Utility of a Handoff Checklist for Student Nurse Anesthetists to Guide Transfer of Care to the Post Anesthesia Care Unit

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INTRODUCTION

Medical errors often are the result of inadequate communication. The dynamics of the perioperative environment includes various professionals and patient populations compounding the likelihood of errors checklists are known to help decrease errors in health care arena. We believe there is a need for a checklist in this complex clinical setting to minimize errors and improve patient outcome. The purpose of this project was to provide the student nurse anesthetist (SRNA) in their pediatric rotation with a checklist to guide the handoff to the post anesthesia care unit.

METHODS

This is a pilot project using SRNAs as subjects to examine the effectiveness of a written hand off check list, adapted from a validated check list used for adult (Table 1)1 Subjects served as their own control. There were 14 items on the check list and each item could earn either 0, 0.5 Or 1 point. Scoring was performed by four CRNAs who received instructions as well as simulation training, to ensure uniform scoring of the handoffs. Scores were averaged to give pre and post scores for each item followed by pre and post mean scores obtained by dividing the total score by 11. Analysis of the mean scores was made using the Wilcoxon Signed Ranked Test

RESULTS

11 SRNAs performed 57 hand offs. Average scores of checklist utilization showed 6.38 pre (42%) and 12.19 on the post intervention (81%). Differences were statistically significant at p<0.001. Often the omissions occurred because information was not applicable to the case. For example, the procedures were not conducted or medications were not administered. Summarizing statements yielded high utility allowing intuitive concerns discovered by anesthesia provider throughout case to be reliably conveyed to PACU nurse. SRNA anxiety levels were higher than expected during data collection.

DISCUSSION

The usefulness of a handoff checklist is not debatable. ACGME common program requirements include training in handoff communication however no such curriculum requirements have been adopted by the AANA. Providing SRNAs with such a tool can teach trainees fundamental patient safety principles that will apply when specific protocols and checklists do not exist2. For implementation in a pediatric setting though customization and collaboration with all involved professionals is necessary.

REFERENCES

1. Petrovic, 2012
2. Lane-Fall, et al., 2014