

USING EVIDENCE-BASED PRACTICE TO IMPLEMENT STANDARDIZED ANESTHESIA-TO-PACU HANDOFF TOOL AND IMPROVE PACU STAFF SATISFACTION

Team Leader: Regina Hoefner-Notz, MS, RN; Clinical Manager
Children's Hospital Colorado, Aurora, CO

Team Members: Mary Wintz, MS, RN, Quality Specialist;
Jackie Sammons, BSN, RN, PACU Staff RN;
Scott Markowitz, MD, Associate Professor, University of Colorado

Identification of the problem-Overview: Children's Hospital Colorado uses the SBAR format for standardized communication throughout its facilities. There was no standardization of PACU specific information delineated within the SBAR framework. This sometimes led to inefficient or incomplete handoff reports. In turn, unnecessary time was spent on follow-up phone calls required to clarify information or request orders. A wealth of literature exists providing evidence that standardization of handoff content leads to safer patient care, fewer care failures, and improved staff satisfaction.

EBP Question/Purpose: Will developing a specialized, standardized anesthesia-to-PACU RN handoff tool improve patient safety, as well as staff satisfaction with the transfer of care process? The purpose of this project was to use an interdisciplinary, evidence-based approach to develop an anesthesia-to-PACU RN handoff process that will improve staff satisfaction.

Methods/Evidence: An interdisciplinary team from PACU nursing leadership, quality improvement, bedside PACU staff, and anesthesiology was formed to develop a standardized specialty tool for handoffs from anesthesia providers to PACU RNs. A literature search was performed using CINAHL, PubMed, and Google Scholar to identify existing tools and handoff processes that yielded evidence of best practices. Nine articles were chosen to substantiate the need for the development of a standardized tool in the PACU. The interdisciplinary handoff team developed an SBAR handoff report that included anesthesia and perioperative specific elements. Prior to implementation of this tool, a five-point Likert scale was used to evaluate staff satisfaction with the existing transfer process. The new handoff tool was then piloted for three months. All RN staff members randomly audited one handoff each month, rating their satisfaction with the transfer of care.

Significance of Findings/Outcomes: Initial findings indicated an increase in use of the handoff tool, as well as an improvement in staff satisfaction. Two care failures occurred in the five month pilot. It is hypothesized that potential care failures are being prevented by diligence of the PACU staff. A new method for tracking potential care failures is being initiated in October 2012.

Implications for perianesthesia nurses and future research: Analyzing results of the standardized handoff provided the basis for new questions:

1. Does standardization of handoff checklist decrease patient care omissions and errors?
2. Does surgeon participation in the handoff process improve patient safety?