



AORN Position Statement on Perioperative Pressure Ulcer Prevention in the Care of the Surgical Patient

POSITION STATEMENT

AORN believes that:

- the entire health care team must collaborate to prevent pressure ulcer formation in the perioperative patient,
- pressure ulcer 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 ulcer,
- the pressure ulcer risk assessment and skin assessment should be communicated during *all* patient hand overs,
- education related to pressure ulcers in the OR should be performed yearly, and
- communication of pressure ulcer development back to the surgical team is imperative.

AORN is committed to providing excellent care to the surgical patient and preventing pressure ulcers in the surgical environment. As a leader in patient safety, AORN is committed to educating health care providers about safe positioning practices, use of positioning devices, the importance of risk assessment, and the latest research on OR bed surfaces, and to encouraging scholarly inquiry on the topic of pressure ulcers.

RATIONALE

Millions of surgeries are performed each year in the United States during which the patient is anesthetized, immobile, and cannot inform the surgical team of pain or discomfort at a pressure site, which may lead to a pressure ulcer.^{1,2} Development of a pressure ulcer in a surgical patient may result in increased pain, a longer hospital stay, re-admissions, multiple surgical interventions, possible disfigurement, and increased cost for the hospital.¹ In 2012, Ganos et al identified the rate of perioperative-acquired pressure ulcers to be between 5% and 53.4%.³ In a systematic review of 17 studies, Chen et al found that the incidence of perioperative-acquired pressure ulcers was between 0.3% and 57%, with a pooled incidence of 15%; they concluded that the incidence of pressure ulcers had increased during the previous five years.⁴

The National Pressure Ulcer Advisory Panel defines a pressure ulcer as a localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure or pressure in combination with shear.⁵ Surgical patients are at risk for development of pressure ulcers due to extrinsic and intrinsic factors. The extrinsic factors include the type of anesthesia, the temperature of the room, the position in which the patient is placed, the bed surface, the devices used, and the length of the surgery.⁶ Intrinsic factors that increase susceptibility to a pressure ulcer include patient co-morbidities, nutritional status, age, and possibly smoking.⁶

Risk assessment and skin assessment of the perioperative patient are primary factors in the prevention of pressure ulcers and entail a comprehensive approach to evaluating risk.⁷ A

standardized risk assessment allows for the identification of persons susceptible to the development of a pressure ulcer during the surgical procedure.^{7,8} Completion of a risk assessment and skin assessment allows the perioperative team to plan interventions to prevent pressure ulcers from occurring.

Pressure ulcers have always been a concern in health care but have become a greater priority since the Centers for Medicare & Medicaid Services developed guidelines that deny reimbursement for care required due to hospital-acquired pressure ulcers.⁹ According to a 2011 estimate, more than 1.6 million patients develop a health-care associated pressure ulcer annually, and those pressure ulcers result in a cost of approximately \$2.2 billion to \$3.6 billion per year.⁹

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