Improving timely discharges and transfers out of PACU

Jami Wenstrup, BSN, RNIII, CPN, Nicole Brabender, BSN, RNIII, CPN, Rebecca Little, MSN, RN, CPN

Background

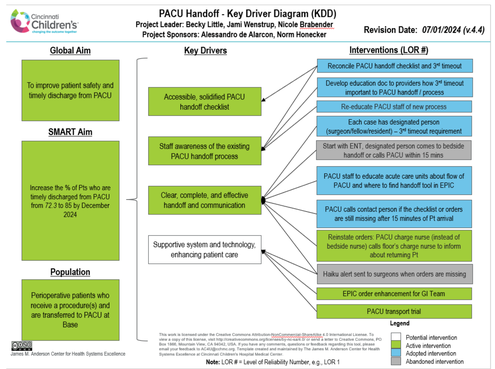
- Timely discharges and transfers out of the Post Anesthesia Care Unit (PACU) contribute to the overall peri-op flow.
- When a patient cannot transfer from the PACU promptly, delays occur within the Operating Room (OR) and Same Day Surgery (SDS). This leads to a decrease in patient, family and employee satisfaction.
- This effort to make a difference and change our process for discharge and transfer led us to form a PACU Handoff project.

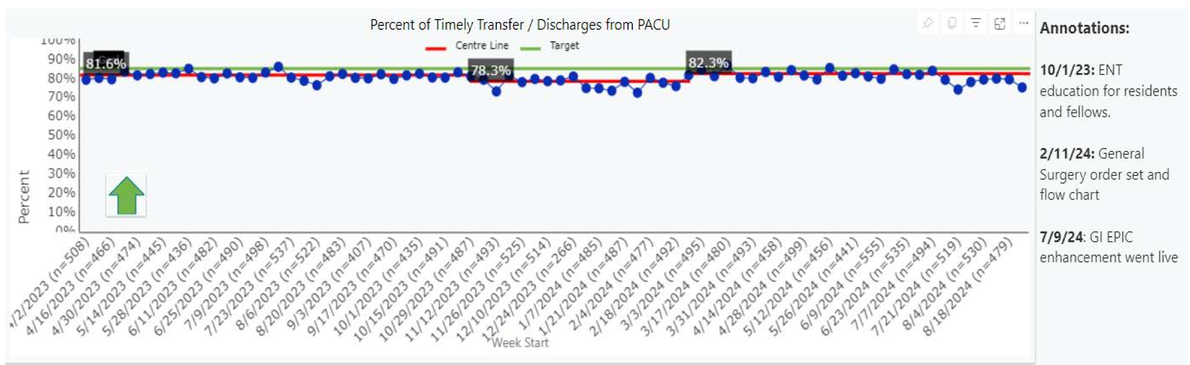
Objective

- To improve patient safety and timely discharge from the PACU.

Improvement Model and Key Drivers

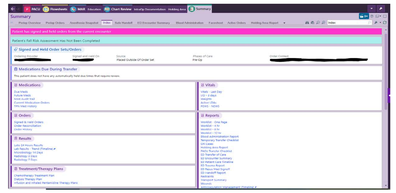
- For this project, our team utilized the Cincinnati Children's Improvement Science Model (ISM).
- A key driver diagram, completion of a plan-do-study-act (PDSA) and analysis of data were used to guide interventions.
- As data was analyzed, several interventions were started that are now part of our sustainment plan.
- The smart aim was to increase the percentage of patients who are timely discharged from PACU from our baseline of 72.3% to 85% by December 2024.



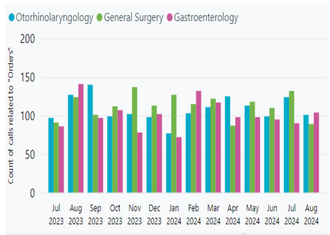


Method

- A PACU handoff team was created : bedside nurses, management, surgical providers and quality improvement team members.
- A data analysis revealed the three largest areas of improvement included physicians placing orders, floor delays, and transportation.
- Initial intervention: Creation of a handoff tool



- Second intervention: Educated acute care staff regarding PACU flow process and where to find PACU handoff tool in EPIC.



- Third intervention: Order placement. A pareto chart was used to analyze order placement compliance among general surgery, Ears Nose and Throat (ENT), and Gastrointestinal (GI) divisions.

	A	B	C
1	Date	# of PACU transports	Total amount of transport time
2	3.6.24	6	2:18
3	3.7.24	23	5:28
4	3.8.24	28	5:15
5	3.9.24	11	2:07
6	3.11.24	21	3:00
7	3.12.24	32	6:10
8	3.13.24	22	4:28
9	3.14.24	11	3:20
10	3.15.24	16	3:47
11	3.18.24	16	3:35
12	3.19.24	20	5:06
13	3.20.24	15	3:08
14	3.21.24	21	4:42
15	3.22.24	24	5:10
16	3.23.24	2	0:21
17	3.25.24	10	2:30
18	3.26.24	12	2:10
19	3.27.24	14	3:12
20	3.28.24	11	2:45
21	3.29.24	23	4:10
22	4.1.24	5	1:03
23	4.2.24	8	1:02
24	22 days	351	72.07
25			

- The last initiative focused on transfers out of PACU by a PACU nurse instead of transport team.

Findings

- Since the PACU has incorporated these changes, the project centerline has shifted to 82%.
- This project streamlined the proceduralist order placement process which attributed to the shift of our centerline. We were able to decrease order placement concerns, along with working towards a decrease in delays due to transporting of patients.
- As the handoff team investigated the transportation concerns, data from one month proved PACU staff members spent over 72 hours transporting their own patients out of PACU.
- The ENT department used re-education to address order placement delays. An education tool was created for general surgery and GI to improve their order placement in the peri-op department. An EPIC build was then created to assist the GI providers with easier identification of their order sets to ensure timely placement of orders.
- We continue to watch current data trends with a focus on continuing the above-mentioned QI initiatives to meet our goal. This initiative could be applicable to any area that needs streamlined processes.

Conclusions/ Implications for Practice

Continued data collection through the monthly "PACU Handoff Patient Safety Report". The team will evaluate the data monthly and proceed with current or new interventions as needed.

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