Process of Implementation: Formed an interdisciplinary group of surgeons, radiology staff, and perioperative nurse leaders to discuss risks and benefits. Approval received for trial utilization. Education, demonstration, and simulation were provided to all perioperative staff prior to implementation and evaluation.

Statement of Successful Practice: By using the AATD to lift the patient, the number of staff exposed to potential injury was reduced from five to zero per spinal fusion patient. The process, which previously took five staff, can now safely be done with two, increasing staff efficiency. Despite pain score data being inconclusive, there has been a slight decrease in opioids administered during PACU stay. Additionally, staff report that patients now appear more comfortable and sleep through postoperative imaging.

Implications for Advancing the Practice of Perianesthesia Nursing: Use air-assisted transfer devices to facilitate lift in order to protect staff from potential injury, create more efficient use of staff, and increase patient comfort.

"I FEEL FINE": FALL PREVENTATIVE MEASURES IN THE POST ANESTHESIA CARE UNIT (PACU)

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Background Information: Falls are linked to prolonged hospital stay, increased discharge to nursing homes, and higher health care expenditure. MIDAS reports indicated four patient falls occurred in the Post Anesthesia Care Unit (PACU) area from January 2017 to October 2017. 1 out of 4 falls resulted in patient injury, requiring a surgical intervention. A post fall focus study revealed that the falls happened while patients used the bathroom or ambulated to the bathroom. In all fall Cases in the PACU, patients have expressed "I feel fine".

Objectives of Project: The purpose of the study was to eliminate the patient falls in the PACU by adapting and modifying the Cedars Sinai Medical Center (CSMC) fall prevention measures to the PACU setting.

Process of Implementation: The CSMC fall preventions measures which included hourly rounding, yellow fall risk identification package, bed alarms, fall video, self-releasing belt, patient/family education, and staying with the patient in the bathroom were reviewed. 'PACU specific fall prevention measures' were created by eliminating the measures that were not applicable to the setting. The measures adopted focused on yellow fall risk identification and managing patient expectation at the point of intake in Preop through patient education that the nurse will accompany and stay with the patient in the bathroom. Standard practices with having patients sit and dangle for a few minutes prior to standing and ambulating

were reinforced. The PACU staff were educated on the 'PACU specific fall prevention measures,' and the project was implemented in November 2017. In the instances where patient refused to have the staff stay in the bathroom, bathroom call light was provided, PACU staff stood outside the bathroom door, and patient's refusal was documented in the electronic medical record.

Statement of Successful Practice: There were zero falls reported in the post-implementation phase after the adoption of the 'PACU specific fall prevention measures.'

Implications for Advancing the Practice of Perianesthesia Nursing: Modifying and curtailing the hospital fall prevention measures to the PACU setting and focusing on the steps that apply to the setting have helped in decreasing the patient falls. The project needs to be continued and data collected for a longer period to monitor and ensure that the results are sustainable.

STANDARDIZING THE INPATIENT PRE-OP PROCESS

Team Leaders: Tracy Herbert, MSN RN CPN, Amber Senetza, MSN RN CPN
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Background Information: Standardizing the process of Inpatient Pre-Op addresses patient safety concerns that arise from a lack of RN to RN report, multiple hand-offs in care, and delays in patient surgery. Previously there was no RN to RN verbal handoff, as the OR unit coordinator would call the Inpatient RN to bring the patient to Pre-Op. The lack of RN to RN verbal handoff resulted in incomplete transfer of care elements. No verbal handoff has the potential for patient errors, delays in surgery, and incomplete patient preparation prior to surgery.

Objectives of Project: The primary goal was to improve consistency with RN to RN verbal handoff for all Inpatients going to the OR. The integration of verbal handoff allows the Inpatient Pre-Op RN to effectively collaborate with the Acute Care RN on the patient's condition, and address concerns prior to surgery. The outcome of this quality improvement initiative was to improve patient readiness for surgery, prevent delays, and enhance the patient and family experience.

Process of Implementation: An Acute Care and Perioperative Services taskforce was established to develop a consistent practice for all patients going to the OR. Prior to standardizing the Inpatient Pre-Op process, internal auditing was performed in Pre-Op from May 2017 - February 2018 to identify concerns with patient readiness for surgery. The audit supported a need to create a new role for an assigned Inpatient Pre-Op RN. Staff participated in developing a standardized patient history questionnaire to obtain a thorough and complete handoff from the Inpatient RN. Obtaining a complete patient history prior to surgery decreases errors, increases unit efficiency, and standardizes the organizational process.

Statement of Successful Practice: The integration of verbal handoff between Pre-Op and Acute Care eliminated inconsistencies in practice, and improved patient readiness for surgery.

Implications for Advancing the Practice of Perianesthesia Nursing: The results showed improvement in the implementation of how consistent RN to RN handoff helped to