

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 tested 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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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 from 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

and Phase II, ensuring that the receiving RN is able to focus on the information, before we commence bedside report.

EFFECTIVENESS OF MULTI-MODAL ANALGESIA



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Background Information: Despite many advances in health care, managing pain in the post-anesthetic period continues to be a challenge. With more procedures being performed on an outpatient basis, shorter lengths of stay and drive to improve patient satisfaction, providers are looking for ways to enhance the surgical care experience and reduce opioid use. In addition, the increase burden of obesity in society has contributed to a rise in co-morbidities such as diabetes, cardiovascular, and gallbladder disease making laparoscopic cholecystectomies the second most frequently performed general surgery procedure in the United States.

Objectives of Project: The purpose of this study was to examine if using multi-modal analgesia prior to incision time effectively reduces post-operative narcotic requirements for pain management in the laparoscopic cholecystectomy patient population. Current search of literature suggests that utilizing multi-modal therapy has shown to significantly reduce pain scores and continual research into this topic is necessary. Pain is a universal phenomenon and nurses must be familiar with the essential concepts of pain and methods of pain management. The concept of multi-modal analgesia is to reduce pain through targeting multiple receptor sites at peripheral and central nociception pathways to reduce the inflammatory response and pain sensation while simultaneously reducing narcotic utilization and their related adverse effects.

Process of Implementation: Utilizing a quantitative, non-experimental research design this particular project retrospectively analyzed 200 elective laparoscopic cholecystectomy patient records from 2015 to 2018 in a specific recovery room unit.

Statement of Successful Practice: The results demonstrated there was a rise in the number of multi-modal agents given with a decrease in the number of narcotics utilized over the course of implementing an enhanced recovery after surgery improvement program.

Implications for Advancing the Practice of Perianesthesia Nursing: The outcome of this project reinforces using multi-modal analgesia and provides a foundation for further research to maximize the benefit of these modalities to manage pain after surgical intervention.

CHANGING LOGISTICS OF EMERGENCY EQUIPMENT IN SAME DAY SURGERY



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Background Information: Same Day Surgery had a total of six separate emergency equipment carts located throughout the

department. This made it difficult to locate the appropriate equipment in emergency situations. This project is important for improving the accessibility of emergency supplies, cost savings by eliminating duplicate supplies, and for the overall safety of our patients.

Objectives of Project: Changing the location of the emergency equipment and eliminating duplicate airway supplies to improve efficiency and cost.

Process of Implementation: Initial inventory of all six emergency carts were completed. Duplicate airway equipment was identified and removed. A cost analysis of duplicate airway equipment was completed. Staff was educated on the new locations of emergency equipment and surveyed afterwards.

Statement of Successful Practice: After completion of this project, eighty-one percent of the staff was able to correctly identify the correct location of the emergency equipment. The staff members are now more knowledgeable about the location of the emergency equipment. A cost analysis of the duplicate airway equipment revealed a savings of 1014.00 dollars.

Implications for Advancing the Practice of Perianesthesia Nursing: Knowledge of the location of emergency equipment is vital to response time. Other nursing units could utilize the findings of this project to improve the logistics of their emergency equipment. Limited research was found on the topic. The authors identified opportunities for nursing research on emergency cart organization.

AIR-ASSISTED TRANSFER DEVICE (AATD) USE FOR PEDIATRIC SPINAL FUSION PATIENTS: IMPROVING CARE



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Background Information: Spinal fusion patients require imaging while in the post-anesthesia care unit (PACU), a reportedly painful process. Prior to this practice change, imaging required five or more staff to safely lift the patient and maintain patient flat time. Despite using multiple staff, it was often difficult to lift the patients high enough to prevent potential shearing near the incision from the imaging board. An AATD had not been previously utilized in the surgical pediatric population at SFCH. This practice change was based on the author’s experience with use of this device in other patient populations and active participation in a Safe Patient Handling committee. There is no known literature about AATD use with pediatric spinal fusion patients.

Objectives of Project:

- Educate staff on proper AATD usage
- Develop workflow and process for use
- Staff will use proper ergonomics during postoperative imaging to enhance staff and patient safety
- Reduce postoperative pain related to imaging lift
- Reduce number of staff exposed to potential injury
- Improve efficient use of staff

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