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IMPLEMENTATION OF A PACU PAUSE IN A PEDIATRIC POST ANESTHESIA CARE UNIT

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Background Information: Effective communication between the surgical team and the PACU nurse is essential to delivering safe postoperative care. Distractions during anesthesia/OR team hand-off to PACU results in gaps in information and leads to adverse patient outcomes. The PACU Clinical Practice Council (CPC) completed an observational survey on the arrival of pediatric patients from OR to PACU. The observations indicated the PACU nurse was distracted during the hand-off because anesthesia/OR team gave report while the PACU nurse placed the monitors and attempted to assess the patient’s respiratory status. Additionally, the audit found that the anesthesia/OR team report did not follow a consistent communication structure. Both observations showed the PACU nurse is not receiving/processing all information needed to safely care for the patient. Distraction and lack of standardization during hand-off may result in information gaps, leading to adverse clinical outcomes.

Objectives of Project: The goal of this nurse led project is to increase patient safety by improving communication between the perioperative teams and provide a safe transition from the OR to PACU.

Process of Implementation: The CPC surveyed the PACU nurses to obtain baseline information on their perception of the current process. Most nurses reported feeling distracted during the arrival and report process of the patient to PACU. They also felt they did not receive all the information needed to safely care for the patient. The CPC completed a review of best practices and collaborated with nursing leadership and the anesthesiologists to implement an evidence-based hand-off protocol and “PACU Pause.” Checklists were created and placed at each bay to facilitate standardized report. The CPC provided education to all nurses and anesthesiologists involved in hand-off and audited the process to evaluate protocol adherence.

Statement of Successful Practice: Implementation of the standardized perioperative protocol has enhanced safety during the transition of care from OR to PACU. Nursing satisfaction increased with the patient arrival process and hand-off from the anesthesia/OR team. Serious safety events related to communication failures decreased.

Implications for Advancing the Practice of Perianesthesia Nursing: Results are consistent with the literature suggesting that implementing a PACU Pause increases patient safety and facilitates undistracted communication of vital information to safely transition the pediatric patient from the OR to the PACU.

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POST ANESTHESIA RESPONSE UNIT: DEVELOPMENT OF AN INTENSIVE CARE UNIT WITHIN A POST ANESTHESIA CARE UNIT

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Team Members: Shea Beiter, BSN RN CPAN CCRN, Martina Landahl, RN

Background Information: During the COVID-19 pandemic, the bed availability in Intensive Care Unit’s (ICU) at Strong Memorial Hospital was limited. The Post Anesthesia Care Unit (PACU) was able to help load balance the intensive care units (ICU’s) by caring for 6 ICU patients utilizing a team nursing model.

Objectives of Project: The goal of the Post Anesthesia Response Unit (PARU) development was to utilize a team nursing model successfully caring for ICU patients. Because not all of the nurses who work within the PACU are traditionally trained to care for ICU patients, perioperative services leadership
wanted to provide comprehensive ICU care by pairing the few ICU trained nurses with added support staff for safe patient care. 

**Process of Implementation:** The PACU converted the extended recovery area into separate areas to care for ICU patients indefinitely. Leadership identified items that were critical in caring for ICU patients, worked alongside the hospital supply chain on creating a supply room, and built a code cart specifically for the PARU. The PARU scheduler paired an in-patient PACU RN who had prior knowledge working in an ICU with an assistive RN creating a buddy pairing. This pairing was maintained throughout the entirety of the PARU and had a patient ratio of two patients to one pairing. Focusing on the PACU RN’s skillset and knowledge base, leadership was able to identify staff member to care for individuals either receiving surgery or the chronic ICU population.

**Statement of Successful Practice:** PARU leadership found by having an ambulatory nurse or nurse anesthetists paired with a PACU nurse, a team nursing model approach was successful. The PACU nurses delegated tasks appropriately to their supportive staff member for safe patient care. PARU was open for total of 46 days caring for chronic surgical ICU patients. There was a total of 26 patients: 11 patients transitioned to floor level of care. 2 patients transitioned to comfort measures only. 2 patients were discharged to long term ventilator care units. 6 patients returned to the ICU’s. Through collaborative efforts, ICU patients were able to be cared for by a nurse pairing in a safe comprehensive manner.

**Implications for Advancing the Practice of Perianesthesia Nursing:** The second surge of the COVID-19 pandemic caused an influx of critically ill patients. Perioperative leadership recognized the opportunity to help load balance the patient population by having 6 patients be cared for within the PACU setting. We learned that PACU nurses can successfully and confidently care for a two patient ICU assignment by utilizing a team nursing model.

