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Changing Hand-off Communication in the PACU setting

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Changing Hand-off Communication in the PACU setting
A Paper Submitted in Partial Fulfillment of the Requirements

For NURS 5382: Capstone

In the School of Nursing

The University of Texas at Tyler

by

Alisa Berndt

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Executive Summary

After investigating several incident reports placed in year 2021 to 2022 related to “near miss” events occurring in the Post Anesthesia Care Unit (PACU) it was found that many of these events were related to lack of good hand-off communication between healthcare staff. These “near miss” events could have led to medication errors, compromised patient or staff safety, and delay in patient care provided based on the information that was received in hand-off report. According to Dunkle (2014), “communication failures have been uncovered as the root cause of over 60% of sentinel events reported to the Joint Commission” (slide 7). These are potential errors that are preventable and have the likelihood of causing serious harm had the line not been stopped or a timeout was taken to receive further clarification on the patient’s situation.

It is imperative to provide a full hand-off report to understand all the factors at play in the patient’s current condition. Electronic communication is not sufficient alone and it is recommended either a verbal or an in-person at bedside handoff report should also be implemented to provide excellent communication between the healthcare staff that is caring for a patient (Joint Commission, 2017). It is important to note that such communication failures are responsible for 30 percent of all malpractice claims, resulting in 1,744 deaths and \$1.7 billion in malpractice costs over a five-year period (The Joint Commission, 2017). These communication failures were related to hand -off communication being too casual and not following a standardized tool.

The current practice does not have a standardized hand-off communication tool that is fully utilized. In addition, there is not a standard process flow for hand -off communication, leaving it to the surgical teams to decide whether to give hand-off report to the receiving PACU RN or not. This inconsistency of communication and bedside hand-off report is not

recommended by the Joint Commission and has led to delays in patient care. To mitigate the occurrence of omitted patient information or miscommunication in the PACU setting it is recommended to implement a standardized hand-off communication tool. After implementing a standardized hand-off communication tool it is recommended to institute a standardized process flow for all surgical cases; thus, providing consistent, accurate, and efficient communication.

Rationale for the Project

Medication errors alone cost approximately \$20 billion a year (Rodziewicz et al., 2022). It was also found that between 500,000 and 1.5 million Americans admitted into hospitals are harmed by preventable medical errors, ranking medical errors as the eighth leading cause of death in the United States (NCSL, 2016). An example of how miscommunication led to a medication error event occurred in the PACU in 2021. The PACU had received a post operative patient and report was given without the use of a standardized hand-off communication tool or process flow in place. The patient expressed uncontrolled pain during phase I recovery, prompting the RN to call the anesthesia provider to assess the patient for an emergency pain relief treatment. As time out for this pain relief treatment was concluding, an operating room nurse questioned the procedure and stopped the line because a particular pain medication had been administered by the resident surgeon. This information had not been provided in hand-off report. If the OR nurse had not coincidentally come to the PACU to deliver additional paperwork

a serious patient safety event related to inappropriate medication administration would have occurred.

To provide safe patient care in the PACU setting, changes in handoff report practices must be implemented by improving the written or electronic charting and verbal hand- off report to meet JCO standards (Joint Commission, 2017). At the KCVA there was a hand-off tool present; however, not all stakeholders were aware of this tool, thus leading to inconsistent use of the tool and varying information provided in hand- off report. To improve the accuracy, efficiency, and consistency of hand-off report received in the PACU a standard operating policy (SOP) has been created. The SOP includes a standardized hand-off communication tool for surgery staff (Surgery resident or staff surgeon, OR circulator RN, CRNA) as well implementing to a standardized flow of communication and the order of hand-off report given (who will provide hand off report first, second, and thirdly). For this project to be successful, full stakeholder buy- in is required for the new process flow and communication tools to be used consistently. The goal of this capstone project will be for the PACU to decrease incident reports related to communication errors by 25% within 6 months of implementation of the standardized hand-off communication tool. As a result, this would increase patient and staff satisfaction rates, patient safety, and quality of care in the PACU.

Literature Synthesis.

The 6 identified keeper studies that were found after conducting a literature review in the spring and fall semesters of 2021 overwhelmingly agree on the importance of implementing a

standardized hand-off communication tool that is tailored to the PACU setting. For successful tool implementation, utilization, and positive outcomes all necessary stakeholders must be included in this tool with overall stakeholder buy in. Due to study limitations, it is recommended to have large sample sizes, pre- and post-implementation surveys, and a randomized or blind survey approach to mitigate the risk of the Hawthorne effect biasing the project (Cyriax et al, 2021; Halladay et al., 2019; Jelacic et al., 2021). Also, older electronic charting systems were found to delay communication between healthcare providers, delay patient care, decrease access to patient information and difficult to use (Braaf et al., 2015). Differences in these studies were related to the funding of these studies, size of the study, and how data was collected. In addition, appropriate education of the communication hand-off tool to end users and stakeholder buy in were found to have a positive correlation with increased tool utilization.

An updated literature search was conducted from June fifth through the sixth of 2022. The electronic databases that were used for this updated search were: APA PsycInfo, Cochrane Library, CINAHL Complete, OVID, and PubMed. To replicate a similar literature search that was conducted in the spring and fall semesters of 2021 the same keywords were used. These keywords included: handoff communication, nursing communication, PACU communication, and standardized communication. An additional limitation was applied to the literature search to prevent overlapping of search results, published articles were limited to the years 2019 to 2022 (current). According to Cochrane Library, 17 new articles have been added in the last year regarding standardized hand-off communication. The OVID database found 42 articles with the keywords and search restrictions. When the PubMed database was used 384 results were found for the keyword hand-off communication and 307 results were found for nursing hand-off communication. The Cochrane Library was able to locate 217 articles related to standardized

communication, and 41 results for standardized nursing communication. After further review, 4 of these articles were selected for further evaluation. Two of the four articles were found to be of moderate or strong evidence. These two new articles have been included in the evidence table after GAO and RCA forms were completed on these two articles.

