Hand-Off Communication: A Requisite for Perioperative Patient Safety

ELAINE J. AMATO-VEALEY, PhD, RN; MARIANNE P. BARBA, MS, RN; RYAN J. VEALEY, BS

With the increasingly specialized nature of surgical care, patients undergoing surgery are at a greater risk of experiencing iatrogenic errors, especially if inadequate hand-off reports occur. The traditional patient report from nurse to nurse now needs to be a sophisticated, precise, comprehensive compendium of patient information that focuses on patient safety. Communication during a hand off (ie, a transition from one care provider to another care provider) should not be an abrupt, meaningless summary concluding one caregiver’s responsibility, but rather a coordinated effort among professionals involved in the changeover of patient care. Hand-off communication must be accurate, clear, and specific and provide the opportunity for all parties involved to ask questions or voice concerns. 

ONE RECOGNIZED APPROACH to addressing this concern is the SBAR (ie, situation, background, assessment, recommendation) communication technique. Reference cards with the SBAR communication approach can be used by all staff members during hand offs in the preoperative, intraoperative, and postoperative phases of care. Transitions between these phases are considered high-risk time frames.

At each phase of the complex journey through a facility’s perioperative department, each team of caregivers has specific responsibilities and objectives that are as different as they are similar. With such specialized care, effective communication between members of the perioperative team is of paramount importance.

Numerous factors and environmental distractors occur during the perioperative process that increase the potential for errors. Care provided in all phases of the perioperative process is driven by the need:
• for rapid turnover,
• for increased volume and efficiency,
• to improve physician satisfaction, and
• to accelerate throughput for the surgical patient.

ABSTRACT

TRANSITIONS FROM ONE CARE PROVIDER to another put patients at increased risk of injuries and errors. A standardized approach to hand-off communication helps minimize these risks.

ONE RECOGNIZED APPROACH to addressing this concern is the SBAR (ie, situation, background, assessment, recommendation) communication technique. Reference cards with the SBAR communication approach can be used by all staff members during hand offs in the preoperative, intraoperative, and postoperative phases of surgical patient care. AORN J 88 (November 2008) 763-770. © AORN, Inc, 2008.
This hurried environment often is the backdrop for communication errors and mistakes that could have fatal implications.

Ineffective communication is the most frequently cited root-cause category of sentinel events. Effective communication, which is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved patient safety. In an effort to prevent sentinel events from occurring, the Joint Commission publishes the National Patient Safety Goals annually. National Patient Safety Goal 02.05.01 states that health care organizations are required to implement a standardized approach to hand-off communications, which must include an opportunity to ask and respond to questions.

**THE SBAR COMMUNICATION TECHNIQUE**

The SBAR (ie, situation, background, assessment, recommendation) communication technique provides a standardized framework for communication between members of the health care team about a patient’s condition. The SBAR technique is an easy-to-remember, concrete mechanism useful for framing a conversation, especially a critical one that requires a clinician’s immediate attention and action. It provides a focused way to set expectations for what will be communicated and how it will be communicated between members of the team, which is essential for developing teamwork and fostering a culture of patient safety.

The SBAR communication technique consists of four components.

- **Situation**—What is going on with the patient? Identify yourself and the patient. State the problem.
- **Background**—What is the background on this patient? Review the chart before speaking up if the situation allows the time. Anticipate questions the other care provider may have.
- **Assessment**—Provide your observations and evaluations of the patient’s current state.
- **Recommendation**—Make an informed suggestion based on sound information for the continued care of the patient.

Operationalizing the SBAR technique during the perioperative period can help minimize patient safety risks.

**OPERATIONALIZING SBAR**

Errors can occur when a procedure is scheduled, when care providers are obtaining the patient’s history and performing the preoperative physical examination, during the informed consent process, and when a care provider is documenting care provided at any point in the surgical process. The SBAR technique helps prevent errors by providing a standardized approach for perioperative staff members to use as a patient
- is prepared for the OR;
- undergoes an operative or other invasive procedure; and
- returns safely to the postanesthesia care unit (PACU), during which the patient progresses from
  - phase I recovery (ie, the immediate postoperative period during which the patient regains physiological homeostasis and receives appropriate nursing interventions as needed) to
  - phase II recovery (ie, the period of time during which the patient becomes more alert and functional and prepares for self-care, care by family members, or care in an extended care environment).

