Positioning the Patient

1.6 CE https://aorn.us/jul21-b2b

Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN

CONTINUING EDUCATION CONTACT HOURS

CE indicates that continuing education (CE) contact hours are available for this activity. Earn the CE contact hours by reading this article, reviewing the outcome and objectives, and completing the online Learner Evaluation at *https://aorn.us/jul21-b2b*. Each applicant who successfully completes this program can immediately print a certificate of completion.

Event: #21517
Session: #0001
Fee: Free for AORN members. For non-member pricing, please visit *https://aorn.us/jul21-b2b*.

The contact hours for this article expire July 31, 2024. Non-member pricing is subject to change.

OUTCOME

The learner will have knowledge of best practices for positioning the patient and will translate that knowledge into practice.

OBJECTIVES

1. Discuss common areas of concern that relate to perioperative best practices.
2. Discuss best practices that could enhance safety in the perioperative area.
3. Describe implementation of evidence-based practice in relation to perioperative nursing care.

ACCREDITATION

Association of periOperative Registered Nurses – Provider is accredited as a provider of nursing continuing professional development by the American Nurses Credentialing Center's Commission on Accreditation.

APPROVALS

This program meets criteria for CNOR and CRNFA recertification, as well as other CE requirements.

Provider approved by the California Board of Registered Nursing, Provider Number CEP 13019 for 1.6 contact hours. Check with your state board of nursing for acceptance of this activity for relicensure.

CONFLICT-OF-INTEREST DISCLOSURES

Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

The behavioral objectives for this program were created by Jocelyn Chalquist, BSN, RN, CNOR, clinical editor, with consultation from Susan Bakewell, MS, RN, NPD-BC, director, Perioperative Education. Ms Chalquist and Ms Bakewell have no declared affiliations that could be perceived as posing potential conflicts of interest in the publication of this article.

SPONSORSHIP OR COMMERCIAL SUPPORT

No sponsorship or commercial support was received for this article.

DISCLAIMER

AORN recognizes these activities as CE for RNs. This recognition does not imply that AORN or the American Nurses Credentialing Center approves or endorses products mentioned in the activity.

http://doi.org/10.1002/aorn.13442

Positioning the Patient

PODCAST

1.6 CE https://aorn.us/jul21-b2b

Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN

Perioperative patient positioning requires a collaborative team effort to maintain safety and prevent injuries.[1] Key goals of patient positioning include providing adequate exposure of the surgical site; maintaining the patient's comfort and respecting his or her privacy; allowing for optimal airway ventilation and access to monitoring devices; promoting blood circulation; maintaining nerve integrity; and protecting skin, bones, joints, and vital organs. The AORN "Guideline for positioning the patient"[1] includes a complete list of goals as well as recommendations for safely positioning patients. Perioperative team members should review the guideline in its entirety and adhere to the basic principles of positioning, including

- maintaining the patient's head and neck in a neutral position to prevent brachial plexus injury;
- repositioning the patient's head to decrease scalp pressure and subsequent breakdown;
- protecting the patient's eyes to prevent corneal abrasion during procedures requiring general anesthesia;
- placing the patient's body in physiologic alignment and away from metal portions of the bed, as well as padding hard surfaces that parts of the body may rest upon to prevent injury; and
- securing the patient to the bed so parts of the body do not unintentionally drop below bed level.[1]

To prevent inadvertent injury, perioperative personnel should be aware of the location of the patient's extremities and genitalia when changing the configuration of the OR bed.

Perioperative team members should advocate for patients when participating in positioning activities because patients cannot respond to pain or discomfort when under the effects of sedation or general anesthesia. Team members should focus on preventing pressure injuries and report any patient positioning events (or near misses) according to facility policies.

