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

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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 ≥ 750mls and/or the surgery length was ≥ 90 minutes. If the bladder scan resulted ≥ 500ml, the RN would perform straight catherization. If these criteria were not met, the patient would be rescanned 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

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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.

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

Implications for Advancing the Practice of Perianesthesia Nursing: Over 90 nurses participated in this project and 100% of those who responded to a survey, said it improved their perianesthesia practice. Using critical thinking, nurses applied capnography to patients beyond the OSA population, and now employ its usefulness to additional PACU patients. Enthusiasm for this project inspired research in the Pediatric PACU to evaluate OSA screening tools for their patient population.

IMPROVING NURSING DOCUMENTATION OF SURGICAL SITE WOUNDS: A COLLABORATIVE EFFORT TO PROMOTE SAFE PATIENT CARE BETWEEN OR AND PACU

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Background Information: When patients transition from the Operating Room (OR) to the Post Anesthesia Care Unit (PACU), the absence of complete documentation in the electronic medical record (EMR) can result in significant adverse events leading to poor patient outcomes (bleeding, infection, delay of care). Lack of proper documentation of surgical site/ wounds creates gaps in the handoff communication between the phases of care, from OR to PACU, and to the inpatient units.
Objectives of Project: The goal of this project is to fulfill RNs (for both OR and PACU) professional responsibility and 100% documentation compliance to prevent errors of omission related to surgical site/ wound documentation.
Process of Implementation: From January to March 2017, data was collected regarding missing surgical site/wound documentation in the EMR, on admission to PACU. Results showed that only 50% of patients were admitted from the OR with complete surgical site /wound documentation. The same audit showed that patients being transferred from PACU (discharged home or transfer to inpatient unit), had 100% completed documentation of surgical sites and wounds.
From March to April 2017, the implementation of assessment and documentation of surgical site/wound documentation was incorporated in the training of new hires, preceptors and float RN's for both OR and PACU departments. A taskforce of OR and PACU RN's were created to provide real time feedback and in-services regarding documentation review for staff and trainees.
Statement of Successful Practice: Compare data pre and post implementation. Data was evaluated and missed documentation was addressed in real time with the OR staff involved. The results of this study indicated that the compliance of surgical site/wound documentation increased from 50% to 95% from implementation (March and April 2017) to present time. We currently sustain 90-100% completed documentation. We continue to reinforce and reeducate during our annual competency and as needed for new hires.
Implications for Advancing the Practice of Perianesthesia Nursing: Evaluation of the results prompted us to apply this process to other OR and PACU areas in the hospital. The overarching goal was to have 100% of our patients being admitted to the PACU with complete documentation. This can be accomplished by promoting a safe environment throughout the different phases of care, via proper assessment and accurate documentation.

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THE IMPACT OF IMPLEMENTING AN EPIC ERAS PATHWAY TO IMPROVE NURSING DOCUMENTATION COMPLIANCE

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Background Information:

- In 2013, ERAS program implemented in the colorectal service
- In 2018 has expanded to include cardiac, liver, pancreas, urology, plastics, thoracic, head and neck, sarcoma
- A need for a standardized method of documentation and recognition of enrolled patients was identified
- With the implementation of an electronic health record, documentation of ERAS variables became challenging

Objectives of Project:

- Identify patients enrolled in ERAS protocol
- Ensure documentation compliance of all ERAS variables
- Educate staff on documentation in the clinical pathway
- Audit documentation and provide individual feedback to staff

Process of Implementation:

- Compliance with paper checklists decreased with initiation of electronic health record (EPIC)
- An electronic pathway was developed in EPIC to allow for standardized documentation
- Banners and icons were created in EPIC to identify patients on ERAS protocol
- Staff were surveyed after initiation of pathway to determine gaps in knowledge regarding ERAS pathway documentation
- Education was developed using staff feedback and implemented through presentations, tip sheets, and bedside support
- Reviewed documentation outcome data to improve compliance

Statement of Successful Practice:

- Patients are now more easily identified with ERAS banner and icon
- Outcome data from pre- and post- EPIC initiation determined engagement and documentation compliance