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
 - o 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.