Association for Radiologic & Imaging Nursing

Clinical Practice Guideline

Handoff Communication Concerning Patients Undergoing a Radiological Procedure with General Anesthesia

Overview

In 2009, the Joint Commission (JC) identified that up to 80% of serious medical errors involve miscommunication during the hand-off between medical providers. The majority of avoidable adverse events are due to the lack of effective communication. (1) Originally implemented as a national patient safety goal, hand- off communication is now imbedded in the JC standards under the section of Transitions of Care.

Rationale for Transition of Care: Hand-off Communication.

A hand-off is a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient specific information from one caregiver to another or from one team to another for the purpose of ensuring the continuity and safety of the patients care.

The primary objective of a "handoff" is to provide accurate information about a patient's care, treatment, and services, current condition, and any recent or anticipated changes. The information communicated during a handoff must be accurate in order to meet patient safety goals.

In health care there are numerous types of patient handoffs, including but not limited to nursing shift changes; physicians transferring complete responsibility for a patient; physicians transferring on-call responsibility; temporary responsibility for staff leaving the unit for a short time; anesthesiologist report to post-anesthesia recovery room nurse; nurse-to-nurse report for patients requiring radiographic or imaging procedures; nursing and physician handoff from the emergency department to inpatient units; different hospitals, nursing homes, and home health care; and critical laboratory and radiology results sent to physician offices (Joint Commission, 2009).

Target Audience

All nurses sending and receiving patients from imaging department who have undergone general anesthesia.

Content/Strategies

A successful Hand-off is critical and the JC has developed "**SHARE**" as an acronym to ensure the process is successful. SHARE includes: **S**tandardize Critical Content, **H**ardwire within your system, **A**llow opportunity to ask questions, **R**einforce Quality and Measurement, and **E**ducation and Coach.

In order for effective hand- off communication to occur, a rudimentary understanding of the procedure must be known. Standardized methods of communication are also important to ensure vital information is not overlooked or forgotten. **SBAR** (Situation, Background, Assessment, and

Recommendation) will be the approved format to ensure standardization of communication. The JC also states that the ability to ask and respond to questions is required for effective communication (see Table 1).

The post procedure SBAR hand off includes the following:

Situation
Name, allergies/alerts, primary physician, diagnosis, and procedure performed

Background
Drains/catheters/ incision/puncture site (groin site)
Local anesthesia used and amount; any special equipment used (coils, stents)

Assessment (post procedure)
Current vital signs, medications given—dose, time; neurological status (may include NIH scale), cardiac, respiratory, CSM-including peripheral pulses, and pain status
IV status: site, Left to Count (LTC)—total IV intake
Output: drainage, Foley, JP, NG
EBL

Recommendations
Concerns, treatments/medications due, unit patient is to be transferred to after recovered, discharge status, family notification

Reference
The Joint Commission. (2010). Joint Commission Center for Transforming Healthcare Tackles Miscommunication Among Caregivers (1) Oakbrook Terrace, IL. Author.

Suggested Reading
Association for Radiologic & Imaging Nursing. (2009). *Orientation Manual for Radiologic and Imaging Nursing.* Pensacola, FL: Author.

Procedure grid. Virginia Mason Hospital, Seattle, WA. Copyright 2008. Reprinted with permission. Updated 2/24/14.

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Approved by the ARIN Board of Directors: September 2014

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