STANDARDIZING PREOP TO OR NURSING HANDDOFF REPORT:
A COLLABORATIVE JOURNEY
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Background Information:
• Problems noted in the preoperative are were patients were taken to the OR without report
being given, resulting in omission of premedications, unsigned consents, and inconsistent
care
• Barriers identified were PreOp RN unavailable to give report, OR nurses not feeling a
need to get report, type, amount and quality of information given, and inconsistency of
information

Objectives:
• Safe care for our patients
• Smooth transition from PreOp to OR
• Efficient, concise report meeting the Joint Commission’s requirements for handoff report

Implementation:
• PACU and OR Unit Practice Councils collaborated to review the Joint Commission’s
requirements for handoff report
• PACU and OR Unit Practice Council members discussed what information needed to be
shared
• Handoff form revised to include signatures of RNs giving and receiving report

Successful Practice Identified:
• Handoff report at patient’s bedside allowed for OR nurse verifying with PreOp nurse and
family that consents are complete/correct, patient is correctly marked, review pertinent
history in computer and with family, premeds have been given, and family questions
have been addressed

Positive Outcome Achieved:
• Safe practice for transferring patients within our department
• Meet the Joint Commission’s Standards for handoff report
• Percent of OR nurses receiving report increased from 64%- 93%

Implications for Perianesthesia Nurses:
• Problem-solving to improve patient safety
• Role-modeling professional care practices
• Improved quality of care based on knowledge of patient