Nursing Handover: Surgical Patient, Emergency Department to Operating Room, MSJ

Site Applicability

Emergency Department and OR/PACU, Mount St. Joseph Hospital

Practice Level

Basic: RN

ESN and Student Nurse in consultation with and with support from most responsible nurse.

Need to Know

Nursing handover is the transfer of accountability and responsibility of the patient's care from one nurse to another for the purpose of ensuring patient safety and continuity of care. This may include some or all of the aspects of care for the patient (e.g. transfers of care for a test, surgical or medical procedure or break relief).

To promote patient safety, nursing handover includes a combination of tools, electronic (CERNER) clinical powerform, AND a verbal handover (in person or on the phone), with the opportunity for questions/clarifications. Nursing handover is completed with clear, concise, and efficient communication.

In ED, the patient assessment must be completed to determine patient transport needs. Using critical thinking skills an interdisciplinary team must assess risk to patient stability during transport and whether accompaniment is needed.

If the patient is medically unstable, a handover needs to be in person. In addition to the ED nurse giving a handover to OR nurse, the ED nurse will also give a handover to the PACU nurse, as the PACU nurse will assist with the patient transport from ED to OR.

In the following circumstances listed below where patients require monitoring, the patient must be accompanied by an ED nurse and/or a PACU nurse during patient transport.

1. Airway/breathing compromise/monitoring
2. Require frequent interventions and/or monitoring
3. Neurological or Hemodynamic compromise/monitoring

Patient must stay in PACU for monitoring until OR can accept the patient in the room.

Guideline

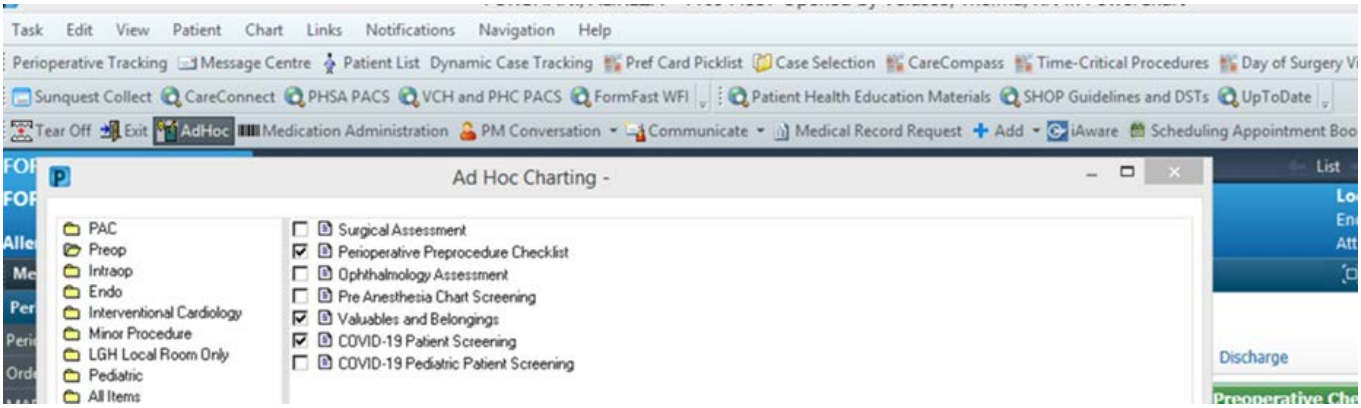
Electronic powerform (CERNER) component of handover:

ED Nurse (giving handover)

As soon as the patient in the ED is scheduled for a surgical procedure, the ED nurse will complete the electronic clinical powerforms in CERNER which include:

- Perioperative Pre-procedure Checklist,
- COVID-19 Patient Screening and
- Valuable and Belongings

A verbal handover must also be given (in person or on the phone).



OR Nurse (receiving handover):

The OR nurse will review the completed electronic clinical handoff tools in CERNER powerform including the Perioperative Preprocedure Checklist and COVID-19 Patient Screening).

Then, the OR nurse will call the ED nurse ahead of time to receive a verbal component of handover report and provide approximate time when the patient can be transferred to the OR.

If the patient is unstable requiring critical care, a handover needs to be in person. In addition to receiving a handover from the ED nurse, the ED nurse will also give a handover to the PACU nurse, as the PACU nurse will assist with the patient transfer to OR.

Verbal component of handover:

Phone/in person handover

Allow time for questions and clarifications.

Both nurses may conduct safety checks (patient ID, IV tubing, fluids, medications, lines, and equipment), when handover is being conducted in person.

The verbal handover includes but is not limited to:

- Patient identification
- Clinical safety alerts (e.g. allergies, infection control & cytotoxic precautions, isolation precautions MRSA/VRE, etc.)

- Clinical status of the patient (e.g. diagnosis, severity of illness, anticipated surgical procedures)
- COVID-19 screening status
- Other medical concerns (e.g. mobility parameters; vision/hearing aids)
- Code status
- Priorities of care (e.g. urgent tasks pending, critical laboratory results)
- Current vital signs, and ongoing assessments / protocols (e.g. CIWA alcohol withdrawal protocol)
- Current medications (e.g. time sensitive, pertinent)

Related Documents

1. B-00-07-10078 - Nursing Handover and Whiteboards
2. B-00-11-10181 – Transferring Patients to Next Appropriate Level of Care (Policy).
3. B-00-07-10073 - Transport for Tests/Treatments/Procedures: Patient Accompaniment

References

1. Eggins, S., & Slade, D. (2015). Communication in Clinical Handover: Improving the Safety and Quality of the Patient Experience. Journal of public health research, 4(3), 666. doi:10.4081/jphr.2015.666
2. Elsevier Clinical Skills (2019). Hand-off Report: Nursing Report – CE. Retrieved on February 7, 2019 from: www.elsevierskills.com
3. Registered Nurses' Association of Ontario (2014). Clinical Best Practice Guidelines: Care Transitions. https://rnao.ca/sites/rnao-ca/files/care-transitions.pdf
4. Shaid, S., & Thomas, S. (2018). Situation, background, assessment, recommendation (SBAR) communication tool for handoff in health care – a narrative review. Safety in health 4(7), doi:10.1186/s40886-018-0073-1

Persons and Groups Consulted

MSJ Nurse Educator Group, OR, PACU/SDCU and ED

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MSJ PCM ED

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