IMPLEMENTATION of a SYSTEM WIDE HAND OFF PROCESS for ALL PHASES OR SURGICAL SERVICES

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BACKGROUND

Ineffective communication among health care providers is one of the leading causes of medical errors and patient harm. Effective communication about patient care can contribute to efficiency, better patient outcomes, and decreased adverse events. During handoffs between providers and units, information can be missed, misunderstood, or withheld, due to lack of knowledge regarding the receiving unit's needs. Standardized communication checklists that are specific for the facility as well as the unit and patient population, promote consistency, improve the quality of information transfer, and decrease the potential for communication errors or misunderstandings.

Description of Team

This project involved the three ANC (Advanced Nurse Clinicians) representing a five hospital healthcare system in Southern New Jersey. Other divisional members included Associated Vice Presidents, Surgical Services Practice Council members, and front line staff.

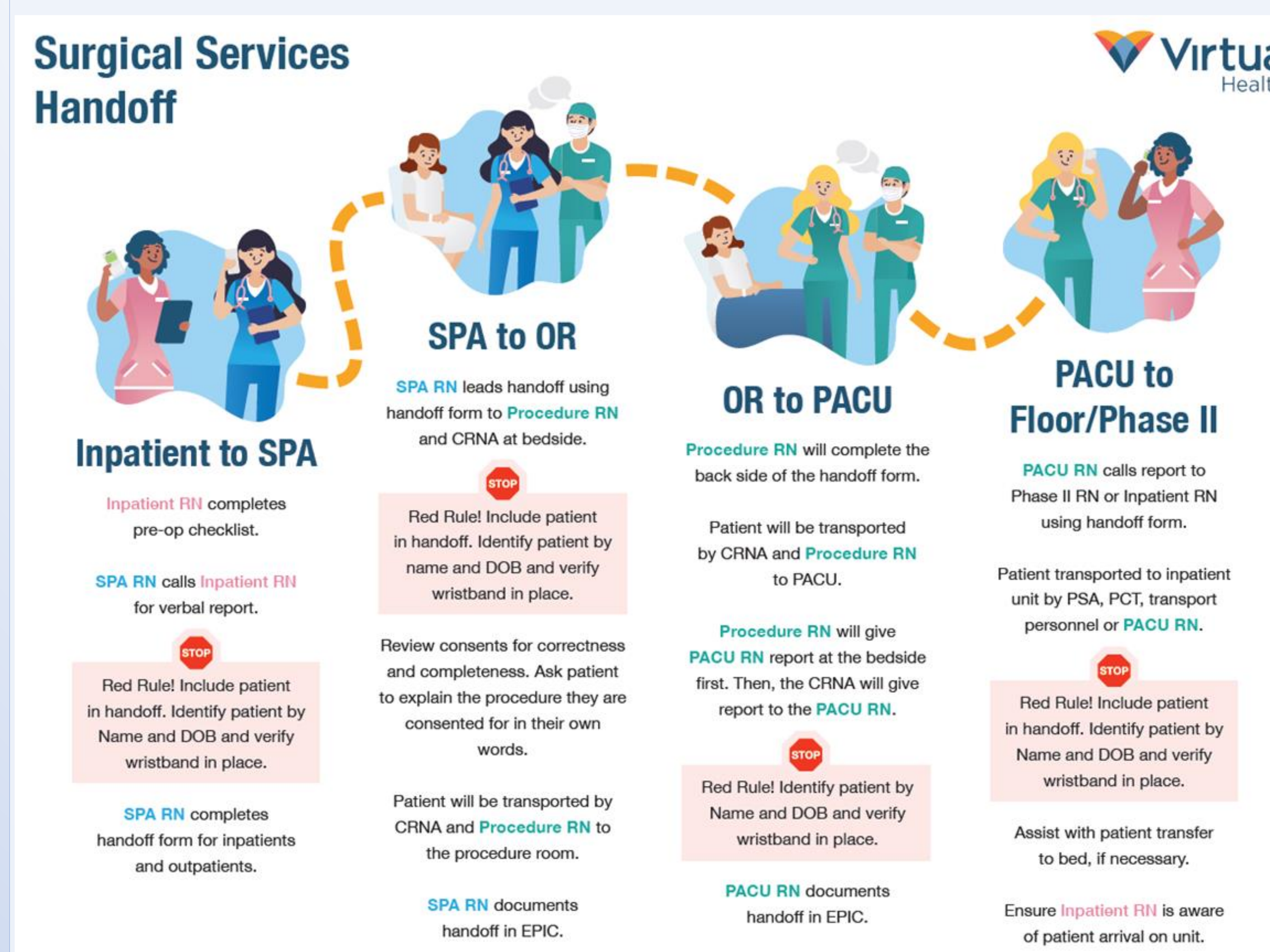
OBJECTIVES

- The learner will understand the importance of handoff between the perioperative areas, such as the SPA, Operating Room and PACU.
- The learner will identify steps taken in the standardization of handoff between surgical services units.

ASSESSMENT

First, the Advanced Nurse Clinicians (ANC) at each campus observed handoffs, gathered current handoff forms, and compared current practices regarding handoff between the Surgical Prep Area (SPA), Operating Room (OR), Endoscopy, Interventional Radiology (IR), and Post- Anesthesia Care Unit (PACU). Similarities and differences between units were compared and used to identify best practices and components that were successful, as well as barriers. Additionally, recommendations from professional organizations such as the Association of Operating Room Nurses (AORN) and the American Society of Peri-anesthesia Nurses (ASPAN) were reviewed. The ANCs made a recommendation for a standardized process which was then presented to and approved by the Assistant Vice Presidents (AVP) of Surgical Services. Handoff forms were updated with staff feedback, specialty specific information for each site, and compliant with AORN and ASPAN recommendations. An educational poster on the process was created, hung on each unit and reviewed at staff meetings.

Educational Poster



OUTCOMES

The new surgical prep handoff form was implemented at all divisions . The Pre-op handoff includes the Pre-op RN, the OR RN, the CRNA and most importantly, the patient. The patient is considered part of the team, and is encouraged to speak up regarding previous history, allergies and the scheduled procedure, especially laterality. The updated process incorporates Red Rule stop signs, calling attention to the transfers of care that require extra attention to ensure the team properly identifies the patient. The roles and responsibilities were reviewed for each team member across the departments and throughout the system.

The goals of this project were to improve patient safety by improving staff communication. Key components related to patient information would be communicated at every handoff thereby decreasing the risk of missing vital information. This change in practice ensures an RN to RN handoff, using the handoff tool, which standardizes critical content that is specific for transfer of the patient from SPA to the OR and OR to the PACU.

IMPLICATIONS FOR PERIOPERATIVE NURSING

Future Research – Direct observations of use of revised tool during handoff will continue. Discussions about potential changes and barriers will continue at all staff meetings. The teams will review the process and make decisions regarding which items on the handoff tool are necessary and helpful, and which items can be discarded.

Handoff Tool

REFERENCES

- Association of Perioperative Registered Nurses (AORN) (2021). Team Communication: Recommendation 2.6.2 and 2.6.4. *AORN Guidelines for Perioperative Practice,* 2021 ed., p1076-1077. AORN Inc., Denver, CO.
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