In collaboration with perianesthesia RNs, perioperative nurses should identify and monitor patients who are at

http://doi.org/10.1002/aorn.13442

increased risk for developing a pressure injury and implement strategies to help minimize that risk.[1] Failure to protect patients and employ the appropriate interventions for patients undergoing surgery may be deemed as negligence or failure to meet the duty of care that health care personnel owe the patient. When a positioning injury occurs, the doctrine "res ipsa loquitur" (ie, "the thing speaks for itself") may be applicable;[2] legal representatives may assume that the circumstances that caused the injury were under the control of perioperative team members and that the injury would not have occurred if the team members had properly cared for the patient. Therefore, perioperative team members should care for and protect patients according to accepted evidence-based recommendations[1] and the fundamental practice points discussed in this article.

PRACTICE POINT: Supine Position

Many surgical procedures require the supine position, which can place increased pressure on some areas of the patient's body (eg, back of the head, elbows, scapulae, sacrum, coccyx, heels).[1] Perioperative personnel should consider implementing strategies to ensure patient safety and comfort, including

- placing a pillow or padding under the patient's lumbosacral area,
- flexing the patient's knees approximately 5 to 10 degrees,
- placing the OR bed safety strap approximately 2 inches above the patient's knees,
- placing the patient's legs parallel without crossing the ankles,
- elevating the patient's heels from the bed surface, and
- protecting the patient's feet from hyperflexion or hyperextension.[1]

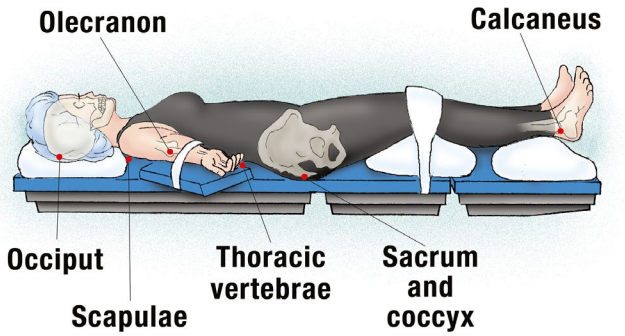
Arm placement is of particular concern in the supine position; to ensure patient safety in this position, perioperative nurses should

- tuck the arms at the patient's sides using a draw sheet,
- secure the arms at the patient's sides using arm guards,
- flex and secure the arms across the patient's body, or
- extend and secure the arms on arm boards.[1]

Perioperative team members may need to use two different arm-positioning methods to accommodate any patient limitations as well as the needs of the anesthesia professional and surgical team members. When tucking the arms at the patient's sides with a draw sheet, perioperative personnel should

- *place the patient's arms in a neutral position with the palms facing the body and without hyperextension of the elbows;*
- *protect the patient's elbows and hands with extra padding;*
- *pull the draw sheet up between the patient's body and arm, place it over the patient's arm, and tuck it between the patient and the OR bed mattress;*
- *tuck the draw sheet snugly enough to secure the patient's arm, but not so tightly as to become a pressure source; and*
- *extend the draw sheet from the mid-upper arm (ie, above the elbows) to the fingertips.*[1(p669)]

When placing the patient's arms on arm boards, perioperative personnel should verify the boards are padded and level with the OR bed mattress before placing the arms in a palms-up position with neutral alignment of the wrists and arms.[1] In addition, personnel should not position the arms above the patient's head or at an angle greater than 90 degrees from the patient's body. Personnel should secure the patient's arms on the arm boards.



Supine position
potential pressure areas shown

KNOWLEDGE CHECK

Lin, an RN circulator, enters the preoperative holding area to meet Mrs G, a 79-year-old patient who will be undergoing an exploratory laparotomy. Lin receives a hand-over report from Del, the preoperative nurse, and learns that Mrs G experiences back and arm pain. Lin reviews Mrs G's electronic health record and asks her about her functional

status and physical limitations. Mrs G tells Lin that she has back issues and usually sleeps on her side; if she sleeps on her back, she places pillows under her lower back and knees to help relieve pressure. Lin transports Mrs G to the OR and introduces her to Jon-Paul, the anesthesia professional; Lin and Jon-Paul assist Mrs G onto the OR bed. Lin requests that Mrs G place her hands and arms on the arm boards in a comfortable position, and notices that she places them palms up. Lin secures the safety strap 2 inches above Mrs G's knees and moves the transport cart to the hallway.