Project Stakeholders

Stakeholder involvement is vital in the successful implementation and longevity of the hand-off communication tools and process flow utilization. A stakeholder is identified as healthcare providers, policy makers, healthcare consumers, or healthcare staff that are needed to design, implement, and manage this project (Melnik & Fineout-Overholt, 2019, p. 536). The stakeholders with direct involvement or participation in this project would be the post op surgical patients and family, CRNA (Certified Registered Nurse Anesthetist) providers, OR (Operating Room) nursing staff, Surgical providers (resident or staff provider), PACU (Post-Anesthesia Care Unit) RN staff. These listed staff can also be categorized as frontline staff, observing, and surveying these stakeholders will be essential in measuring the tools and process flow effectiveness as well as identify areas of improvement. If the frontline staff do not have adequate training or education and buy in these tools and new process flow may not be utilized consistently or correctly. The midlevel management such as the CRNA manager, OR RN manager, and PACU RN manager will ensure the tool and process flow are implemented, observational studies are conducted, in services or educational meetings are held, and pre-implementation and post implementation surveys are provided. Lastly, the senior management stakeholders are the Chief of Surgery and the Associate Chief Nurse of Surgical services; these

two individuals are needed to support, approve, and take ownership of the SOP and the process flow that are being implemented.

Implementation Plan

Once project excitement has been obtained through constructive open discussion among PACU nursing staff the creation of an implementation team will be formed. The project will be conducted over a 3-month period in the PACU. After the roles have been delegated, these project members will refer to the Staff and Stakeholders to Engage as All Levels, figure 9.4, to identify and educate all needed stakeholders for this project to obtain unanimous buy in and tool compliance (Melnyk & Fineout-Overholt, 2019, p. 275). Prior to starting the implementation of the project, a pre-implementation survey will be given to participants from the stakeholder groups. This pre-implementation survey will obtain information from the stakeholder participants such as: staff satisfaction of current hand off report information, consistency of vital information being communicated, efficiency, and information participant deems vital in hand-off report. The hand-off communication tool will start being used in the Ambulatory Surgery Unit (ASU) as communication from ASU nurses to Operating Room (OR) nurses, surgical staff, and anesthesia staff. The tool will follow the patient through surgery where the tool will be used during the time out process, and then used in the PACU hand-off report given by the OR nurse, surgical resident, and anesthesia staff. This tool will provide all vital surgical tour information, patient health history, medications, pre-op vital signs, and surgical site information. Potential barriers that have been identified for this project is obtaining stakeholder buy in; education and keeping stakeholders well informed will increase the buy in, compliance, and consistent utilization of the tool. Another barrier identified is the surgical resident roster rotating monthly;

to prevent surgical residents from being absent in PACU to provide hand-off report. The PACU RN manager, project gatekeeper, will remind residents to accompany patient to PACU after surgery to provide hand-off report and educate residents about the hand off tool at the all-staff monthly meeting.

Two nursing staff will be responsible for providing the pre- and post-implementation surveys and dissemination of evidence and project results. In addition, two PACU nurses will take on the observation role to evaluate the compliance, accuracy, and effectiveness of the hand-off tool. The hand-off communication tool will be created based on all the stakeholders' needs. It is anticipated that tool creation may take 2- 4 weeks to create prior to implementation as per the Sample EBP Implementation Project Plan (Melnik & Fineout-Overholt, 2019, p. 283). The observer nurses will attempt to remain anonymous during the implementation period. These nurses will be using a standardized evaluation tool to obtain consistent and accurate data. Below is the projected implementation plan provided in a step-by-step fashion:

1. Assess or observe PACU unit hand-off communication. Determine whether the communication is standardized by using a communication hand-off tool.
2. Conduct a survey of the nursing staff in PACU to obtain baseline satisfaction level of hand-off report received from surgery staff (Surgery resident or surgeon, OR circulator RN, CRNA).
3. Identify all stakeholders: ASU nursing staff, PACU nursing staff, phase II nursing staff, Surgery residents or staff surgeons, OR circulator RN staff, CRNA staff, and management of these departments.
4. Meet with ASU, PACU, and phase II nursing staff and create a list of identified vital patient information in hand-off report.
5. Create a flowchart of current process and estimated time spent in each step of flow chart. Then create the projected flowchart when a standardized hand-off communication tool and flow is used.
6. Schedule and present a rough draft of a SOP, standardized hand-off communication tools, and flowcharts in sale pitch meeting with stakeholder management.
7. Once buy-in from all stakeholder management is obtained, schedule meetings with staff from stakeholder departments to obtain majority buy-in. Adjust tools and SOP as needed for staff compliance.
8. Optional: assign or obtain a volunteer liaison from each stakeholder department. Identify 1 to 2 observers in the PACU that will be conducting data collection observations of hand-off report (once tools and flow have been implemented for 1–3-month period).
9. Initiate or implement communication hand-off tools and flow after all appropriate staff have been educated on the tools and flow.
10. Every month review data collected, and quality check the 1-2 observers to make sure they are both observing hand-off report the same way and documenting the same way to eliminate data collection variances

11. End observation and data collection once the deadline is met. Review, evaluate, and present the results to the stakeholders.
12. Based on the results, determine whether standardized hand-off communication tools and flow had a positive impact or positive outcomes. If positive outcomes are found, permanent implementation is recommended to promote patient safety, patient and staff satisfaction rates, and high-quality care.

Timetable/Flowchart

The projected timetable is a rough estimation and may take less time or longer depending on the length of time it takes for stakeholder buy-in. The initial assessment of the PACU setting's hand-off communication and process flow along with conducting a survey and identifying the appropriate stakeholders for this project should take 1 week to complete. Step 4 and 5, meeting with ASU, PACU, and phase II nursing staff to create a list of items requested in hand-off report with the creation of the two flow charts (current process, and future process) will take 2- 3 weeks depending on the OR schedule and staffing. The creation of an SOP, hand-off communication tools, and presentation sales pitch for stakeholder management will take 2 weeks to complete.

It will take 2 weeks to obtain stakeholder buy-in including the education and sales pitch meetings. After overall buy-in has been achieved, the implementation of the hand-off communication tools, process flow, and the delegation of roles (volunteer project liaison and 2 PACU RN observers) and data collection period will take 1- 3 months. The evaluation and sharing of results with stakeholders will take 2 weeks to complete and formally decide permanent implementation based on project outcomes. In total, this project is projected to take 13 – 22 weeks (3.25- 5.5 months) to complete.

