Prevention of Perioperative Pressure Injury Tool kit

Sample Document: Hand-Over Script

This sample script describes a hand-over communication between the RN circulator and intensive care unit (ICU) RN related to a patient's plan of care to reduce or prevent the development of a pressure injury after surgery.

RN Circulator: Mr. Smith is a 75-year-old white male who was admitted with a myocardial infarction and had emergency coronary artery bypass grafting that lasted 5 hours. He was in the emergency department for 1 hour before surgery. His ASA score was 3. He is extremely obese with a BMI of 42. He is diabetic with an A1C of 7.5. He has a history of peripheral artery disease, and his lower extremity pulses could only be found using a Doppler ultrasound. His Scott Trigger score was 3, which places him at high risk for pressure injury.

He was positioned supine, and he had several episodes of hypotension during the surgery. He was also hypothermic. The skin in his sacral area was deep red in color upon transfer. He was on a standard OR table pad with a gel pad in place. His heels and occiput were padded with foam. His chest and leg incisions are dry and intact. He will come to the ICU on a ventilator, and he has on soft wrist restraints.

He needs to be placed on an ICU bed with an alternating air mattress. Reposition him every 2 hours while in bed and keep him off of his back; turn him from the right to left side. He should get out of bed tonight after he is extubated. The physician has ordered daily skin assessments by the wound care RN, and when he is repositioned, his skin should also be checked. If he develops a pressure injury, the communication process is for the wound care RN to notify the OR pressure injury prevention team. The OR pressure injury prevention team can evaluate the pressure injury prevention processes that were implemented for Mr. Smith to see if they need improving.

ICU RN: Ok, so you want me to initiate the pressure injury protocol, activate an alternating air mattress, position him off of his back, initiate a weaning protocol, and get him out of bed after extubation. Also, we will observe him for any sign of a deep tissue injury or worsening of his skin. The wound care RN will be assessing his skin daily, and we will check his skin each time he is repositioned. The wound care RN will be working with the OR pressure injury prevention team to evaluate and improve our protocol if needed. And also, if the ICU protocol changes, I will notify the OR. Anything else?

RN Circulator: No, that is all, thanks.