, incision locations, skin condition, and surgeon preferences.
 - b. Place absorbent materials (sterile towels, if appropriate) under the patient before skin preparation to prevent prep solution from saturating bed linens or pooling under patient; remove prior to draping.
 - c. Allow antimicrobial solutions drying time prior to draping.
 - d. Observe for any allergic-type responses to prep solutions.
 - e. Prevent burns to patient's skin/tissues by completely rinsing high-level disinfectants from the surface of equipment or devices.
 - f. Inspect entire area prepped with antimicrobial solution for signs of redness, rash, abrasion, blisters, or chemical injury.
4. Positioning/Devices
 - a. Pad positioning devices and OR bed surface with gel overlays and/or pressure reduction devices, as needed.
 - b. Avoid contact between skin and metal parts of OR bed/positioning devices.
 - c. Ensure correct anatomical alignment that minimizes or eliminates pressure over bony prominences.
5. Ignition sources
 - a. Select electrosurgical unit (ESU) dispersive pad site with intact skin.
 - b. Evaluate skin integrity after ESU use, paying close attention to any imprint on the dispersive pad itself and areas under dispersive electrode.
 - c. Follow ESU safety policy regarding jewelry and removal thereof to prevent current diversion and potential burns.
 - d. Protect skin and nontargeted tissues from unintended laser beam

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- exposure.
- e. Implement fire protection measures, as appropriate
- 6. Tourniquet devices
 - a. If tourniquet cuff is used, prevent solution from seeping under cuff.
 - b. Remove cuff, dry extremity, and replace cuff with dry cuff if solution has wet cuff.
 - c. Inspect skin after cuff removal for signs of skin damage.
- 7. Wound care
 - a. Clean around incisions and puncture sites with aseptic technique.
 - b. Provide sterile dressing supplies and assist in dressing wound, as needed.
 - c. Secure dressings with tape or other material, without stretching or otherwise compromising skin.
- 8. End of procedure
 - a. Assess skin at bony prominences or pressure sites for reddened or raised areas.
 - b. Assess dispersive pad site, per above.
 - c. Document any changes from baseline preoperative assessment.
 - d. Report any changes from baseline preoperative assessment during Hand-off to postoperative nurse.

POSTOPERATIVE

1. Perform and document a visual skin assessment as part of the admission process, referring to preoperative/intraoperative nursing assessment data to individualize plan of care.
2. Reposition patient as needed and if stay exceeds 2 hours. Positioning devices such as pillows should be used to keep bony prominences from direct contact with one another.
3. To avoid sacral pressure ulcers in the bariatric population, avoid prolonged periods of time in high Fowler's position whenever possible.
4. To avoid shearing and/or friction injuries, use lifting devices such as a trapeze, bed linen or patient lift to move or reposition patients who cannot assist during transfers and position change.

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5. Communicate skin assessment and preoperative Braden scale to nurse on the receiving unit during hand-off.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 8/09

APPENDIX A

Bed Types, Indications/ Functions and Weight Capacity

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BED TYPE	Indications/Functions	Weight Capacity
VersaCare by Hill Rom - JDH owned	Hospital owned bed with blue mattress, bed alarm, turn assist, bed scale (see user manual on unit for full description of features) Pressure relief surface good for up to a stage III.	440 lbs
First Step Select - KCI rental	Air mattress overlay- appropriate for stage I-II's when a VersaCare is not available	250 lbs
KinAir - KCI rental	Low air loss bed- appropriate up to a stage III or IV with frequent ambulation	300 lbs
Total Care Sport (generally ICU patients, Hill Rom hospital owned)	2 layered cushioned therapeutic surface with zoned pressure relief with percussion and rotation features	Pressure reduction to 350 lbs, weight capacity to 500 lbs
FluidAir - KCI rental	Sand/bead bed- for complicated stage III and stage IV ulcers.	250 lbs
RotoProne (ICU - KCI rental)	For critical care patients that meet the criteria for prone positioning. Low-air loss bed.	350 lbs
	BARIATRIC CONTINUUM OF CARE	
BariMaxx - KCI rental	Basic hospital level bed	1,000 lbs
BariKare - KCI rental	Air surface, cardiac chair function, front exit, scale. Recommended for high risk of break down, stage I and II ulcers	850 lbs
BariAir - KCI rental	Low Air loss surface, front exit, percussion and pulsation, turn assist, scale. For Stage III and IV ulcers	850 lbs
Bariatric Accessories - KCI rental	Wheel chair Walker Commode/Shower Chair EZ lift	700 lbs 850 lbs 1,000 lbs 1,000 lbs