during critical times in Perioperative Services when their usual expert care provider, often a parent, is not present.

Objectives of Project:

- Design supplies and education to ensure that all disciplines and departments are equipped to care for the unique needs of the EB patient.
- Develop a mechanism to alert any provider who may come in contact with the patient in Perioperative Services that this patient is at high risk for injury.

Process of Implementation:

- Identify an individual in each department or service line that would serve as the "EB Champion." Provide education to all staff that may provide direct patient care.
- Creation of the EB STOP Sign visual tool.
- Ongoing work with a product innovator to develop equipment for the Perioperative environment that is both safe for EB patients' skin and functionally allows for safe monitoring of the patient.

Statement of Successful Practice:

- Demonstrate commitment to being a center of excellence for the EB patient, with resource support to meet the goal of skin injury prevention.

Implications for Advancing the Practice of Perianesthesia Nursing:

- Multidisciplinary collaboration supported by leadership and implemented by anesthesia and nursing staff allows these patients at high risk for skin injury to be cared for in the safest way possible. Perianesthesia nurses provide critical elements of the care required to provide comprehensive treatment aimed at improving the quality of life for children living with EB.

LEADERSHIP OF PERIOPERATIVE QUALITY IMPROVEMENT COUNCIL

Team Leader: Esther Lee, MNP MBA RN CHEL
UC San Diego Health, San Diego, California
Team Members: JoAnn Daugherty, PhD RN CNL, Thomas Hamelin, MBA DNP RN

Background Information: Our Perioperative Senior Director and Perianesthesia Nursing Director developed a Quality Council (QC). The QC consists of the Senior Director for Perioperative Services, Perianesthesia Nursing Director, 2 Clinical Educators from Operating Room (OR) and 2 Clinical Educators from Perianesthesia (PA).

Objectives of Project: The QC's mission is to lead quality improvement initiatives within perioperative services, provide mentoring for clinical nurse promotion on the career ladder, and support research and publications in peer reviewed journals by Team Members within the perioperative service.

Process of Implementation: The QC was formed in 2016. The group charter was written by 3 members of the committee and voted on by the group. The Senior Director and Director of Perianesthesia Nursing lead the monthly meetings. The group discusses initiatives around the core mission and shares best practices to promote the continuum of care across perioperative services.

Statement of Successful Practice: This meeting has been a perfect vehicle to promote communication and patient flow between preoperative holding unit (PH), operating rooms (OR), and post anesthesia care unit (PACU). For example, the development of PH to OR handoff improvements was facilitated by this council. To date, in addition to educational role, the members of the team have published 9 articles, presented over 15 posters in national and international conferences, facilitated the promotion of 4 clinical nurses to the next level of the clinical ladder, developed unit guidelines for new procedures and updates existing guidelines.

Implications for Advancing the Practice of Perianesthesia Nursing: Perioperative Divisions should consider implementation of a QC for directors and educators to communicate directly about the educator's role in quality improvement, evidenced based practice projects, research studies and professional development of staff.

REIMAGINE HEALTH CARE LEADERSHIP, CHALLENGES AND OPPORTUNITIES IN THE 21ST CENTURY

Team Leader: Esther Lee, RN MBA MNP CHEL
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Team Members: Thomas Hamelin, RN MBA DNP NEA-BC, JoAnn Daugherty, RN PhD CNL

Background Information: Healthcare leaders face many challenges in redesigning the healthcare ecosystem of the 21st century. Important considerations include human capital (leaders and staff) management and cost control. Under hospital-wide, centralized services in Information technology (IT), material services (MS) and finance models, these support teams for Perioperative Services were disconnected from the frontline managers who needed data for quality improvement and monitoring budget and resource utilization. In this model, support staff and clinical managers took several days to communicate managers' needs, complete database searches or financial reports, and notify requestor of results.

Objectives of Project:

1. To reduce communication and feedback delays among division Team Members.
2. To reduce surgical costs by providing surgeons with feedback on resource utilization in the operating room (OR).

Process of Implementation: The Senior Director (T.H.) of Perioperative Services championed a change management strategy that promoted more interactions across teams and mutual learning. Chief Administrative officers (CAO) at first expressed doubt about the new model but improved accuracy in reporting data because computer analyst staff had better understanding of clinical data & managers' needs by working side-by-side in same department was persuasive. Also, OR cost reductions proved the value of the model.

