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.

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

- Documentation of clearfast, hibiclens, and antibiotic prep all improved with EPIC documentation
- Results from staff surveys allow education to be targeted at specific gaps in practice

Implications for Advancing the Practice of Perianesthesia Nursing:

- Improving documentation compliance with ERAS protocol
- Educating staff to improve compliance rates of documentation
- Improving patient outcomes, decreased surgical site infections, cardiac arrhythmias and length of stay

ASSESSING AVAILABLE PRESSURE INJURY PREDICTOR TOOLS IN THE PERI-OPERATIVE SETTING

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Background: Pressure injuries (PI) have been observed in patients across the peri-operative setting, particularly among patients undergoing prolonged surgical procedures. Yet the majority of instrumentation developed to assess risk for pressure injury has been developed in the acute, intensive, or long-term care settings. As part of a quality improvement initiative at a comprehensive cancer center, validated PI prediction tools were applied retrospectively to patients who experienced a PI post-operatively.

Objectives of Project: The aim of this to evaluate the sensitivity of the Braden Scale and Scott Trigger Tool to predict the occurrence of intra-operative PI in a surgical oncology population.

Process of Implementation: An interprofessional team consisting of nurses, physician assistants, quality officers, physicians, and performance improvement professionals reviewed data of patients who developed an intraoperative hospital acquired pressure injury based on safety intelligence event reports over an 18 month period (September 2016-January 2018). Thirteen reportable Cases were identified and the Braden and Scott Trigger assessments were used to evaluate risk for PI development in this cohort of patients based on their pre-operative (within 1-2 hours of surgery) data. A team of three nurses completed the initial retrospective scoring which was then reviewed with the team to validate the results.

Statement of Successful Practice: Outcomes suggested that risk scoring with the Braden Scale was not predictive of intraoperative risk, and that the Scott Trigger Tool was overly sensitive to risk when applied to a later cohort of 72 patients, for which

the Scott Trigger score suggested all patients would have skin breakdown. However, of the 72 no intraoperative PI was observed.

Implications for Advancing the Practice of Perianesthesia Nursing: Findings suggest the need for further evaluation of these tools, specifically in the surgical oncology population and possibly in broader populations to evaluate sensitivity and specificity among individuals undergoing prolonged surgery. The ability to refine instruments to predict PI in this population is fundamental to reducing risk for PI events in the peri-operative setting.

COLLABORATIVE CARE OF PATIENTS DURING PACU HOLDS

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Background Information: High quality, safe patient care is our priority at the Cleveland Clinic. Communication between all members of the care team is vital to provide safe, high quality care. Occasionally, there is a delay in the transfer of patients from the OR to PACU. This event is referred to as a PACU Hold. Once surgery is complete and all notes and orders are entered, the surgeon is not required to remain in the OR. Usually, an in-person report from the surgeon offers a chance, not only for the surgeon to discuss individualized findings and care of the patient, but allows the PACU nurse to ask questions regarding the plan of care. PACU nurses recognized that, in the event of a PACU Hold, there is potential for vital information to be lost.

Objectives of Project: The goal was to develop and implement a hand-off tool that improved communication; ensuring safe, high-quality patient care from the OR and into the post-operative phase of care for PACU Holds.

Process of Implementation: A multi-disciplinary team consisting of Perioperative educators, PACU, OR, Anesthesia, and Surgeon leadership was formed. Input was solicited from the nurses who would be utilizing the communication tool. A hand-off communication tool was developed and trialed by one surgical service line. OR nurses were educated on the use of the tool. The first trial revealed the need for changes in verbiage and process. Regular meetings were held to review the use of the tool. Multiple changes were made to the hand-off tool over time. Once all Team Members were educated on the final version, it was implemented in all service lines for PACU Holds.

Statement of Successful Practice: The use of the written hand-off tool for PACU Hold patients provides clear communication of vital information regarding the plan of care for our patients at the Main Campus of the Cleveland Clinic.

Implications for Advancing the Practice of Perianesthesia Nursing: Clear communication between perioperative caregivers is imperative in the pursuit of reaching our goal to provide safe, high quality care. Collaboration between all