Our goal is to increase the use of a Moses PACU handoff form for ASA ≥4 or ICU/step down patients from 0% to 50% by July 1, 2019.

**BACKGROUND**

- Thorough handoffs improve patient outcomes and reduce medical error in perioperative setting
- Per the Joint Commission, 80% of serious medical errors are due to failures in communication (2012)
  - Delays in diagnosis & treatment
  - Discontinuation of necessary therapies

**AIM**

Our goal is to increase the use of a Moses PACU handoff form for ASA ≥4 or ICU/step down patients from 0% to 50% by July 1, 2019.

**PDSA Cycle #1**

**Goals:**
- To increase the adherence of the Moses Anesthesiology Team to the use of a PACU Handoff Form for ASA ≥4 and ICU/Stepdown borders through improved awareness and communication
- Create a PACU handoff form and send department wide email to make all aware of its existence
- Communicate with anesthesia teams whose patients meet criteria, on day of surgery

**PDSA Cycle #1 -- Case Selection**

- 74 cases reviewed
- 58 cases reviewed
- 39 cases reviewed

**PDSA Cycle #1 -- Results**

- Study: Introduced 74 cases from May 26 to June 9, 2016
- 39 cases not filled
- 7 cases with incomplete form
- 33 cases where form filled out but not sent

**PDSA Cycle #1 -- Takeaways:**

- With education about the existence of the form most Anesthesia team members are compliant.

**Moving Forward:**

- Assess whether intraoperative reminders would increase compliance with hand off form.

**PDSA Cycle #2**

**Goals:**
- Increase compliance of the Moses Anesthesiology Team to the use of the PACU handoff form for our target patient population through increased awareness and improvement of the form following feedback from prior PDSA cycle.

**PDSA Cycle #2 -- Case Selection**

- 111 cases reviewed
- 85 cases reviewed
- 53 cases reviewed

**PDSA Cycle #2 -- Takeaways:**

- Increased compliance amongst anesthesia team with increased awareness
- Improved perception by PACU nurses regarding handoff process using handoff form

**Moving Forward:**

- Multidisciplinary approach to developing signout form involving anesthesia, PACU and ICU/SDU teams in order to standardize handoff process
- Incorporating handoff form into workflow

**Results**

- Numerous studies have shown that inadequate communication is a leading cause of patient harm
- Communication tools were developed to mitigate this problem
  - I.e. - SBAR, IPASS
- We identified the lack of standardized handoff guidelines at Montefiore
- Our aim was to improve PACU handoff for patients meeting inclusion criteria
- After PDSA 1, we saw improve utilization of handoff form
  - Due to increased awareness
- After PDSA 2, we say further increase in handoff form use. We also received improved feedback from PACU nurses
- Target goal (50%)
- Achieved 30% adherence
  - However this results indicates that with continued education and reminders, a goal of 50% is attainable