Creation of a Handoff Tool Between the Preprocedural Area and OR Team

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Introduction: 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 patient safety, while allowing for questions to be asked and answered. These handoff checklists ensure proper communication and acceptance of responsibility for patient care between nurses or nursing teams.

Identification of the problem: The team identified a gap in communication between the preprocedural RN and the OR team. Previously, key information either verbally or through the use the EMR was the only form of communication. Ineffective handoff communication is a primary factor leading to errors.

QI question/Purpose of the study: The purpose of the project addresses the inconsistency in handoff between procedural RN and OR teams. The creation of a standardized communication tool reduces the risk throughout the patient's surgical process.

Methods: The team created and implemented a standardized checklist, to address the inconsistency in handoff. The new communication tool aligns with the elements corresponding with The Joint Commission Patient Safety Goals. Every patient entering the OR is subject to this process change.

Outcomes/Results: After implementation of the handoff checklist, items necessary for surgery and verification process are available prior to entering the OR. Use of evidence-based guidelines, included in our handoff checklist decreases preventable omissions and errors. Implementation of this handoff tool allows for greater interdepartmental communication.

Discussion: When our handoff tool is used consistently, communication is improved and safer outcomes are evident. The handoff tool is used throughout the entire surgical event, creating a closed loop narrative.

Conclusion: This communication tool has improved the process and reduced errors related to the handoff activity. Thereby, verifying the required elements and promoting patient safety.

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. Since the inception of the checklist, additional items were added to encompass the entire OR process, including handoff to PACU phase 1 and phase 2. ASPAN and AORN best practice recommended guidelines have been implemented in the version of the updated communication tool with focus on patient safety.