Perioperative Patient Handoff

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Introduction: Handoff is communicating and accepting responsibility for patient care from one caregiver to the next. An inadequate handoff increases the risk of miscommunication and preventable safety events, placing the patient at risk. Stakeholders from within the entity, including nurses from all phases of care, were identified to pinpoint impactful changes that would improve the entity's handoff process and increase patient safety.

Identification of the problem: Pertinent pre-op patient information must be more consistently shared with the OR/Endo circulators. The availability of the Preop RN to give handoff was 25%. The patients' belongings were locked 50% of the time, and staff satisfaction was 25%.

QI question/Purpose of the study: The purpose of the study was to improve perioperative communication and ensuring patient safety by sharing pertinent medical information and including the patient in the conversation.

Methods: The methods used were observations by the stakeholder team for the initial data. The team developed a paper handoff tool and standard work to educate the perioperative staff. The OR/Endo Circulators provided constructive feedback to the stakeholder team to decrease barriers to the improved process. The circulators collected the data during all phases of the improvement project (pre, during, and post-implementation).

Outcomes/Results: A decrease in unproductive staff time awaiting handoff was achieved in addition to improved communication and quality of information shared between the perioperative team. Patient belongings were secure 95% of the time.

Discussion: Through reinforced staff education utilizing standard work, there has been improvement with the handoff. The development of the handoff tool was valuable for the team. The impact of the interdisciplinary team showed a great example of working as one in the facility.

Conclusion: There was a significant improvement, evidenced by data, in the quality of information shared between phases of care, supporting evidence-based practice and the National Patient Safety Goals.

Implications for peri anesthesia nurses and future research: Peri anesthesia nurses can collaborate to implement future workflows with an interdisciplinary team. The handoff work can easily be adapted for positive outcomes in any procedural area. The impact can improve patient care by decreasing communication errors, increasing meaningful interaction with staff

and patients, and improving staff satisfaction, while maintaining crucial components in the perioperative environment such as efficient turnover times.