Data Collection Methods

The data collection team has been selected, there are 2 PACU staff that have been educated on the data collection and observation process to ensure both observers are consistently and accurately observing staff using the communication tools and process flow by using the same observation template. There is 1 ASU RN that is the hand-off communication tool liaison, and all stakeholders are aware to go to this person with questions or concerns regarding the tools. Stakeholders buy-in has been achieved, due to unforeseen circumstances there was a malfunction in the Sterile Processing Supply (SPS) department which halted OR surgeries for almost 3 weeks at this location. This has delayed the ability to implement and begin the observation process of this capstone project. Clearance has been given to resume some surgical cases but not all surgery cases at this time and the plan is to implement the hand-off communication tools and process flow by December 2nd of 2022 so an average of 7- 19 observations can be made per day Monday through Friday between 0730am- 8pm.

Unfortunately, there are no outcomes yet due to the implementation delay. Once the implementation and observation phases have been completed in this project, comparison measurements between pre- and post-implementation surveys may be evaluated. The results of the observation staff compliance/ utilization of tools and process flow can be disseminated to stakeholders, and the JSPR system can be reviewed to measure the reports of miscommunication events that took place in the PACU during the capstone project implementation phase. Positive outcomes are the following increased staff satisfaction levels related to surveys, 100%

compliance of tool use achieved, and zero miscommunication events found during the implementation phase.

Cost/Benefit Discussion

There are no projected added costs by implementing this project in the PACU. Currently, there is a patient information sheet being printed for surgical patients, this sheet will be revised and the communication hand off tools will be added to this sheet so no additional paper will be needed, and the additional ink usage is too marginal to calculate. This project should be saving time and not costing time for staff/ stakeholders that are providing or receiving hand-off report using the standardized hand-off communication tools and process flow. In addition, the implementation of this project should decrease the length of time the patient spends waiting in the PACU for doctor's orders to be placed and/ or additional patient information to be received and verified. Due to increased communication efficiency, this project should significantly mitigate the need for the PACU RN to page or call the surgeon or resident for additional information and potentially decrease incidents of next surgical cases from being delayed.

Discussion of Results

At this time this capstone project has not been fully implemented in the PACU setting and not enough data has been collected to determine if the project has been successful with positive outcomes. This lack of data collection is due to the unforeseen surgery stoppage at this facility due to machinery malfunctions in the SPS department halting all surgeries requiring the use of reusable medical equipment (RME) for almost 3 weeks. After this project has been implemented it is projected to have full compliance of tool use and process flow from stakeholders because of the unanimous buy-in that was achieved for this project. Due to such

positive emotions and input received from stakeholders and what research has found there is a high probability this project will have positive outcomes and permanent project implementation in the PACU.

Conclusions/Recommendations

Technology and healthcare are always changing and evolving with one another. Taking a few crucial minutes to deliver a standardized hand-off report to the receiving healthcare professional is vital in maintaining patient safety, and efficient high-quality care. The PACU setting is a revolving door where recovering patients stay for 30 minutes to 2 hours under the PACU RN's care before transferring to their next level of care. Due to high patient turnover rates and multitude of providers involved in patient's surgical tour, it is essential to have a communication tool that compliments the electronic charting system and is approved of by all the stakeholders, to ensure compliance with the tool. By implementing a standardized hand-off communication tool in conjunction with a standardized communication process flow, it is expected that incident reports related to miscommunication in the PACU will significantly decrease thus improving patient outcomes. The next step I recommend in this capstone project is to implement the standardized hand-off communication tools that have received all necessary stakeholder buy-in and implement the process flow to increase patient safety through accurate, consistent, and high-quality hand-off report in the PACU.

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Appendix A

Synthesis Table

Citation: Author, Date of Publ. & Title	Purpose of Study	Conceptual Framework	Design/ Method	Sample/Sett ing	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Worth to Practice: LOE Strengths/Weaknesses Feasibility Conclusion RECOMMENDATION
(Study #1) Rosenthal, J. L, Doiron, R., Haynes, S. C., Daniels, B., & Li, S.-T. T. (2018). The Effectiveness of Standardized Handoff Tool Interventions During Inter- and Intra-facility Care Transitions of Patient-Related Outcomes: A	Determine if using a SHOT during care transitions will improve PRO	None	Design: SR 6 databases searched: PubMed, Cochrane, PsycINFO, CINAHL, Embase, and Web of Science	N: 1810 E: 142 (After 1 st round of screening exclusions applied) E2: 14 (After 2 nd round of exclusions applied) Studies were EX vs QE and SHOR vs NHOR, Inter and Intra facility with IT	DV: HOR IV: RQSS	Data abstraction DV: Quality scoring system, Riesenberget al, tool used in prior systematic reviews on handoff interventions	Scoring system = 12 items scoring from 1 to 16 points 16 = highest quality score 12 items include: 2 items for study type and sample size, 5 items for reporting, and 5 items for internal validity	DSS: 1810 articles → 1654 T&ASP ↓ to 156 articles FTR ↓ to 14 studies were used	LOE: Level I evidence S: Utilized multiple credible databases W: inconsistent outcome measures & limited quality studies restricted, not able to perform meta-analysis F: Not feasible to apply to clinical practice due to the inconsistent results. CO= Study failed to find standard practice because of inconsistent heterogeneity of outcomes prohibiting a conclusion to be made R: Use a consistent and valid tool to measure outcomes. Expand study



A: Agree; ADN: Associates Degree Nurse; ANE: Anesthetic Providers ; BHOP: Baseline Hand off Observation with Published checklist; C: Control ; CF: Conceptual Framework ; CO: Conclusion; CS: Convenience Sample; D: Disagree; DC: Data Collection; DCM: Donabedian conceptual model; DS: Descriptive Study; DSS: Database Search strategy; DV: Dependent Variable; E: Experimental; EF: Effectiveness; ET: Evaluation Table; EU: Ease of Use F: Feasibility; FG: Focus Group; FTR: Full Text Review ; FT: Full- time; HIFS: Hospital # Interview and Focus Group Surgeons; HOS: Hospital # Observation of Surgeons; HIFA: Hospital # Interview and Focus Group Anesthetists; HOA: Hospital # Observation of Anesthetists; HIFN: Hospital # Interview and Focus Group Nurses; HON: Hospital # Observation of Nurses; HOR: Hand-off Report ; HOT: Hand off Tool; I: Intermittent Time; IMP: Implementation; IN: Initial Number; IT: Intervention Targeting; IV: Independent Variable; KS: Keeper Study; L: Location; LOE: Level of Strength; LOT: Length of Time; MDD: Minimal Detectable Difference; MSN: Masters of Science Nurse; Mo: Months; N: Number; NHOR: Not Standardized Handoff Report; OM: Outcome Measures; P: Physician providers; PIM: Pre-Implementation ; PT: Part-time; POIM: Post-Implementation ; PRN: Post Anesthesia Care Unit (PACU) Registered Nurse (RN); PIP: Pre-Implementation Phase; POP: Post-Implementation Phase; PRO: Patient Related Outcome ; PS: Patient Safety; QE: Quasi-experimental; R: Recommendations ; RQSS: Riesenber Quality Scoring System; QS: Quantitative Sample; S: Strengths; SA: Strongly Agree; SD: Standard Deviation; SHOR: Standard Handoff Report; SSI: Semi- Structured Interview ; SR: Systematic Review; SUR: Surgical Providers; SVR: Standard Verbal Report; T&ASP: Title & Article Screening Process; TIFS: Total Number of Interviews and Focus Groups, Surgeons ; TIFA: Total Number of Interviews and Focus Groups, Anesthetists; TIFN: Total Number of Interviews and Focus Groups, Nurses; TOS: Total number of Observations, Surgeons; TOA: Total number of Observations, Anesthetists ; TON: Total number of Observations, Nurses; TN: Total Number; TP: Total Providers; U: Usefulness; UN: Undecided; W: Weaknesses ; 3WPOIM: 3 Weeks Post- Implementation; 3MPOIM: 3 Months Post-Implementation

