

Implementation of a Standardized Pre-procedure Handoff Bundle

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Problem Statement

- Wrong-patient, wrong-procedure, and wrong-site events occur approximately 50 times per week within the United States, making the prevention of these events one of the Joint Commission's National Patient Safety Goals.

Within the Interventional Radiology (IR) department at a large, academic medical center, instances of sentinel events have occurred due to improper patient, procedure, or site verification.

- Lack of a standardized pre-procedure handoff between pre-procedure and intra-procedure nurses leads to an increased risk of patient harm and sentinel events.

Purpose & Goals

Quality Improvement (QI) Project: The aim of this QI project included the implementation of a standardized pre-procedure handoff bundle to increase communication amongst staff and decrease sentinel events, including wrong-person, wrong-procedure, or wrong-site events.

Goals:

- Process Goals**
- 80% of IR nurses will utilize the Procedure Pass checklist
 - 80% of IR nurses will complete bedside handoff

- Outcome Goal**
- 100% of adult patients undergoing procedural intervention will be free from wrong-person, wrong-procedure, or wrong-site events

Methods

Setting: IR department in large, academic medical center

Population: Adult patients undergoing vascular or neurovascular intervention

Intervention: Handoff bundle implemented over 15 weeks

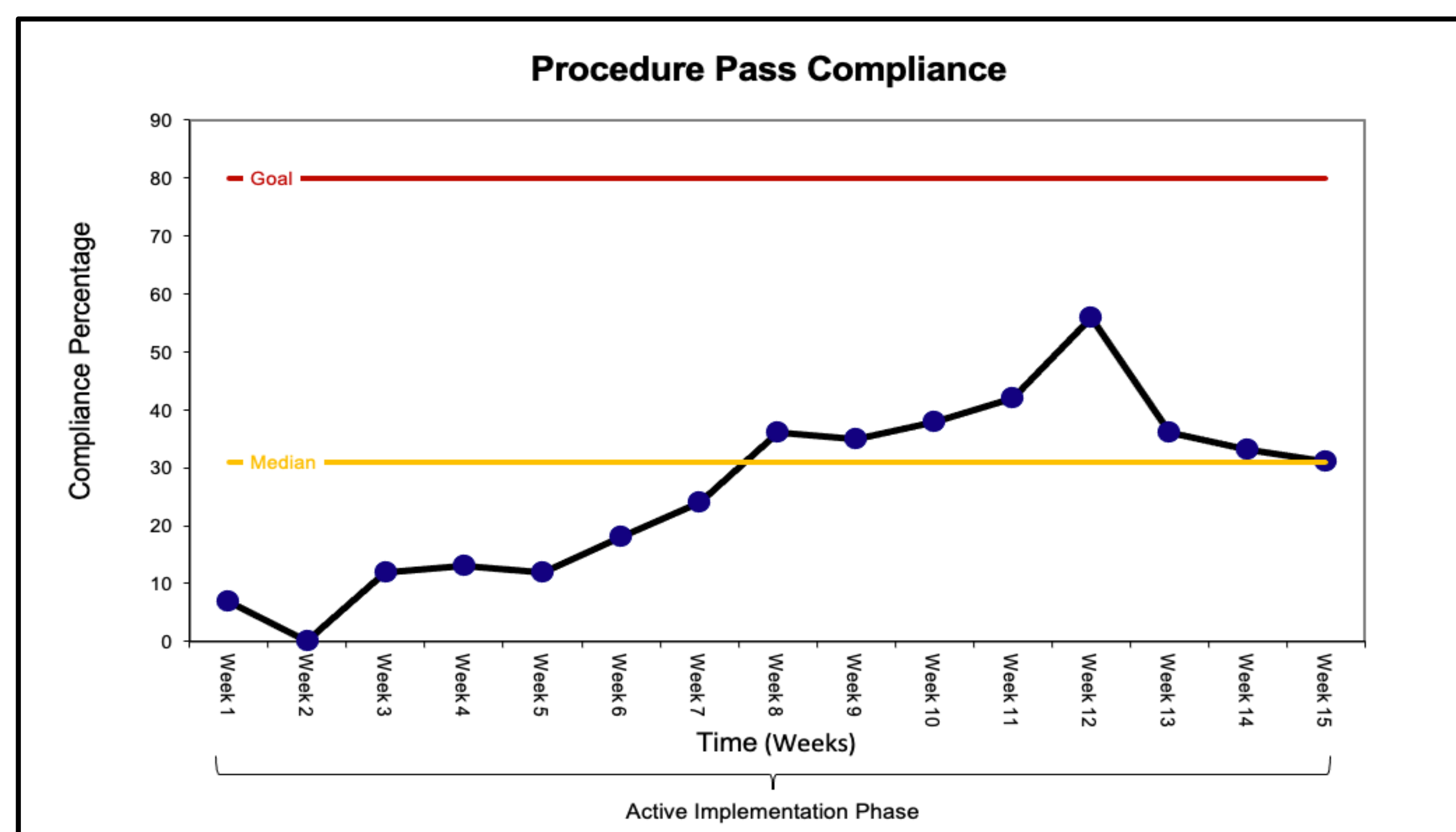
- Use of a pre-procedure checklist to document task completion (Procedure Pass).
- Bedside handoff between the pre-procedure and intra-procedure nurses using the Situation, Background, Assessment, and Recommendation (SBAR) model.