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

e20ASPAN NATIONAL CONFERENCE ABSTRACTS

Statement of Successful Practice: The result of embedding the support teams into meetings with clinical management fosters more dynamic exchanges and consultation.

Objective 1 Outcomes: communications from finance support, material services manager and computer analysts to frontline managers reduced from 3-4 days to 6 -24 hours. Managers were able to learn more about the financial and material services ordering aspects of the leading a unit by being directly connected to these resource individuals within the service line rather than a centralized resources for finance and materials management.

Objective 2 Outcome: In the 4 months after the introduction of the surgical receipt the average cost/surgical case of $18 - 34$ procedures dropped by 53%.

Implications for Advancing the Practice of Perianesthesia Nursing: Nursing leadership development must be supported by appropriate level of educational preparedness, and requisite set of competencies and skills. Skill building for our leadership team has been supported by having financial, IT, and material services support staff employed within the service line.

VISITATION GUIDELINES IN THE PERIANESTHESIA SETTING: FROM EVIDENCE TO PRACTICE CHANGE

Team Leader: Antoinette A. Zito, MSN RN CPAN
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Team Members: Bridget Simpson, RN CMSRN, Jennifer Spurlock, BSN RN, Tammy DiCarlo, RN CPAN, Jennifer Jones, BSN RN, Ali Kalifoot, RN, Amy Berardinelli, DNP CPAN NE-BC

Background Information: In the perianesthesia setting, the promotion of family-centered care includes visitation for the postoperative patient. A variety of nursing practices amongst nurses exist that lead to delays in family presence at the bedside.

Objectives of Project: By creating formal guidelines and educating Team Members, bedside visitation will occur sooner.

Process of Implementation: Literature review took place at our shared governance unit council meetings. Visitation guidelines were drafted and submitted to nursing leadership for review. Perianesthesia staff received education and guidelines were made available for patients/families in the surgical waiting area.

Statement of Successful Practice: Outcome measurement is the patient time in Phase I prior to family visit. The time decreased by seven minutes in the initial three month time period after implementation.

Implications for Advancing the Practice of Perianesthesia Nursing: In the perianesthesia setting, the promotion of family-centered care includes visitation for the postoperative patient. With the implementation of the new guidelines, there was a decrease in family waiting to visit the patient.

MEASURES TO REDUCE AIRWAY EVENTS IN PACU

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

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Background Information: In a large oncology Post Anesthesia Care Unit (PACU), nurses sought to evaluate interventions that could lead to a reduction in emergent airway events. A group of senior nurses collaborated with the Anesthesia Medical Director, Quality Improvement Specialist and clinical nurses to evaluate all airway events reported in PACU in fiscal year 2017. After reviewing the report, an airway-auditing tool was created, and, monthly action items for Team Members. Best practice guidelines were also established for monitoring patients for potential airway events in the PACU.

Objectives of Project: Reduce airway events by 5% in PACU from FY2017 to FY2018.

Process of Implementation:

- Collaborated with multidisciplinary team
- Reviewed all airway events reported in the event reporting system for FY2017
- Established set criteria by event type
  - Anesthesia event
  - Complication of surgery r/t anesthesia
  - Airway management
  - Respiratory failure requiring unplanned support
  - Unplanned use of a reversal agent
- Provided education to all nurses regarding the use of capnography and established PACU standards per ASPAN guidelines
- Provided skills checkoff and accountability statement to all clinical nurses
- Monthly staff in-services and education provided on measures to promote lung expansion, EtCO2 monitoring, and escalation process
- Monthly audit tools tracked compliance with capnography monitoring
- Audit tool results shared with PACU team monthly
- Action items implemented based on audit tool findings

Statement of Successful Practice: Review of all airway events reported in the Safety Intelligence reporting system for FY2017 yielded 31. After establishing guidelines, staff education, use of capnography and monthly audits, the number of airway events reduced to 14 in FY2018, which generated a 54% reduction of airway events in PACU within one fiscal year.

Implications for Advancing the Practice of Peri-Anesthesia Nursing: Increased surveillance in the clinical area with airway team audit members, education to ensure understanding, competency in airway management, use of capnography, and nursing airway interventions can reduce the number of airway events in PACU.

"I'M A SAME DAY SURGERY! ARE YOU A SAME DAY SURGERY? WHO IS A SAME DAY SURGERY?" STREAMLINING THE SAME DAY SURGERY WORKFLOW FOR TOTAL JOINTS FROM A PREOPERATIVE PERSPECTIVE

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