Systematic Review				Articles dated from 01/2000 to 05/2016 Language: US English only articles					to inter-facility transitions of care
(Study #2) Halladay, M. L., Thompson, J. A., & Vacchiano, C. A. (2019). Enhancing the Quality of the Anesthesia to Postanesthesia a Care Unit Patient Transfer Through Use of an Electronic Medical Record-Based Handoff Tool	Investigate miscommunication from CRNA to PACU RN to improve PS by using a standard EMR HOR checklist .	None	Design: QE, observational PIM and POIM Method: CS of 100 patients PIM, 3 weeks POIM, and 3 months POIM.	N: 100 BHOP1: 50 BHOP2: 50 3WPOIM1: 50 3WPOIM2: 50 3MPOIM1: 50 3MPOIM2: 50	C1: PACU 1 C2: PACU 2 DV: level of accurate, consistent, and concise observed HOR IV: HOT implementation	TO: 300 PIM: 150 POIM 150	Likert Scale Statistical analysis: IBM SPSS v.24 (value set to <0.05) ANOVA Levene's test = homogeneity variance analysis was changed to Welch's F. χ^2 test	ANOVA: difference in time points, mean percentage of total items addressed, $F(2, 147) = 5.88, P < .01$ χ^2 found: PI=n = 41, 41% Pol= n = 49, 55.7% 3wkPol-3moPo= n = 61, 61.6% PACU 1 data, Levene's test for homogeneity of variance was significant ($P < .05$), differences between groups, Welch's $F(2, 89.68) = 91.33, P < .001$	LOE: Level III evidence S: Large sample size use of many analyses' tools W: convenience sample conducted on nonrandomized providers F: Can be used in the PACU setting, may not be applicable in other settings C: Found an increase in PACU nurses' satisfaction rates with the implemented standard EMR in accurate information during HOR without affecting LOT R= perform a randomized controlled study to determine the general efficacy of SHOR.
(Study #3) Braaf, S., Riley, R., & Manias, E. (2015). Failures in communication through documents and documentation	Identify causes of charting communication failures between CRNAs, SUR and RNS.	None	Design: Qualitative Method: observation, focus groups, SSI	N: 800 SSI: 20 L: Melbourne, Australia Study Time: 01/2020-10/2020 350 hours of observation	DV: effectiveness of HOR IV1: Hospital 1 IV2: Hospital 2 IV3: Hospital 3	TN : 800 TP : 125 SUR : 18 ANE : 22 PRN : 75	deductive approach Data analysis: Ritchie and Spencer's (1994) thematic framework approach	H1IFS: 4 H1OS:6 H1IFA: 2 H1OA:10 H1IFN:5 H1ON:37 H2IFS:1 H2OS:4 H2IFA:2	LOE: Level V evidence S: Large sample size conducted at multiple facilities W: did not show data on the communication failures and compare which failure had a higher rate of occurrence

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n across the perioperative pathway				female (64%) between ages of 41–50 years (42%) SUR (n = 17, 16%) CRNA (n = 19, 18%) RN (n = 71, 66%) . 30 participated in FG and interviews, 12 observed. In all, SUR (n = 6, 20%), CRNAs (n = 5, 17%) and RNs (n = 19, 63%)				H2OA: 3 H2IFN: 7 H2ON: 18 H3IFS: 1 H3OS: 2 H3IFA: 1 H3OA: 4 H3IFN: 7 H3ON:11 TIFS: 6 TIFA: 5 TIN: 19 TOS: 12 TOA: 17 TON: 66	F: May be used as a reference to guide future studies C: miscommunication occurred due to poor documentation that was: insufficient, inaccurate, out of date technology, or not verbally reinforced leading to delays R: Future studies to examine interventions to improve communication via documents and documentation across perioperative pathway
(Study #4) Lauren S. Park, Gloria Yang, Kay See Tan, Charlotte H. Wong, Sabine Oskar, Ruth A. Borchardt, and Luis E.	Investigates effectiveness of SHOT and PS	None	A cross-sectional observational study	Sampling technique: cross-sectional observational study Sample Size: 60 PIP 60 POP Characteristics:	IV: 12 item physical checklist DV: Effectiveness of SHOR	SD: 5 MDD: 2.85 and 3.25 Stata 13: alpha level 0.05	Fisher's exact test Wilcoxon rank sum test	PIP: 8.7 items reported POP: to 10.9 reported SUR mean of 5.9 items PIP and 5.5 items POP MDD= 2.85 (80%) 3.25 (90%) power translates to (assumed mean) 7.85 and 8.25 for POP If SD = 2, MDD = 1.1 (80%) and 1.30 (90%) power	LOE: Level III evidence S: 100% consensus made between 2 observers post HOR W: Hawthorne Effect, user lack of training, HOR LOT F: May be used as a reference to guide future studies C: 12 item HOR checklist has +

