Perioperative Patient Handoff

Janey Farish, MSN, RN, Tricia Gilmore, RN, BSW, Tracy Kepler, BSN, RN, CGRN, MEDSURG-BC, Beth Magid, BSN, RN, CNOR
Danette Ochoa, BSN, RN, MEDSURG-BC, Megan Shaffer, BSN, RN, MEDSURG-BC
WellSpan Apple Hill Surgical Center, York, Pennsylvania

Background:

The Surgical Center's Perioperative Patient 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. It was identified that increased quality of information and the availability of the pre-op nurse for handoff to the circulator could be improved. Preventable delays, such as patient's belongings not being locked up prior to handoff, could contribute to increased operating and endoscopy room turnover times. The availability of the Preop RN to give handoff occurred 25% of the time. The patients' belongings were locked 50% of the time, and staff satisfaction about the overall handoff process was 25%.

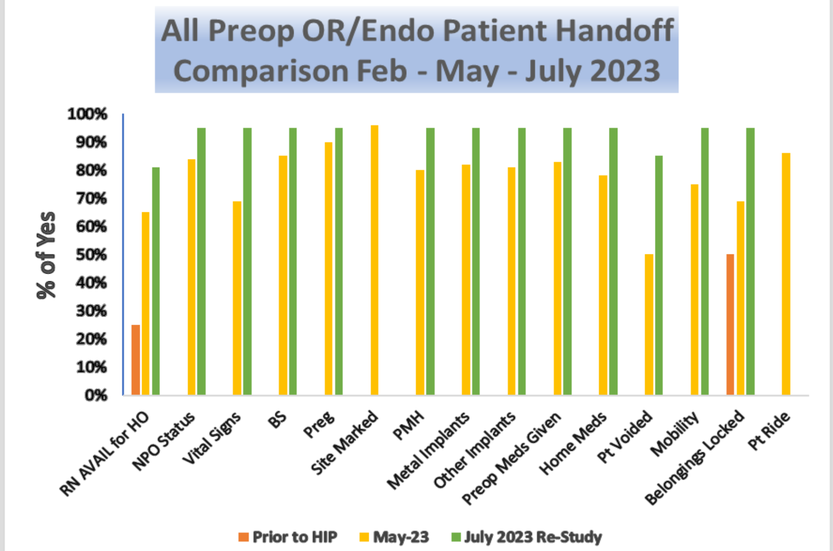
Objective:

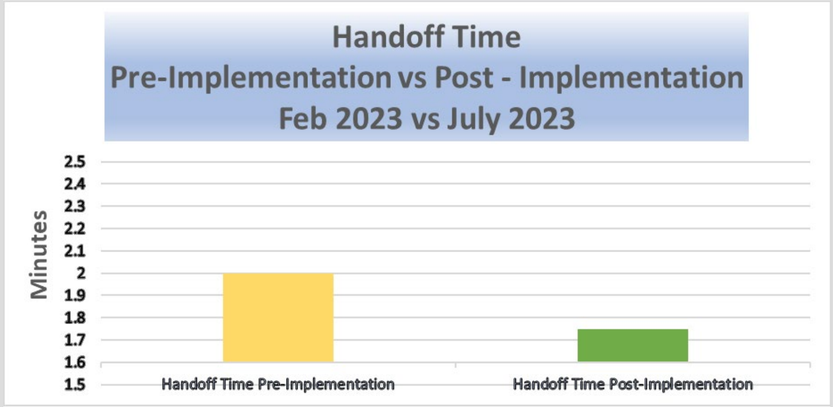
The purpose of the study was to improve perioperative communication and ensuring patient safety by sharing pertinent medical information and including the patient in the conversation reducing the risk of sentinel events.

Process of Implementation:

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. The methods used were observations of handoff processes by the stakeholder team for the initial data. The team developed a paper handoff tool which included pertinent medical information that was relevant to the procedure and all phases of care. A standard work was then created 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 Graphs:





Outcomes:

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. 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. Improvements have continued to be made to the handoff tool based on staff feedback. Patients have reported feedback stating they have appreciated being included in the handoff process. The stakeholder team predicted the handoff would take longer after implementing the counter measures to improve this workflow; however, the time was statistically insignificant.
Recently, the anesthesia team has been participating in the perioperative handoff for the surgical patients. The facility's room turnover for the endoscopy population is quick. The stakeholders are working with the Chief CRNA and have decided to develop a sound process with the surgical handoff before implementing anesthesia's participation with the endoscopy handoffs.

Implication in Perioperative Nursing:

Perianesthesia 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.

References & Tools:

References | Handoff sheets | Standard Work | Contact Info