

nurse receivers. The ability of providers in the checklist group to identify all 6 key elements of the report was statistically significantly higher than that in the non-checklist group. There was also a decrease in the need for information clarification because the rate of callbacks was significantly lower in the checklist group. The PACU RNs were more likely to rate the handoff as adequate when it was given using a checklist, compared with the handoff without a checklist. All 26 reports received with a checklist were considered adequate (100%) compared with 22 (85%) in the group that received the report without a checklist. Furthermore, using a checklist did not appear to affect provider time in the PACU.

There are a few limitations of our current study. The anesthesia residents did not participate in the pilot study. This may have affected the overall information scores based on provider experience. CRNAs in the study had a minimum of 1-year experience as an anesthesia provider. This may have influenced their ability to give a report based on experience, affecting the initial score when no checklist was used.

Another limitation was that of the PACU RNs' ability to rate the report as adequate or inadequate. The PACU RNs were trained at a staff meeting, with follow-up written communication, regarding the adequacy score. This rating was subjective, and the nurse's experience level may have influenced the overall adequacy rating. The level of experience for the PACU nurses ranged from new graduates to more than 30 years' experience. This subjectivity was difficult to control and therefore identified as a limitation to this study.

Last, the provider time in PACU from "Time In" to PACU to "Anesthesia End" might not be accurately measured, because of the large variation among practitioner documentation practice. For example, some CRNAs closed out the electronic medical record while giving the handoff, and others preferred to wait until the handoff was completed.

Conclusion

The use of a checklist during a handoff can help providers correctly exchange information and thereby increase the adequacy of the handoff. Use of a checklist does not increase the length of time a provider is in the PACU exchanging information during a report. The time spent using a checklist for handoff does not appear to affect turnover time, yet improves accuracy of the report. The use of a checklist did decrease information loss and the need for clarification among providers. Although this improved the communication among providers, it was not in the scope of this study to assess whether or not a checklist improved patient outcomes. Larger-scale studies are needed to assess the effect of improved communication using a checklist for handoffs on patient outcomes. The potential to decrease errors related to miscommunication

is a potential benefit of implementing a checklist for the transfer of care in the postoperative setting.

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DISCLOSURES

The authors have declared they have no financial relationships with any commercial interest related to the content of this activity. The authors did not discuss off-label use within the article.