



Post-operative Handoff in an Outpatient Endoscopy Post Anesthesia Care Unit

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Figures

Background

- Miscommunication during patient handoffs leads to **80% preventable serious medical errors**.
- Poor handoffs** are linked to gap in patient care and loss of critical information.
- Joint Commission requires a **standardized handoff process to improve patient safety**.
- A **standardized handoff** provides a structured format for presenting patient information which improves patient safety by communicating pertinent information during handoff and **improves communication between members of health team**.

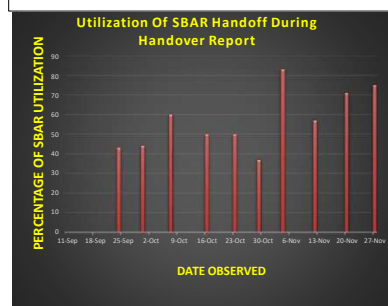
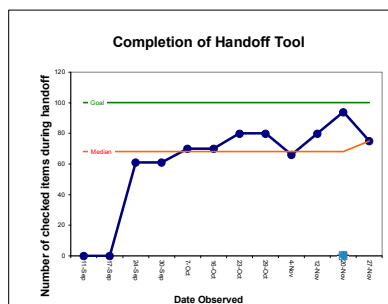
Despite the recommendations, a standardized handoff process was not utilized in the PACU unit

Objectives

- Purpose of this quality improvement (QI) project is to implement and evaluate a standardized handoff tool to:
 - Improve staff satisfaction
 - Improve handoff tool utilization
 - Improve transfer of information during handoffs

Methods

- Setting: 9 bed-Outpatient Endoscopy Unit
- Population: 9-12 intraoperative and postoperative nurses, 70-80 patient handoffs
- Intervention: **Standardized SBAR handoff tool**
- Handoff satisfaction survey**: Assessed pre and post implementation
- Nurses educated on SBAR handoff
- Compliance with Handoff**: Nurses compliance with SBAR tool measured by random weekly audits **via EHR**
- Completion of Handoff**: Random weekly direct observation
- Data Analysis
 - Exported from "Handoff Audit Form"
 - Run chart and Bar chart via Excel
 - Mann U Whitney test via SPSS



PACU HAND OFF	
S Situation	Patient Name Procedure and Diagnosis Allergies
B Background	PMH Significant Labs Notable Baseline VS Baseline Neuro Status
A Assessment	Anesthesia Type (GTA, LMA, MAC, Region, all) Medications Given Opioids <input type="checkbox"/> Benzos <input type="checkbox"/> Antiemetic <input type="checkbox"/> Antibiotics <input type="checkbox"/> Vasopressors <input type="checkbox"/> Other Pain Management Plan IVs/Catheters I & O Surgical or Anesthetic Issues & Concerns
R Recommendation	Patient Destination Abnormal Results Additional Questions/Comments

Survey Questions	Pre intervention Mean (N=9)	Post intervention Mean (N=8)	p-value Mann-Whitney U test
Satisfied with handoff process in PACU	2.77	4.13	0.0156
Satisfied with current postoperative handoff tool in PACU	2.44	3.87	0.0156
Satisfied with usefulness of the current postoperative handoff tool	2.77	3.5	0.1875
Firm understanding of the care goals after postoperative handoff	3.44	3.5	0.75
Need to contact the surgical teams to clarify care goals after postoperative handoff	2.77	3.13	0.375
Firm understanding of the procedure performed after handoff	3.44	3.75	0.375
Feel included in the handoff	4	4.13	0.9
Feel comfortable asking questions during handoff	4.88	4.5	0.375
Feel all questions are answered during handoff	4.11	3.87	0.6875
Feeling too busy with routine activities to participate in handoff	2.88	2.5	0.9
Feeling too busy with urgent activities to stop to participate in handoff	3.11	3.37	0.5
Use of current postoperative handoff tool during handoff	2.66	4.25	0.03
Perceive a formalized handoff tool as being important	4	4.75	0.25

Discussions

- Handoff tool utilization**: Increased from 0% to an average of 70%.
- Completion of Handoff**: Upward trend indicates more items were communicated after the implementation of SBAR checklist.
- Satisfaction Survey**: Staff were satisfied with the SBAR handoff tool and process ($p < 0.05$) and utilized the handoff tool ($p < 0.05$) after SBAR checklist implementation.

Limitations

- Nonparametric test
- Small sample size limits generalization

Conclusion

Future recommendations

- Larger sample size
- Unit based policy regarding standardized handoff
- Implement and adapt a unit specific handoff tool.

Use of standardized handoff can improve staff communication and improve patient safety.

References

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