# Creation of A Hand Off Tool Between The Preprocedural Area and OR Team

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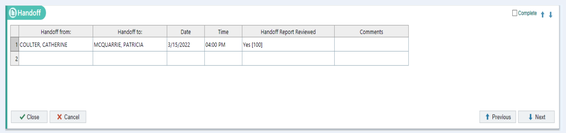
## INTRODUCTION

- The Joint Commission and the Agency for Healthcare Research and Quality's hospital survey on patient safety culture have cited care transitions as an area of concern.
- Miscommunication, care continuity disruption, critical data omission, medication errors, and serious adverse outcomes during handoffs create a vulnerable gap in care.
- Ineffective communication is one of the root causes of sentinel events reported to The Joint Commission.
- Handoff checklists are tools that assure continuity of care and promote safety between nurses and/or nursing teams.

## IDENTIFICATION OF THE PROBLEM

- A gap exists in the handoff process between the preprocedural RN and the OR team.
- Key information was communicated verbally between the preprocedural RN and OR team.

### Current Handoff in Epic



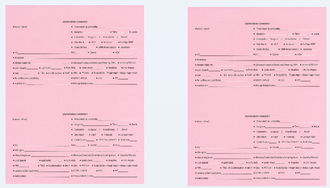

## PURPOSE OF THE STUDY

- To ensure that all relevant documents and related information or equipment are available and verified.
- Addresses the inconsistency in handoff between procedural RN and OR teams.
- Creation of a standardized communication tool reduces the risk throughout the patient's surgical process.
- To improve the process of the handoffs conducted at the bedside and encourage the patient and family to participate in the report of health information.

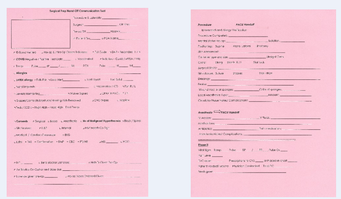
## METHODS

- To create a tool which aligns with The Joint Commission Patient Safety Goals UP..01.01.01 for every patient entering the OR is subject to this process change.

### Original Handoff Forms
**(2 Sperate Forms)**



### New Handoff Form
**(1 Form-Front & Back)**



## OUTCOMES/RESULTS

1) Implementing a preprocedural process to verify the correct procedure, for the correct patient, at the correct site. Include patient, family, or guardian in the verification process.

2) Identify the items that must be available for the surgery and use a standardized method to verify their availability. At a minimum, these include the following: (a) Relevant documentation (for example, history and physical, signed surgical consent form, nursing assessment, and preanesthetic assessment). (b) Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed. (c) Any required blood products, implants, devices and/or special equipment for the procedure.

3) The OR nurse is to confirm the OR room is ready for procedure patient is having done. Preventable omissions among surgical patients may lead to a range of surgical errors which are avoidable when using evidence-based guidelines, included in our handoff checklist.

### Handoff Sign Posted in Each Pre-Op Bay


## DISCUSSION

- Improved and safer outcomes
- Creating a closed loop narrative ensures questions are asked and answered.

## CONCLUSION

- The communication tool has improved the process and reduced errors related to the handoff activity.

## IMPLICATIONS for PERI-ANESTHESIA NURSES and FUTURE RESEARCH

- As a multi-building health system, it is important to work towards standardizing practices and policies ensuring consistency in patient care.
- Additional items were added to encompass the entire OR process, including handoff to PACU phase 1 and phase 2.
- To have the IT team build into the electronic medical record (EPIC) a procedural handoff/boarding pass to encompass components listed on the handoff form, creating a permanent record.

## REFERENCES

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