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

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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

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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