Improving the Quality and Consistency of OR to PACU Handoff

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Background Information: The Joint Commission requires a standardized approach for patient handoff, which has also led to National Patient Safety Goal 2E. The American Society of Perianesthesia Nurses (ASPAN) also supports a complete and systematic approach to transfer of care as best practice. PACU RNs have identified the need for a standardized OR to PACU transfer process and hand off. PACU handoff comes from multiple providers and often contains overlapping information and/or gaps. Reports are at times delivered while the RN is distracted performing patient care tasks and assessment of critical elements.

Objectives of Project: The purpose of this project was to develop a standardized process for handoff/SBAR (Situation Background Assessment Recommendations) report from OR (Anesthesia Provider/OR RN) to the receiving PACU RN.

Process of Implementation: A literature search was conducted and several important elements were found to support the improvement and consistency of OR to PACU handoff. Resources utilized included The Joint Commission, National Patient Safety Goals, and The ASPAN Position Statements. An Anesthesia Provider Champion collaborated with me to build an SBAR tool. The Anesthesia Providers and PACU RNs were educated on the tool. Pre and Post surveys were conducted to identify nurse satisfaction of report completeness and timing. In addition audits were completed to identify an improvement in medication administration accuracy.

Statement of Successful Practice: Utilizing an evidence-based consistent handoff/SBAR tool between OR and PACU increases nurse satisfaction and improves patient safety.

Implications for Advancing the Practice of Perianesthesia Nursing: Inadequate and/or inconsistent OR to PACU handoff/SBAR can result in delay in patient care and safety concerns for patients. Communication breakdown during handoff has been identified as a primary contributing factor to sentinel events. The delivery of patient care while receiving report can distract the Perianesthesia nurse and may be a factor in missed elements of report. The standardization of SBAR elements and appropriate timing decreases variability, increases consistency, improves efficiency and ensures safety of the surgical patient population. Standardizing handoff/SBAR has shown a decrease in reported safety events and increased nurse satisfaction.