

# Promoting Patient Safety With Perioperative Hand-off Communication

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*Effective perioperative hand-off communication is essential for patient safety. The purpose of this quality improvement project was to demonstrate how a structured hand-off tool and standardized process could increase effective perioperative communication of essential elements of care and assist in the timely recognition of patients at risk for clinical deterioration in the initial postoperative period. A team-based pilot project used the Iowa Model of Evidence-Based Practice and the principles of Lean Six Sigma to implement Perioperative PEARLS, a perioperative specific hand-off communication tool and a standardized framework for hand-off communication. The implementation of a structured hand-off tool and standardized process supports compliance with regulatory standards of care and eliminates waste from the hand-off process. A review of pre-implementation and post-implementation data revealed evidence of safer patient care. Evidence-based perioperative hand-off communication facilitates expedited patient evaluation, rapid interventions, reduction in adverse events, and a safer perioperative environment.*

**Keywords:** *hand-off communication, perioperative, evidence-based practice, patient safety, Lean Six Sigma.*

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**EFFECTIVE COMMUNICATION OF INFORMATION** between health care providers is a fundamental principle of patient care. Efficient nursing communication is the foundation that ensures safe patient care during times of transition. Lack of complete, accurate communication between the caregiver and the receiver of patient information at points of transition is a major issue affecting the quality and safety of patient care in the current health care system. The focus of this quality improvement project was to promote best hand-off practice for perioperative nurses.

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## Background and Significance

The process of hand-off communication has three objectives: transferring of the responsibility of care, establishing an audit or end point in care between providers, and conveying knowledge to facilitate continuation of patient care.<sup>1</sup> Communication failures are a leading cause of preventable adverse events that a hospitalized patient experiences in the modern American health care system.<sup>2</sup> Each transition of care when patient information is communicated from one provider to the next is a high-risk period for communication breakdown where information can be lost and/or misinterpreted.

In the postanesthesia care unit (PACU), frequent, brief, and complex handoffs occur. Handoffs are typically succinct and informal, without written documentation of the content. Handoffs involve clinical tasks, the transfer of information, and responsibility for patient care. Owing to the clinical

instability of the postoperative patient, the PACU nurse simultaneously performs patient care tasks with information transfer from the operating room (OR) and anesthesia staff. The combination of nursing care tasks with information transfer makes communication of intraoperative information susceptible to loss and error. Effective communication is adversely impacted by distractions and interruptions. Given the complexity of surgery, it is critical that adequate patient information is communicated during transitions of care.

Effective and standardized communication between care providers at perioperative handoff points helps to facilitate patient safety, anticipate, and limit complications. Ineffective handoffs can contribute to gaps in patient care and failures in patient safety. National and state accreditation and regulatory entities have recognized the significance of hand-off communication.

The purpose of this quality improvement project was to demonstrate how a structured hand-off tool and standardized process can increase effective perioperative communication of essential elements of care and assist in the timely recognition of patients at risk for clinical deterioration in the initial postoperative period (phase one). This project supports compliance with established regulatory standards for hand-off communication and eliminates waste from the hand-off process.

### **Evidence Used for the Practice Change**

There is no universal approach to hand-off communication. A handoff in care occurs when accountability and responsibility for a patient are transferred from one health care provider to another.<sup>3</sup> The primary function of the handoff is to communicate essential patient data to provide safe, contiguous care. The health care providers assuming care of the patient require up-to-date patient information to make informed decisions and provide seamless care.

An analysis of sentinel events by The Joint Commission identified communication as the top contributing factor to medical error, with handoff playing a distinct role in an estimated 80% of serious preventable adverse events.<sup>4</sup> National Patient Safety Goal 2E, initiated in 2009, is now Element of Performance 2 for Standard

PC.02.02.01. ("The hospital coordinates the patients' care, treatment, and services based on the patients' needs.")<sup>5</sup> The safety standard for hand-off communication requires communication that is timely, accurate, completely unambiguous, and understood by the recipient. The redesign of the perioperative hand-off processes in this project met The Joint Commission standard and promotes safe patient care.<sup>5</sup>

### **Critical Appraisal of the Evidence**

The current format of postoperative handovers in the PACU did not meet the primary purpose of a handoff, which is the accurate transfer of information about a patient's state and care plan to ensure the safety and continuity of patient care.<sup>6</sup> The literature has described perioperative handoff using terms such as brief, inconsistent, unstructured, incomplete information transfer, and informal. Disparity exists with the expectations of the Joint Commission that handoffs follow the structured formal approach of communication that is seen in highly reliable industries such as the airline and nuclear power industry.<sup>7</sup>

The lack of a standardized perioperative hand-off process creates the potential for error. The PACU environment is filled with distraction, concurrent activities and interruptions that influence the attention of nurses during handoff. Different members of the PACU are involved transiently in the care of the patient, so the primary care nurse is not clearly identifiable.<sup>1</sup> In the perioperative setting, a premium is placed on efficiency. There are strict schedules that must be kept despite constant interruptions from emergencies, add-ons, delays, and complications. Time becomes a barrier to communication. Rushing the handoff can lead to small, yet critical mistakes that can ultimately harm patients.<sup>8</sup> When insufficient time is allotted for handoffs, time constraints lead to omission of pertinent patient details.<sup>9</sup>

The current recommendation is a guided, structured communication process for patient hand-off communication. Several standardized frameworks for generic hand-off communication are available. The SBAR (situation, background, assessment, and recommendation) communication tool is one of the most well established. The SBAR tool provides a focus to the hand-off

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