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A mild degree of hypothermia, defined as a core temperature of 34.0–36°C, it is preventable if precautionary measures are implemented and maintained. Hypothermia may lead to surgical complications and morbidity. This state has negative effects on bleeding and transfusion requirements, shivering, discomfort, postanesthetic recovery, morbid cardiac events, surgical wound infection, and duration of hospitalization (Choi et al., 2018). Post-operative patients experience hypothermia, shivering, decreased oxygen saturation, and noted to have cold hands and feet, that require an extended period in recovery to manage hypothermia that delays the post-operative treatment or management in the floor unit. Patients become more susceptible to infection and complications that prolong hospitalization time and increases the risk of mortality and morbidity (Maleki et al., 2018). Patients are shaking, unsteady, and uncomfortable which is challenging for recovery nurses during the first few hours after having anesthesia during the surgical procedure. Surgical patients are exposed to heat loss that if not given immediate intervention may lead to some complications such as increased oxygen demand, higher infection risk, and cardiovascular problems. Prevention of accidental hypothermia starts from the time patient admitted to the preoperative area to the time of the patient is discharged in the Postanesthesia care unit (PACU) Broback, Skutle, Dysvik, & Eskeland, (2018).

**Proposed Solution**

Intervention to provide quality health care and address the safety issue in the perioperative unit, a proposal of warming patients at least thirty minutes preoperatively, during the surgical procedure, and during recovery is necessary. The goal of this proposal is to decrease the incidence of hypothermia on patients who will undergo any type of surgery. Warming patients is attainable and appropriate to implement in the perioperative unit. It may add some cost to implement this project by purchasing additional supplies and forced air machines but, the benefit to this new practice will compensate the expenses by improving patient outcomes, increase patient satisfaction and decrease hospital expenses. The aggressive intervention of warm forced air has to administer to intervention is unable to start from the admission, in order to reach the patient’s normal body temperature to prevent more complications in having a low temperature. Hypothermia can lead to coagulation disorder that can cause obstruction of blood circulation that leads to delay in the healing process (Choi et al., 2018). The benefit is greater than the risk. Through the manufacturer guidelines and hospital policy compliance it will further decrease the accidental potential incident of burn to the patient. Warm forced air cannot be applied to patients’ bare skin directly. The manufacturer includes insulating material between the skin and heat source to provide adequate protection from burns, it will not 100 % guarantee however it is very unusual to happen. (Giesbrecht & Walpoth, 2019). The use of the paper gown that has a thermal insulator, with inlet where to insert the tube that blows warm air place is safe to use and decrease the risk for a burn. Perioperative warming the surgical patient decreases the incidence of surgical complications such as hypothermia, increased the risk of infection due to decreased oxygen in the blood and hypotension. Proper training of all the perioperative team members is necessary for the success of this project. Knowing the benefit of this project that may bring out to our unit it necessitated to implement this project at the earliest possible time. Implementation and documentation will be monitored to maintain the continuity of the best practice. Inservice will be provided to support staff members and all the negative feedback will be addressed to improve healthcare service. Yearly competency and education to patients and clinicians on the benefits of warming patient and maintaining normal temperature produces cooperation and understanding, good teamwork as a patient-centered care service that includes patients to be more involved in the treatment plan.

**Organization Culture**

The organization has different cultures, there are hospitals that embrace the culture of evidence-based and some are not. As a nurse in different hospitals and units requires intensive behavioral, practice, and culture adjustment in order to be more comfortable and gain harmonious relationship with the team. To be a part of the organization there’s only one common mission and vision that is aligned to interdisciplinary care, innovation, research and evidence-based practice, clinical excellence, and leadership development, collaborative governance, quality metrics, and education. Identifying a priority issue in the unit that needed intervention to ensure patients' safety and the improved patient outcome can lead in to research. A community hospital with workers who establish themselves for so many years or even decades, it is a challenge since it was recently acquired to change the organization in practicing the best practice. Most of the employees are still in the culture of the traditional practice, that they live and practicing for decades, while new young clinicians are performing what is called the best practice or the evidence-based practice (EBP). Resistance to some changes in guidelines is not easy to implement because of the concept “this is how it works here” and not because it is the best practice. Conflict issues between new nurses and older clinicians arise in this situation. The manager as a lead role must be the first one to promote and practice EBP to provide examples and guidance in the recent changes. Clinical experience prior to this organization, the EBP has been the model of the hospital. Educators, managers, clinicians are known to be EBP oriented which leads to changing clinical practice based on what is the best practice. For this new practice to be successful it requires everyone to embrace the culture of EBP and the culture of change by following what is the recent best practice. Perioperative warming helps prevent hypothermia, infection, shivering, and hypotension. Organizations and hospitals strive to approved accreditation by continuously updated and promote the best evidence-based practice to help decrease the risk of postoperative surgical infection for the patient improved outcomes, patient satisfaction, and hospital revenue. Perioperative team members must recognize that the traditional way of warming the patient is not as effective as the warm forced- air machine in maintaining core body temperatures throughout the surgical process.

