Section I Core Concepts

Chapter 1

Perianesthesia Organization and Administration

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Modern perianesthesia nursing care may involve adult and pediatric phase I and phase II patients, extended-care patients, and preoperative patients. Areas of the hospital in which care is provided are often blended units encompassing preoperative and postoperative areas. Therefore, the perianesthesia management team and the overriding institutional organization must be nimble and able to adapt to the rapidly changing clinical environments that characterize perianesthesia care.

1. What is the origin of the postanesthesia care unit?

The first public demonstration of the safe use of inhaled anesthesia (in the form of ether) was in 1846 at the Massachusetts General Hospital in Boston (Desai & Desai, 2015), and at the same hospital, a ward was established in 1873 for patients to recover from ether after surgery (Allen & Badgwell, 1996). In the 1940s, during the Second World War, the need for a recovery room was recognized after patients died of respiratory failure after surgery from the administration of anesthesia (American Society of PeriAnesthesia Nurses [ASPAN], 2016). Recovery rooms became a specialized area to monitor patients who were physically close to the operating room (OR) and to provide a place that offered safe and competent patient care. Recovery rooms were also needed to separate ward patients from experiencing the sights and sounds of postoperative vomiting and the pain of the patients recovering from anesthesia (Barone, Pablo, & Barone, 2003). Today, modern recovery rooms are called postanesthesia care units (PACUs).

2. How are PACUs organized within a facility?

Many PACUs around the country are organized into a perioperative area (including all recovery areas), preoperative holding (PREOP), and the OR. Other hospitals consolidate the PACU with the critical care areas, and some exclude the OR from the perioperative area. Although the actual location of the care may vary from institution to institution, perianesthesia nursing care may be simply defined as all care that is provided to a patient before and after anesthesia. In contrast, perioperative nursing encompasses all nursing care received before, during, and after a procedure or surgery and comprises all three phases of care: preoperative, intraoperative, and postoperative.

Structuring the facility to include the single category of perioperative services typically means that one director will oversee the different units. This kind of organization usually leads to standardized policies, procedures, and charting methods and can foster better communication and integration between the different areas and their management teams.

3. How many PACU beds are needed?

According to the American Society of Anesthesiologists' design manual, the number of PACU bed spaces required is 1.5 to 2.0 per OR, but this number will depend on many factors, including surgical case mix, recovery times, and the turnover time of both the PACU and the OR (2012). A large number of short, fast, and ambulatory cases or intensive care unit (ICU) patients with long recovery times will increase the number of beds required. It

is important to gain insight into these factors and model patient flow through the OR and PACU to ascertain the required number of beds for optimal patient throughput (Schoenmeyr et al., 2009).

4. What is the recommended PACU management structure?

There is little in the literature to support one PACU management team structure over another; however, some principles should guide whatever structure is chosen in any given facility. Although titles vary greatly across the country, there is typically a nurse manager or patient care manager who covers the PACU. The patient care manager may cover a variety of perioperative areas, including preoperative and postoperative or procedural areas, and/or adult or pediatric areas. Patient care managers should be visible to staff to establish trust and to foster regular communication between the staff and the management team. Managers may have assistant nurse managers, and if so, this role may be more "frontline" than that of the patient care manager. Assistant nurse managers may still function as charge nurses, be counted into staffing on certain days, or provide break relief, as necessary, in addition to their administrative duties. The PACU needs a flexible staffing plan to accommodate patients when they are ready to arrive from the OR, and the assistant manager(s) may be a critical component in providing this flexibility and in enabling the unit to accommodate patients during peak times.

The patient care manager should foster a shared decision-making model to enable a horizontal power structure. In this complex setting, with differing patient populations and variable care needs, establishing a trusting and communicative environment is essential. In a shared decision-making environment, staff nurses are empowered to be active participants in many types of unit decisions, including policies, work-related rules and guidelines, and practice issues. Shared decision making can be facilitated through unit-level committees that focus on different topics, including quality, patient and family care, education, research, and recognition and retention, among others. These committees can be the driving force behind unit-level decisions, assuming the manager allows and encourages this from staff members. With shared decision making, the staff nurse will feel heard and respected by management and will embrace unit changes more readily (Timmins, 2010).