Before placing the monitoring leads, Jon-Paul repositions Mrs G's arms in the palms-down orientation and secures them with a strap. The surgeon, Dr N, enters the room to talk briefly with Mrs G before general anesthesia induction, and when Mrs G mentions her back issues, Dr N reassures her that Lin is planning to place a pillow under her knees to relieve pressure during the procedure. Jon-Paul administers the general anesthesia and then tells Lin that she can proceed with positioning and skin preparation. As Lin places the pillow under Mrs G's knees before beginning the skin antisepsis, she notices that Mrs G's eyes are not protected; she mentions it to Jon-Paul, who thanks her and proceeds to address the concern. As Dr N re-enters the room and prepares to don his gown and gloves, he asks Lin to place Mrs G's arms in the palms-up position before he drapes, and Lin accommodates his request.

1. In this scenario, who did not follow the practice point?
   a. Del
   b. Lin
   c. Dr N
   d. Jon-Paul

PRACTICE POINT: Trendelenburg Position

Surgeons use the Trendelenburg position for procedures on organs in the pelvic cavity[1] because the abdominal contents shift toward the head when the patient's feet are raised approximately 15 to 30 degrees.[3] Although surgeons may require steep bed angles (eg, greater than 30 degrees), personnel should minimize the amount of time that a patient spends in this position and decrease the angle when possible.[1] The Trendelenburg position redistributes blood from the lower body into the patient's torso and head, which can negatively affect pulmonary circulation and venous blood return from the head. Venous pooling can cause increased intraocular pressure,[4] and venous stasis can result in edema of and around the face (eg, tongue, eyes, lips, larynx) and lead to respiratory distress.[1]

The Trendelenburg position requires the same safety precautions as the supine position; if the Trendelenburg position is coupled with the lithotomy position, perioperative personnel also should implement lithotomy-specific safety precautions. Robotic surgery can require the Trendelenburg position, either by itself or in conjunction with the lithotomy position.[5] Some experts suggest that the perioperative team conduct a second time out three to four hours after beginning a robotic procedure to discuss the patient's position and address any patient safety concerns as specified on a checklist.[5] The additional time out provides the team members an opportunity to assess, discuss, and remediate positioning considerations, including

- the patient's head position,
- eye protection and padding,
- upper and lower extremity placement and padding,
- pooling of solutions on the patient's back and buttocks area,
- the appearance of extremities (eg, mottled),
- pressure points and padding, and
- placement of safety straps.[1]

Perioperative team members also should consider transitioning patients to the supine or reverse Trendelenburg position as needed or at specified intervals during the procedure.[1]

Perioperative personnel should position patients in a manner that prevents sliding on the OR bed, which can increase the risk of skin tears and breakdown.[1] Preventing shear forces helps to reduce pressure on the brachial plexus and strain on the abdominal wall. To prevent sliding, perioperative personnel can place convoluted foam or viscoelastic gel overlays on the OR bed or use vacuum-packed positioning devices to maintain the patient's position.[1] However, personnel should not use shoulder braces because these can cause acromial compression resulting in a brachial plexus injury.[1] Likewise, personnel should not use circumferential wrist restraints, which can pull the humeral head downward and cause a brachial plexus injury.[1]

After placing the patient in the Trendelenburg position, the anesthesia professional should verify the patient's airway

device is secure and take corrective actions if needed. When securing the patient's arms for the Trendelenburg position, perioperative personnel should avoid using arm boards because of the possibility of excessive abduction and brachial nerve injury. Rather, the staff members should either tuck the patient's arms at the sides with a draw sheet or secure the arms at the sides with arm guards.[1] Finally, perioperative personnel should avoid using the Trendelenburg position for patients with a body mass index greater than 40 kg/m^2 because the position may compromise oxygenation.

