

Structured Handover in the Pediatric Postanesthesia Care Unit

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Purpose: To establish a structured handover in the pediatric postanesthesia care unit.

Design: An observational prequality and postquality improvement design was used.

Methods: Convenience samples of 52 preimplementation and 51 postimplementation handover interactions ($N = 103$) were observed and compared to a 42-item Introductions, Situation, Background, Assessment, Recommendations, & Questions checklist. Patient care team members' satisfaction was assessed using voluntary electronic surveys. Data were analyzed for descriptive measures and differences in the pre- and postchecklist, and satisfaction total scores were compared using a two-sample t test.

Finding: The implementation of the handover checklist resulted in a statistically significant increase in the percentage of items discussed during five of six handover phases ($P < .001$). Overall, a significant increase in provider satisfaction was demonstrated from preimplementation to postimplementation ($P < .01$). The average duration of handover (in minutes) was not significantly different from pre (mean = 5.80 ± 3.80) to post (mean = 6.80 ± 2.30), $P = .15$.

Conclusions: A structured handover checklist is associated with increased communication of handover content information and improved provider satisfaction. No statistically significant effect on handover duration time was found.

Keywords: handover, PACU, pediatric, SBAR, communication, ISBARQ.

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PATIENT HANDOVERS DESCRIBE the transfer of care from one person or team to another. The term handover is also synonymous with handoff or transfer of care. Ineffective handover communi-

cation among health care providers is recognized as a critical patient safety issue. When there is a breakdown in communication during patient handover, adverse events, increased costs, as well as patient and employee dissatisfaction occur.¹⁻³

An estimated 80% of serious medical errors involve miscommunication between caregivers when patients are transferred or handed over.¹ In 2006, the Joint Commission's National Patient Safety Goal 2 focused on implementation of a standardized approach to handoff communications as a primary patient safety goal. The goal recommends specific processes to improve handover communication, including development of protocols to structure clinical activities and offering an opportunity to ask questions.⁴

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The Duke University Medical Center (DUMC) pediatric postanesthesia care unit (PACU) was challenged with providing structured handover communication for patients recovering from anesthesia. Handovers contained inconsistent or missing information and varying degrees of clinician participation. Problems that occurred both nationally and at DUMC during handovers included (1) the absence of an explicit surgery team report, (2) information omission leading to increased risk for medical errors, (3) diminished staff satisfaction, (4) delays in operating room (OR) turnover time, and (5) delays in patient care.⁵⁻⁹

Evidence supported the involvement of all core patient care team members in the handover process. In the DUMC pediatric PACU, core patient care team members included a surgery patient care team member directly involved in the surgery or procedure performed (eg, attending, fellow, resident, nurse practitioner, physician assistant, or registered nurse), an anesthesia patient care team member (eg, attending, fellow, resident, certified registered nurse anesthetist [CRNA], or student nurse anesthetist), and the PACU RN. Evidence also supported following a standardized approach to the handover process, such as the framework designated by the acronym SBAR (Situation, Background, Assessment, Recommendations).¹⁰⁻¹² This quality improvement project implemented the use of a modified SBAR communication framework to facilitate the exchange of patient information between core patient care team members on the patient's arrival to the PACU. The modified SBAR framework added an *Introductions* and a *Questions* section: Introductions, Situation, Background, Assessment, Recommendations, and Questions (ISBARQ). Introductions are not part of the original SBAR framework but were included to ensure identification of each core patient care team member participating in the handover process.¹³ One of the specific communication issues in academic medical centers is the varying time frames for pediatric resident specialty rotations. Because rotations change frequently, a means for identification of new core patient care team members was seen as essential to effective handover communication. In addition, a specific pause at the conclusion of the handover report for an opportunity to

ask questions was included in the framework based on feedback from patient care team members at this institution, evidence in the literature, and the Joint Commission Patient Safety Goal recommendation.^{3,4,13}

Purpose and Aims

The purpose of this project was to identify, describe, and implement a structured handover process at the bedside between anesthesia providers, surgical providers, and pediatric PACU RNs on the patient's arrival to the PACU in a tertiary medical center. This quality improvement project aimed to evaluate the following outcomes related to a structured handover: (1) participation of each patient care team member during handover, (2) compliance with the modified SBAR (ISBARQ) format and subsequent exchange of specific content noted on the handover checklist, (3) patient care team member satisfaction with the handover process and the ISBARQ handover checklist, and (4) the average duration of handover measured in minutes.

Methods

Study Design

The project was structured as a pre- and postimplementation design to evaluate the impact and fidelity of a structured handover process using the ISBARQ communication checklist. The quality improvement project was submitted and approved by the Duke University Institutional Review Board.

Setting

By focusing on the pediatric population, this quality improvement project expands current organizational efforts to improve patient care team member handover communication related to all DUMC postanesthesia patients.^{2,3,14-16} The pediatric PACU is an eight-bed unit located within DUMC, which is a full-service tertiary care hospital licensed for 924 acute care beds.¹⁷ Each year, more than 7,000 postanesthesia patients, ranging in age from infancy up to 18 years, are admitted to the pediatric PACU where they receive postanesthesia care and treatment before being discharged to either home or an inpatient care unit.¹⁸

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