5. What are the other important leadership roles?

A perianesthesia clinical nurse specialist (CNS) is a treasured resource in perioperative areas. The CNS may function in a full-time or part-time position, may cover multiple units, and may have several managers with whom he or she collaborates. The perianesthesia CNS has multiple roles or domains of practice, including that of clinical expert, educator, researcher, consultant, and liaison (Glover, Newkirk, Cole, Walker, & Nader, 2006). As perioperative nurses are required to care for an increasingly wide range of patient types and acuities, the CNS plays a critical role in developing the necessary education, policies, and procedures to support their practice. In addition, the CNS plays a vital role as a liaison between the perianesthesia units and the OR as well as between the surgical units and ICUs. Finally, perianesthesia CNSs also provide a critical link to enhancing communication and collaboration between medical and nursing staff.

The perianesthesia educator role is also advantageous for any facility. The educator is a mentor for staff, working side by side to engage them in learning, helping them to grow in areas of weakness, and empowering them to become clinical mentors for other staff. The perianesthesia educator may coordinate with the CNS, if available, to facilitate staff education, develop and maintain competencies, and develop and revise new hire orientation programs. The nurse educator should spend ample time in direct patient care, alongside the staff members, to assess their educational needs and plan accordingly with classes and/or in-services. In conjunction with the educator and CNS, a perianesthesia patient care manager may also have an assistant patient care manager as part of the administrative team. Hereafter, the term *administrative team* will be used to refer to the individuals that comprise the perianesthesia nurse management team.

6. What is the role of a charge nurse?

Charge nurses are designated unit leaders, given the authority to "run" a unit for the duration of their shift. Charge nurse responsibilities vary by facility, but, in general, the charge nurse is responsible for ensuring patient flow through the unit by making safe patient–nurse assignments. This is accomplished through communication with procedural or operating areas, hospital bed placement areas, and through regular communication with their supervisors. In addition, the charge nurse may be responsible for coordinating break relief, changes, or transfers in patient assignments, and daily unit "chores." Some charge nurses may also be responsible for providing patient care; however, depending on the pace of the unit, patient acuity, and scope of the role, it may be unsafe for patient care and at cross purposes with the overall

function of the position to have the charge nurse focusing on patient care in addition to coordinating an entire unit. The charge nurse role is a dynamic position in perianesthesia areas; the constant changes in patient volume, acuity, and staffing needs require unique skills that should be mentored by the administrative team and other seasoned charge nurses.

7. How many charge nurses are needed?

Some perianesthesia areas may require more than one charge nurse per day. The preoperative and postoperative areas may each need charge nurses, and if there are separate units for different patient populations, charge nurses may be necessary for each unit to ensure safe patient care and coordination of resources. If the unit has a variety of shifts or is open all night, there may be more than one charge nurse per day in any given area for different shift coverage. In bigger and busier perianesthesia areas with larger caseloads, having charge nurses that overlap on staggered shifts may be helpful for break relief, assisting staff with difficult patient assignments, and in maintaining unit flow.

8. Should the charge nurse group be limited in size?

Having a small and limited group of charge nurses may provide more reliable leadership in the unit with more consistent practices. One study found a significant increase in both charge nurse and staff satisfaction if the charge nurse is well trained in areas of leadership, delegation, decision making, power, conflict resolution, negotiation and persuasion, team building, communication, and image (Thomas, 2012). The learning of these skills and their regular practice in the charge nurse role is important to the maintenance of the well-trained charge nurse experience.

The disadvantage to a core group of charge nurses may be the limitation this may create for the rest of the staff. Limiting the charge nurse opportunity and responsibility to a small few could be a disincentive for staff members who feel ready to take on this type of leadership but are not given the opportunity. If the core charge nurse model is utilized, it is important to offer other staff the opportunity to become a charge nurse through charge nurse training and other professional development opportunities.

9. What are the ASPAN standards for staffing ratios in the PACU?

ASPAN standards for staffing ratios state that "[t]wo registered nurses, one of whom is an RN [registered nurse] competent in Phase I postanesthesia nursing, are in the same unit where the patient is receiving Phase I level of care" (ASPAN, 2015, p. 35). The standards also differentiate between which patients should receive 1:1 and 2:1 nurse-to-patient ratios. ASPAN staffing guidelines were developed in consideration of evidenced-based research, professional opinion, and consensus.