KNOWLEDGE CHECK

Mr B will be undergoing a robotic-assisted pelvic procedure requiring the Trendelenburg position. When Rose, the RN circulator, interviews Mr B and explains the planned position, he does not mention any positioning-related issues or concerns. Rose and Luc, the anesthesia professional, transport Mr B to the OR and assist him onto the OR bed. When Dr V, the surgeon, enters the OR, she reminds Rose and Luc that the procedure may last six hours and requests that the team complete a second time out three hours after the beginning of the procedure to assess Mr B's condition and address any identified safety concerns.

After induction, Dr V assists Rose, Luc, and Misha, the assigned surgical technologist, with positioning Mr B. When Misha volunteers to obtain shoulder braces to help secure Mr B to the OR bed, Luc reminds Misha that the braces are no longer available in the department because of the risk of patient injury. The procedure begins and proceeds as expected; at the designated three-hour point, Rose calls for the second time out. Luc reports no anesthesia concerns and states that the vital signs are stable with minimal blood loss and adequate urine output. Neither Misha nor Dr V identify any concerns, and Dr V states that she will complete the procedure in approximately one hour. Rose does not identify any equipment or supply concerns; however, upon assessing Mr B's extremities, she identifies mottled skin coloring and shares her finding with the team. Dr V replies that this is not a concern because she will be finished with the procedure in an hour.

2. In this scenario, who did not follow the practice point?

a. Dr V
b. Rose
c. Luc
d. Misha

PRACTICE POINT: Lithotomy Position

The perioperative team uses the lithotomy position for procedures requiring genitourinary or rectal access. Personnel classify the type of lithotomy position according to the elevation of the legs and pelvis (ie, low, standard, high, hemi-, exaggerated). Raising the patient's legs causes blood to flow from the legs into the central circulation, which decreases leg perfusion and increases cardiac output and venous return.[6] Leg elevation can cause respiratory compromise because the abdominal organs shift upward and increase pressure on the diaphragm. The increased chest weight and abdominal pressure of bariatric patients with a body mass index greater than 40 kg/m^2 increase the risk for aspiration and decrease lung volume, which may require mechanical compensation (eg, positive-pressure ventilation via endotracheal tube).[7] Perioperative personnel should place bariatric patients in the lithotomy position for the shortest amount of time possible.[1]

Patient injuries associated with the lithotomy position include lower-leg muscle contusion and compartment syndrome, rhabdomyolysis, and acute renal failure.[1] Perioperative team members should discuss the patient's planned procedure during the preoperative huddle to determine if the patient will require intraoperative repositioning and identify the positioning intervals and interventions (eg, completely remove the patient's legs from the leg holders every four hours, lower the patient's legs in the leg holders every four hours).[1]

When placing patients in the lithotomy position, perioperative team members should apply the same principles as for the supine position. In addition, they should

- place the patient's buttocks even with the lower break of the OR bed, with the sacrum on the surface of the bed;
- place a positioning device under the patient's sacrum to help support the hips in the exaggerated lithotomy position;
- avoid excessive flexing, rotating, or abducting of the hips (especially with candy cane–shaped leg holders);
- place the leg holders at an even height;
- provide support for as much surface area of the patient's legs to redistribute pressure and help prevent pressure injury;
- place the patient's heels in the lowest position possible; and
- avoid resting the patient's legs against the posts of the leg holders to prevent a common peroneal nerve pressure injury.[1]

Two staff members should place the patient's legs in the leg holders and coordinate positioning to allow for both simultaneous placement and the physiological adjustment resulting from the shift in circulatory volume. During the procedure, scrubbed personnel should avoid leaning against the patient's legs, which can cause abduction and external rotation and lead to femoral neuropathy. At the end of the procedure, two staff members should use a two-step process that includes

- slowly removing the patient's legs from the leg holders simultaneously and bringing them together and
- simultaneously lowering the patient's legs to the OR bed.[1]

