ASCs take steps to improve handoffs

Here comes the 10th patient of the day, out of the operating room and into the postanesthesia care unit (PACU). Quick: Does she have any allergies? What medications has she received? And is that her daughter in the waiting room?

Even in the smaller setting of an ambulatory surgery center (ASC), where most of the staff know each other and are usually in speaking distance, it is easy for a patient and information about his immediate needs to become separated unless there is a consistent procedure in place for conveying that information.

The need for handoff procedures

The Joint Commission believes so strongly in the importance of communicating about a patient’s condition at the time of a transfer that it mandates handoff standards in its National Patient Safety Goal 2. In an analysis of 3,000 sentinel events between 1995 and 2004, the Joint Commission found 65% were associated with poor communication, especially during handoffs.

The Goal 2 requirement is to “implement a standardized approach to ‘handoff’ communications, including an opportunity to ask and respond to questions.”

The Accreditation Association for Ambulatory Health Care (AAAHC) has introduced its own standard, which will be effective March 1, 2009.

AORN has extensive handoff guidelines, although they are directed toward a range of health care delivery settings, including hospitals, rather than small surgery centers. AORN developed its “handoff toolkit” in coordination with the Department of Defense (DoD) Patient Safety Program. The kit is free at www.aorn.org. (Look under Practice Resources.)

ASCs create their own

Meanwhile, ASCs have not waited for a universal handoff standard to emerge. ASCs have created their own checklists, charts, and operating procedures for transferring responsibility for a patient.

At MCR Surgery Center at the Medical Center of the Rockies, Loveland, Colorado, which has 4 ORs, a buff-colored 1-page form accompanies each patient from the preoperative area to the OR and from the OR to the recovery room. The form is completed every time, according to CEO Rebecca Craig, RN, BA, CNOR, CASC. “We never rely [solely] on verbal communication,” she says.

The preprocedure part of the form asks the name the patient prefers to be called, the procedure that will be done, the type of anesthesia to be used, allergies, medications administered, and any abnormal vital signs. It also asks how to contact the family, whether relatives are waiting in the lobby or at home by the telephone.

The second part (OR to PACU) asks what procedure was actually performed, the patient’s condition, and medical information that would be helpful to PACU staff. This includes a description of drains and dressings, medications received, presence of a tourniquet, and relevant medical history, such as diabetes or asthma. Both sections include a place for the person filling in the information to sign.

Sharp Memorial Outpatient Pavilion, San Diego, also has a 1-page handoff form with 3 sections and spaces for additional patient information. The Outpatient Pavilion is the ASC arm of Sharp Memorial Hospital, which is part of the Sharp Health System. With 11 ORs and 2 pain rooms, the Sharp facility performs 11,000 procedures per year including outpatient spinal surgery.
About 1% of procedures include a planned transfer to the main hospital for what is termed a “short stay,” meaning 23 hours or less.

The 3 main sections of the Sharp handoff form are preop to OR, OR to PACU, and PACU to hospital. At the top are spaces to indicate vital signs and allergies. The medical assistant completes the top section and then gives the form to a nurse. As a final check, a patient ID sticker is attached to the lower right corner.

Quick reference for physicians

“One purpose of the form is physician convenience,” explains Jan Lee Kwai, RN, MSN, manager of the center.

“We don’t use it in place of the patient chart, but it’s a way to collect everything in one place. For example, the anesthesiologists can look at the form before going into the OR, because it flags anything significant or unusual. The form is in front of the chart. Next, they look at the chart and then go to interview the patient.”

Like other centers developing in-house handoff forms, Sharp had to determine what information was necessary and what could be left out, or the form would miss its goal of providing clear, rapid communication.

“Equipment needs,” for example, in the preop to OR section, could mean bed extensions or lifts for very tall or heavy patients. But at that point, Lee Kwai notes, the form is just a reminder: “The OR still needs a phone call ahead of time.”

An item called “alerts” is used to identify infectious diseases as well as patient vulnerabilities such as fall risk.

“A fair amount of our patients need to be in isolation in the preop area,” Lee Kwai adds. They’re not here because of the infection, but they have to have surgery, yet avoid transmitting infections such as MRSA” (methicillin-resistant Staphylococcus aureus).

The preop section also indicates whether the patient has been taking Flomax (tamsulosin HCl). The reason is that the center performs many eye procedures, and the preparation for cataract surgery is different if the patient is on Flomax.

Each section contains the usual mention of whether the family is waiting or how to reach them.

Closing the loop

In its 3 surgery centers, BayCare Health System, Tampa Bay, Florida, has a specific protocol for communicating patient status from one area to another.

