Introduction
The focus on surgical risk has evolved from solely considering the patient’s disease process and complexity of the procedure to including additional focus on the health provider’s impact when evaluating surgical outcomes.

Identification of the Problem
From November 2015 to November 2016, thirty-three patients were reported to have crossed the red line with incomplete or missing required documentation. Other concerns included:
• The patient was not involved in a transfer of care process.
• Time restraints and pressures of efficiency were a source of strained employee relations and root cause of error.
• Absent handoff from the PreOperative RN to the OR Circulator.
• Only CRNA was transporting patient to the OR frequently without any handoff.
• Due to lack of a handoff process historically, perioperative staff did not value the need of a handoff.
• Patient Satisfaction scores for Overall level of Safety were poor.

QI Questions/Purpose of the Study
The purpose of this project was to reduce the risk for patient harm or near miss due to communication breakdowns and to improve staff and patient engagement in the preoperative verification process.

Goals
• Create a standard procedure for transfer of care where the patient is at the center.
• An electronic patient summary page to be utilized for investigation and as an SBAR tool was developed.
• A standard PreOp verification process to decrease compliance errors with documentation.
• Increase the patient’s participation in a handoff and perception of safety upon entering the OR.
• Patient Satisfaction scores for Overall level of Safety improve.
• Reduce delays in the OR due to incomplete documentation.
• Ensure that the Perioperative team (OR and PeriAnesthesia) in the PreOp area.
• Identification of the need for a script for the three teams to use in order to facilitate a thorough but time efficient process.
• Circulators and CRNAs transport patient together to OR after the completion of the PreOperative Time-Out.
• Significant improvement of 71% of compliance with red line required documentation.
• As the beginning of implementation: Time-out was performed 50%-75% of the time.
• After implementation: Time-out is completed 75-100% of the time.
• 60% increase in Patient Satisfaction Scores regarding Overall Level of Safety.

Methods
• An electronic patient summary page to be utilized for investigation and as an SBAR tool was developed in February 2016 with Go-Live of tool in November 2016.
• Patient-centered standardized tool developed to ensure compliance by all three disciplines (PeriAnesthesia, OR and Anesthesia) in the PreOp area.
• Incident reporting was continually captured during the project to provide a baseline comparison for any changes in the number of incidents reported.
• With a standardized process, registration was identified as an area that contributed to errors with incorrect patient identification in the EHR.

Implications for Practice
• PreOperative Time-Out Tool included patient at the center of the handoff process.
• Improved staff relationships between PeriAnesthesia and OR.
• Circulators and CRNAs transport patient together to OR after the completion of the PreOperative Time-Out.
• Significant improvement of 71% of compliance with red line required documentation.
• A transparent transfer of responsibility process.
• Staff understanding of the value of the PreOperative Time-Out tool increased.
• Compliance of all three disciplines involved proved to be very high.
• Identification of the need for a script for the three teams to use in order to facilitate a thorough but time efficient process.
• Our main aim in the development of this tool was to address the almost total lack of research evidence on the need of a formalized standard process for hand off prior to crossing the red line. We have developed this tool from direct observation and incident reporting on the daily workflow and best practices in the PreOperative areas.
• A significant emphasis on patient and family-centered care in the PreOperative area due to the observation and incident reporting on the daily work of the perioperative teams in the PreOperative area.
• A transparent transfer of responsibility process.
• Further education causing increased awareness of the necessity of thorough hand off.
• Complete of all disciplines has shown to be necessary for success. The perioperative team cannot work in silos.

Results-Patient Satisfaction Graph
• Significant improvement of 71% of compliance with red line required documentation.
• As the beginning of implementation: Time-out was performed 50%-75% of the time.
• After implementation: Time-out is completed 75-100% of the time.
• 60% increase in Patient Satisfaction Scores regarding Overall Level of Safety.

Conclusion
The patient-centered standardized process and formalized time-out in the PreOperative area has proven to be more beneficial than just an informational transfer. Examples include:
• A significant emphasis on patient and family-centered care in the PreOperative area due to the whole team meeting the patient and family together.
• Improved staff relationships between PreOp, OR and anesthesia teams.
• An impact upon patient safety with earlier identification of errors or missing documents.
• A transparent transfer of responsibility process.
• Further education causing increased awareness of the necessity of thorough hand off.
• Complete of all disciplines has shown to be necessary for success. The perioperative team cannot work in silos.

Discussion
For inpatient nursing, bedside handoff has been identified as an important component during critical transitions impacting safety outcomes. Decades of published literature and guidelines on bedside handoff attest to various results regarding the achievement of improvements with quality and safety. When nurses integrate patient expertise, nurse-to-nurse handoff becomes patient-centered (nurse and patient), and the weak link between quality and safety is mitigated.
As recognized by patient satisfaction surveys and incident reporting, the non-patient centered handoff that was practiced in the PreOperative area was noted to be ineffective in minimizing errors and creating a perception of safety for the patient. Although the sample size for this project was very small, considering the large surgical volume the institution experiences (4,000 cases/year), both before and after the implementation of the tool, the impact on each individual patient was significant enough for us to investigate and continue to change the culture including the patient as a partner in the handoff process in the Preoperative area.
For the operating room, with competing efforts in efficiency and multidisciplinary incentives to transition to the OR from the PreOp area quickly, it was observed that the hand off culture was a nurse-centered interaction rather than a patient-centered partnership. Barriers to changing the culture to a patient-centered partnership were often secondary to OR production pressures.
Although there was an improvement in the patient’s perception of safety and a decrease in the amount of errors with the tool, errors did continue. A barrier that was identified even with the tool was the practice of a large charge nurse transport to nurse transition. A common occurrence was a PreOp RN had multiple patients transferring to the OR at the same time, which caused errors due to lack of continuity of care with a new patient and not knowing the patient and the patient not knowing the nurse.
Even after the tool was implemented in all three disciplines (OR RNs, PeriAnesthesia RNs, CRNAs), it was noted that learning how in conduct a partnership-driven handoff required a new skill set for both nurses and patients. A script was then developed in order to standardize conversations with nurses and the patients. This created an opportunity for nurses and patients to address all information and questions in an efficient manner to prevent a time barrier in transition to the OR, as compared to only using a PreOp check list.
Outcomes
• 60% increase in Patient Satisfaction Scores regarding Overall Level of Safety.
• Significant improvement of 71% of compliance with red line required documentation.
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• After implementation: Time-out is completed 75-100% of the time.
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