KNOWLEDGE CHECK

Ms L, a healthy 60-year-old patient, is preparing for a uterine polypectomy. During the preoperative interview, Ms L tells Juliet, the RN circulator, that she experienced a traumatic leg injury 10 years ago that required a total hip arthroplasty; she expresses concern about ongoing lower back pain and limited range of motion. Before transporting Ms L to the OR, Juliet meets with Dr H, the surgeon; Dr R, the surgical resident; Nusrat, the anesthesia professional; and Simone, the surgical technologist. Dr H estimates that the procedure will require 90 minutes to complete and requests candy cane–shaped stirrups for a high lithotomy position. When Juliet mentions the possible effects of the planned position on Ms L, Dr H acknowledges the concern but says the surgery will be more difficult and prolonged with a different position and recommends careful positioning to decrease risk of injury. He also requests that the team plan to reposition Ms L at the one-hour mark if the procedure is not nearing completion. Dr H tells Dr R that they need to place the patient's legs in the stirrups carefully and simultaneously; Nusrat agrees with the plan to expedite the surgery because she is concerned about the risk of circulatory and respiratory compromise related to Ms L's age and comorbidities.

The team positions Ms L as planned and Dr H begins the procedure. A few minutes after the one-hour mark, the team completes the final surgical counts and there is no need for patient repositioning. Juliet and Simone confirm the specimens with Dr H before he leaves the OR to talk with Ms L's support person. As Juliet and Simone finish managing the specimens, Dr R removes Ms L's legs from the stirrups one at a time and places each leg slowly and carefully on the bed. Later in the postanesthesia care unit, Ms L complains of lower back and hip pain.

3. In this scenario, who did not follow the practice point?
   a. Dr H
   b. Dr R
   c. Simone
   d. Juliet

PRACTICE POINT: Prone Position

Surgeons use the prone position to perform procedures on the dorsal side of the patient. For sacral, rectal, or perineal procedures, surgeons may require a variation of the prone position (ie, jack-knife or Kraske position) in which the patient's head and feet are lower than the torso and pelvis.[1] Prone patients are at risk for a variety of complications, including

- increased abdominal pressure and bleeding,
- abdominal and limb compartment syndrome,
- nerve or pressure injuries,
- cardiovascular system compromise,
- stroke,
- liver dysfunction,
- ophthalmic injury,
- oropharyngeal edema,
- inadvertent airway device dislodgment, and
- venous air embolism.[8]

When placing patients in the prone position, perioperative personnel should elevate the head of the OR bed 5 to 10 degrees to help reduce venous congestion in the face, intraocular pressure, and facial edema.[1] Perioperative personnel can place the patient's head in a positioner designed to help maintain a neutral alignment, protect the patient from facial pressure injury, and maintain airway devices.[1] However, the staff members should avoid using horseshoe-shaped head positioners because pressure may cause postoperative vision loss.[9,10] Perioperative personnel should monitor the patient for direct pressure on the eyes during the positioning process and surgical procedure.[1] The patient's airway device may become dislodged when personnel turn the patient to the prone position. The anesthesia professional should assess the airway maintenance device after the patient is placed in the prone position and remediate any placement concerns.[1]

Prone positioning steps include

- placing two chest supports from the clavicle to the iliac crest to facilitate chest and abdominal expansion and decrease pressure on the abdomen;
- verifying that the patient's breasts, genitalia, and abdomen are free from pressure or torsion;
- padding the patient's knees and placing padding under the patient's lower legs to elevate the toes from the bed and to prevent pressure on the toes; and
- ensuring that a patient transport cart or bed is easily accessible for rapidly placing the patient into the supine position (eg, for cardiopulmonary resuscitation).

Arm-positioning methods for prone patients include

- tucking securely, but not tightly, at the sides with a draw sheet;
- securing at the sides with arm guards;
- placing on padded arm boards that are parallel to the OR bed; or
- placing on padded arm rests with articulated joints.[1]

Perioperative personnel should place arm rests with articulated joints at a level below the patient's chest. Personnel should secure the arms to the arm boards or arm rests with palms facing downward, maintain a neutral arm alignment, and avoid abducting the patient's arms more than 90 degrees with the elbows flexed.