Measures: Weekly chart audits for staff compliance, monthly morbidity and mortality (M & M) reports for sentinel events

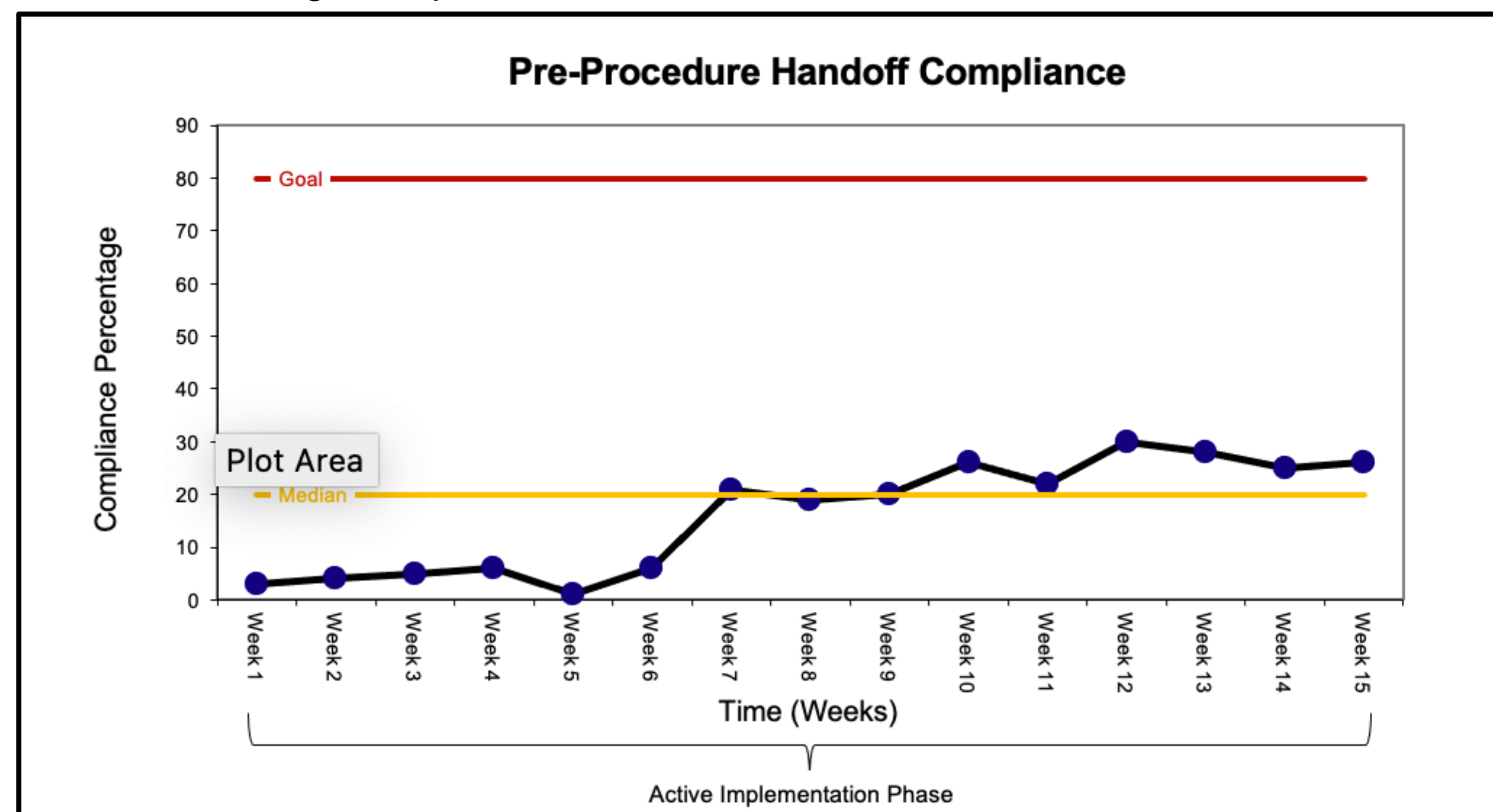
Strategies: Staff education, unit champions, incentives

Results & Figures

- 100% (952/952) of eligible patients were included in data collection.
- Procedure Pass compliance** ranged from 0% during week 2 to 56% during week 12. Average compliance rate was 31%.



- Pre-procedure handoff compliance** ranged from 1% during week 5 to 30% during week 12. Average compliance rate was 20%.



Outcome goal was successfully achieved with 0 instances of wrong-patient, wrong-procedure, or wrong-site events occurring during the 15-week intervention implementation.

Discussion

- Evidence-based literature supports the use of a pre-procedure checklist and performance of bedside handoff using the SBAR model to improve patient outcomes.
- The goal of 80% compliance with use of Procedure Pass and performance of bedside handoff was not met. However, the outcome goal was successfully achieved, thereby displaying consistent results compared to the literature.

Limitations:

- Nursing and radiology technologist staffing shortages, with approximately 50% traveler staff
- Leadership transition, including the lack of a nurse manager during project implementation

Conclusions

Implementation of a pre-procedure handoff bundle, resulted in improved communication between staff members and an increase in patient safety.

Spread & Sustainability:

- Pre-procedure handoff bundle is generalizable and can be utilized within any procedural setting, such as the OR or an outpatient surgical setting
- Continued education and communication with staff will improve compliance

Implication for Practice:

- Continued use of handoff bundle to improve patient safety and staff satisfaction
- Incorporation of handoff bundle in new nurse orientation
- Partnership with peri-operative services to standardize pre-procedure handoff bundle hospital-wide

References



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