Standardizing Handoff from OR to PACU

Team Leader: Christine Zoet Cajigal BSN RN CMSRN CPAN
Cedars Sinai Medical Center, Los Angeles, California
Team Members: Rowena Cabunoc RN CCRN, Lini Thomas MSN RN CCRN CNRN,
Joanna Pasion BSN RN CMSRN

Background Information: According to the Joint Commission, two-thirds of sentinel events occur from communication errors during patient handoff. Studies show that handoffs in the Post Anesthesia Care Unit (PACU) are prone to communication errors that correlate to suboptimal patient care. A pre-survey completed on PACU Registered Nurses (RNs) perceptions on the Operating Room (OR)-PACU handoff revealed multiple distractions during the process.

Objectives of Project: Does implementation of a standardized OR-PACU handoff improve efficiency and decrease RN's perception of being rushed through the handoff process?

Process of Implementation: A video on the standardized handoff process was made with the collaboration of PACU/OR RNs and the anesthesiologists. The video was shared with the nurses from PACU, OR and the anesthesiologists. After staff viewed the "handoff video", to help reinforce the new process, a reminder sign was posted on each PACU bay. From May to December 2017, staff was observed applying this new process. Deviations from the new process were corrected immediately. A post-survey was completed in January 2017, and the results were analyzed.

Statement of Successful Practice: 68% of PACU RNs agreed on receiving a complete report from the anesthesiologist, while 95% agreed on receiving a complete report from OR RNs. 84% PACU RNs agreed that intraoperative events or concerns were shared in the handoff. 26% of the PACU nurses agreed that they were given enough time to connect the patient to the monitor. Barriers identified included, the doctors not acknowledging the RN's request to wait to provide a handoff; and different nurses and anesthesiologists floating to the unit were unaware of the project. To improve compliance, the PACU nurses recommended OR RNs and anesthesiologists to implement the new handoff process.

Implications for Advancing the Practice of Perianesthesia Nursing: In the post-implementation phase, the OR team continued to give their handoff while the PACU nurse was focused on getting the patient settled in. Despite the outcome, nurses agreed that the project was a good initiative and recommended the need for proper buy-in from OR RNs and anesthesiologists. The project was shared with anesthesia and OR leadership to reinforce the standardized process with OR RNs.