10. How do PACU nurses provide safe and competent care to anesthetized patients during the off-hours?

In the perianesthesia setting, it is not uncommon for nurses to work some form of off-hour call in their institution. An on-call program should give careful attention to ensure staff skill mix and to avoid staff fatigue (Olmstead et al., 2014). Regardless of time of day, it is important for facilities to follow the ASPAN *Standards for Perianesthesia Nursing Practice*, as they were written to ensure safe patient care. The standards are updated every 2 years to reflect changing practice and the science that supports the practice.

11. How do PACUs staff for overnight patients?

Patients may spend a night in the PACU at hospitals that provide operations to patients who do not have a room reservation before surgery. Additionally, patients who were previously scheduled to be discharged home from the hospital may be kept longer or may remain in the PACU if surgeons require that specific patients can only be admitted to specific floors. Overnight patients are becoming increasingly more commonplace in many PACUs and hospitals across the country. To meet the inadequate bed situation, some hospitals require floor nurses or ICU nurses to "float" to the PACU to provide care to an overnight patient who has recovered (and has met PACU discharge criteria), but who is awaiting a bed. This practice still provides the procedure-specific care that the patient would have received on their indicated floor if the bed would have been available and does not require the PACU to meet the staffing needs of these recovered patients. Whenever this happens, it is important to ensure that the standards of care for the specific patient destination are provided for in the PACU setting. Additionally, special attention should be paid to patient and family satisfaction as a prolonged stay in the PACU may not afford the same overnight comfort as a patient room or an ICU.

12. How do PACUs deal with delays in patients being admitted from the OR?

The PACU may be unable to admit patients for many reasons; for instance, there may not be enough PACU nurses or bed spaces; patients may be waiting for transport to other units or departments; patients may not be fully recovered from anesthesia; and patients may be waiting for floor, stepdown, or ICU beds. When this happens, the PACU cannot continue to accommodate the flow of the OR schedule, and patients may need to be recovered from anesthesia in the OR under the care of the anesthesia providers. This bottleneck leads to dissatisfaction among the physicians, nurses, and ancillary staff as well as patients and their families (Shoenmeyr et al., 2009). The PACU administrative team may need to make regular adjustments to the unit to accommodate these delays.

Recently, advanced computer modeling has been used for surgery scheduling to optimize patient flow, decrease clinical resource idling, and make it less likely that OR patients would be competing at the same time for a limited number of PACU beds (Lee & Yih, 2014).

13. What does it mean to "flex" staff?

PACUs across the country all experience downtime at some point in a given day, and there is much evidence to support the fact that downtime or nonproductive use of staff can be a problem for a PACU budget. A PACU cannot run effectively without enough nurses to cover the patient recoveries or with too many nurses and not enough patients. "Flexing" of staff means being able to look at the unit as a whole and stagger nurses appropriately in order to accommodate changes in PACU arrivals and discharges. Many patient care managers will study the OR caseload the day before and set up a plan for nurses who may voluntarily go home early; they will look at union contracts and/or staffing policies to decide how and when to send nurses home.

14. How do PACUs ensure an adequate skill mix of nurses for all shifts?

Many PACUs require varied or staggered nursing schedules to accommodate the daily OR cases. The PACU administrative team must be aware of the budgetary constraints and the efficiency of the unit. The multiple shifts should be staffed by nurses with varied skills. For example, it is never advisable to place all new or inexperienced hires on the same shift; rather, it is more prudent to ensure that nurses across the skill-acquisition continuum comprise the staffing for any given shift. Blending the skill mix helps to ensure that quality and safe patient care is delivered consistently across all days of the week and all hours that a unit is open. It also creates opportunities for new hires and less experienced staff to learn from the more seasoned staff.

15. Are perioperative assistants needed in the PACU?

Although the title varies from facility to facility, unlicensed personnel or patient care assistants (PCAs) are commonly employed in many hospitals. Either providing direct patient care or care that is more supportive in nature, PCAs perform countless tasks and multiple and indispensable duties. The advantage to having a PCA in the PACU is the potential for reduced PACU turnover time and the creation of a skilled employee that is a combination of a patient transporter and a patient care assistant (Speers & Ziolkowski, 1998). Some hospitals train PCAs to work in the OR and PACU, whereas other PACUs may share their PCAs with different parts of the hospital, and still other PACUs have dedicated PCA staff.

