

members of this multi-disciplinary team is necessary to ensure every surgical patient at the Main Campus of the Cleveland Clinic is provided with individualized, safe, and high quality care.

STANDARDIZING HANDOFF FROM OR TO PACU



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Background Information: According to the Joint Commission, two-thirds of sentinel events occur from communication errors during patient handoff. Studies show that handoffs in the Post Anesthesia Care Unit (PACU) are prone to communication errors that correlate to suboptimal patient care. A pre-survey completed on PACU Registered Nurses (RNs) perceptions on the Operating Room (OR)-PACU handoff revealed multiple distractions during the process.

Objectives of Project: Does implementation of a standardized OR-PACU handoff improve efficiency and decrease RN's perception of being rushed through the handoff process?

Process of Implementation: A video on the standardized handoff process was made with the collaboration of PACU/OR RNs and the anesthesiologists. The video was shared with the nurses from PACU, OR and the anesthesiologists. After staff viewed the "handoff video", to help reinforce the new process, a reminder sign was posted on each PACU bay. From May to December 2017, staff was observed applying this new process. Deviations from the new process were corrected immediately. A post-survey was completed in January 2017, and the results were analyzed.

Statement of Successful Practice: 68% of PACU RNs agreed on receiving a complete report from the anesthesiologist, while 95% agreed on receiving a complete report from OR RNs. 84% PACU RNs agreed that intraoperative events or concerns were shared in the handoff. 26% of the PACU nurses agreed that they were given enough time to connect the patient to the monitor. Barriers identified included, the doctors not acknowledging the RN's request to wait to provide a handoff; and different nurses and anesthesiologists floating to the unit were unaware of the project. To improve compliance, the PACU nurses recommended OR RNs and anesthesiologists to implement the new handoff process.

Implications for Advancing the Practice of Perianesthesia Nursing: In the post-implementation phase, the OR team continued to give their handoff while the PACU nurse was focused on getting the patient settled in. Despite the outcome, nurses agreed that the project was a good initiative and recommended the need for proper buy-in from OR RNs and anesthesiologists. The project was shared with anesthesia and OR leadership to reinforce the standardized process with OR RNs.

BEDSIDE HANDOFF REPORT TO IMPROVE COMMUNICATION: PACU AND RECEIVING MEDICAL/SURGICAL UNIT



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Background Information: In 2016, when a surgical patient met PACU discharge criteria and was ready for transport to the medical/surgical nursing unit, the PACU nurses provided handoff report via phone call to the receiving nurse. The PACU nurses spent time away from the bedside to wait for the receiving nurses to answer calls while the medical/surgical nursing staff experienced repeated interruptions. This resulted in delays in transport, conflicts among caregivers, and risks to patient safety.

Objectives of Project: The purpose of this project was to promote teambuilding and improve the patient experience while engaging patients and caregivers in the handoff communication process during the postoperative phase of care.

Process of Implementation: PACU and medical/surgical nurses utilized a handoff communication tool. Compliance is tracked and reported monthly in Performance Improvement Manager (PIM). Goal is greater than or equal to 90%.

Statement of Successful Practice: PACU nurses' compliance with bedside handoff report has consistently achieved the target of 90% since implementation in 2017. PACU and medical/surgical nursing teams verbalize their satisfaction with this process and it has been fully integrated into their workflow as a best practice.

Implications for Advancing the Practice of Perianesthesia Nursing: The practice of bedside or face to face handoff report serves as method to improve patient and caregiver satisfaction while promoting patient safety with the postoperative patient. Communication between PACU and the medical/surgical unit has dramatically improved. PACU and medical/surgical nurses report enhanced professional relationships with their peers.

POST-OPERATIVE PHONE CALLS: DOES IT MAKE A DIFFERENCE TO PATIENTS?



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Background Information: In PACU the following criteria reported by HCAHPS were monitored: 1. Patient Advocacy (Likelihood to recommend) 2. Staff doing everything to help with pain 3. Clear Communication by patient care staff. HCAHPS rating showed a decline in the above criteria in spite of other improvement initiatives.

Objectives of Project: To develop/redesign a structure and process to improve patient outcome in the above 3 parameters by the implementation of post-operative phone calls.

Process of Implementation: Previous problems associated with post-operative phone calls were assessed. A community