**HAND-OFF COMMUNICATION BETWEEN THE SURGEON’S SCHEDULING OFFICE AND THE HEALTH CARE FACILITY SCHEDULING DEPARTMENT.** The surgical verification process begins at the time the surgical procedure is scheduled, originating from the surgeon’s office and moving to the health care facility’s surgical scheduling office. Potentially, this interaction can be the first break in the communication process. An error that occurs here can go undetected and has the likelihood to result in patient harm. Unfortunately, miscommunications at this point may not be picked up until the day of the surgery and may cause a delay in the OR or, more significantly, result in wrong site surgery. One solution to prevent such last-minute errors would be to call both the surgeon’s office and the patient on the day before the surgery to verify the correct date, time, and procedure.
Hand-off communication between the health care facility’s scheduling department and the preoperative area. One of the first responsibilities of the preoperative nurse is to obtain the surgery schedule. The preoperative nurse then ensures that the scheduled procedure is consistent with the patient’s understanding of the procedure as well as the informed consent, and that both are consistent with the patient’s diagnosis. The nurse also ensures that all required documents are in place, including the history and physical examination (H&P), blood work results, and any other diagnostic test results required for surgery. The nurse ensures that the surgeon has performed an H&P update before surgery.

The Joint Commission’s Universal Protocol has become a guiding principle for all perioperative team members and should be applied to or adapted for all operative and other invasive procedures. The Universal Protocol is now included in the overall 2009 Hospital National Patient Safety Goals document. The surgical verification process must include the following essential elements:
- active communication among all members of the surgical team;
- involvement of the patient or a legally designated representative in the process; and
- a requirement for site marking that focuses on surgical procedures involving laterality (ie, right/left distinction), multiple structures (eg, fingers, toes), or multiple levels (eg, spine).

Verification of the correct person, correct site, and correct procedure occurs at the following times including...any time the responsibility for care of the patient is transferred to another member of the procedural care team, (including the anesthesia providers) at the time of, and during, the procedure.

The patient’s family members may be distractors in the surgical verification process because of the stress they are experiencing from their loved one’s impending surgery. The preoperative nurse should endeavor to involve the patient’s family members in the verification process at every opportunity to ensure that they are fully knowledgeable of the process and the correct surgical procedure.

Hand-off communication between the preoperative area and the intraoperative area. Hand-off communication improves patient outcomes when all participants take active part in the process. In the past, the hand-off communication between the preoperative and intraoperative areas sometimes was a short, terse statement or no report at all. Implementation of a standardized guide during hand-off communication can increase efficiency and patient safety and reduce unnecessary redundancy while encouraging built-in redundancy of vital facts. Table 1 outlines the SBAR elements of the optimal preoperative to intraoperative hand-off communication. This transition of care summarizes critical patient information such as
- verifying the correct patient and surgical procedure,
- reviewing required documents,
- discussing patient safety concerns,
- assessing preoperative vital signs and pain level,
- identifying cultural implications and the need for family presence, and
- verifying that all components of the surgical process have been followed correctly.

This hand-off communication serves as a baseline for future clinical transfers and ensures that patients are safe, secure, and comfortable as they are brought to the OR suite. All subsequent actions are based on this hand-off communication.

Another component of the Universal Protocol is the surgical time out. Before starting any operative or invasive procedure, a final “time out” verification should be conducted to confirm the correct patient, procedure, and site. This time out should include ensuring that all relevant documentation, related information, and necessary equipment are available. Although the surgical time out is initiated by a designated member of the surgical team, all immediate members of the surgical team must participate in the time out, during which all other activities are suspended as much as possible without compromising patient safety. The procedure is not started until all questions and concerns have been addressed satisfactorily.
Hand-off communication between the intraoperative area and Phase I PACU. In the past, the patient’s response to the surgical experience may have been noted in a routine report with little emphasis on specific surgical events. Hand-off communication during this transition of care often occurs when nursing staff members are performing several tasks simultaneously. Staff members should set aside time for hand-off communication, allowing opportunities to ask questions or to ask for clarifications. Table 2 outlines the SBAR elements of the intraoperative to PACU transition, highlighting OR events that have occurred. Being as specific as possible is critical. Informing the PACU nurse about the patient’s past medical history also may be vitally important.

