Improved Perioperative Handoff Through Informatics
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Background
- Ineffective communication between healthcare providers can lead to sentinel events and may be the primary reason for errors in healthcare (Nether, 2017).
- To combat this, handoff communication was highlighted as a Joint Commission National Patient Safety Goal in 2006 (JCAHO, 2006).
- Missing information during handoff often results from illegible paper documentation (Nether, 2017).
- Use of an embedded electronic medical record (EMR) report for handoff improves communication by eliminating concerns of illegible documentation and ensuring all care team members have access to the most up-to-date information.

Objectives of Project
- Develop and integrate a seamless handoff communication report within the EMR to improve handoff communication throughout the perioperative area.

Process of Implementation

Literature Review
- Completed a literature search and the Themes included illegible or missing information from the paper documentation, a need to supplement handoff with follow up phone calls and pages rather than providing patient care.

Stakeholder Input
- Solicited input from multiple stakeholder groups, including:
  - Pre-operative nursing staff
  - Post-operative nursing staff
  - Anesthesia

Development
- We consulted the nursing informaticists to determine if we would be able to use an existing report template or if possibly needed to create one. Using the critical elements previously identified, we formulated the template.

Stakeholder Evaluation
- Staff feedback has evolved the handoff collaboration.
- Stakeholder Input
  - We consulted the nursing informaticists to determine if we would be able to use an existing report template or if possibly needed to create one. Using the critical elements previously identified, we formulated the template.

Integration
- Prototype constructed and is currently being trialed by staff.
- Implementation of handoff tool to the other perioperative and procedural units.

Statement of Successful Practice
- A handoff tool was developed that is comprised of the critical elements previously identified by staff and information documented in the EMR.
- This tool contains the essential information that may be lost as the patient progresses through the perioperative care continuum.

Implications for Practice & Future Research
As we move forward and the information of our patient's care is documented in an electronic format, we should be able to use it to its full potential and provide safe effective patient care.

References