

## **HIGHWAY TO HANDOFF**

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### **BACKGROUND INFORMATION:**

In 2012, the Post Anesthesia Care Unit (PACU) of a tertiary pediatric hospital received results of a AHRQ Culture of Safety Survey revealing an opportunity for improvement in the "handoffs and transitions" and "teamwork" domain. Handoff of patient care from PACU to our surgical inpatient unit is a critical transition event in the continuum of postoperative care.

### **OBJECTIVES OF PROJECT:**

Our ultimate goal was improving patient safety, decreasing care failures and increasing nurse satisfaction by creating a standard handoff process. This standardized handoff process would decrease the variability in the handoff process between the Phase I PACU and the surgical inpatient receiving unit.

### **PROCESS OF IMPLEMENTATION:**

A team consisting of RN's from both nursing units and Quality Improvement reviewed efficacy of the handoff process. We examined handoff care failures and reviewed handoff assessment evaluations. Process maps were based on findings. A reporting tool was developed to provide nurses an opportunity to rate handoffs for content, timeliness and cooperation. Both units agreed to specific handoff guidelines to be implemented during this evaluation. After utilizing the defined process for four months, both units contributed to a post implementation evaluation and participated in a review of care failures. Findings at that time indicated dissatisfaction scores correlated with not using the handoff reporting tool. Handoff guideline education was provided to both units. Six month after this education the evaluation was repeated and care failures reviewed.

### **STATEMENT OF SUCCESSFUL PRACTICE:**

A review of the data indicates the use of the standardized handoff tool along with reporting timeframe guidelines decreased care failures as well as increased perception of teamwork between both nursing units.

### **IMPLICATIONS FOR ADVANCING THE PRACTICE OF PERIANESTHESIA NURSING:**

Transfer of a patient from PACU to an inpatient unit is a critical time of information sharing and utilizing excellent teamwork. Standardizing handoff and reporting guidelines has increased patient safety as well as overall nurse satisfaction.