Improving Handoff in Perioperative Services

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Introduction

Effective communication during handoff in perioperative services **is critical** to ensuring patient safety, improving nurse satisfaction, and maintaining operational efficiency. Despite its importance, a gap analysis at Dell Seton Medical Center revealed inconsistencies in handoff practices, with **information reported as missing and PACU nurses rating the quality, efficiency, and satisfaction of handoff at just 5.97/10.** These findings underscored the **need for a standardized approach** to streamline information exchange and reduce errors.

Gap Analysis

	Best Practice Strategy	How current practice differs from best practice	Barriers to best practice implementation	Implement? Y/N and why or why not?
#1	**Use a checklist/tool during handoff**	Currently there is **no standard, expectations, or tool/checklist during handoff**. Each provider gives and receives report in their own way. There is some consistency that it taught, however the consistency does not always exist.	-**Complex patient** populations -Difficult to obtain buy in from users related to **added workload** -**Difficulty landing on one tool/checklist** that supports the various needs of the users	Yes it will improve communication, decrease errors, improve safety, increase satisfaction
#2	**PACU Pause** - This describes a time when on arrival to PACU the care team secures monitors, lines, oxygen, and performs a quick operative site focused assessment before proceeding with report.	Our **current practice is dependent** on the CRNA and OR nurse. Some allow time for these things and ask if the pacu nurse is ready once everything is set up. Others on arrival sometimes start report immediately on arrival to pacu.	-Gaining buy in from **OR/Anesthesia team who are held accountable for room turnovers** -Encouraging the pacu nurse to use this method and remind others to wait until these things are completed.	Yes it will improve communication and satisfaction

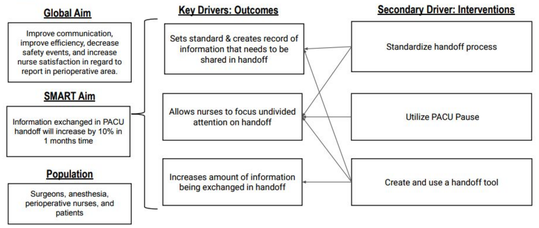
Abstract Flyer

Bibliography

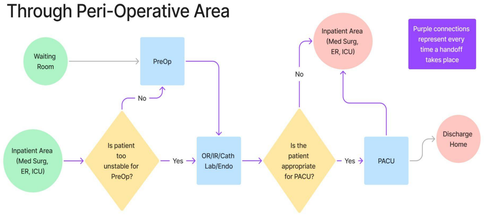
Purpose

How does the use of a **standardized perioperative handoff tool and process**, compared to standard practice, affect PACU nurses' ratings towards handoff satisfaction, quality, and efficiency?

Key Driver Diagram (KDD)



Process Map of Patient Handoffs Through Peri-Operative Area



Methods

Study Intervention (Study Title)	Outcome (Citation)
Use of **Handoff Checklist** (Improving PACU Handoff by Implementing a Succinct Checklist)	20% more information was exchanged in handoff (Potestio et al., 2015)
Use of **Handoff Checklist** (Implementing a Standardized Handoff Checklist)	Decreased errors, increased efficiency, improved patient safety, and improved quality of handoff (Harris, 2022)
Use of **PACU Pause** (Navigating the Path to a Sustainable PACU Pause)	Increased nurse satisfaction and improved amount of information exchanged (Cain et al., 2022)
Use of **Handoff Tool** (Improving the Quality and Consistency of OR to PACU Handoff)	Improved handoff (ASPAN, 2023)

