identified by staff and information documented in the EMR. This tool contains the essential information that may be lost as the patient progresses through the perioperative care continuum.
Implications for Advancing the Practice of Perianesthesia Nursing: As we move forward and the information of our patient's care is documented in an electronic format, we should be able to use it to its full potential and provide safe effective patient care.

STANDARDIZED HANDOFF REPORT USING ELECTRONIC MEDICAL RECORD

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Team Members: Deborah Kozel, RN BSN, Senior Clinical Analyst, Sara Thul, RN, Nurse Manager, Juliann Paulisich, RN MS CPAN, Nurse Manager, Erin Hanson, RN

Background: Our Orthopedic Medical and Surgical Unit approached our Practice Council hoping to adapt a report tool that was successfully used when transferring patients from the ED to the inpatient unit. The handoff smart text note was entered in the Electronic Medical record using key items from the RN's charting.
Objectives:

- Create a standardized report through our Electronic Medical Record to eliminate variations in nurse to nurse report out when transferring from PACU to inpatient unit.
- Improve communication that could inadvertently be omitted during a verbal handoff.

Implementation:

- Representatives from our Practice Council met with the Med/Surg Nurse Manager and Clinical Analyst to modify the current note template created by the ER.
- Informatic specialists created a draft of initial template.
- While trialing template PACU nurses gave suggestions for drop down menu items that would not autofill from our charting.
- Final team meeting focused on efficiency of note and eliminating unnecessary key strokes.
- Tip sheets were distributed to the staff for self-guided training.
- Initial implementation, PACU staff both entered the smart text note, but also gave verbal report over the phone.

Successful: With the Med/Surg Nurse reviewing key components of our patient's history through the smart text note prior to our phone call we decrease time away from the bedside to give report over the phone. Nurses were giving a more consistent report as it is all prompted in the smart text note created. While our previous report given over the phone was not recorded, our new report is saved as a nurse's note in the chart for future shifts to reference.

Implications: When using a smart text note within the Electronic Medical Record Nurses give a complete handoff that prompts them to address key components for their patient's care.

A UNIT METHOD OF CHANGING BEHAVIOR CULTURE

Team Leaders: Deborah L. Threats, MDIV BSN RN CAPA CPAN, Anne M. Burke, BS BSN RN CAPA
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Introduction: "In OR Holding, how does staff usage of sacred word, sacred person and mediation compared to ad hoc use of tradition/policy of MGUH, affect disruptive behavior among peers."
Background Information: Disruptive behavior is defined as "any inappropriate behavior, confrontation, or conflict ranging from verbal abuse, physical or sexual harassment" (Rosenstien 2006).
The staff in OR Holding, continue to fear peer retaliation and nothing will be done by leadership. Therefore, alternative methods were designed to fulfill the needs of the staff to minimize disruptive behavior. After a review of the literature we found a dearth of evidence on intervention of disruptive behavior. Therefore we developed our own intervention focusing on a non punitive approach, which was directed at the behavior and not the person.
The following were developed:

A. Sacred word; which is a word spoken when a staff member demonstrated disruptive behavior. This word was chosen by staff via voting. (We choose marshmallow)
B. Sacred person; a person trusted and chosen by staff members to express their opinion without fear of reprisal.
C. Mediation; a face to face meeting with both parties and the mediator; chosen by the parties involved. The outcomes were kept between the people that were involved.

Process of Implementation: A case study focused on OR Holding staff, with the support of the staff and management. Survey was done by staff pre and post on disruptive and assertive behavior. The Sacred word, person and mediation protocol trial for 6 months using this interventions. This was done with a formal collection of data, and results given to the staff.
Statement of Successful Practice: This project now spans three years. The first year the staff was surveyed and educated on disruptive behavior and its prevalence on the unit. The results were disruptive behavior existed and the staff wanted a solution to the problem. The staff did a formal survey on assertive behavior and they all agreed that they had an assertive personality but the problem continued. The staff was educated at the start of May 2017 and started using the collected data through October 2017. An informal survey was done with the staff and the results showed an earnest adaption of the intervention. The use of the sacred word and person declined during the six month. The perception of the unit staff was that the disruptive behavior decreased. The use of the sacred word decreased over a six month period to less than 1 per day, sacred person also decreased to less than 1 per day, and only 3 mediations during

this time. These methods yield no disciplinary actions by leadership.

Discussions: The staff in OR Holding upon being educated on disruptive and assertive behaviors decided that the education was needed. As a unit, through informal discussions, became more cohesive and a better place to work. The unit feels free to talk about and confront this behavior. We as a unit felt that based on the evidence the interventions have effectively decreased the disruptive behavior on the unit.

