



Association for Radiologic & Imaging Nursing

Clinical Practice Guideline

Handoff Communication Concerning Patients Undergoing a Radiological Procedure with General Anesthesia

Overview

The Joint Commission (JC) has identified that ineffective communication has been the root cause for sentinel events compromising safe patient care. To that end, a National Patient Safety Goal (NPSG) requires a “handoff” communication when care is transferred from one clinician to another.

NPSG Requirement

Implement a standardized approach to “handoff” communications, including an opportunity to ask and respond to questions.

Rationale

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’s 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 (The Joint Commission, 2009).

Target Audience

Imaging/ PACU nurses sending and receiving patients from the imaging department who have undergone general anesthesia.

Content/Strategies

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 but is not limited to the following:

Situation

Name, allergies/alerts, primary physician, diagnosis, pertinent past medical history (e.g., diabetes, pacemaker, hard of hearing, blindness), isolation precautions, and procedure performed

Background

Drains/catheters/ incision/puncture site (groin site); local anesthesia used and amount; any special equipment used (e.g., 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, intake and output, EBL, type, and amount of contrast given

Recommendations

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

Reference

The Joint Commission. (2009). 2009 national patient safety goals: hospital program. Oakbrook Terrace, IL. Author.

Suggested Reading

Association for Radiologic & Imaging Nursing. (2009). Orientation manual for radiologic and imaging nursing. Pensacola, FL: Author.

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Imaging Post Procedure Plan of Care (Table 1)
Accompanies ARIN Handoff Communication Concerning Patients Undergoing a Radiological Procedure with General Anesthesia Clinical Practice Guideline