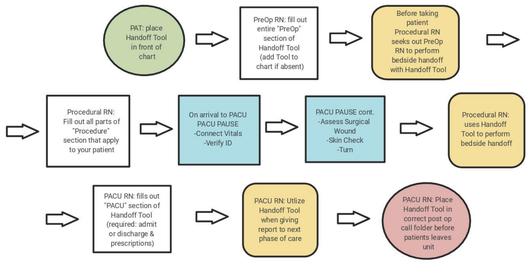
Implementation Planning: Phase 1

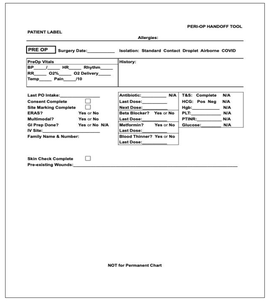
Steps of Intervention	Details
1. Obtain Leadership Approval	Leadership approval obtained from the highest level due to increased safety events related to communication during handoff
2. Identify Stakeholders	Stakeholders: PAT, Pre Op, OR, Endo, IR, Cath Lab, PACU, Anesthesia
3. Obtain data for baseline metrics	Determine baseline KPIs & obtain survey data from nurses
4. Creation of Handoff Tool & Standardized Handoff Process	Create Handoff Tool & standardized process (including PACU Pause) based on research, tools being used in our network, and with emphasis on input from stakeholders
5. Educate stakeholders on Handoff Tool & Standardized Process	Individual education, email, huddles, & meetings
6. Phase 1 Go Live Date: 5/13	Phase 1 - Educate stakeholders on Handoff Tool and standardized process Phase 2 - Implement Handoff Tool and standardized process

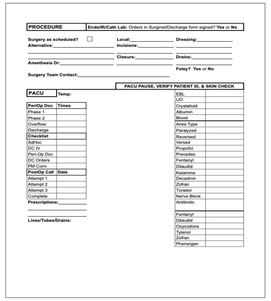
Transition from Implementation Planning to Implementation Execution:

1. **Accelerated implementation:** The original plan involved a two-phase approach, but a decision was made to roll out both Phase 1 and 2 simultaneously.
2. **Limited education:** Due to the change in the implementation plan, minimal education had occurred prior to the go-live date, which was originally scheduled for more extensive training.
3. **Adaptation of timeline:** The timeline and approach were quickly adjusted in response to the change in the implementation plan.
4. **Continued education challenges:** After the go-live, there was a need to educate staff that the new tool and process were not just for the short term, but a permanent change.
5. **Feedback collection:** The change in the implementation plan allowed for gathering valuable feedback earlier than planned, which was used to adapt the tool and process accordingly.

HANDOFF TOOL PROCESS





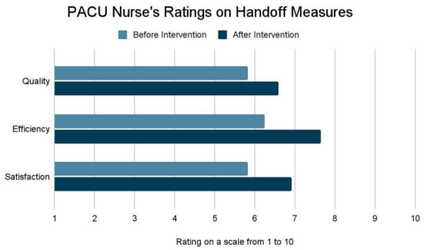


Handoff Tool

Results

The **key performance indicator assessed the proper completion of the Handoff Tool** in each area, though direct auditing of tool usage during handoffs was not feasible. While the pre-implementation goal was 90% adoption, **post-implementation data showed an average adoption rate of 66% across PreOp, OR, and Endo departments.** PACU nurses reported improved handoff experiences, with **satisfaction, quality, and efficiency ratings increasing from 5.97/10 to 7.05/10. However, opportunities to provide additional information were still identified.** The **swift implementation limited the time available for comprehensive education, contributing to lower-than-expected adoption rates.** Additionally, the inherent challenges in directly measuring communication effectiveness led to a reliance on survey data rather than direct outcome measures, potentially impacting the accuracy of results.

Impact Evaluation: Survey #1 Results



Impact Evaluation: Survey #2 Results

Comparing survey data from before and after the intervention reveals a **2.83% increase in the exchange of information**.

Conclusion & Recommendations

Conclusions:

- Clear **evidence supports that standardized tools and processes can improve communication** during handoff in perioperative settings.
- The project **laid a foundation for standardized handoff practices** and initiated important conversations about improving communication.

Recommendations:

- **Encourage departments to evaluate current handoff practices and consider implementing standardized tools or checklists.**
- Utilize a **multi-phased approach** with emphasis on early user input and feedback.
- **Recruit departmental "champions"** to assist in education and adoption efforts.
- **Adapt interventions based on user feedback to address barriers and improve processes.**
- **Optimize timing** for process changes by aligning with other initiatives.
- Continue work to ensure adoption, sustainability, and further explore the impact on patient care outcomes.

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