**Expected Outcomes**

Preventing hypothermia in the perioperative area requires all staff members to be on board. Teamwork, accountability, and compliance towards change into the best practice promote success in changing the behavior and practice into the best practice. When staff members, perioperative team members comply with the guidelines in perioperative warming the patient, that means before, during, and after the surgery, a significant decrease in the incidence of hypothermia to patients who will undergo surgery will be observed. Implementation of forced warming air in surgical patient prevents the incidence of hypothermia that leads to improve patient outcome, decrease post-operative surgical infection, and promote comfort. The top priority of postoperative patient is pain, having a cold temperature just increases the pain intensity for some surgical procedure. Benefits from warming the patient promote faster healing and prevent infection that leads to increased patient’s experience satisfaction, fewer hospital expenses and increase hospital reimbursement.

**Method to Achieve Outcomes**

Patients who will undergo surgery will be check-in in the preoperative area. Personal identification will be asked and verified. Baseline vital signs will be checked such as the temperature, blood pressure, heart rate, and respiratory rate. The patient will have an opportunity to change the clothes into a surgical gown or surgical paper gown. Before laying on the stretcher patient will be encouraged to go to the bathroom and after warming to forced air will start. Prior to the application of forced warm air patients will have education about the warming method and the benefits that entail it. Some of the patients may refuse to use the forced warm air due to some conditions such as menopausal hot flushes, hyperthyroid that unable to tolerate heat. Careful assessment of patients during this process to prevent any complication can Patient will be asked for any contraindication to warming. Patients' paper gown will be hooked to a tube connected to a warm forced air machine that will blow warm air from the machine going to the patient’s gown, the patient will be covered with a blanket. Maintaining the temperature above 36 degrees Celsius is the goal to achieve a positive outcome. Patients and families will be given a survey form that will ask questions about how they like the forced warming air. Staff members will be asked for feedback for any negative or positive changes that were observed during this process to improve patient outcomes. Documentation of vital signs including temperature, and documentation that the forced warm air was given in the perioperative unit will be audited, mandatory compliance to warming the patient on the perioperative unit will be imposed. The perioperative manager must ensure the proper utilization of warming device to provide the best care to the patient. The availability of machines in all areas of perioperative is needed for easy access. Educators will provide staff members for proper training in using the device of warm forced air to safely and effectively apply at the bedside practice.

**Outcome Impact**

Continuous implementation of forced-air warming to surgical patient promote a decrease incidence of accidental hypothermia, post-operative infection, and some cardiovascular complications such as hypercoagulation and hypotension. Hospitalization expenses are expected to decrease due to shortened stay and faster recovery after surgical procedure. Warming patient during the entire surgical procedure promote comfort, patient care is improved and promote patient’s cooperation during treatment and intervention. Patient and family experience satisfaction will significantly increase. Hospitals will be known to be reliable, efficient, updated, delivering the best quality of care and service through the application of evidence-based practice and patient-centered care. The hospital will be able to reimburse from the government will increase, and accreditation of the hospital to the agencies and government that monitor the quality and safety of the hospital (Lippincott Solutions, 2018). Clinicians are more expert in the process of perioperative warming patient, professional practice, and expectation improved.

**Conclusion**

Perioperative warming of the patient to prevent hypothermia is one of the quality measures that the surgical unit has been monitoring, it is one of the basic intervention in keeping patients more comfortable during surgery but also to prevent complications related to low body temperature such as infection, shivering, hypotension, cardiovascular disease and slow progress of recovery. It is less expensive, easy to administer, they can be delegated to a nurse’s aide in the hospital. Very low risk of burn if not properly administered, compared to the benefits that this provides to the patients, clinicians, and to the organization. This intervention will improve the quality of care rendered by the hospital to the patient, increase trust from people and community, improve hospital revenue and reimbursement, increase patients and family satisfaction and staff members expertise in maintaining the normal body temperature of the patients by continuously warming patient from the preoperative area, operating room and recovery room.

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