



# Audit: Patient handover in theatre recovery

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# Background

The improving patient handover project by Karen Horton and Dr Sanghera aimed to find ways to improve the theatre recovery handover process and documentation.

This was then expected to reduce critical incidents, delays in treatment administration and the number of tasks for the DFA (duty floor anaesthetist).

Also necessary to bring us in line with the RCoA accreditation standards 2015 (1.1.1.5).

## Background (2)

An SBAR communication was adopted as a more structured model, along with an acronym; NOAH GO FAST.

Name, Operation, Anaesthetic, History

Glucose, Oxygen

Fluids, Analgesia, Sickness, Thromboprophylaxis

Recovery and anaesthetic staff were all informed of the new format and posters were put up around recovery as visual cues. Paper copies were also given out.

## Background (3)

Audit results between February and August 2015 suggested that DFA calls were reduced by around 50% after implementation of the new handover format.

# Background (4)

RCoA accreditation:

“There are documented and agreed policies and documentation for the handover of care of patients from one team to another throughout the perioperative pathway.”

Not just the verbal handover needed. Documentation required too to meet the RCoA standards.

# Re-audit

Aiming to ensure the use of SBAR system and that the handover documentation is properly filled out, after nearly 2 years.

Also collecting data, which will be useful in future comparisons.

# Re-audit method

Observed 25 handovers to theatre recovery staff from anaesthetists, noting if specific parts of the SBAR handover were covered.

Then also reviewing the handover documentation on the back of anaesthetic charts and the drug cards (after giving sufficient time to be filled in).

With help of sisters in recovery, keeping track of number of DFA calls over the day, for future comparisons.

# Re-audit results

The good news, we seem to start off well in handover:

Patient's name given: 25/25 (100%)

Operation stated: 25/25 (100%)

Type of anaesthetic stated: 24/25 (96%)

PMHx given: 23/25 (92%)

Status intra-op mentioned: 22/25 (88%)

Anecdotally; the ones missed here were mainly NAD (e.g no PMHx, no problems intra-op), they just weren't mentioned specifically.

# Re-audit results

Plan for recovery:

Patient parameters stated / **box ticked**: 20/25 (80%) / 20/25 (80%)

Analgesia prescribed / **box ticked**: 25/25 (100%) / 20/25 (80%)

Fluids prescribed / **box ticked**: 20/20 (100%) / 17/20 (85%)

(5 patients did not need fluid, this was indicated verbally or written in all 5)

Oxygen prescribed / **box ticked**: 22/25 (88%) / 18/25 (72%)

Anti-emetics prescribed / **box ticked**: 25/25 (100%) / 19/25 (76%)

# Re-audit results

Contact point for anaesthetist given?

Only **1/25** said which theatre. 10 patients seen were picked up from theatre.

External interruptions to handover?

Only **2/25**, which was due to clinical problems e.g patient desaturating. No interruptions observed from members of staff at all.

Anaesthetic chart signed?

Anaesthetists: **18/25 (72%)**

Recovery Nurse: **10/25 (40%)** OR **10/23 (43.5%)**

(note that two charts were old version with no space for nurse)

# Re-audit results

DFA called 8 times during day.

Only one was for non-clinical reason – prescription.

All others due to clinical problem / ERB patient.

# Conclusion

The S and B parts of SBAR are generally well covered. The structure seems consistent / well established between observed staff.

Despite a high percentage of appropriate prescriptions being in place, the level of documentation for these is noticeably lower.

Signing of handover sheets is a weak area, especially amongst recovery staff, who are distracted by other tasks after handover takes place.

## Conclusion (2)

Handover time is respected by all staff and is not interrupted unless clinical problem arises.

Contact points for anaesthetists are readily available from theatre lists / recovery sister / collecting recovery staff.

Despite these not being given specifically by most staff members, I would argue that focusing on this would not be of any tangible benefit.

# Recommendations

Departmental meeting to reinforce the previous work of improving the handover process with specific focus on documentation.

Re-audit after this takes place to ensure a performance improvement / compare DFA calls.

Ensuring that the old anaesthetic charts are properly phased out hospital-wide.



# Thankyou

Thanks to Karen Horton and Dr Sanghera for access to previous work and initial planning for the re-audit.