When PACU reached its maximum capacity due to holding patients overnight and the lack of beds to accommodate all the scheduled cases for that day, “PACU Red” was called and the flow of patients through the surgical suite stopped. Management and staff needed to identify processes that would facilitate patient throughput utilizing an interdisciplinary and interdepartmental approach.

The goal of the project was to develop a system that would provide standardized alerts as the bed availability in the PACU decreased. Using a color code system that identified specific responsibilities for team members established consistency in dealing with throughput issues. The ultimate goal was to maintain the flow of patients by proactively addressing bed availability issues rather than reactively.

A team of nurses in collaboration with management worked to develop a work flow diagram that identified actions required for each team member at each warning level in the flow diagram. This flow diagram was initially introduced and implemented in the PACU and In & Out Surgery units with participation of the staff from those units, anesthesia staff, and the nursing supervisor. The nursing supervisor would communicate with admitting, individual nursing units, and environmental services to facilitate room readiness for discharge.

After implementation of the initial phase of the process the incidences of “PACU Red” have decreased.

Patient and family satisfaction are improved with timely transfer to a patient room. Efficiency in the surgical suite is enhanced and additional staffing needs are reduced, resulting in improved staff satisfaction.