KNOWLEDGE CHECK

Jerry, an RN circulator, transports Mr K, a patient who is undergoing a spine procedure that requires the prone position, to the OR. After applying monitoring leads and inducing general anesthesia, Dr B and Ramon, the anesthesia professionals, assist Jerry and Dr M, the surgeon, with placing Mr K in the prone position. The team maintains neutral head alignment when turning Mr K and Dr B uses a face positioner designed to protect the patient's forehead, eyes, and chin. The team places chest supports that extend from Mr K's clavicles to iliac crests, padding under his knees, and a pillow under his lower legs to elevate his toes off the bed. Jerry then tightly tucks Mr K's arms at his sides with a draw sheet and Ramon places the oximetry probe on the patient's ear for ease of access. During the procedure, Ramon notices that the IV in Mr K's left forearm appears to malfunction intermittently, but it does not stop flowing completely. The surgery lasts six hours; when the team returns Mr K to the supine position, all of the team members notice that his left forearm and hand are

Resources

Guideline *Essentials*: Positioning the Patient. AORN. *https://www.aorn.org/essentials/positioning-the-patient* [member access only]. Accessed March 18, 2021.

Pressure Injury Prevention Program Implementation Guide. Agency for Healthcare Research and Quality. *https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressure-injury/guide.html*. Reviewed October 2017. Accessed March 18, 2021.

Resources. National Pressure Injury Advisory Panel. *https://npiap.com/page/resources*. Accessed March 18, 2021.

The Joint Commission. Preventing pressure injuries. *Quick Safety*. July 20, 2016;25. *https://www.jointcommission.org/-/media/tjc/documents/newsletters/quick-safety-issue-25-july-2016-final2-w-addendumrev.pdf*. Updated July 2018. Accessed March 18, 2021.

Clinical tools. Wound, Ostomy, and Continence Nurses Society. *https://www.wocn.org/learning-center/clinical-tools/*. Accessed May 24, 2021.

Pressure Ulcer Prevention in the O.R.: Recommendations and Guidance. Minnesota Hospital Association. *https://www.mnhospitals.org/Portals/0/Documents/patientsafety/Pressure%20Ulcers/MHA_perioperative_recommendations.pdf*. Published March 2013. Accessed May 24, 2021.

Preventing pressure ulcers in hospitals. Agency for Healthcare Research and Quality. *https://www.ahrq.gov/patient-safety/settings/hospital/resource/pressureulcer/tool/index.html*. Reviewed October 2014. Accessed May 24, 2021.

swollen and blistered. When Ramon places the pulse oximetry probe on the patient's left index finger, there is no visible waveform; the radial pulse is not palpable but Ramon identifies it with an ultrasound probe. Dr M diagnoses Mr K with acute compartment syndrome of the left arm, which requires an immediate fasciotomy to reduce the pressure.

4. In this scenario, who did not follow the practice point?
   a. Dr B
   b. Ramon
   c. Jerry
   d. Dr M

CONCLUSION

When participating in positioning activities, all perioperative team members should advocate for patient safety and apply evidence-based principles of patient positioning. Perioperative personnel should monitor patients closely for compromise or injury and implement corrective actions to rectify any practice deviations after positioning patients. Reviewing and adhering to the information in the AORN patient positioning guideline should help perioperative nurses decrease the risk of patient injuries resulting from positioning.