Components of this transition should include presenting information on how the patient tolerated the procedure and whether the procedure went as planned. The circulating nurse should inform the PACU nurse whether the patient is hemodynamically stable (eg, heart rate and rhythm) and whether the patient

**Table 1**

### Elements of the Preoperative to Intraoperative Hand-Off Communication

<table>
<thead>
<tr>
<th>Situation</th>
<th>Name of patient and date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of operative or invasive procedure to be performed including modifiers and site</td>
<td>Pertinent documents are present and consistent</td>
</tr>
<tr>
<td>Pertinent documents are present and consistent</td>
<td>Medical clearance</td>
</tr>
<tr>
<td>Patient allergies and NPO status</td>
<td>Patient’s vital signs and pain level</td>
</tr>
<tr>
<td>Medication profile and medications taken today</td>
<td>Specific laboratory results</td>
</tr>
<tr>
<td>Specific laboratory results</td>
<td>Code status of patient</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>Elements of patient history pertinent to surgery</td>
</tr>
<tr>
<td>Type of anesthesia administered and name of anesthesia care provider</td>
<td>Intraoperative medications administered including dose and time</td>
</tr>
<tr>
<td>IV fluids administered</td>
<td>Estimated blood loss</td>
</tr>
<tr>
<td>Pertinent information related to the surgical site such as dressings, tubes, drains, or packing</td>
<td>Any significant OR events</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Patient’s current level of understanding of the surgery</td>
</tr>
<tr>
<td>Special patient needs or precautions</td>
<td>Pertinent aspects of the patient’s emotional and spiritual status</td>
</tr>
<tr>
<td>Pertinent cultural implications</td>
<td>Anesthesia requests</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>State whether the patient has been seen preoperatively by the surgeon and anesthesia care provider</td>
</tr>
<tr>
<td>Determine whether the patient is ready for surgery</td>
<td>Allow an opportunity for preoperative and intraoperative staff members to ask questions or voice concerns</td>
</tr>
</tbody>
</table>

**Table 2**

### Elements of the Intraoperative to Postanesthesia Care Unit (PACU) Hand-Off Communication

<table>
<thead>
<tr>
<th>Situation</th>
<th>Name of patient and date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of operative or invasive procedure performed including modifiers and site</td>
<td>Background</td>
</tr>
<tr>
<td><strong>Background</strong></td>
<td>Type of anesthesia administered and name of anesthesia care provider</td>
</tr>
<tr>
<td>Intraoperative medications administered including dose and time</td>
<td>IV fluids administered</td>
</tr>
<tr>
<td>Estimated blood loss</td>
<td>Pertinent information related to the surgical site such as dressings, tubes, drains, or packing</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>Hemodynamic stability</td>
</tr>
<tr>
<td>Airway and oxygenation status</td>
<td>Thermal status (eg, presence of hypothermia or hyperthermia)</td>
</tr>
<tr>
<td>Urine output</td>
<td>Presence or absence of surgical complications</td>
</tr>
<tr>
<td>Level of pain</td>
<td>Method of pain management</td>
</tr>
<tr>
<td><strong>Recommendations</strong></td>
<td>Ensure that immediate postoperative orders have been completed</td>
</tr>
<tr>
<td>Discharge from the PACU when stable</td>
<td>Allow opportunity for intraoperative and PACU staff members to ask questions or voice concerns</td>
</tr>
</tbody>
</table>
experienced any intraoperative complications. The circulating nurse should inform the PACU nurse of any medications he or she gave intraoperatively including the dose(s), time(s), and therapeutic responses. The circulating nurse also should report the patient’s current comfort level to the PACU nurse.

**Hand-off communication between phase I PACU to the phase II recovery area.** At the completion of phase I recovery, patients may be admitted to a hospital room or proceed to phase II recovery for discharge. These transitions of care are similar, but are differentiated by emphasis placed either on continuing hospitalization or discharge. Table 3 outlines the SBAR elements of the PACU to inpatient unit hand-off communication, which should mirror that of the intraoperative to PACU transition. Specific emphasis is placed on medication reconciliation. Medications administered in the PACU must be added to the medication reconciliation form and the patient response noted, as well as the time that the last dose was administered. Vital signs and pain level also are emphasized during this transition of care. As the patient’s level of consciousness returns, assessment parameters are reestablished as a baseline for hand-off communication to the next caregiver. Patients who are fully recovered and are preparing to leave the health care facility require education for discharge as well as the completed medication reconciliation form.