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<p>Tollinche, (2017). Does Checklist Implementation Improve Quantity of Data Transfer: An Observation in Postanesthesia Care Unit (PACU)</p>				<p>Study observed the HOR between: RNs, PACU midlevel providers, CRNAs and SUR</p>					<p>outcomes data transfer and omission of patient information R: include multimodal staff training models, conduct study in a traditional randomized study</p>
<p>(Study #5) Claire Cyriax, Eunhea You,(2021) Developing and Implementing an Ambulatory Postanesthesia Care Unit Hand-Off Tool</p>	<p>Our study investigate using a SHOT for communication of critical patient information between PACU and ASC RNs</p>	<p>None</p>	<p>DS</p>	<p>Sample: QS Setting: ASC 20/24 RNs participants Characteristics: RN status FT, PT, or I Ages ranged from 30- 65 years Edu: AND-MSN RN exp.: 5 to 40 years LOT: 3 mo.: Phase 1: create HOT Phase 2:</p>	<p>IV: Standardized HOT for PACU RNs & ASC RNs DV: perceived relevance of HOT: EU, EF, & U.</p>	<p>Likert Scale Cronbach alpha coefficient</p>	<p>SPSS Statistics V21.0 (IBM Corp, Armonk, NY)</p>	<p>EU: 97% rate A (61.3%; n ¼ 60) or SA (35.7%; n ¼ 35) , 1% D, 2% UN (2%; n ¼ 2) EF: 97% A (63.3%; n ¼ 62) or SA (33.7%; n ¼ 34), 3% UN</p>	<p>LOE: Level VI evidence S: 20/24 RN participants, LOT 3 mo. W: small study population, only ASC staff surveyed F: Easy to be conducted LOT is reasonable, 3 mo. Short survey of 3 questions to increase compliance with completing survey. May be used as a reference to guide future studies C:  in useful, effective HOR with the HOT noted with RN  satisfaction with HOT</p>

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				implement HOT Phase 3: DC					R: sample size, include al stakeholders involved in HOR in PACU and ASC, conduct pre, intra, and post implementation surveys
(Study #6) Monica W. Rose, Susan Newman, Courtney Brown, (2018) Postoperative Information Transfers: An Integrative Review	Examine literature on protocols, checklists and tools for HOR with PACU staff	None	SR	Technique: IR Sample Size: 17 Characteristics: Systematic search of Cumulative Index to Nursing and Allied Health Literature, PubMed, SCO Agency for Healthcare Research and Quality, and Cochrane The DCM and PRISMA used	IV: SHOT implemented DV: Effectiveness of SHOT vs NHOR	DCM LOE PRISMA	None ET of KS	Abstract review = 497 articles 54 articles article review= 17	LOE: Level I evidence S: Utilized multiple credible databases W: 1 researcher was used, and may not have found all relevant studies, selection bias from screening limitations F: Consistent results validate need and ability to implement SHOT in PACU C: HOF and in omitted data R: Utilize additional researchers to expand research and screening process.
(Study 7)	Improve the process of transferring	None	CS	Technique: PACU	IV: HOT implemented	HOF Accuracy Scoring Tool	None	<i>P</i> < POP mean score= 20.9.05 HOI transferred	LOE: Level III of evidence S: large sample size, conducted PIP and POP surveys

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<p>Bruno, G., Guimond, M., (2017). Patient care handoff in the Postanesthesia Care Unit: A Quality Improvement Project.</p>	<p>patient information from CRNA to PACU RN using an EBP HOT and evaluate EF</p>				<p>DV: reported EF of HOT from CRNAs and PACU RNs</p>			<p>without the use of a SHOT was deficient, mean score = 9.5</p> <p>POP data mean = 20.9, SD = 1.74 ↑ improvement as compared with data obtained in PIP mean = 9.5, SD = 3.6 HOR score, $t(19) = 13.21, P < .0001$ compared with the SVR</p>	<p>W: schedule changes and inconsistent data collection F: this is a feasible project to implement in the PACU setting at KCVA, project low to no implementation cost C: Overall ↑ in pertinent patient information in HOR between CRNA and PACU RN R: ↑ in # of CRNAs that are trained on DC and ↑ consistency of DC</p>
<p>(Study 8) Jelacic, S., Togashi, K., Bussey, L., Nair, B. G., Wu, T., Boorman, D. J., & Bowdle, A. (2021). Development of an aviation-style computerized checklist displayed on a tablet computer for improving handoff communication in the</p>	<p>Implementation of an aviation style electronic approach utilizing tablet technology to improve PACU handoff communication</p>	<p>None</p>	<p>OS, SR</p>	<p>Technique: Observational Size: PIP:209 POP: 210</p>	<p>IV: Tablet HOT DV: Staff perception HOT</p>	<p>Statistical analyses were performed with STATA 11.0</p>	<p>Control (Shewhart) chart created unequal variance (Satterthwaite's degrees of freedom) or chi-square checklist was used in 125 out of 210 (59.5%) observed cases</p>	<p>No SD in the PACU LOT, PONV, RE, and pain</p>	<p>LOE: Level III evidence S: Large sample size, conducted with observational study and a 19 question checklist used, and a pre and post implementation survey W: There was a conflict of interest in study, this is the only research found studying the use of tablet technology in nursing setting Randomization and blind study was not feasible. Hawthorne effect identified F: If funding allowed it this is a feasible project to implement in the PACU setting at KCVA C: Tablet based handoff PACU HOR, no SD of PRO for LOT, RE, PONV, pain</p>

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post-anesthesia care unit									R: use of the tool only 50% used tool and re-assess outcomes.
(Study 9) Gates, T., Goff, T., & Thomas, L. (2021). Reinventing the Handoff Process: Bringing Standardized Bedside Report to Perioperative Services	to improve HOR communication in Phase I and Phase II to increase satisfaction rates	None	QS	6mo long Surveys to RN and patient & OS in Phase I and II	IV: SHOT DV: Staff perception HOT	Unknown or None	None	POP improvements were noted a 30% ↓ hand off time 28% ↑ efficiency in nursing workflow ↑ 100% with nursing satisfaction with 11.6% ↑ patient satisfaction	LOE: Level V evidence S: LOT 6 mo OS of Phase I and Phase II staff W: small sample, only conducted in Phase I and II F: Easy to implement with low costs associated with change C: Overall, ↑ in RN and patient satisfaction, RN efficiency R: Needs additional information on survey or sample size and compliance with tool. Were all participants compliant and 100% satisfied with tool.
(Study 10) Miller, D. (2021). I-PASS as a Nursing Communication Tool.	to improve HOT in the children's Hospital	None	QS, PIP & POP survey		IV: SHOT DV: Staff perception HOT and compliance	unknown	none	72% RNs did survey, mean staff employed at hospital for 7 years. 94% RN know of tool 98% reported distractions when using HOT.	LOE: Level V evidence S: sample size is of children's hospital W: failure to provide statistics, measurement tools, data to substantiate study finding percentages F: feasible to implement change, not feasible to replicate study C: will improve outcomes, RN champions will ↑ staff compliance and confidence with SHOT R: Provide the data obtained from study to prove results