ASPAN has created "A Competency Based Orientation and Credentialing Program for the Unlicensed Assistive Personnel in the Perianesthesia Setting" which provides a comprehensive format for educating and assessing the skill of PCAs in the perianesthesia setting (2012).

16. How do PACUs ensure competent nursing staff?

Evaluating nurses' clinical skills, clinical reasoning, and problem-solving abilities should be a continual process in every facility to maintain safe and quality patient care (Burns, 2009). Each facility has its own requirements for annual competency evaluation; this may be addressed through a centralized mechanism that provides annual review days and online modules, or annual competencies may be evaluated at the divisional or unit level.

Hospital-wide competencies may be insufficient for perianesthesia nurses given the specialization of perianesthesia areas. Deciding which skills require a competency is the first step. Then it is important to determine which competencies need regular or annual review and how the review will be accomplished. In some cases, regulatory and accrediting bodies provide guidance and stipulate which skills require an annual review. In other cases, the frequency of review may depend on the unit and facility resources, as well as the acuity of the patient population. Low-volume and high-risk clinical skills and reasoning should be reviewed more regularly than high-volume, low-risk clinical skills. Low-volume items need consistent review to maintain a basic level of competency so that if a particular patient need or device is seen infrequently, the

nursing staff is still prepared to competently manage the care when it does arise. In perianesthesia areas, where the patient population is vast, there may be several clinical skills that are high risk and low volume and even some that are high risk and high volume. Unit-specific competency completion should be tracked by the perianesthesia educator or administrative team, and made available for charge nurses when they are making patient assignments. A competency grid placed within charge nurse reference material can be useful so that, when a particular type of patient that requires a certain competency is expected in the PACU, the charge nurse has a quick reference as to which nurses are competent to care for that type of patient.

In addition to unit-specific competencies, PACUs should require basic life support (BLS) and advanced cardiac life support (ACLS) certification. If the scope of service includes pediatric patients, pediatric advanced life support (PALS) certification should also be maintained by the nursing staff. These certifications assure a unit-wide and standardized competency for patient emergency response.

Perianesthesia nurses can maintain competency through continuing education, specialty certification, BLS, ACLS, and PALS certification. In addition, the department should identify unique clinical skills required for providing safe, quality patient care and assure competency in these areas through regular review and evaluation of every nurse. Competency review should be mandatory, nonpunitive, and continuous (Burns, 2009). Staff nurses can work together with the administrative team to develop and implement these competency reviews to create a successful program.

17. What does Magnet designation mean and why does it matter?

Magnet designation was developed by the American Nurses Credentialing Center (ANCC) (ANCC, 2016) to recognize healthcare organizations that promote nursing excellence. Nurses in Magnet facilities report more support from frontline management, increased job satisfaction, and better relationships with other nurses than in facilities without the Magnet designation (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2007).

18. What are the components of Magnet recognition?

The Magnet Model has five components: (1) transformational leadership; (2) structural empowerment; (3) exemplary professional practice; (4) new knowledge, innovation, and improvements; and (5) empirical quality results. These components encompass the 14 "Foundational Forces of Magnetism." Of the 14 forces, the most relevant for management are Force 1 (Quality of Nursing Leadership), Force 3 (Management Style), Force 4 (Personnel Policies and Programs), Force 8 (Consultation and Resources), and Force 9 (Autonomy) (ANCC, 2016). These aspects of Magnet are directly influenced by the administrative team.

19. How can the administrative team support the Magnet designation quest or sustain it?

Administrative teams can support Magnet designation through frontline interaction on their given units. The administrative team can provide paid time off for education, foster shared decision making, be visible on the unit, and assess and reassess staffing needs to support quality patient care. When obtaining Magnet designation or at renewal time, certain sources of evidence are required. The administrative team can plan an important role in ensuring that these are maintained and available when required.