**Case Study**

Mrs L is a 66-year-old woman who presented to her physician’s office with a three-month history of vaginal bleeding. After a lengthy discussion and physical examination, the physician recommended and the patient consented to undergoing an abdominal hysterectomy. Mrs L met with the physician’s surgical coordinator to have her surgery scheduled. The office was busy with telephones ringing, several patients signing in to be seen, and a product representative asking to see the surgeon. The surgical coordinator asked, “What date is good for you?” Mrs L identified a preferred date for surgery and the surgical coordinator suggested a 9 AM start time and then informed Mrs L that she would call her later to confirm all the information. Although this never occurred, Mrs L assumed that it meant her surgery date and time were approved.

Mrs L presented to the ambulatory surgical center (ASC) for an abdominal hysterectomy at 9 AM on the suggested date. On arrival, the
ASC secretary asked Mrs L to verify her name, date of birth, and surgical procedure. The secretary noted that the surgical schedule listed Mrs L as being scheduled for a “vaginal” hysterectomy. The secretary immediately notified the OR manager of the discrepancy in procedure type. The OR manager then notified the assigned circulating nurse. The nurse and assigned scrub person worked cooperatively to repick a case cart for the corrected procedure, repositioned the OR bed, and reset up the OR for an abdominal rather than a vaginal hysterectomy.

This error resulted in a surgical delay, which frustrated the surgeon. Although the patient understood the error and delay, she became very anxious. Mrs L’s family also was very anxious and required reassurance that the correct surgery was going to take place.

Using the SBAR communication technique, the preoperative nurse gave the following hand-off report to the circulating nurse.

- **Situation**—This is Mrs L, date of birth 9/21/42, a 66-year-old patient of Dr H. She has been preoperatively prepared for an abdominal hysterectomy. All documentation, laboratory reports, and signed informed consent are present in the record. Mrs L’s history and physical examination are on the chart and have been updated.
- **Background**—For the past three months, Mrs L has experienced postmenopausal bleeding. Furthermore, she has a medical history of atrial fibrillation that is controlled with diltiazem and warfarin and has chronic obstructive pulmonary disease (COPD) that is well controlled with an ipratropium/albuterol inhaler. As instructed by her surgeon, Mrs L has not taken the warfarin for the past five days. She has no known allergies and has been NPO since 10 PM last night.
- **Assessment**—Mrs L experienced a scheduling error today, so she is extremely nervous. To verify again, she is scheduled to undergo an abdominal hysterectomy.
- **Recommendations**—Mrs L has been seen preoperatively by her surgeon and her anesthesia care provider. Do you have any questions?

The surgical procedure proceeded without incident and the anesthesia care provider and the circulating nurse transported Mrs L to the PACU. The following hand-off report, which did not follow the SBAR technique, took place between the circulating nurse, anesthesia care provider, and PACU nurse:

> Mrs L—abdominal hysterectomy. Received general. Is on her fourth bag of lactated Ringer’s (LR) solution. Minimal blood loss. Dressing is dry. Catheter placed in the OR. Was given ondansetron and morphine in the OR before coming out.

By comparison, the following exchange would have complied with the Joint Commission’s National Patient Safety Goal on hand-off communication. The circulating nurse and anesthesia care provider could have used the SBAR communication technique and cooperatively reported the following information to the assigned PACU nurse:

- **Situation**—This is Mrs L, date of birth 9/21/42, a 66-year-old patient of Dr H. She just underwent an abdominal hysterectomy.
- **Background**—Mrs L has experienced postmenopausal bleeding for the past three months. Mrs L has no known allergies, but she has a medical history of atrial fibrillation that is controlled with diltiazem and warfarin. Mrs L also has COPD that is well controlled with an ipratropium/albuterol inhaler. Mrs L received general anesthesia with endotracheal intubation and has received 3,000 mL IV LR solution during surgery. This is her fourth bag of LR. Mrs L had approximately 200 mL of blood loss, and her abdominal dressing is dry and intact.
- **Assessment**—Mrs L’s tympanic temperature is 37°C. An indwelling urinary catheter was placed in the OR, which drained 300 mL of clear urine during surgery, and the bag was emptied before transfer. She was given morphine 4 mg at 10:15 AM and ondansetron 4 mg at 10:30 AM. Mrs L’s vital signs when leaving the OR were 96/64, 78, 16, pulse oximetry 99% on 3 L of oxygen. She is
hemodynamically stable although she continues in atrial fibrillation. No complications occurred.