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<p>(Study 11) Kim, J. H., Lee, J. L., & Kim, E. M. (2020). Patient safety culture and handoff evaluation of nurses in small and medium-sized hospitals</p>	<p>Investigate and evaluate current HOR, perception of PS in small and medium-sized hospitals</p>	<p>None</p>	<p>DS</p>	<p>425 RNs at small and medium-sized hospitals in South Korea</p>	<p>IV: SHOT DV: Staff perception HOT and compliance, EU, and education</p>	<p>independent t-test as well as Cronbach's $\alpha = 0.95$</p>	<p>ANOVA and the Scheffé post hoc test PS was $3.65 \pm 0.45 =$ moderate level HOR evaluation was 5.24 ± 0.85.</p>	<p>245 respondents (57.6%) = satisfied. Regarding reasons for dissatisfaction= HOR interruption (31.4%) was ranked highest, only 21 (5.0%) = no HOR errors, total respondents = 329</p>	<p>LOE: Level VI evidence S: large sample size, focused study at small and medium South Korean Hospitals W: very large sample with lots of data collected F: adding SHOT is realistic to add in PACU setting C: SHOT may ↑ patient safety ↓ HOR error rates R: ↑ staff education prior to study to increase staff knowledge and confidence of tool</p>
<p>(Study 12) Collins, S. A., Stein, D. m, Vawdrey, D. A. K., Stetson, P. D., & Bakken, S. (2011, August). <i>Content overlap in nurse and physician handoff artifacts and the potential role of electronic health records: A systematic review.</i></p>	<p>to improve SHOT</p>	<p>None</p>	<p>SR</p>	<p>575 potential resources 18 MD and RN HOR studies</p>	<p>IV: database, keywords, ET DV: Staff perception HOT</p>	<p>None</p>	<p>ET</p>	<p>575 articles refined to 36</p>	<p>LOE: level II evidence S: large study combined with a HOR study encompassing stakeholders: RNs and MDs W: only used Pub Med search database F: adding SHOT is realistic to add in PACU setting C: The same SHOT may not be appropriate to implement in every unit of the hospital but having a tailored SHOT for each unit is appropriate and assists with hospital coding. R: This source will be used for guidance, the data collected helps guide areas of which may need to be</p>

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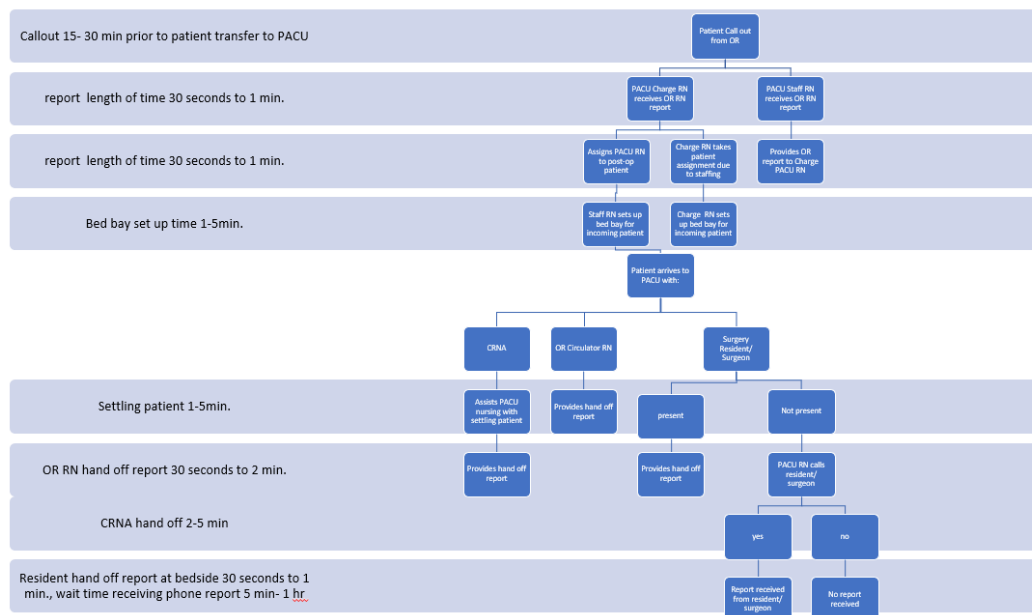
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A: Agree; ADN: Associates Degree Nurse; ANE: Anesthetic Providers ; BHOP: Baseline Hand off Observation with Published checklist; C: Control ; CF: Conceptual Framework ; CO: Conclusion; CS: Convenience Sample; D: Disagree; DC: Data Collection; DCM: Donabedian conceptual model; DS: Descriptive Study; DSS: Database Search strategy; DV: Dependent Variable; E: Experimental; EF: Effectiveness; ET: Evaluation Table; EU: Ease of Use F: Feasibility; FG: Focus Group; FTR: Full Text Review ; FT: Full- time; HIFS: Hospital # Interview and Focus Group Surgeons; HOS: Hospital # Observation of Surgeons; HIFA: Hospital # Interview and Focus Group Anesthetists; HOA: Hospital # Observation of Anesthetists; HIFN: Hospital # Interview and Focus Group Nurses; HON: Hospital # Observation of Nurses; HOR: Hand-off Report ; HOT: Hand off Tool; I: Intermittent Time; IMP: Implementation; IN: Initial Number; IT: Intervention Targeting; IV: Independent Variable; KS: Keeper Study; L: Location; LOE: Level of Strength; LOT: Length of Time; MDD: Minimal Detectable Difference; MSN: Masters of Science Nurse; Mo: Months; N: Number; NHOR: Not Standardized Handoff Report; OM: Outcome Measures; P: Physician providers; PIM: Pre-Implementation ; PT: Part-time; POIM: Post-Implementation ; PRN: Post Anesthesia Care Unit (PACU) Registered Nurse (RN); PIP: Pre-Implementation Phase; POP: Post-Implementation Phase; PRO: Patient Related Outcome ; PS: Patient Safety; QE: Quasi-experimental; R: Recommendations ; RQSS: Riesenber Quality Scoring System; QS: Quantitative Sample; S: Strengths; SA: Strongly Agree; SD: Standard Deviation; SHOR: Standard Handoff Report; SSI: Semi- Structured Interview ; SR: Systematic Review; SUR: Surgical Providers; SVR: Standard Verbal Report; T&ASP: Title & Article Screening Process; TIFS: Total Number of Interviews and Focus Groups, Surgeons ; TIFA: Total Number of Interviews and Focus Groups, Anesthetists; TIFN: Total Number of Interviews and Focus Groups, Nurses; TOS: Total number of Observations, Surgeons; TOA: Total number of Observations, Anesthetists ; TON: Total number of Observations, Nurses; TN: Total Number; TP: Total Providers; U: Usefulness; UN: Undecided; W: Weaknesses ; 3WPOIM: 3 Weeks Post- Implementation; 3MPOIM: 3 Months Post-Implementation

