

“Preoperative shaving is deleterious and the practice should be abandoned.”

**J. Wesley Alexander, MD, et al
University of Cincinnati
Medical Center¹**

“. . . preoperative shaving is a ritual with little scientific evidence to support it and . . . it results in more harm than good.”

**Roberta Hallstrom, RN, BSN,
CNOR; Susan L. Beck, RN, PhD
University of Utah Hospital²**

“Electrical clipping is superior to razor shaving”

**Wilson Ko, MD, et al
New York Hospital —
Cornell University³**

“[Clipping offers] clear benefits from the absence of delays in the beginning of surgical procedures, lack of depilatory rash and better use of OR staff.”

**Mary M. Olson, RN, et al
Veterans Administration Medical
Center and the University of
Minnesota⁴**

“The use of clippers is cheaper over the long run than razors.”

**Colleen K. Harvey, RN, and the
AORN Professional Advisory
Committee⁵**



Clipping results in fewer cuts and lower infection rates than shaving.

The practice of preoperative shaving began sometime in the mid to late 1800s and for years was an accepted practice. After years of research, however, the health care community has come to realize that clipping is a better method of pre-op hair removal.

Research clearly shows that shaving produces nicks, cuts and microscopic epidermal injuries that can permit bacterial contamination at the operative site.⁶ Clipping, on the other hand, results in lower infection rates than shaving — the evidence is overwhelming:

Sellick et al found that using a clipper decreased the risks of deep wound infection compared to razor preparation.⁷ Ko et al concluded that electrical clipping is superior to manual shaving in the prevention of suppurative mediastinitis.³ Alexander et al found similar results to support clipping over shaving.¹ The list goes on and on.

Clip the high cost of infections

Clipping not only cuts the risk of infection, but also helps cut costs — partly because infections can lead to longer hospital stays. One study found that the length of stay would be reduced by 655 days per 1,000 patients, resulting in a savings of \$275,000, if all patients were clipped the morning of surgery rather than shaved.¹ Another study found that the cost of clipping was less

than half that of using a razor for pre-op prepping.⁸

Clipping is recommended over shaving . . .

Several health care organizations recommend a procedural change from shaving to clipping.

AORN recommends that “if hair is removed, the best option is clipping immediately before the procedure using a disposable clipper . . .”⁹

Clipping hair results in less skin trauma and lower infection rates than shaving hair.¹

The CDC rates clipping as a preferred method of hair removal in the Category II ranking. This means there is a logical, theoretical rationale indicating effectiveness, and that it is practical to implement in hospitals.¹⁰

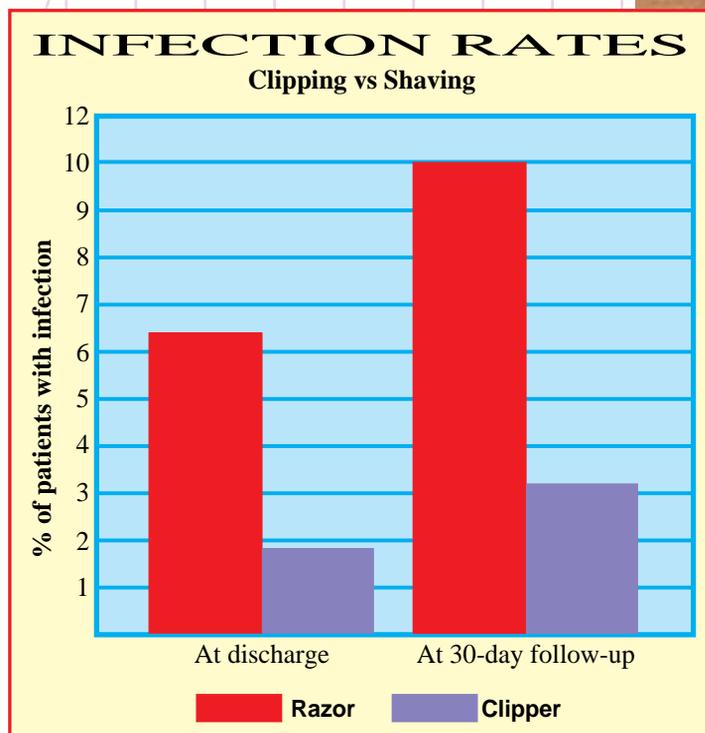
APIC states that “a depilatory or clipping in preference to shaving for hair removal is an intervention that reduces microbial contamination of the wound and lowers the infection risk.”¹¹

The ACS and other health care organizations also advocate clipping over shaving.

Hair should be removed only when it interferes with the procedure or wound dressing. But when hair removal is necessary, it should take place in as small an area as possible, immediately prior to the procedure, and with a clipper.

. . . and preferred over depilatories

Although chemical depilatories are also associated with lower infection rates, they are messy, odorous, time consuming and expensive. One study, in fact, found that the cost of clipping was 11 times less than using a depilatory.⁸ What’s more, depilatories can irritate the skin⁴ and, if introduced into the wound, interfere with healing.¹²



Alexander et al found that clipping resulted in significantly lower infection rates than razor preparation, both at discharge of the patient and within a 30-day follow-up.¹ (Patients were shaved or clipped the morning of surgery. At discharge, P<.027; at 30 days, P<.006.)

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not the patient*



*Cut the risk,
not the patient*



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3M Center, Building 275-4E-01
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