REFERENCES

1. Guideline for positioning the patient. In: *Guidelines for Perioperative Practice*. Denver, CO: AORN, Inc; 2021:643-718.
2. Sawyer RJ, Richmond MN, Hickey JD, Jarratt JA. Peripheral nerve injuries associated with anaesthesia. *Anaesthesia*. 2000;55(10):980-991.
3. MacDonald JJ, Washington SJ. Positioning the surgical patient. *Anaesth Intensive Care Med*. 2012;13(11):528-532.
4. Arvizo C, Mehta ST, Yunker A. Adverse events related to Trendelenburg position during laparoscopic surgery: recommendations and review of the literature. *Curr Opin Obstet Gynecol*. 2018;30(4):272-278.
5. Song JB, Vemana G, Mobley JM, Bhayani SB. The second "time-out": a surgical safety checklist for lengthy robotic surgeries. *Patient Saf Surg*. 2013;7(1):19. https://doi.org/10.1186/1754-9493-7-19.
6. O'Connell MP. Positioning impact on the surgical patient. *Nurs Clin North Am*. 2006;41(2):173-192.
7. Brodsky JB. Positioning the morbidly obese patient for anesthesia. *Obes Surg*. 2002;12(6):751-758.
8. Kwee MM, Ho YH, Rozen WM. The prone position during surgery and its complications: a systematic review and evidence-based guidelines. *Int Surg*. 2015;100(2):292-303.
9. Song JS, Yim JH, Lee KB. Unilateral blindness after posterior cervical spinal surgery: a case report. *Neurosurg Q*. 2015;25(1):78-81.

10. Van Wicklin SA. Systematic review and meta-analysis of prone position on intraocular pressure in adults undergoing surgery. *Int J Spine Surg.* 2020; 14(2):195-208.

Lisa Spruce, DNP, RN, CNS-CP, CNOR, ACNS, ACNP, FAAN, is the director of Evidence-Based Perioperative Practice at AORN, Inc, Denver, CO. *Dr Spruce has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.*

Knowledge Check Answers:

1. In this scenario, Jon-Paul did not follow the recommended practice point.
2. In this scenario, Dr V did not follow the recommended practice point.
3. In this scenario, Dr R did not follow the recommended practice point.
4. In this scenario, Jerry did not follow the recommended practice point.

Continuing Education

Positioning the Patient

1.6 CE https://aorn.us/jul21-b2b

This evaluation is used to determine the extent to which this continuing education program met your learning needs. The evaluation is printed here for your convenience. To receive continuing education credit, you must complete the online Learner Evaluation at *https://aorn.us/jul21-b2b*. Rate the items as described below.

OUTCOME

The learner will have knowledge of best practices for positioning the patient and will translate that knowledge into practice.

OBJECTIVES

To what extent were the following objectives of this continuing education program achieved?

1. Discuss common areas of concern that relate to perioperative best practices.
   Low 1. 2. 3. 4. 5. High
2. Discuss best practices that could enhance safety in the perioperative area.
   Low 1. 2. 3. 4. 5. High
3. Describe implementation of evidence-based practice in relation to perioperative nursing care.
   Low 1. 2. 3. 4. 5. High

CONTENT

4. To what extent did this article increase your knowledge of the subject matter?
   Low 1. 2. 3. 4. 5. High
5. To what extent will you translate the knowledge of the subject matter into practice?
   Low 1. 2. 3. 4. 5. High
6. To what extent were your individual objectives met?
   Low 1. 2. 3. 4. 5. High
7. Will you be able to use the information from this article in your work setting?
   1. Yes 2. No
8. Will you change your practice as a result of reading this article? (If yes, answer question #8A. If no, answer question #8B.)

8A. How will you change your practice? (*Select all that apply*)
1. I will provide education to my team regarding why change is needed.
2. I will work with management to change/implement a policy and procedure.
3. I will plan an informational meeting with physicians to seek their input and acceptance of the need for change.
4. I will implement change and evaluate the effect of the change at regular intervals until the change is incorporated as best practice.
5. Other: _____

8B. If you will not change your practice as a result of reading this article, why? (*Select all that apply*)
1. The content of the article is not relevant to my practice.
2. I do not have enough time to teach others about the purpose of the needed change.
3. I do not have management support to make a change.
4. Other: _____

http://doi.org/10.1002/aorn.13442