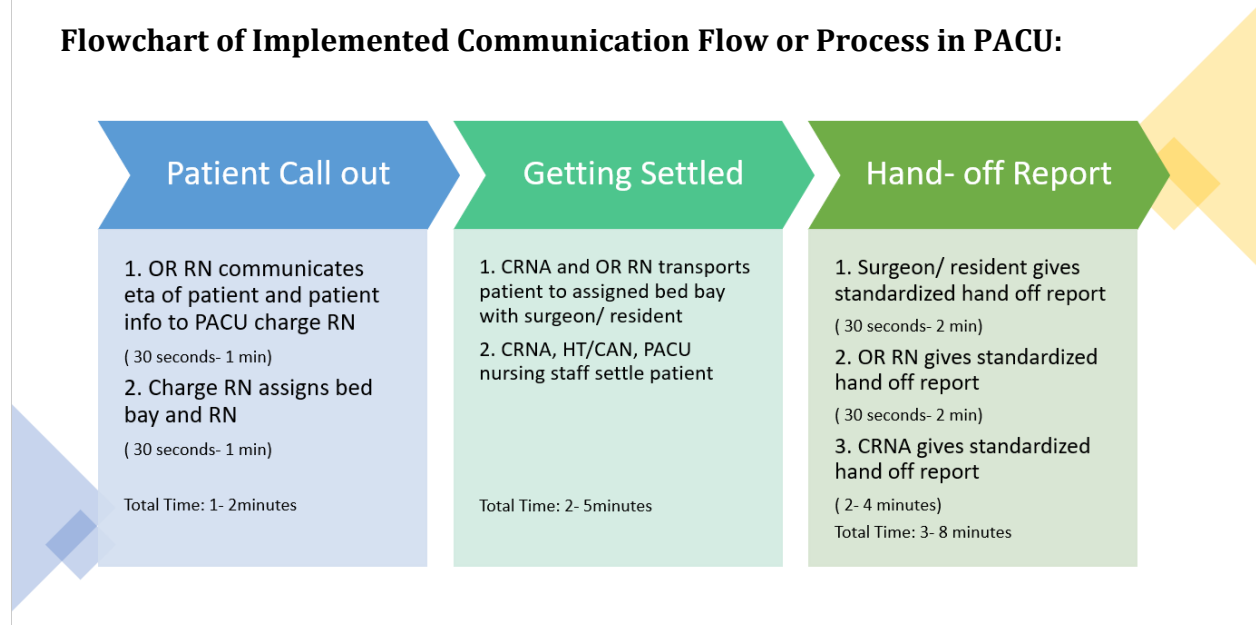
Appendix B

Flowchart

Current Communication Process Flowchart:



Flowchart of Implemented Communication Flow or Process in PACU:



Appendix C

Instrument

Post Heart Catheterization/ IR
<input type="checkbox"/> Bedrest start time: _____ Bedrest end time: _____
<input type="checkbox"/> HOB max elevation: _____
<input type="checkbox"/> Sheath: Arterial or venous
<input type="checkbox"/> Sheath location: _____
<input type="checkbox"/> Sheath size: _____
<input type="checkbox"/> Closure device: Perclose___ Angioseal___ Manual pressure___
<input type="checkbox"/> Sheath: Arterial or venous
<input type="checkbox"/> Sheath location: _____
<input type="checkbox"/> Sheath size: _____
<input type="checkbox"/> Closure device: Perclose___ Angioseal___ Manual pressure___
TR Band or PreludeSync_____cc inflated
Last ACT_____

Surgery Resident/ Surgeon
Resident in case _____ pager# _____
Staff Surgeon _____ pager # _____
<input type="checkbox"/> Procedure
<input type="checkbox"/> Approach
<input type="checkbox"/> Dressings & closure device: ____sutures____staples____glue
Wound vac settings _____
<input type="checkbox"/> Assess pulses with receiving RN if applicable
<input type="checkbox"/> Complications:
<input type="checkbox"/> OPS or admit status
<input type="checkbox"/> Additional pertinent information:

Anesthesia/ CRNA		
Surgical Procedure _____ Allergies _____		
Age _____ General – SAB – MAC – Local _____ Reversal Y/N _____		
Nerve Block site _____ time placed _____ & will last _____ hrs.		
Vol. injected _____ mL 0.50% bupivacaine, 0.25% bupivacaine, 0.50% ropivacaine, 0.20% ropivacaine _____ mL 2% lidocaine, Exparel _____ mg Decadron		
EBL _____ Crystalloid _____ Colloid _____ Blood _____ Urine _____		
Fentanyl _____	Zofran _____	Tylenol _____
Versed _____	Reglan _____	Celebrex _____
Dilaudid _____	Decadron _____	Gabapentin _____
Morphine _____	Zantac _____	Oxycodone _____
Propofol _____	Ketamine _____	Vicodin _____
Precedex _____	Toradol _____	Meloxicam _____
	Heparin _____	
Antibiotics _____		
Diabetic yes/ no Pre-op FSBS Intra-OP Insulin PACU _____		
OSA yes/ no cpap yes/no _____		
Isolation _____		
BladderScan _____		

