Prevention of Perioperative Pressure Injury Tool Kit

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INTRODUCTION

• The incidence of perioperative pressure injuries over the past 5 years has NOT decreased but increased (Denz, 2012).

• According to a 2014 publication from the National Pressure Ulcer Advisory Panel the incidence rate for pressure injury attributed to the operating room range from 5% to 53.4%.

• As a result substantial patient harm has been reported leading to complications, disfigurement, disability, and death.

• Despite published guidelines specific to the operating room (OR) significant gaps in knowledge, practice, and research exist.

• The Association of Perioperative Registered Nurses (AORN) shared a task force including AORN subject matter experts and representation from the Wound, Ostomy and Continence Nurses Society.

• The task force has created a Perioperative Pressure Injury Prevention (PPIP) online toolkit for both association and society members.

• The roadmap describes how to utilize the quality model (DMAIC) Define-Measure-Analyze-Improve-Optimize to create a strategic plan for prevention.

AORN POSITION STATEMENT

• Perioperative Pressure Injury Prevention in the Care of the Surgical Patient

AORN believes that:

• The entire health care team must collaborate to prevent pressure injury formation in the perioperative patient.

• Pressure injury prevention should begin before the patient enters the surgical suite.

• Every patient experiencing a surgical procedure should be assessed for risk factors that may lead to the development of a pressure injury.

• The pressure injury risk assessment and skin condition should be communicated during all patient hand overs.

• Education related to pressure injury in the OR should be performed yearly, and.

• Communication of pressure injury development back to the surgical team is imperative.

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BIBLIOGRAPHY


