

## Standardized Handoff Tool for OR/PACU Nurses

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# Standardized Hand-Off Tool for PACU/OR Nurses

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# Background/Significance

- **Effective hand-off communication between OR nurses and PACU nurses is associated with increased patient safety, increased PACU nurse satisfaction, and increased trust among the healthcare team.**
- **Our personal clinical experiences and literature on the topic reveal that hand-off communication in the OR is far from standardized. This has the potential to cause our patients harm, from the omission of critical details.**

# PICO QUESTION

- **For OR and PACU RNs, will a standardized PACU hand-off tool compared to a non standardized hand-off tool, increase PACU RN satisfaction and reduce number of errors?**
- **P: OR/PACU RNs and surgical patients**
- **I: Standardized perioperative hand-off tool**
- **C: Non standardized hand-off tool**
- **O: Reduced number of errors and increase PACU RN satisfaction**

# TRIGGER?

- **Knowledge vs. Problem**
  - **This evidenced based project was triggered by identification of a clinical problem.**
  - **The evidence has shown that standardized hand-off tools between registered nurses greatly improves patient outcomes.**
  - **Although many nursing units within the network have adopted a standardized hand-off report, the operating room has struggled to incorporate one into their practice.**

# EVIDENCE

- **EBSCO host, Medline, CINAHL, and The AORN Journal were searched using the following key words**
  - Hand-off tools
  - Handover to PACU
  - Postoperative Handover
  - Communication in the OR
  - Standardized report

# EVIDENCE

- **Pre-procedural and post operative hand-over phases have the maximum number of information transfer and communication failures.**
- **SBAR improves teams communication and collaboration, and helps build trust between multi-disciplinary team members.**
- **Many of the information transfer and communication failures at the postoperative phases are due to incomplete hand-off.**
- **Standardized hand-off minimizes risk injuries and errors.**

# EVIDENCE

- **Communication failures have been uncovered as the root cause of over 60% of sentinel events reported to the Joint Commission.**
- **Healthcare professionals agreed that postoperative handover should be structured in the form of a standardized protocol so as to prevent omissions of any critical information.**
- **In some cases there was no verbal hand-off between RN to PACU nurses.**
- **Healthcare organizations with a strong hand-off communication process in place have reported an increase in patient, family member, and staff member satisfaction, and better patient flow through the hospital experience.**



# BASELINE DATA

- **37% of PACU RNs are not satisfied with hand-off communication**
- **74% PACU RNs feel rushed during OR-RN hand-off**
- **52% PACU RNs feel hand-off report is not detailed enough to provide safe patient care**
- **89% PACU RNs believe optimal report is done when one person gives report at a time**
- **63% PACU RNs believe hand-off report is not consistent from members of the OR team**
- **48% PACU RNs agree that important details were missed during hand-off communication**

# Current Practice at LVHN

- **Currently, at Lehigh Valley Health Network, there is no standardized report from OR RN to PACU RN.**
- **Each nurse gives report differently, some with sufficient details, and others with just the patient's name.**
- **In the past, the educators have tried making a small card for nurses to put on their I.D. badge with what needs to be addressed in report. This method had a low compliance rate.**

# IMPLEMENTATION

- **Pre and post survey for PACU RNs**
- **From the Pre-survey we collected our baseline data**
- **From those surveys and the evidence we found we put together an ISBAR**
- **We educated the PACUs and OR RNs**
- **We implemented the ISBAR sheets**
- **Post survey was initiated to PACU RNS**
- **Our results were collected**

# Practice Change

- **We hope to implement a standardized PACU report, network wide.**

# RESULTS

- **The results of our pre and post surveys of PACU RNs stayed the same. There was neither improvement nor worsening in post operative report.**
- **PACU RNs still feel that important details from reports are missed, report from the OR RN is not consistent, report is not detailed enough from the OR RN, and report is being rushed.**

# Where Do We Go From Here?

- **We need to target colleagues whose practice is underserved and reeducate them on the importance of hand off report.**
- **It would be beneficial to incorporate the work sheet that PACU already uses, to record data from anesthesia, with our ISBAR sheet and have everything condensed to one sheet.**
- **Incorporating anesthesia and educating them on ISBAR will also be helpful.**

# Implications for LVHN

- **Increase nurse satisfaction.**
- **Increase patient safety.**
- **Better communication between team members and therefore increased trust among the team and increased satisfaction.**

# Strategic Dissemination of Results

## ■ **PLAN for DISSEMINATION**

- **Share evidence about standardized report sheets with OR and PACU nurses and staff, network wide.**
- **Share evidence about how a standardized report sheet will improve RN satisfaction.**
- **Share results/ findings of the ISBAR sheet from our trial study.**
- **Distribute ISBAR worksheets throughout the network's operating rooms.**
- **Plan to make standardized PACU report a standard of care at Lehigh Valley Health Network.**



# Lessons Learned

- **Experienced nurses can be resistant to change in practice.**
- **Presenting supporting evidence to nurses can reduce resistance in changing practice.**
- **Making an ISBAR work sheet on colorful, attention grabbing paper, encourages nurse participation.**
- **Working with anesthesia, not just PACU and OR RN's, could help incorporate one, continuous, flowing report.**
- **Compliance may be higher if the sheet is implemented at a site where there is adequate staffing and less work stress.**
- **More time is needed to properly implement and analyze a standardized report sheet.**

# References

- **Amatovealey, E., Barba, M., & Vealey, R. (2008). Hand-Off Communication: A Requisite For Perioperative Patient Safety. AORN, 88(5), 763-774.**
- **Anwari, J. (2002). Quality of Handover to the PostAnesthesia Care Unit Nurse. Anesthesia Forum, 57, 488-493.**
- **Arora, V., & Johnson, J. (2006). A Model for Building a Standardized Hand-off Protocol. Joint Commission Journal on Quality and Patient Safety, 32(11), 646-655.**
- **Mitchell, E. N. (2013). Improving communication and building trust. AORN Journal, 98(3), 218-219.**
- **Nagpal, K., Vats, A., Ahmed, K., Smith, A. B., Sevdalis, N., Jonannsson, H., et al. (2010). A Systematic Quantitative Assessment of Risks Associated With Poor Communication in Surgical Care. Archives of Surgery, 145(6), 582-588.**
- **Nagpal, K., Vats, A., Ahmed, K., Vincent, C., & Moorthy, K. (2010). An Evaluation of Information Transfer Through the Continuum of Surgical Care. annals of surgery, 252(2), 402-407.**
- **Nagpal, K., Arora, S., Abboudi, M., Vats, A., Wong, H. W., Manchanda, C., et al. (2010). Postoperative Handover: Problems, Pitfalls, and Prevention of Error. annals of surgery, 252, 171-176.**
- **Smith, A., Pope, C., Goodwin, D., & Mort, M. (2008). Interprofessional Handover and Patient Safety in Anaesthesia: Observational Study of Handovers in the Recovery Room. British Journal of Anaesthesia, 101(3), 332-337.**
- **Wheeler, K. K. (2014). Effective handoff communication. OR Nurse, 8(1), 22-26.**

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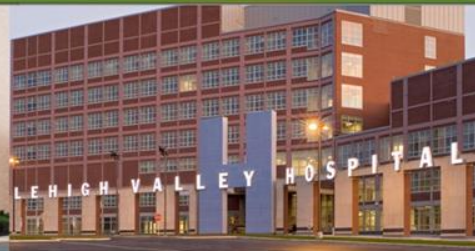
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