- **Recommendations**—Maintain the patient on 3 L of oxygen by face mask because of her history of COPD. Discharge her to the patient care unit when stable. Does anyone have any questions?

As illustrated by the above example, the SBAR communication technique provides much more context into which clinical data related to surgery is communicated. Too often, critical pieces of the patient’s past medical history are omitted from the hand-off report given by the circulating nurse and anesthesia care provider to the PACU nurse because these details are not deemed “pertinent.” Such omissions can, in fact, be detrimental and even catastrophic for the patient. The extra few minutes required to provide hand-off communication in a standardized way can prevent miscommunications from occurring, which could ultimately result in an unnecessary adverse event.

**Effective Hand-Off Communications**

Effective and standardized communication between care providers at hand-off points during the perioperative process will help them facilitate safety and anticipate and limit complications. Communication that is timely, accurate, complete, unambiguous, and understood by the recipient reduces error and results in improved patient safety.

The SBAR mnemonic outlines caregiver conversations to summarize critical patient information. With this format, communication occurs effectively with information being transmitted in the same format and order, every time. Operationalizing hand-off communication throughout the perioperative process can be challenging; however, for each transition phase, the SBAR technique not only contains unique information pertinent to that phase of care but also provides built-in redundancy of vital facts so that essential information is not lost in the process.

It is possible that certain errors cannot be avoided during the surgical experience, but a communication error is not one of them. It is recommended that reference cards be created similar to the tables presented in this article. These reference cards can be attached to employee identification badges for quick and easy reference to facilitate safe patient care and encourage adequate hand-off communication.

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**Editor’s note:** The Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery is a trademark of the Joint Commission, Oakbrook Terrace, IL.

**REFERENCES**


**RESOURCES**


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**Pine Bark Extract May Reduce Menstrual Pain**

Taking a French maritime pine bark extract may reduce symptoms of dysmenorrhea, a condition that causes extremely painful menstruation, according to a June 18, 2008, news release from Natural Health Science, Inc, Hoboken, New Jersey. Research showed that women taking the extract had less painful menstrual periods and took fewer nonsteroidal anti-inflammatory drugs (NSAIDs) than women taking placebo.

The double-blind study, conducted in Japan, included 116 women ages 18 to 48 years. The women kept a diary throughout the six-cycle study to note pain levels and NSAID usage. For the first two cycles, the women did not receive any treatment; for the second two cycles, they were randomly assigned to receive either pine bark extract or placebo; and for the final two cycles, they discontinued treatment.

Analysis showed the number of painful days decreased from an average of 2.1 days prior to treatment to 1.3 days with pine bark treatment. When treatment was discontinued, pain did not immediately return and NSAID usage did not increase.

Dysmenorrhea is believed to be caused by elevated levels of inflammation. The pine bark extract was studied for alleviating symptoms of menstrual pain because of its natural anti-inflammatory properties.

*New study: pine bark significantly reduces menstrual pain [news release]. Hoboken, NJ: Natural Health Science, Inc; June 18, 2008.*
Hand-Off Communication: A Requisite for Perioperative Patient Safety

PURPOSE/GOAL
To educate perioperative nurses about how to operationalize the SBAR (ie, situation, background, assessment, recommendation) technique for hand-off communication during perioperative transitions.

BEHAVIORAL OBJECTIVES
After reading and studying the article on perioperative hand-off communication, nurses will be able to

1. define hand-off communication,
2. explain how National Patient Safety Goal 02.05.01 addresses hand-off communication,
3. describe the SBAR communication technique, and
4. explain how to use the SBAR technique in hand-off communication during perioperative transitions.

QUESTIONS

1. A hand-off report
   1. is communication that takes place during a patient’s transition from one care provider to another.
   2. is a comprehensive compendium of patient information.
   3. must be accurate and specific.
   4. should provide an opportunity for all parties involved to ask questions and voice concerns.
   5. should focus on the patient’s safety.
       a. 1 and 3
       b. 2, 4, and 5
       c. 2, 3, 4, and 5
       d. 1, 2, 3, 4, and 5

2. National Patient Safety Goal 02.05.01 states that health care facilities must
   a. conduct preprocedure verification.
   b. communicate a complete list of the patient’s medications when the patient is transferred to another setting.
   c. implement a standardized approach to hand-off communications that includes an opportunity to ask and respond to questions.
   d. use at least two patient identifiers when providing care, treatment, and services.

