Implementation of a PACU Pause in a Pediatric Post Anesthesia Care Unit

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Background

- Effective communication between the surgical team and the PACU nurse is essential to delivering safe postoperative care.1
- Distractions during anesthesia/OR team transfer of care to PACU results in gaps in information and can lead to adverse patient outcomes1,2.
- Additionally, a lack of standardization during this handoff may result in information gaps, leading to adverse clinical outcomes1-3.
- During fiscal year 2020, 2 serious PACU safety events within our organization were found to be related to ineffective communication during the handoff process.

Process of Implementation

- In June of 2020 and again in 2021, the PACU Clinical Practice Council (CPC) completed an observational survey of the current transfer of care process as well as a baseline survey of PACU nurse perception of the current transfer of care process.
- Identified opportunities for improvement:
  - The anesthesia/OR team report did not follow a consistent, and repeatable communication structure.
  - The PACU nurses reported that they are distracted and do not receive basic information needed to safely care for the patient.
- In July of 2020, the CPC completed a review of best practice and collaborated with leadership and anesthesiologists to implement an evidence-based handoff protocol called the “PACU Pause”.4,5
- Created checklists for anesthesiologists and the OR nurse. In November of 2021, checklists were placed in each PACU bay with “PACU Pause” expectations and instructions.

What is the “PACU Pause”?

- “PACU Pause” consists of a cessation of talking when the patient arrives to PACU from the OR.4,5
- Patient is placed on the monitors by all team members.
- The PACU RN performs a basic assessment of the patient stability and respiratory status.
- When ready, the PACU RN gives the anesthesiologist and the OR nurse the checklist and announces they are ready for report.
- The patient is identified, and report is given using the checklist.

Outcomes

- Post-implementation observational and nurse surveys were repeated by the CPC in February 2022.

Statement of Successful Practice

- Serious safety events related to communication decreased from 2 in FY 2020 to 0 in FY 2021 and 2022 to date.
- Nursing satisfaction with the patient arrival process and handoff from the anesthesiologist/OR team increased.
- Implementation of the Standard “PACU Pause” protocol has enhanced safety during the transition of care from the OR to the PACU.
- Continued auditing is needed to reinforce this change in practice.

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.

Objectives of the Project

- The goal of this nurse-led project was to improve handoff communication between the perioperative teams to facilitate a safe patient transition from the OR to PACU.
- October 2021, the CPC educated all nurses and anesthesiologists, with a go live date of 11/01/2021.

References

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