SNAPSHOT Report: A uniformed handoff Tool for all Perioperative Services

Elizabeth Steffen BSN, RN, CAPA

St. Elizabeth Healthcare, Edgewood, KY

Edgewood/Covington/Grant/Florence/Ft. Thomas

Background

The Joint Commission reports 80% of serious medical errors are the result of miscommunication during transfer or hand-off and 5 out of 10 sentinel events are directly relate to the perioperative setting.

Project Goal

- Develop a handoff process to ensure patient safety for all perioperative patient encounters
- Build a handoff too within the electronic medical record using the ASPAN key safety elements
- Educate all perioperative nurses on the new process
- Monitor handoff process and track usage and compliance

Snapshot Tool

Design/Methods

Evidence-Based Practice

1. Identified a practice concern
   - handoff process within perioperative service line
2. Evaluated and appraised current literature
   - Johns Hopkins EBP tools
   - Reviewed the ASPAN safety elements
   - Reviewed hospital policies
3. Designed and Implemented the change
   - Ensured all stakeholders involved
   - Education plan for staff
   - Compliance and Sustainability plan

Implications for Practice/ Results

- Since June 2020:
- Zero medication errors reported
- Increase in patient satisfaction scores
- Delay On time starts down from 10% to 5%
- Improved nurse satisfaction with teamwork between doctors and staff

References: Available upon request