Background and Significance: In today’s ever-changing healthcare system a high-quality nursing handoff process is a critical part to maintain patient safety. The preservation of necessary patient data during the handoff process is fundamental to make certain continuity of care and patient safety is our number one priority. We identified a need to change our current practice. The purpose of this project was to increase patient safety by eliminating data loss during handoff communication in the perioperative setting.

Learner Objectives of Project:
1) Verbalize the impact of data loss on perioperative patient safety.
2) Describe the impact of team care using a written checklist on data loss during handoff communication.

Process of Implementation: An Evidence-based pilot study labeled “Team Care” was designed to refocus handoffs so as to improve surgical patient safety and standardize the handoff process. The process included a Surgical RN visiting the patient’s room and conducting a face-to-face verbal handoff with the patient and the floor RN. This “Team Care” handoff process also occurred in conjunction with a newly developed written surgical specific SBAR-Q handoff tool that is completed at the patient’s bedside.

Results: The same series of data was collected and compared to base-line data for telephone handoffs. Results showed that the developed SBAR-Q tool and “Team Care” minimized the loss of patient data during transfer of care (p<0.019).

Discussion/Implications for Practice: The use of “Team Care” handoff process standardizes our handoff process for surgical inpatients and has transformed handoffs to make patient safety our priority.