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.