with LMVe within 30 minutes of PACU discharge (Group B) and those without (Group A).
Outcomes/Results: Group B had a significantly higher rate of LMVe compared to Group A in the PACU (1.3±1.44/hr vs 0.20±0.46/hr) and on the GHF (1.57±1.46/hr vs 0.24±0.49/hr). There were no differences in opioid dosages between groups.
Discussion: Patients with LMVe in the PACU continued to experience it on the GHF. We therefore propose a PACU RVM use protocol that allows nurses to objectively monitor patients whom they identify as at risk of respiratory compromise. Patients with RVM alarms should be stimulated, repositioned and have their sedating agent dosage adjusted. Recurring alarms should trigger consultation with a physician. Patients with one or more LMVe within 30 minutes of anticipated PACU discharge should continue RVM monitoring on GHF.
Conclusion: Patients at risk for respiratory compromise on the GHF can be identified in the PACU using the RVM. Our protocol can help nurses identify and triage patients with respiratory compromise prior to PACU discharge.
Implications for perianesthesia nurses and future research: The implementation of RVM will allow nurses to objectively identify patients at risk for respiratory compromise. Proper protocols should be further developed and clinically tested.

PREOPERATIVE ACETAMINOPHEN IN SURGICAL PATIENTS: DOES THE ADMINISTRATION ROUTE (INTRAVENOUS VERSUS ORAL) AFFECT POSTOPERATIVE OUTCOMES?

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Co-Investigators: Jennifer Cox, BSN RN, Elizabeth Burgess, MD, Rachel Baker, PhD RN

Introduction: The administration of acetaminophen is part of a multimodal approach to surgical pain management in the perianesthesia setting. For a time prior to the fall of 2016, our institution's standard anesthesia orders included a preoperative dose of IV acetaminophen. A system-wide change occurred, and oral (po) acetaminophen became the standard of care.
Identification of the problem: Anecdotally, perianesthesia nurses noticed that the route of medication administration impacted symptoms experienced by patients in the post anesthetic recovery period.
Purpose of the Study: This direct care, nurse-led, interdisciplinary research study compares the following outcomes in surgical patients receiving IV acetaminophen versus oral acetaminophen: Patient reports of pain, postoperative opioid consumption, negative opioid effects, PACU length of stay, and patient satisfaction with pain control.
Methodology: This was a double-blind study. 120 participants were recruited preoperatively from the surgical unit at a hospital in the mid-western US. Eligible, consenting adult patients scheduled for outpatient surgery under general anesthesia were randomly assigned to receive IV or po acetaminophen preoperatively.
Results: Final results are pending. Preliminary data after the first 60 patients revealed mean postoperative "highest pain" scores were significantly lower in the IV group (3.2) compared to the po group (4.83); opioid use was higher in the po group, but not yet significant ($p = 0.06$); PACU length of stay was slightly higher in the po group; neither negative opioid effects nor patient satisfaction were associated with the route of administration.
Discussion: An extensive literature search revealed no studies comparing the IV and po routes of acetaminophen in surgical patients; in fact, experts in the field have called for studies that compare which route is more effective. This study proposes to fill this gap in the literature to determine if there is a significant difference in clinical outcomes related to the administration route of preoperative acetaminophen.
Conclusion: This study was completed on February 14, 2019. At the time of this abstract, final data analysis was pending.
Implications for perianesthesia nurses and future research: When faced with surgery, pain management is one of the primary concerns voiced by patients. Ultimately, results from this study will be used to advocate for patients and best practice in preoperative care.

Note: All abstracts are printed as received from the authors.

IMPLEMENTING ENHANCED SURGICAL RECOVERY ACROSS SERVICE LINES: THE FUTURE IS YESTERDAY

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Introduction: Variability in care leads to decreased quality and poor surgical outcomes. As the landscape of healthcare shifts from fee-for-service to value-based care, patient outcomes have come under the microscope in effort to provide better quality of care for the patients we serve. Enhanced Recovery After Surgery (ERAS) pathways are shown to decrease variability and improve outcomes by delivering quality care.
Identification of the problem: A lack of standardization was noted amongst surgical and anesthesia providers. This was not only confusing to perioperative staff, it also lent to delayed case starts and negative impacts on surgical outcomes and length of stay.
QI Question: Can the implementation of an evidence-based, quality improvement program across specific surgical lines decrease variations in care, length of stay (LOS), and cost in a community hospital?
Methods: Through retrospective chart review of colorectal and bariatric surgical Cases, significant variations in care were noted amongst providers within the same groups and also individual providers performing like procedures. In effort to improve care and outcomes, an ERAS pathway was implemented in colorectal and bariatric surgery. May 2016 through October 2018, 1,674 total patients were included in the ERAS group with matched retrospective controls.
Results: Reductions in LOS: colorectal 4.5 to 2.05 days and bariatric 2.15 to .95 days, cost per case: decreased by 20% and 10% in colorectal and bariatric respectively. In addition, both groups showed significant reductions in postoperative opioid.