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**SNAPSHOT REPORT: A UNIFORMED HANDOFF TOOL FOR ALL PERIOPERATIVE SERVICES**

**Team Leader:** Elizabeth Anne Steffen, BSN RN CAPA
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**Background Information:** The Joint Commission reports 80% of serious medical errors are the result of miscommunication during transfer or handoff and 5 out of 10 sentinel events are directly relate to the perioperative setting. This setting is unique due to large intermittent patient volumes in a brief period, multiple interdisciplinary caregivers, decreased ability for nurse engagement due to sedating medications.

**Objectives of Project:** The handoff process requires a complete understanding of the patient's condition and status to ensure their safety. bedside handoff is evidence based and is known to reduce errors in patient care, decrease length of stay and improve patient satisfaction. The snapshot tool was created within the EMR to ensure all ASPAN key safety elements were included. The snapshot tool promotes inclusion of important patient details in one report.

**Process of Implementation:** Assessed and appraised present literature on best practices concerning handoff tools/process/reviewed present hospital policies. Performance Improvement council members worked with unit staff for input on needs for handoff tool. Final draft sent to our IT department where the tool was drafted. Education of staff prior to implementation. Snapshot tool implemented June 2020. 

**Statement of Successful Practice:** No medication errors reported. Improvement in “overall teamwork between doctors, nurses and staff” patient satisfaction scores. Delay in first case on time starts with “due to nursing” code approximately 5% per month down from 10%. Nurse satisfaction of handoff improved with snapshot tool due to ease and consistency of use at handoff as well as the ability to review a patient case prior to report and admission to the receiving unit.

**Implications for Advancing the Practice of Perianesthesia Nursing:** Perianesthesia nurses will understand the benefits and use a uniformed handoff process within all phases of the perioperative service lines. Perianesthesia nurses will understand potential risk factors from lack of communication during handoff. Perianesthesia nurses will be able to apply JACHO and ASPAN best practices in handoff reporting. Perianesthesia nurses will understand and be able to use the seven steps of implementing practice changes. 

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**NURSE LED COLLABORATION AND INNOVATION: FOSTERING A SURGE IN STAFF AUTONOMY WITH ENHANCED COMMUNICATION RESOURCES**

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**Background Information:** An important aspect of Magnet designation is striving to improve patient outcomes by fostering autonomy amongst nurses. Communication in the perianesthesia area was inconsistent and unreliable leading to repetitive questions. There was a need to establish a standardized communication processes that would provide staff with easily accessible and up-to-date unit information.

**Objectives of Project:** To improve the delivery of readily available, accurate information through the use of visual resource guides enabling perioperative staff to take ownership of unit centered issues to create a safer, efficient, and more productive work environment.

**Process of Implementation:** The Perianesthesia Clinical Lead Group identified the need to better delineate unit specific information patient census and special patient centered considerations, staffing, and equipment issues, and improve communication practices. They collaborated with the Quality Improvement Manager to create new communication tools to address identified staff and unit needs through two Visual Management Boards and a Phone Tree Badge Buddy.

**Daily Visual Management Board:** Color coded, white board displayed providing staff with ‘at a glance’ unit information

**Procedural Board:** Dry erase magnetic board listing RN staff and color-coded competency status for PACU procedures

**Phone Tree Badge Buddy:** Frequently called departments with phone number and pager information.

**Statement of Successful Practice:** Visual management boards and badge buddy cards are now available in each unit and to each staff member. Staff has reported to feel more prepared for the patient population being cared for in a workday and aware of challenges and enhancements in the unit. Staff have reported feeling more able to find information to autonomously deal with issues that arise on the unit which reduces duplication of work.

**Implications for Advancing the Practice of PeriAnesthesia Nursing:** PeriAnesthesia nurses are in a unique position to develop cost effective, innovative communication tools that enhance non-verbal communication to create a safer, efficient, and more productive work environment.

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**IMPLEMENTATION OF VIRTUAL PREOPERATIVE EVALUATION DURING A PANDEMIC**

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**Team Member:** Pam Park, APRN FNP-C

**Background Information:** Preadmission testing visits have historically been in-person and or via phone calls facilitated by nurse practitioners and registered nurses. Due to the pandemic, a change in process was required to address national and state social distancing recommendations. Project was conducted at a 171-bed community teaching hospital in the Northeast United States.