

hospital visit. Anecdotal comments in the Press Ganey survey yielded positive feedback. Continuous evaluation and education are in progress to refine and expand the process on additional units.

Implications for advancing the practice for perianesthesia nursing: Multidisciplinary teams can work to screen and provide individualized care for patients with developmental disabilities which may aid in avoiding exacerbation of caregivers' and patients' stress levels during the preoperative phase.

A RISK-BASED PERIOPERATIVE BLADDER MANAGEMENT GUIDELINE BASED ON POST-OPERATIVE URINARY RETENTION (POUR) RISK FACTORS



Team Leader: Karin Conklin, MSN RN CAPA
UW Health at The American Center, Madison, Wisconsin
Team Members: Karen Bauer, BSN RN CNOR, Kevin Colwin, BSN RN CCRN, Kira DeBels, BSN RN CNRN, Tricia Ejzak, MSN RN CNOR, Michael Ford, MD, Michael Garren, MD FACS, Gabrielle Hatas, BSN RN CAPA, M. Hiram Moretta, MSN CRNA, Penny Marsch, RN, Kelly Quade, BSN RN MSRN

Background Information: A chart audit in April 2018 determined compliance of our perioperative bladder management guideline was low (27%). The current guideline instructed operating room nurses to bladder scan surgical patients at the end of the case if the total amount of IV fluids given were ≥ 750 mls and/or the surgery length was ≥ 90 minutes. If the bladder scan resulted ≥ 500 ml, the RN would perform straight catheterization. If these criteria were not met, the patient would be re-scanned in PACU every 1-2 hours based on the bladder scan result and the patient's ability to void.

Objectives of Project: A multi-disciplinary process improvement team formed to uncover why the current guideline was not being followed, how to improve compliance and/or revise the guideline to reflect current evidenced based practice. The team set a goal to increase guideline compliance to achieve 40% by August 1, 2018.

Process of Implementation: The improvement team utilized a FOCUS-PCDA process improvement method. We observed in the OR and PACU as well as obtained feedback from nurses, surgeons and anesthesiologists to understand the current state. Next, the team conducted a cause & effect analysis to uncover why the current guideline was not being followed. Simple changes included educating patients on POUR risk and ensuring patients void just prior to surgery. A revision to the current guideline was indicated because a review of the current literature suggested IV fluid amount was not a risk factor for POUR. The revised bladder guideline is patient-centered and evidenced-based via a pre-operative risk assessment. These include: Advance age; diabetes; previous major pelvic/abdominal surgery; history of POUR after previous surgery; history of urological/prostate conditions; spinal/epidural anesthesia; and total surgery length ≥ 3 hours.

Statement of Successful Practice: A series of small tests of change using the new risk-based perioperative guideline resulted in improved compliance to 94% in August 2018. The guideline was piloted to the entire perioperative department and after a 1-month pilot, compliance was 92%.

Implications for Advancing the Practice of Perianesthesia Nursing: Using an established process improvement method to integrate current best practices enhanced the development and implementation of a cross-functional, risk-based perioperative bladder guideline.

RIDING THE (END) TIDAL WAVE TO CO2 MONITORING: USING CAPNOGRAPHY FOR OBSTRUCTIVE SLEEP APNEA FOLLOWING ANESTHESIA



Team Leader: Kathryn Scully, MSN RN CCRN CAPA
Inova Fairfax Medical Campus, Falls Church, Virginia
Team Members: Sally Schermer, MBA BSN RN CCRN CPAN CAPA, Erin Sever, BSN RN, Adrian Jones, BSN RN, Parul Shah, RRT-NPS ACCS, Catherine Hodgkins, MS CRNA, Elspeth Stanley, MS CRNA, Jessica Dunn, BSN RN DNP, Student—George Mason University, Jennifer Rickerby, MSN RN DNP, Student—George Mason University

Background Information related to Problem Identification: Almost 25% of adult patients entering the hospital for elective surgery have obstructive sleep apnea (OSA), with the majority of these patients (>80%) undiagnosed at the time of surgery (Chest, 2010). At our institution, approximately 150 surgeries occur each day. This large surgical population has hidden, undiagnosed OSA patients that are at increased risk for respiratory complications.

To safeguard these patients, we implemented American Society of PeriAnesthesia Nursing (ASPAN) practice recommendation #10 on three perianesthesia units after we upgraded our monitors to provide ETCO2 monitoring.

Objective of Project: The intent was to educate and implement OSA screening preoperatively and use capnography monitoring in the post anesthesia care unit (PACU), with the end goal of making this the standard of practice preoperatively and in all PACUs across our institution.

Process of Implementation: A multidisciplinary team provided extensive staff education employing a variety of teaching methods. Using the STOP-Bang screening tool, preoperative patients were assessed for OSA, with 5 or more positive responses indicating high risk for OSA. The patient received an identification band, OSA staff alert sign, and additional education on what to expect in recovery. In the PACU, capnography was applied and the patient monitored closely for hypoventilation. A PACU audit tool was used to track use of capnography, identification of hypoventilation events and responsive nursing interventions.

Statement of Successful Practice: Perianesthesia nurses were able to incorporate OSA screening and capnography monitoring into their practice. They quickly identified hypoventilation events via capnography and intervened to prevent respiratory complications. This process is now utilized in all six PACUs at our hospital and we are working to expand its usefulness to all procedural areas where anesthesia is administered.