What are the possible perioperative handoffs and how do they differ?

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Objectives

- Discuss different types of perioperative handoffs
- Discuss similarities and differences between the types of handoffs
- Identify barriers to effective communication and communication failure types

Perioperative Handoffs

Preoperative

Floor

Holding Room

Emergency Room

Intensive Care Unit

Operating Room

MD — MD

Provider — Provider

Interventional/ Radiology

Intraoperative

Post Anesthesia Care Unit

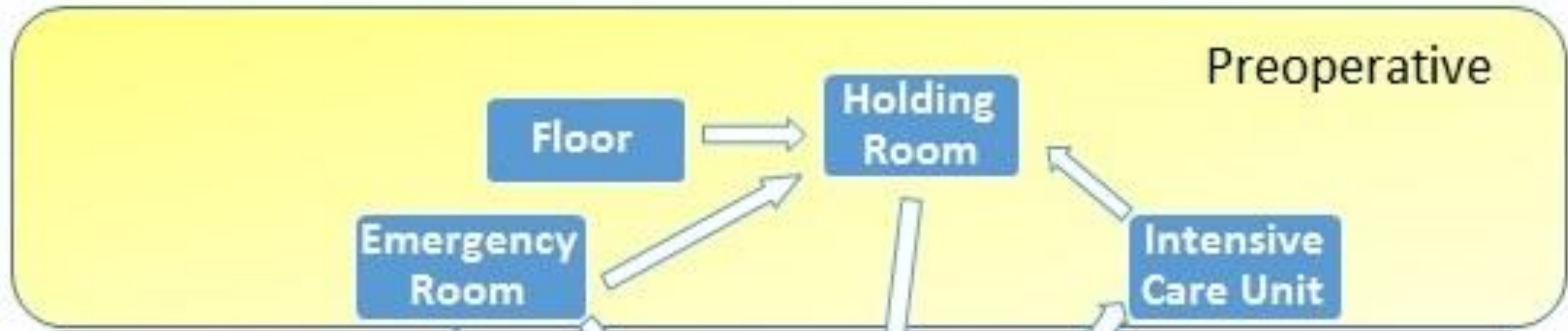
Intensive Care Unit

Postoperative

Phases of Handoffs

- Preparation
  - By both parties
- Patient arrival
  - To new location or new team
- Handoff
  - Provider interaction
- Post-handoff management

Preoperative Handoffs



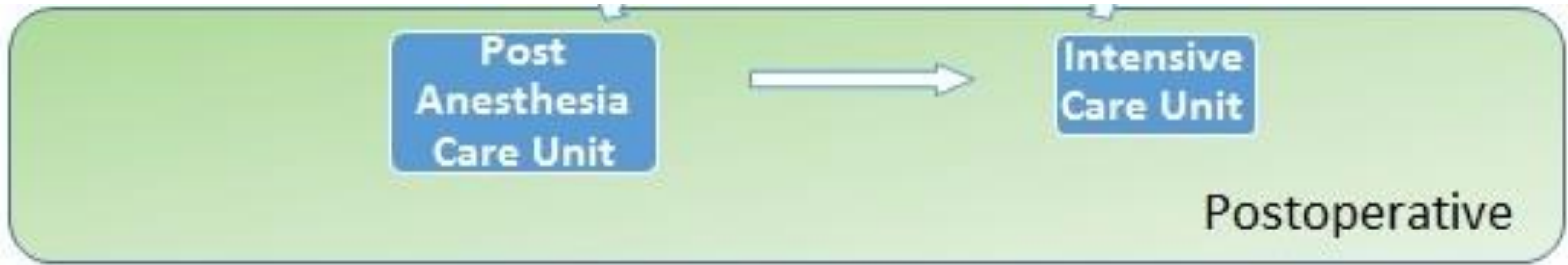
- Nursing staff (HR, floor, ER, ICU)
- Anesthesia staff
- Surgery staff
- ICU/ER staff (MDs, NPs, PAs, RTs)

- Different prep techniques prior to OR transfer.
- Team composition, policies, charting, communication may differ unit to unit
- Emergent procedures= Limited information

Intraoperative Handoffs

- Operating room
  - Short relief breaks
  - Shift to shift
  - Anesthesia MD attendings, CRNAs, Residents/fellows
- Location change
  - Anesthesia staff
  - Surgical staff
  - Nursing staff
  - Technical/support staff
- Rushed, conversational, lack structure
- Variable depending on location, setting and culture
- Team members may not have been part of the initial handover & have limited info
- May provide a "new set of eyes"

Postoperative Handoffs



- OR to PACU
  - PACU RN, anesthesia staff, +/- surgery staff
- OR to ICU
  - Anesthesia staff, surgery staff, ICU team (MDs, NPs, PAs, RNs, RTs)

- May be first structured handoff in a patient's hospital course

How do the differ?

- Different providers present
  - Different languages, priorities, roles
  - Lack of key stakeholders
- Different locations with differing cultures/policies
  - Interpersonal issues
  - Lack of standardization
- Different amounts of knowledge/information
  - Changing patient status, lack of understanding

Barriers to Effective Handoffs

- lack of a standardized report
- patient not prepared for transfer
- unclear transition of care between team members
- unclear provider roles
- significant provider traffic in and out of the room
- distractions/interruptions
- lack of understanding
- production pressure
- incomplete information exchange
- poor interpersonal interactions

Types of Communication Failures

- Source failures
  - information at different places
  - consents missing
  - inadequate documentation
- Transmission failures
  - lack of communication between anesthesia and surgical teams
  - lack of communication between the ward and OR staff
  - information not relayed
- Receiver failures
  - specialists' opinions not followed
  - checklists not followed

Why is this so hard???