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.

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.

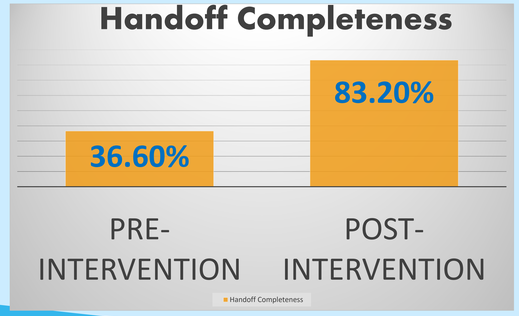
Methods & Evidence

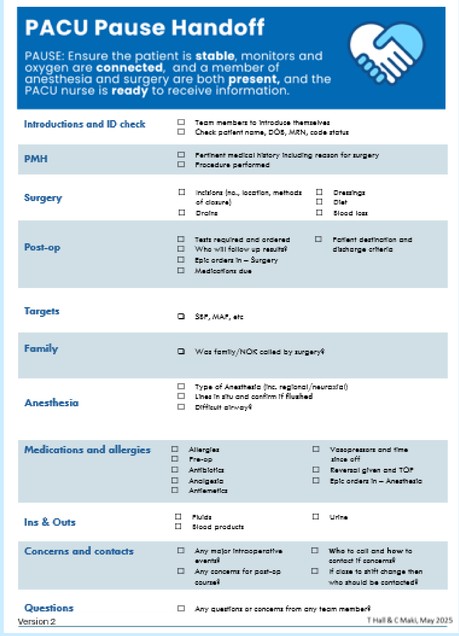
A multidisciplinary team from surgery, anesthesia, and nursing developed PACU Pause, a cognitive aid for unified handoffs, using I-PASS principles, literature, and baseline audits. Following simulation testing, stakeholder feedback, and in-situ pilots, it launched on East and West Campuses in 2025. PACU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

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.

Communication failures accounted for **20%** of adverse PACU events!





PACU Pause Handoff

PAUSE: Ensure the patient is **stable**, monitors and oxygen are **connected**, and a member of anesthesia and surgery are both **present**, and the PACU nurse is **ready** to receive information.

Introductions and ID check	☐ Team members to introduce themselves ☐ Check patient name, DOB, MRN, code status	
PMH	☐ Pertinent medical history including reason for surgery ☐ Procedure performed	
Surgery	☐ Incisions (no., location, methods of closure) ☐ Drains	☐ Dressings ☐ Diet ☐ Blood loss
Post-op	☐ Tests required and ordered ☐ Who will follow up results? ☐ Epic orders in – Surgery ☐ Medications due	☐ Patient destination and discharge criteria
Targets	☐ SBP, MAP, etc	
Family	☐ Was family/NOK called by surgery?	
Anesthesia	☐ Type of Anesthetic (inc. regional/neuraxial) ☐ Lines in situ and confirm if flushed ☐ Difficult airway?	
Medications and allergies	☐ Allergies ☐ Pre-op ☐ Antibiotics ☐ Analgesia ☐ Antiemetics	☐ Vasopressors and time since off ☐ Reversal given and TOF ☐ Epic orders in – Anesthetic
Ins & Outs	☐ Fluids ☐ Blood products	☐ Urine
Concerns and contacts	☐ Any major intraoperative events? ☐ Any concerns for post-op course?	☐ Who to call and how to contact if concerns? ☐ If close to shift change then who should be contacted?
Questions	☐ Any questions or concerns from any team member?	

Version 2 — T Hall & C Maki, May 2025

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.
- 90% 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 Nursing 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.

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