Standardizing OR-to-PACU Handoffs:
Implementing the PACU Pause Cognitive Aid

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Introduction: Communication failures remain a leading contributor to preventable patient harm and staff burnout, particularly during care transitions. In perioperative settings, incomplete or inconsistent handoffs between the Operating Room (OR) and the Post Anesthesia Care Unit (PACU) jeopardize patient safety, staff efficiency, and institutional trust.

Identification of the Problem: At our tertiary academic center, internal safety data revealed that communication failures accounted for 20% of PACU adverse events. Staff surveys and safety reports further highlighted handoffs as a high-risk area for miscommunication, with 55% of perioperative providers identifying OR-to-PACU transitions as problematic.

EPB Question/Purpose: PICO Question: In perioperative teams (P), does the implementation of a standardized cognitive aid for OR-to-PACU handoffs (I), compared to current non-standardized practices (C), improve completeness of communication and reduce adverse events (O)?
Databases searched included PubMed, CINAHL, and Cochrane Library.

Methods/Evidence: A multidisciplinary team from surgery, anesthesia, and nursing developed PACU Pause, a cognitive aid for unified handoffs, using I-PASS principles, literature, and baseline audits. Following simulation testing, stakeholder feedback, and in-situ pilots, it launched on East and West Campuses in 2025. PACU Pause champions provided on-unit support, reinforced consistent use, and maintained engagement through ongoing communication.

Significance of Findings/Outcomes: Post-intervention, handoff completeness improved from 36.6% to 83.2% without extending average duration (4:37 pre vs. 4:11 post). Staff reported better collaboration, fewer follow-up calls, and improved morale. Ninety percent of providers agreed, the tool enhanced handoff quality. Ongoing monitoring of safety outcomes continues.

Challenges included perceived time constraints and resistance to change, especially among surgeons preferring to give their report first and leave. The tool was revised to support the preferred workflow while insisting all team members stay at the bedside. Some nurses hesitated to enforce use when physicians opted out; leadership reinforced expectations through talking points, observation, and staff empowerment to ensure consistency.

Implications for perianesthesia nurses and future research: The PACU Pause enhanced interdisciplinary communication and improved staff confidence in patient safety during transitions. For perianesthesia nurses, this intervention provides a structured framework

that strengthens their role as advocates for safe, thorough handoffs. Next steps are integration into staff onboarding, and exploration of broader applications in ICU and Labor & Delivery settings.