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Standardized OR to PACU Handover Communication

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Background/Problem

- Currently, there is no standardized format for handover communication for a patient transitioning from the OR to the PACU, resulting in variation of practice
- This can result in patient safety issues as patient information can be omitted related to lack of standardized practice
- Joint Commission reports 60% of sentinel events occur due to communication errors with half of those occurring at point of handover (Caruso, et al., 2015)

PICOT

P = patients transitioning from OR to PACU
I = standardized handover communication
C = informal handover/ lack of standardization
O – promote patient safety by reducing omitted patient information

Practice Question

Does standardization of patient handover communication compared to informal communication when transitioning from the OR to the PACU promote patient safety by reducing omitted patient information?

Evidence Summary: Strength and Quality of Evidence

Level I (1 Quality A article)

- RCT (Salzwedel, et al., 2013) supports use of standardized handover tool to decrease omission of patient information report from anesthesiologist to PACU RN with overall information transmitted increased to 48.7% from 32.4% (p <.001)

Level II (3 Quality A and 4 Quality B articles)

- Collection of quasi-experimental and prospective cohort studies demonstrate use of standardized format for handover communication increased the amount of patient information communication based on developed checklists used for evaluation of quantity of patient information communication (Park, et al., 2017; Potestio, et al., 2015; Nagpal, et al., 2013; Petrovic, et al., 2015; Petrovic, et al., 2012; Caruso, et al., 2015)
- Meta-analysis reviewed nearly 100,000 pre and post intervention data points for handover communication standardization intervention, finding improved patient, provider and organizational outcomes by decreasing omitted patient information and preventing adverse events (Keebler, et al., 2016)

Level III (2 Quality A articles)

- Observational study found no consistent handover report format, thus variation in practice and omission of patient data that was deemed important such as EBL (Siddiqui, et al., 2012)
- Prospective analysis observed >700 handovers to review quality, utilizing a checklist to evaluate and found handovers were unstructured and highly variable. Example – EBL only communicated 35% of the time (Milby, et al., 2014)

Level V

- 6 Quality A quality improvement projects
- 2 Quality A systematic review of literature/integrative review articles

Recommendations for Change Based on Evidence Synthesis

Based on the extensive evidence review and synthesis, it is consistent that a standardized handover communication format reduces the amount of patient information omitted during patient transition from the OR to the PACU. Standardized handover should include anesthesia providers, OR RNs and PACU RNs with some studies including surgeons and surgical residents. This will reduce variation in practice and preventable adverse events.

Translation of Evidence into Practice

- Review recommendations of evidence with perioperative stakeholders
- Develop standardized handover format with perioperative stakeholders
- Educate perioperative staff regarding standardized handover communication format
- Implement standardized handover communication format to decrease variation in practice

Evaluation of Practice Change/Outcomes

- Observer to utilize developed standardized checklist to evaluate information transmitted during handover by OR RNs and anesthesia providers to PACU RNs pre-intervention and post-intervention
- Assess barriers to standardized handover communication
- Discuss barriers and needed improvements with stakeholders upon evaluation results

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Database Search Strategy

CINAHL
EbscoHost
PubMED
Ancestry method from relevant articles
Google Scholar

Keywords

Operating room (OR), Post anesthesia care unit (PACU), handovers, handoffs, communication, data transfer, perioperative, patient safety, standardized, checklist, omission errors

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