3. The SBAR technique
   1. is a concrete mechanism for framing a conversation.
   2. provides a focused way to determine what information will be communicated.
   3. can be used to develop teamwork and foster a culture of patient safety.
       a. 1
       b. 2
       c. 2 and 3
       d. 1, 2, and 3

4. The component of the SBAR communication technique during which the relieving care provider supplies the receiving clinician with observations and evaluations of the patient’s current state is the
   a. situation.
   b. background.
   c. assessment.
   d. recommendation.

5. One element that is unique to the preoperative to intraoperative hand-off report is communicating
a. whether the patient has been seen preoperatively by the surgeon and anesthesia care provider.
b. the name of the operative or invasive procedure performed including modifiers and site.
c. the patient’s hemodynamic stability and thermal status.
d. what IV fluids have been administered.

6. The intraoperative to postanesthesia care unit (PACU) hand-off communication should include
   1. the type of anesthesia administered.
   2. the estimated blood loss.
   3. any significant OR events.
   4. pertinent information related to the surgical site.
   a. 1
   b. 2 and 4
   c. 1, 2, and 3
   d. 1, 2, 3, and 4

7. Specific surgical events do not have to be relayed during the intraoperative to phase I PACU hand-off communication because nursing staff members are performing several tasks simultaneously during this transition time.
   a. true
   b. false

8. One element that is unique to the PACU to inpatient unit hand-off report is communicating the
   a. need to provide discharge instructions.
   b. patient’s airway and oxygenation status.
   c. presence or absence of surgical complications.
   d. type of anesthesia administered.

9. During the PACU to inpatient unit hand-off communication, specific emphasis is placed on medication reconciliation.
   a. true
   b. false

10. Elements that are common to all perioperative hand-off communications (eg, preoperative to intraoperative, intraoperative to PACU, PACU to inpatient unit) include
    1. the patient’s name and date of birth.
    2. the name of the operative or invasive procedure.
    3. any significant OR events.
    4. the patient’s level of understanding of the surgery.
    5. the opportunity for staff members to ask questions or state concerns.
    a. 1 and 3
    b. 1, 2, and 5
    c. 2, 3, 4, and 5
    d. 1, 2, 3, 4, and 5

The behavioral objectives and examination for this program were prepared by Rebecca Holm, RN, MSN, CNOR, clinical editor, with consultation from Susan Bakewell, RN, MS, BC, director, Center for Perioperative Education. Ms Holm and Ms Bakewell have no declared affiliations that could be perceived as potential conflicts of interest in publishing this article.

This program meets criteria for CNOR and CRNFA recertification, as well as other continuing education requirements.

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This evaluation is used to determine the extent to which this continuing education program met your learning needs. Rate these items on a scale of 1 to 5.

Purpose/Goal
To educate perioperative nurses about how to operationalize the SBAR (ie, situation, background, assessment, recommendation) technique for hand-off communication during perioperative transitions.

Objectives
To what extent were the following objectives of this continuing education program achieved?
1. Define hand-off communication.
2. Explain how National Patient Safety Goal 02.05.01 addresses hand-off communication.
3. Describe the SBAR communication technique.
4. Explain how to use the SBAR technique in hand-off communication during perioperative transitions.

Content
To what extent
5. did this article increase your knowledge of the subject matter?
6. was the content clear and organized?
7. did this article facilitate learning?
8. were your individual objectives met?
9. did the objectives relate to the overall purpose/goal?

Test Questions/Answers
To what extent
10. were they reflective of the content?
11. were they easy to understand?
12. did they address important points?

Learner Input
13. Will you be able to use the information from this article in your work setting?
   1. yes
   2. no
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   1. the AORN Journal I receive as an AORN member.
   2. an AORN Journal I obtained elsewhere.
15. What factor most affects whether you take an AORN Journal continuing education examination?
   1. need for continuing education contact hours
   2. price
   3. subject matter relevant to current position
   4. number of continuing education contact hours offered

What other topics would you like to see addressed in a future continuing education article? Would you be interested or do you know someone who would be interested in writing an article on this topic?
Topic(s): __________________________________________
__________________________________________
__________________________________________

Author names and addresses: __________________________
__________________________________________