

- 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

members of this multi-disciplinary team is necessary to ensure every surgical patient at the Main Campus of the Cleveland Clinic is provided with individualized, safe, and high quality care.

STANDARDIZING HANDOFF FROM OR TO PACU



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Background Information: According to the Joint Commission, two-thirds of sentinel events occur from communication errors during patient handoff. Studies show that handoffs in the Post Anesthesia Care Unit (PACU) are prone to communication errors that correlate to suboptimal patient care. A pre-survey completed on PACU Registered Nurses (RNs) perceptions on the Operating Room (OR)-PACU handoff revealed multiple distractions during the process.

Objectives of Project: Does implementation of a standardized OR-PACU handoff improve efficiency and decrease RN's perception of being rushed through the handoff process?

Process of Implementation: A video on the standardized handoff process was made with the collaboration of PACU/OR RNs and the anesthesiologists. The video was shared with the nurses from PACU, OR and the anesthesiologists. After staff viewed the "handoff video", to help reinforce the new process, a reminder sign was posted on each PACU bay. From May to December 2017, staff was observed applying this new process. Deviations from the new process were corrected immediately. A post-survey was completed in January 2017, and the results were analyzed.

Statement of Successful Practice: 68% of PACU RNs agreed on receiving a complete report from the anesthesiologist, while 95% agreed on receiving a complete report from OR RNs. 84% PACU RNs agreed that intraoperative events or concerns were shared in the handoff. 26% of the PACU nurses agreed that they were given enough time to connect the patient to the monitor. Barriers identified included, the doctors not acknowledging the RN's request to wait to provide a handoff; and different nurses and anesthesiologists floating to the unit were unaware of the project. To improve compliance, the PACU nurses recommended OR RNs and anesthesiologists to implement the new handoff process.

Implications for Advancing the Practice of Perianesthesia Nursing: In the post-implementation phase, the OR team continued to give their handoff while the PACU nurse was focused on getting the patient settled in. Despite the outcome, nurses agreed that the project was a good initiative and recommended the need for proper buy-in from OR RNs and anesthesiologists. The project was shared with anesthesia and OR leadership to reinforce the standardized process with OR RNs.

BEDSIDE HANDOFF REPORT TO IMPROVE COMMUNICATION: PACU AND RECEIVING MEDICAL/SURGICAL UNIT



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Background Information: In 2016, when a surgical patient met PACU discharge criteria and was ready for transport to the medical/surgical nursing unit, the PACU nurses provided handoff report via phone call to the receiving nurse. The PACU nurses spent time away from the bedside to wait for the receiving nurses to answer calls while the medical/surgical nursing staff experienced repeated interruptions. This resulted in delays in transport, conflicts among caregivers, and risks to patient safety.

Objectives of Project: The purpose of this project was to promote teambuilding and improve the patient experience while engaging patients and caregivers in the handoff communication process during the postoperative phase of care.

Process of Implementation: PACU and medical/surgical nurses utilized a handoff communication tool. Compliance is tracked and reported monthly in Performance Improvement Manager (PIM). Goal is greater than or equal to 90%.

Statement of Successful Practice: PACU nurses' compliance with bedside handoff report has consistently achieved the target of 90% since implementation in 2017. PACU and medical/surgical nursing teams verbalize their satisfaction with this process and it has been fully integrated into their workflow as a best practice.

Implications for Advancing the Practice of Perianesthesia Nursing: The practice of bedside or face to face handoff report serves as method to improve patient and caregiver satisfaction while promoting patient safety with the postoperative patient. Communication between PACU and the medical/surgical unit has dramatically improved. PACU and medical/surgical nurses report enhanced professional relationships with their peers.

POST-OPERATIVE PHONE CALLS: DOES IT MAKE A DIFFERENCE TO PATIENTS?



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Background Information: In PACU the following criteria reported by HCAHPS were monitored: 1. Patient Advocacy (Likelihood to recommend) 2. Staff doing everything to help with pain 3. Clear Communication by patient care staff. HCAHPS rating showed a decline in the above criteria in spite of other improvement initiatives.

Objectives of Project: To develop/redesign a structure and process to improve patient outcome in the above 3 parameters by the implementation of post-operative phone calls.

Process of Implementation: Previous problems associated with post-operative phone calls were assessed. A community