PROMOTING A CULTURE OF SAFETY: PATIENT DEBRIEFINGS IN PACU

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Background: The Institute of Medicine reports 44,000 – 98,000 hospital deaths occur per year due to medical errors. Research has shown that adverse events, defined as any harm that occurs to patients from medical error… are preceded by physiological signs that are clearly abnormal. PACU is committed to providing a safe environment for our postoperative patients by monitoring the quality of patient care while ensuring standards are in place to improve clinical practice and patient outcomes. We have established an educational partnership between the RN and MD to promote situational awareness and critical thinking to decrease adverse events.

Objective: Create a learning environment to improve recognition and response to changes in patient’s condition by reviewing best practices, protocols and policies.

Implementation: Monthly case study reviews were conducted in an open forum with MD to discuss patient postoperative course and recognition of “need to rescue”. We focused on what went RIGHT and emphasized early intervention/communication to minimize/prevent clinical deterioration. These case studies provided an opportunity to focus the learner to analyze clinical decision points and problem solving skills.

Success Practice: 100% of PACU staff who attended felt these case reviews were helpful to their practice and positively impacted their professional knowledge.

Implications: Through an educational partnership with MD and increased professional knowledge, staff are taking vested interest to reduce adverse events and improve patient outcomes supporting a culture of safety.