	Arterial Access Procedures							Drains and Tubes		Biopsies		
	Cerebral / Visceral / Thoracic Diagnostic	Intracranial Angioplasty / Stent / Coil / Embolization	Carotid Stent	Visceral / Thoracic Angioplasty/ Stent	Aorta with Run-off / Angioplasty / Stent	Visceral / Thoracic / Uterine Embolization	Bland / Chemo Embolization	Percutaneous Biliary / Nephrostomy / Abscess or Fluid Collection	Gastrostomy Tube Placement	Lung	Thyroid / Bone / Lymph Node / Parotid	Liver / Renal / Pancreas
Length of Recovery	2-6 hours	Variable. Dependent on procedure and MD. 4-6 hours if outpatient; however, patient may be admitted. Review physician orders.					0.5 - 1.0 hours	2 - 4 hours or overnight	1-2 hours	0.5 - 1.0 hours	3 - 4 hours	
Activity	Bed rest for 4 -6 hours after hemostasis achieved following sheath removal. May raise HOB to 30° after 1 hour. Affected leg must be kept straight. If closure device used, may be up after 1- 2 hours (see closure device protocol).							Ad lib when stable.		Ad lib when stable.		Bed rest 4 hours after procedure end.
Potential Complications and Management	<p align="center">Bleeding or thrombosis at arterial puncture site. Pseudo aneurysm. Retroperitoneal bleed.</p> <p>Check site. Hold pressure adequate to stop bleeding if needed. Monitor pedal pulses. Frequent CMS checks of accessed extremity. Notify MD if changes. C/O abdominal pain will require further investigation. Anticipate ultrasound or repeat angiogram for treatment.</p>							<p align="center">Sepsis</p> <p>Observe for fever, rigors, hypotension, tachycardia, pain. Anticipate antibiotics if not already given, or inpatient admission</p>	<p align="center">Pain</p> <p>Notify MD for pain meds if needed</p>	<p align="center">Pneumothorax</p> <p>Observe for SOB, Chest X-Ray 1 hour post. NPO until chest x-ray cleared by MD. Anticipate chest tube placement.</p>	<p align="center">Bleeding</p> <p>Rare. Observe</p>	<p align="center">Internal bleeding from biopsy.</p> <p>Observe for abd pain, hypovolemia. Treat for shock. Poss. HCT 3 hours post.</p>
	<p align="center">Embolic Stroke (for cerebral)</p> <p>Perform neuro checks. Notify MD of changes. Anticipate repeat procedure.</p>			<p align="center">Pain Management</p> <p>Critical to stay ahead of pain. Prepare for PCA.</p>		<p align="center">Peritonitis</p> <p>Do not use tube for 24 hours</p>						
	<p align="center">Hemorrhagic Stroke from anticoagulation.</p> <p>Immediate head CT. Immediate transfer to critical care unit. Monitor neuro status.</p>	<p align="center">Hypotension, bradycardia.</p> <p>Fluid challenge if appropriate. Monitor VS. Anticipate meds (ephedrine, atropine, Sudafed)</p>	<p align="center">Potential hypotension with renal stents</p> <p>Check BP. Anticipate meds (ephedrine)</p>	<p align="center">Peripheral Thrombosis</p> <p>Monitor pulses and pain. Anticipate repeat procedure.</p>	<p align="center">Unresolved Bleeding</p> <p>Monitor VS. Anticipate repeat procedure for GI bleeds. Administer blood products as needed.</p>		<p align="center">Embolization Syndrome: fever, nausea, vomiting, pain.</p> <p>Observe and notify MD if symptoms occur. Anticipate antiemetics</p>					
<p align="center">Clotting of stent</p> <p>Be aware of possible orders for Plavix or ASA</p>												
Special Considerations	General anesthesia - critical care unit admission required.		Often critical care unit admission.		Thrombolytic infusion may be needed - will require critical care unit admission.		See Chemo Embo Orders	Do NOT use 3-way stopcock or aspirate after flushing. Do NOT flush nephrostomy tubes.		Recommend non-ASA medications (e.g., Tylenol) for pain X 24-48 hours post-procedure, if necessary.		
Patient Teaching	Give angiogram instruction sheet. Drink extra water (double usual amount) for 24 hours. Hold Metformin containing medications for 48 hours after procedure.							Provide drain care instructions and supplies.	Give Gtube instruction sheet. f/u in 2 wks for suture removal. Nutrition Consult	Give lung biopsy instruction sheet.	Give needle biopsy instruction sheet.	
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	Venous Access Procedures				IR Other		GI Procedures				
	Venogram / IVC Filter / Petrosal or Adrenal Sampling	Foreign Body Retrieval	PICC lines and Central lines	Fistulogram	RFA (radio-frequency ablation)	Vertebroplasty	ERCP D/C Home	ERCP Admit to Hospital	Colonoscopy with Stent or Decompression	EGD with dilation / NJ / NG/ Placement	EGD with Esophageal Stent
Length of Recovery	2 hours	2-4 hours	0.5 - 1.0 hour	0.5 - 1 hour	4 - 6 hours or overnight	3 hours	1 - 2 hours	0.5 - 1.0 hours			0.5 - 1.0 hours or overnight
Activity	Bed rest 2 hours if femoral access. HOB to 30° after 1 hour. Immediate HOB up 45° if jugular access.		Ad Lib when stable.		Ad lib when stable	Flat for 1 hour, HOB up 30°-45° for 1 hour, then ad lib.	HOB up 30°, 60°, 90° to dangle	HOB up 30° as tolerated			HOB 90° immediately post procedure
Potential Complications and Management	Bleeding at puncture site Check site and apply pressure adequate to stop bleeding if needed.				Pain Notify MD for pain meds if needed		Bleeding Observe for change in VS. Notify MD				
					Burns from grounding pad Notify MD	Rare: Leakage of glue from vertebra leading to paralysis. Check motor and sensory function and notify MD if abnormal	Perforation Observe for abd pain, crepitus. Notify MD				
	Thrombosis of fistula/graft. Check for bruit and thrill. Notify MD if absent. Anticipate repeat procedure						Pancreatitis Observe for abd pain, chills, fever. Notify MD	Stent or Tube Migration Observe for abd pain, chest pain. Notify MD. Check external drain tube placement for decompressions. Anticipate Barium Swallow for esophageal Stent			
							Over sedation Observe VS and LOC. Treat as needed				
Special Considerations	Access may be femoral or jugular.		Angioplasty may be necessary to open up narrowed vessel. Sterile dressing per protocol.	Patient may go to dialysis the same day.						May be painful. Notify MD	
Patient Teaching					Response time highly variable		NPO post procedure			Clear liquids to soft diet as ordered	