Implications for Advancing the Practice of Perianesthesia Nursing: To make this a sustainable policy or guideline needs to be established. This policy/guideline has to be adapted by the unit as part of the orientation policy. A formal survey must be done to test the validity of the decrease of disruptive behavior on the unit. To test the soundness of this change in behavior it would need to be test on other units and assess for the same results. The poster and podium presentations should also be continued. Publication would also help with having this be sustainable.

IMPLEMENTING GUIDELINES FOR UPDATING FAMILY OF PATIENTS IN THE PACU

Team Leader: Abigail Kathleen M. Acosta, RN BSN CPAN CAPA
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Team Member: Mario Zermeno, RN BSN

Background Information: The family of the patients in our PACU may end up not seeing the patient until an hour or more after the Phase I finished, patient is transferred to the floor or to a Phase II outpatient unit. Pediatric patients and those with extenuating circumstances get a visit from family. Other PACU patients' family may not get an update during the entire PACU stay.

Objectives of Project: To implement **consistent** standards in family visits and updates for patients in the PACU. Within 6 months of implementation, this project will increase patient and family satisfaction by increasing the rate of update occurrence of PACU patients' family, from less than 10% to at least 80% within a year.

Process of Implementation: Evidence-based guidelines were drafted and presented to the practice council. After meeting with Outpatient Services, Concierge and Security, changes were made. These were revised from visitation to updates because there were Cases when a visit may not be feasible, for example, patient preference, emergent issues in the PACU, etc.

Guidelines were explained to the patient and family. They were advised to designate a main update recipient. The Concierge and Security staff clarified processes on visitation and traffic into the unit. Handover of the contact number of the update recipient is ensured in case of non-feasibility of a visit.

Statement of Successful Practice: After a year, only 18% of patients in the PACU did not have documentation of an update and were mostly Cases done on-call, in the middle of the night. Currently, an annual evaluation has shown a trend of increasing compliance with the update process.

Implications for Advancing the Practice of Perianesthesia Nursing: Patient engagement and communication with their family members is valuable in ensuring patient-centered care. We were able to implement guidelines that addressed this and at the same time enhanced the workflow of the units and stakeholders involved in the process. We had limitations of having a small, open unit, with privacy concerns. A previous push from the Clinical Manager to implement visits was unsuccessful. By using a structured process, collaborating with all stakeholders involved, this project succeeded.

STOP! IN THE NAME OF SAFETY… IMPLEMENTING A PAUSE IN PACU HANDOVER

Team Leaders: Abigail Kathleen M. Acosta, PACU RN BSN CPAN CAPA, Julie Mungridis, AHN OR RN BSN CNOR (Perioperative Clinical Practice Council Co-Chairs)
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Team Members: Frances Bullman, OR RN MSN CNOR, Caroline Estrada, PACU RN, Deborah Ralph, AHN OPS RN, Heidi Phillips, OPS RN, Susan Ruiz Endoscopy, RN, Antonio Lira, SSPD Tech, Kelly Marsh Hogue, RN BSN MBA-HCM, Perioperative Services Director (Mentor)

Background Information: Handover communication is an essential part of safe patient care. In a unit like the PACU, we depend on quality report form the OR team to initiate our interventions for the patients we receive. Historically, OR RNs who are pressed to achieve increasingly stringent turnover times have been in a hurry to finish handover to the PACU RN, regardless of the patient stability upon admission in the PACU. This has led to staff dissatisfaction and unsafe patient care conditions.

Objectives of Project: To implement a safety pause in the PACU in 100% of handovers from units transferring patients to the PACU.

Process of Implementation: A pre-survey was done which revealed that all PACU RNs feel strongly about the need to implement a safety pause. After approval by the practice council, education was done for two weeks for PACU, OR, Endoscopy, DI and Cath Lab staff. Literature on safety pause was made available. Upon arrival, the RN with the patient helps settle and attach the patient to the monitor. Unless there are urgent interventions needed, the PACU RN assigned to the patient states: "I'm ready for report. Let's identify our patient." The handover report then commences.

Statement of Successful Practice: Within a month of project initiation, all the units handing over care of patients to PACU staff has started to comply with a safety pause. Initially, the PACU RNs and PCPC members had to coach individual RNs on the need for a safety pause. Currently, a survey being done has noted 100% compliance from a stratified sample of handover reports done in the PACU.

Implications for Advancing the Practice of Perianesthesia Nursing: The safety pause quality improvement project has emphasized the principle of safety despite efficiency. In units like ours, that measures patient stay in minutes, the push to do everything faster can sometimes blind clinicians to the unintended consequences of speed. Implementing a pause allowed the RNs to focus on the information being communicated during verbal report. This has also made PACU RNs cognizant of our behavior when we handover the patient to the floor