20. What is the difference between CPAN and CAPA certification?

The certified postanesthesia nurse (CPAN) and certified ambulatory perianesthesia nurse (CAPA) certifications were developed when surgical, preanesthesia, and postanesthesia patient care moved from the inpatient hospital setting to outpatient clinics or centers (Niebuhr & Muenzen, 2001). CPAN certification examinations were first offered by the American Board of Perianesthesia Nursing Certification (ABPANC) in 1986, and the CAPA certification examination was first offered in 1994. The current versions of these exams were developed after an extensive study, initially conducted by ABPANC in 1999 and 2000. This role delineation study (RDS) was conducted to determine patient needs and nursing knowledge necessary to care for these needs in both ambulatory and inpatient perianesthesia settings. The results of the 1999–2000 RDS determined that patient care needs were the same in ambulatory and inpatient settings, but that they varied in amount of nursing time spent meeting these needs (Niebuhr & Muenzen, 2001). In 2005 and 2006, another RDS was conducted and the examinations were updated as follows: the CPAN exam placed greater emphasis on behavioral/cognitive and safety patient needs, and the CAPA exam placed more emphasis on advocacy needs (Niebuhr & Muenzen, 2008). Both exams included four areas of patient need, physiologic, behavioral, cognitive, and advocacy (ABPANC, 2016). Another RDS

was conducted in 2010-2011 and the need for two (CAPA and CPAN) exams was reaffirmed, though the four domains were reduced to three, incorporating advocacy throughout the other three domains (Niebuhr & Siano, 2011).

21. Who is eligible for CPAN and CAPA certification?

The current requirement to be eligible for either certification is a U.S. registered nursing license and 1,800 hours of direct patient care in a perianesthesia setting within the prior 2 years. Nurses that were certified before this requirement and that did not meet it are still eligible for recertification. Nurses may choose to take either exam; however, nurses caring mostly for phase I postanesthesia patients will find the CPAN exam more relevant to their practice and nurses spending the majority of their time caring for preanesthesia, phase II, and extended-care patients will find the CAPA exam more relevant for their practice. Nurses may choose which certification to pursue if they meet the requirements, and may also obtain both certifications (CPAN and CAPA).

22. Why should management support specialty certification?

Specialty nursing certification is an objective measurement of nursing knowledge in a specific area of nursing and has many benefits for patients, nurses, managers, and the facility. Postanesthesia patients are a vulnerable population, and specialty nursing knowledge and skill should be encouraged for the benefit of safe and effective patient care. Additional benefits of specialty certification for nursing staff include an increased sense of professionalism, empowerment, personal satisfaction, and autonomy (Altman, 2011). Certification is also beneficial for hospitals pursuing Magnet status as the total number of certified nurses is one element in the Magnet application.

23. How can the management support specialty certification?

The biggest barriers to certification include the cost of taking the exam, lack of rewards, and lack of institutional support (Altman, 2011). The administrative team can eliminate these barriers and promote specialty certification through financial, award-based, and logistical support.

Financial incentives for staff certification include paying for continuing education hours for certification preparation classes, paying for the certification examination itself, and providing a salary differential for certification once it is achieved. The administrative team can also support specialty nursing certification by recognizing the certification achievement on a unit level, departmental level, or facility-wide level. Certified employees' names can be engraved onto plaques that are placed in prominent public spaces, and nurse achievements, such as certification, should be announced in staff meetings and newsletters. If allowed by the institution, nurses may want their certification listed next to their name on their identification badge.

Logistical support may be provided through coordination of review courses and study sessions by the unit educator or members of the administrative team. Staff should be given access to certification preparation books by having them available for checkout from the unit or facility library.

24. How can management impact patient satisfaction?

Healthcare organizations use various means to collect patient satisfaction data. One popular method is to conduct surveys on discharged patients. It is important for the manager to understand which patients are to be surveyed and the substance of the survey. Management can promote improved satisfaction scores by encouraging employee engagement, removing identified patient dissatisfiers, implementing a bedside handoff report (with patient involvement, where appropriate), and regular rounding on patients (Kearns, 2015).

25. What is Outpatient Ambulatory Surgery CAHPS (OAS-CAHPS)?

The Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery Survey is a national survey that collects information about the adult patient's experience in hospital outpatient surgery departments and ambulatory surgery centers. This survey covers, at a minimum, the check-in process, facility, communication with administrative staff and clinical providers, attention to comfort, pain control, and the provision of both pre- and post-procedure information (Centers for Medicaid and Medicare Services [CMS], 2015).

Starting in 2016, the CMS plans to launch this initial, voluntary survey (OAS-CAHPS). According to the industry consulting firm, Press Ganey, in the future, as with other CAHPS, CMS may require facilities to conduct the survey as part of the Outpatient Quality Reporting Program or the Ambulatory Surgical Center Quality Reporting Program (Press Ganey Resources, 2015).

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