THE EFFECTS OF A "PACU PAUSE" AND PERIOPERATIVE HANDOFF PROTOCOL IN PROMOTING SAFETY AND IMPROVING PROVIDER SATISFACTION

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Introduction: According to the Joint Commission Center for Transforming Healthcare (2013), The Joint Commission (TJC) has attributed 80% of serious medical errors to miscommunication during handoff between medical providers.

Identification of the problem: PACU nurses receive handoff from the perioperative team concurrently during monitor-line setup, vital signs and airway assessment. Post-anesthesia patients are at substantial risk for clinical instability. Distractions during report can result in communication gaps and adverse patient outcomes.

EBP Question/ Purpose: Will a "PACU PAUSE" and a standardized perioperative handoff protocol enhance communication while improving satisfaction of the perioperative team?

Methods/Evidence: The Iowa Model was used for this evidence-based project. The evidence supported standardizing handoffs to optimize safety. A prospective interventional study was done by observing perioperative handoff content pre/post implementation of a standardized handoff protocol. The Johns Hopkins Perioperative Tool Kit, Johns Hopkins School of Medicine and Healthcare System, was used as a model. A satisfaction survey tool and educational video were utilized with consent from the Johns Hopkins University Health System. The "PACU PAUSE" was branded requiring a pause for monitor-line setup prior to handoff. Participants included anesthesia providers, surgeons, prep room, OR and PACU RN staff. SBAR handoff templates were developed for anesthesia providers and OR nurses as a reference. Participants were educated using multiple formats. A handoff audit was created to track omissions of a "PACU PAUSE" and 17 other critical elements in the perioperative handoff. Handoffs were audited pre/post-intervention (N=51 total). Handoff satisfaction surveys were obtained pre/post-intervention from two groups: Anesthesia Provider/OR nurse and PACU RN staff.

Significance of Findings/Outcomes: The quantitative analysis comparing handoff audits of pre/post-intervention showed a 37% increase (40.16% to 77.36%, $p<0.01$) in critical elements exchanged. Specifically, the utilization of a "PACU PAUSE" rose 50% (42.3% to 92.3%). The qualitative analysis showed slight improvement in anesthesia provider/OR nurse handoff satisfaction (92% to 100%) and a 47% improvement (46.7% to 93.3%) in the PACU nurses' handoff satisfaction.

Implication for perianesthesia nurses and future research: The implementation of the "PACU PAUSE" and standardized perioperative handoff protocol had a significant effect in promoting safety in handoff practices and improved satisfaction of all providers.

The following databases were searched: CINAHL Complete and MEDLINE Complete. We removed eight articles lacking desired patient population (adult) or setting (perioperative), resulting in twelve articles used for the synthesis.

Key words: *patient handoffs, patient handovers, OR patient hand-off, post-anesthesia handover, perioperative handover*