

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

Objective 1 Outcome: 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



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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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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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