It is called “MAPS,” an acronym that covers the 4 major categories of information:

- medications
- allergies
- procedure/pertinent information
- special needs.

“It’s a memory aid, a way to ensure consistency,” notes Nancy Burden, RN, MS, CAPA, CPAN, BayCare’s director of ambulatory surgery (sidebar). Before the MAPS system was instituted in July 2007, staff passed on the same information but less formally.

Now MAPS is part of every employee’s orientation, and colorful wall posters serve as reminders. Burden says BayCare is working on a written form to document the oral communication.

“This handoff of oral information gives us an opportunity to question each other,” she says. “We still have the responsibility to review a patient’s written information. It’s not a replacement; it’s just one more layer.”

Even though Rikki Knight, RN, BHS, MHA, says her ASC does not currently have a handoff model, the surgery center has a grassroots system that makes communication a top priority. Knight is clinical director of Lakeview Surgery Center, Des Moines, Iowa, a freestanding multi-specialty joint venture between a large physician group, Iowa Clinic PC, and the Iowa Health System. The 6-OR facility opened 7 years ago and performs 7,000 procedures a year.

MAPS for handoff communication

MAPS is an acronym guiding handoff communication for 3 ASCs in Baycare Health System. An example of a handoff:

M = Medications
Preop nurse to OR nurse: “Mr Jones had 1 g vancomycin and 2 mg midazolam preop. He is calm but not overly sedated. He has been taking aspirin as an anti-inflammatory for a month but has been off of it for the past 5 days.”

A = Allergies
“He is allergic to penicillin.”

P = Procedure/pertinent information

- “He is having a left knee scope with Dr Smith, and his knee is prepped.”
- “He has a history of asthma but has not had any acute symptom for over a year and is on no medications for it.”

S = Special needs
“He needs glasses for reading, and they are in his clothing bag. His wife went home and needs to be called when he gets to the PACU.”
Taking the patient full circle

The center’s quality management team, headed by Kate Foreman, RN, is in charge of developing handoff standards, Knight says, but was waiting to see the new AAAHC guidelines before signing off on a specific format.

“We looked at the AORN and Joint Commission standards,” she says, “but many of them are not pertinent to surgery centers because we don’t have all those departments. But it’s still an important issue, and it’s something we do anyway.”

At Lakeview, nurses and physicians make it a point to talk together during transitions from preop to OR and from OR to PACU. To back up the discussions, the staff place “chart magnets” outside the OR. The magnets are purchased at a local craft store and labeled with markers. They contain brief notices about the patient’s history, condition, allergies, and other specific details. When attached to a metal door frame or clipboard, they provide visual reminders to surgeons, Knight says.

The discussion continues after release from PACU to the person handling the discharge, and to the patient and family. Because Lakeview performs many pediatric procedures, the handoff to parents is an important link.

“You’re taking the patient in a full circle,” Knight says. “There’s a loop we have to close.”

She agrees with other ASC managers who note that while written documentation prompts efficiency and consistency, it is no substitute for having a conversation at the time of transfer.

“I think the oral communication is most important,” Knight says. “It gives nurses the opportunity and time to ask questions and respond.”

BayCare’s Nancy Burden adds: “I think it’s a very big issue because we have to constantly balance speed and patient safety. We’re going a mile a minute, but that doesn’t mean we can compromise any patient’s safe care.”

It helps to remember that overall goal of patient safety, Lee Kwai notes. The Joint Commission’s focus on patient safety was the “driving force” in Sharp’s decision to create the handoff procedure. “It demonstrates that we have a mechanism in place to support patient safety through complete communication.”

AAAHC has new standard

AAAHC includes a standard for patient-care communication in its 2009 handbook, expected to be available in late January or early February, according to AAAHC spokeswoman Marsha Wallander.

The final 2009 AAAHC standard is general, stating: “A process is in place for the observation, care, and communication of that care in all periprocedural areas of the patient’s facility experience. The organization must define and implement a process in which information about the patient’s care is communicated consistently. The process must include means to educate the staff and medical care providers about the process and support implementation consistently throughout the organization.”

Wallander says the standard originally included a dozen or so details about the communication process, but the Standards and Survey Procedures Committee decided to remove the details and make a more general statement.

She said surveyors would look for whether the ASC has a process for communication in place, has implemented the process, and carries it out consistently.

The standards do not use the term “handoff.” “The AAAHC calls it ‘documentation and communication,’ ” Wallander notes. “‘Handoff’ is a Joint Commission term.”

—Paula DeJohn

Paula DeJohn is a freelance writer in Denver.