Implementation of a Standardized OR to PACU Handover at an Urban Pediatric Tertiary Care Centre

Team Leader: Jessica Tang MScN RN
The Hospital for Sick Children, Toronto, Ontario
Team Members: Janina Lagason BScN RN, Venus Shyu BScN RN, Monika Magnatta BScN RN

Background Information: PACU RNs expressed concerns related to poor communication during post-operative handovers that contributed to safety events and increased length of stay. A trend of patient safety reports supported these concerns. Handover audits and a literature review identified a gap in communication due to the absence of surgical staff and the lack of a standardized handover checklist and process.

Objectives of Project: This nurse-led project aimed to improve the OR to PACU handover process to facilitate stronger interprofessional communication and improve patient safety. We intended to achieve our goal by creating a standardized handover checklist and process informed by evidence-based research and clinical feedback. A secondary goal was to sustain the handover practice for new staff and trainees across disciplines through the development of an educational video.

Process of Implementation: A nursing focus group initiated the needs assessment and planning for quality improvement through benchmarking and review of current literature. A working group of key partners from surgical, anesthesia, OR, and PACU teams was formed with a goal of creating a standardized handover checklist and process. Surgical and anesthesia representatives across 3 services piloted the new handover process and checklist over a 1-week trial. Once the checklist was finalized and a go-live date was established, education was implemented through different modalities such as just-in-time training, an interactive practice station, and didactic teaching. To promote this initiative, handover champions and laminated resources were made available to the unit. A mandatory educational training video was later created for all new perioperative staff and trainees.

Statement of Successful Practice: To evaluate the project, we gathered subjective and objective data through a survey, focus group, and audits. 90% of survey respondents reported satisfaction with the quality and efficiency of communication to deliver safe and effective patient care. Audits of surgical staff presence at handover revealed sustained surgical staff presence (~90%) over 2 years.

Implications for Advancing the Practice of Perianesthesia Nursing: PACUs are considered high-risk areas due to patient factors, staff workload, and possible communication challenges (Redley et al., 2016). By implementing a standardized OR to PACU handover process and checklist, all staff have the tools to share patient information in a comprehensive and efficient way.