Clinical Practice Frequently Asked Question

Q: What is best practice for a preoperative skin assessment for preprocedure/ preoperative patients?

A: A preoperative skin assessment during preadmission testing and on the day of surgery is an essential first measure of the overall health of the patient scheduled for surgery or a procedure. ASPAN's *2025-2026 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements*, Practice Recommendation, Components of Assessment and Management for the Perianesthesia Patient, includes this initial assessment. This Practice Recommendation further recommends assessments for preadmission testing and the day of surgery related to skin integrity and multi-drug resistant organisms (MDROs).[1] MDROs may be present on the skin, in the nose or other moist areas of the body.

During the preadmission testing visit, the nurse should question the patient regarding recent infections and falls and examine the skin and skin folds. The skin assessment and any significant findings alert the perioperative team members to skin integrity issues and potential for infection.[2]

On the day of surgery, assessment of skin integrity is of prime importance and documentation is crucial (including noting that skin is intact.) Many institutions have implemented the "two sets of eyes" or "four eyed assessments" as an assessment tool targeting patients with high risks for pressure injuries (e.g., the patient with immobility issues or known history of pressure injuries). The benefits of this detailed assessment include early identification of pre-existing skin conditions as well as the opportunity to initiate early intervention. A break in skin integrity is not the only irregularity to note. The assessment should also include uneven coloring of the skin, rashes, insect bites, blemishes or poor continence. These findings may be indicators of other co-morbidities or conditions that can affect healing. In addition, any redness, bruising or discoloration of any type should be documented prior to surgery. Skin texture should also be observed and documented. Some patients take medications that further give rise to friable skin, which is easily compromised. Most pressure injuries occur over bony prominences, but the manifestation of that injury or the extensiveness of that injury may not be immediately seen for hours or even days.

Prolonged pressure in the operating room leads to ischemia, which then leads to a pressure injury. Perioperative nurses in Phase I PACU receive report from the operating

room nurse regarding positioning, however, it is the skin assessment from the preoperative nurse that discriminates new findings from existing findings.[1,2] The patient may be discharged to home after their procedure, but recovery from the procedure may have them immobile in one position for a prolonged period of time. Prolonged immobility can contribute to a pressure injury.[1,2] Skin assessment is an essential part of the physical assessment completed by the preoperative perianesthesia.

References

1. American Society of PeriAnesthesia Nurses. Components of assessment and management for the perianesthesia patient. In: *2025-2026 Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements*. ASPAN; 2024:64-65.
2. Odom-Forren J, ed. The integumentary system. In: *Drain's Perianesthesia Nursing: A Critical Care Approach*. 8th ed. Elsevier; 2024:184-187.