Implementation of an SBAR Checklist to Improve Healthcare Provider Satisfaction with Post-Operative Handoff

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Abstract

Purpose:

This quality improvement (QI) project sought to improve PACU nurse and CRNA satisfaction with the handoff process, as well as identify barriers to implementation of the SBAR checklist.

Design:

A pre and post implementation survey with Likert-scale questions was used to gauge self-reported changes in comprehensiveness and satisfaction of postoperative handoff, with and without the checklist.

Methods:

The SBAR checklist was implemented within a small, rural hospital in Wisconsin over a period of six weeks. Pre and post surveys were analyzed to assess for improvement in comprehensiveness as well as PACU nurse and CRNA satisfaction with the postoperative handoff process.

Conclusion:

The results of this quality improvement project showed no statistical significance between pre and post surveys. Overall, healthcare provider satisfaction with PACU handoff improved with the implementation of the SBAR checklist. Despite acknowledged limitations, the project provides a valuable opportunity to contribute to a culture of continuous improvement in the perioperative setting.

Problem Statement

- Miscommunication during the transfer of patient care can result in delays of necessary care, inappropriate medication administration timing, and even patient injury or death (Bruno et al., 2018).
- The use of a detailed handoff checklist can reduce the number of errors that may occur during the transfer of patient care from the CRNA intraoperatively, to the PACU nurse post-operatively (Lamber & Adams, 2018).
- PACU nurses at a small, rural hospital in Wisconsin have disclosed that the current handoff tool alone is not conducive to a systematic report from the CRNA.
- The goal of this project is to promote safe and effective care during their perioperative experience by minimizing errors during handoff after surgery.
- The PICOT statement to address this is: According to PACU nurses and CRNAs at a rural Wisconsin hospital (P), how does the implementation of a SBAR checklist tool (I), compared to no checklist tool (C), affect reported satisfaction of post-operative handoff (O) within six weeks of implementation (T)?

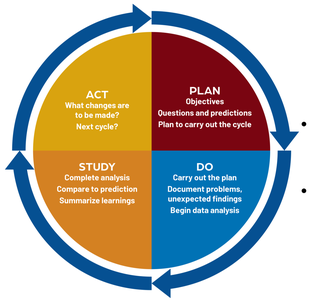
Review of Literature

- There are consistent themes throughout available literature, outlining the direct improvement in communication based on standardized handoff tools utilized.
- The handoff between an anesthesia provider and a PACU nurse is often verbal bedside report which is susceptible to information being lost in the fast-paced PACU environment filled with distractions, interruptions, and multi-tasking (Lazzara et al., 2022).
- With the use of a standardized handoff tool, events which threaten patient safety are reduced, and healthcare profession satisfaction improve.
- Evidence shows that communication failures during patient handoffs between anesthesia providers and PACU nurses continue to be a problem.
- The top cause of anesthesia-related sentinel events is linked to communication breakdowns during handoffs and are associated with increased patient morbidity and mortality (Bruno et al., 2018).
- A user-friendly handoff tool is beneficial in the effective communication and continuity of care of the patient during the post operative period (Burns et al., 2018).

Design and Methods

- 5 CRNAs and 12 PACU nurses within a rural, Wisconsin hospital participated in the QI project.
- The PDSA cycle utilized as a four-step approach aimed at continuous improvement.

- An initial survey was provided to PACU nurses and CRNAs to assess satisfaction with the current handoff process, perceived quality of report, and missed information during handoff.
- After receiving initial results from the survey, the SBAR checklist was implemented for all post-anesthetic handoffs between PACU nurses and CRNAs.
- The checklist was instituted for six weeks, after which, post-implementation surveys were completed.

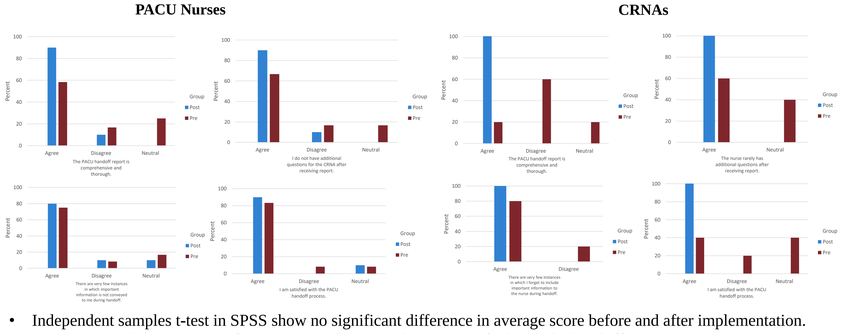


- The post-implementation survey remained the same as the initial survey to assess identical parameters during handoff, but with the use of the SBAR checklist.
- Comparison of the pre- and post-surveys revealed data for analysis.
- The goal was to improve CRNA and PACU nurse satisfaction, increase quality of report, and reduce missed information during handoff through the implementation of the PACU SBAR checklist.

Implementation

- Coordination with faculty in anesthesia department to coordinate appropriate day and time for introduction of the SBAR handoff tool and follow-up.
- Brief teaching and educational reference provided to explain importance of SBAR checklist implementation.
- Pre and post surveys provided via QR code linked to online Survey Monkey.

Results



- Independent samples t-test in SPSS show no significant difference in average score before and after implementation.
- In comparing the percentage of participants who agree they are satisfied with the handoff process pre and post implementation:
  - 90% of PACU nurses and 100% of CRNAs agree that the PACU handoff report is comprehensive and thorough with the checklist as compared to 58.33% of PACU nurses and 20% of CRNAs before its implementation.
  - 90% of PACU nurses and 100% of CRNAs agree that there are not additional questions following report with the use of the checklist as compared to 66.6% of PACU nurses and 60% of CRNAs before its implementation.
  - 80% of PACU nurses and 100% of CRNAs agree that important information is not missed with the use of the checklist as compared to 75% of PACU nurses and 80% of CRNAs before its implementation.
  - 90% of PACU nurses and 100% of CRNAs agree that the PACU handoff report is comprehensive and thorough with the checklist as compared to 83.3% of PACU nurses and 40% of CRNAs before its implementation.

Limitations

- Time constraints with requirement to finish and disseminate the QI project by May 2025 imposed a restriction on the time available for data collection.
- Small sample size, influenced by the hospital's 11-bed PACU, limiting the scope of data collection.
- Lack of generalizability of project findings due to limited diversity of participant population with majority being Caucasian and female.
- To increase both reliability and validity, a 7-point rather than a 3- or 5-point Likert scale, could have been chosen for this project (Taherdoost, 2019).
- Threats of this project include the willingness of staff to adopt the new handoff tool following the conclusion of the project.
- There is also potential for the development of new literature that does not support SBAR checklist implementation for improved patient outcomes.

Discussion and Conclusion

- This project addresses miscommunication during patient handoffs, aiming to improve post-operative reports at a rural Wisconsin hospital.
- The need for a standardized handoff tool arises from identified shortcomings impacting CRNA and PACU nurse satisfaction and patient safety.
- The project's significance lies in its potential to minimize errors, enhance communication, and positively impact CRNA and PACU nurse satisfaction.
- Aligned with the PDSA cycle, the SBAR checklist can improve healthcare provider satisfaction with post-operative report and reduce missed information.
- Successful implementation of the handoff tool fosters a culture of collaboration within the healthcare team.
- The project provides a valuable opportunity to enhance patient safety by minimizing missed information during handoff.
- By addressing weaknesses and building on strengths, it aims to contribute to a culture of collaboration and continuous improvement in perioperative care.

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