Disposition	CRNA	MDA

OR RN Hand-off Report
<input type="checkbox"/> Procedure
<input type="checkbox"/> Position Bovie pad site/ skin issues
<input type="checkbox"/> Implants/ allograft charted/ in Trackcore
<input type="checkbox"/> Medications given (joint block or local infiltration) @ _____ ____ mL 0.5% ropivacaine ____ mL Toradol ____ mL epinephrine ____ mL Lidocaine ____ mL Marcaine
<input type="checkbox"/> Catheter/ Ostomies / drains (placed &/or removed, straight Cath, difficult to place?) -Type and location
<input type="checkbox"/> EBL: _____ mL
<input type="checkbox"/> X-rays done in OR
<input type="checkbox"/> Dressings & closure device: ___sutures___staples___glue
<input type="checkbox"/> Bladder scan if IV fluids > 1L. or case \geq 4 hrs Bladder scan results: _____ mL at _____
<input type="checkbox"/> Other pertinent info (diet, positioning, restrictions):
<input type="checkbox"/> Adverse events/ equipment issues

Standardized PACU Hand- off Communication

Kansas City Veterans Affairs Medical Center
Kansas City, Mo 64128

Rescinded Document:
See paragraph 6

Signatory Authority:
ASU/PACU Manager, Chief of Surgery, Associate
Chief Nurse of Surgical Services

Service Line(s):
Surgery

Responsible Owner:
ASU/PACU RN Manager

Effective Date:
October 1, 2022

Recertification Date:
October 1, 2027

1. PURPOSE AND AUTHORITY

a. The purpose of this standard operating procedure (SOP) is to establish procedures on standardized hand off communication process and communication tool. This SOP must be followed by surgical staff including certified nurse anesthetists (CRNA), OR RN staff, and surgery residents or staff surgeons who are transferring the patient’s care to the receiving post anesthesia care unit (PACU) RN for post- op phase I recovery.

b. There is no governing document.

2. PROCEDURES

a. Patient arrival or admission to PACU

(1) Prior to arrival OR RN communicates with PACU Charge RN to notify of case ending, estimated arrival time of patient to PACU, confirm bed bay placement, and PACU Charge RN to communicate PACU RN that will be receiving patient and if there are any staffing or bed bay availability concerns

(2) Physically transfer patient into PACU bed bay by the CRNA, OR RN, with surgery resident or surgeon present

(3) Settle patient in appropriate or assigned bed bay. Person(s) assisting with settling patient in bed bay: PACU nursing staff (resource RN, charge RN, HT/CNA), CRNA, and OR RN

(a) Surgery Staff provides hand-off report to receiving PACU RN in this order:

- ((1)) Surgeon or surgery resident
- ((2)) OR RN
- ((3)) CRNA

ASSIGNMENT OF RESPONSIBILITIES

b. **Surgeon or surgery resident** the surgeon or surgery resident is assigned the responsibility to:

(1) Provides hand off report while using standardized hand off report sheet/ tool to the receiving RN, PACU RN, providing information but not limited to: surgery conducted, approach, medications instilled by the provider conducting surgery, closure device used, complications during surgery, dressing, etc.

(2) Assessing surgical site and/ or incision site with receiving RN, if an extremity was operated on surgeon or surgery resident will confirm presence of pulses with PACU RN.

(3) Verifies with PACU RN receiving report does not have any questions or concerns before leaving bedside

c. **OR RN** The OR RN is assigned the responsibility to:

(1) Assists with settling patient in PACU bed bay PRN

(2) Provides hand off report while using standardized hand off report sheet/ tool to the receiving RN, PACU RN, providing information but not limited to: length of time of surgery, verify dressing and closure devices, wound vac or drainage tubes and output, Foley catheter placement, patient placement during procedure, etc.

(3) Verifies that PACU RN receiving report does not have any questions or concerns before leaving bedside

d. **CRNA** The CRNA is assigned the responsibility to:

(1) Assist with settling patient in PACU bed bay

(2) Provides hand off report while using standardized hand off report sheet/ tool to the receiving RN, PACU RN, providing information but not limited to: type of anesthesia, medications administered and last dosage time, IV sites, central lines, arterial line placement, intake and output, patches, pertinent patient health history, labs, FSBS, baseline vitals pre-op, intra-procedure vital sign trends, last set of vital signs, any other pertinent information.

(3) Evaluates line placement with receiving PACU RN

(4) Verifies that PACU RN receiving report does not have any questions or concerns before leaving bedside

e. **PACU RN** The PACU RN is assigned the responsibility to:

(1) Delegate settling of patient to resource RN, charge RN, or health tech/ CNA

(2) Obtain hand off report from: surgery resident or surgeon, OR RN, and lastly CRNA.

(3) Evaluates dressing with surgeon, surgery resident, or OR RN

(4) Evaluates line placement with CRNA.

3. DEFINITIONS

a. "None."

4. REFERENCES

a. [Insert references. If there is only one reference, remove the list, that is, "a".]

b. Joint Commission. (2017). *8 tips for high-quality hand-offs - joint commission*. What is hand-off? Retrieved October 1, 2022, from https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_8_steps_hand_off_infographic_2018pdf.pdf?db=web&hash=F4BCE57E34ED03DF76411EB9E302038E

c. The Department of Corporate Communications. (2017, September 12). *Sentinel event*. The Joint Commission. Retrieved October 2, 2022, from <https://www.jointcommission.org/resources/sentinel-event/>

d. MCP NUMBER, Title, dated Month Day, Year, LINK.

e. SOP NUMBER, Title, dated Month Day, Year, LINK.

5. RESCISSION

[SOP NUMBER, Title, dated Month Day, Year, is rescinded. OR If no rescission, "None."]

6. REVIEW

[List frequency of required review, at minimum at recertification, when there are changes to the governing document (for example, national policy or a health care accreditation body mandate), and any regulatory requirement for more frequent review. If applicable, cite the location where the review is documented.]

7. RECERTIFICATION

This SOP is scheduled for recertification on or before the last working day of [Month Year – 5 years from effective date]. In the event of contradiction with national policy, the national policy supersedes and controls.

8. SIGNATORY AUTHORITY

[Name]

[Additional title, as appropriate]

[Title of Service Line Chief]

Date Approved: Month Day, Year

[Name] (if applicable) [Delete this if not needed]

[Additional title, as appropriate]

[Title of Service Line Chief]

Date Approved: Month Day, Year

NOTE: *The signature remains valid until rescinded by an appropriate administrative action.*

APPENDIX/APPENDICES:

Appendix A Surgery Resident/ Surgeon Hand- off Report

Surgery Resident/ Surgeon
Resident in case _____ pager# _____
Staff Surgeon _____ pager # _____
<input type="checkbox"/> Procedure
<input type="checkbox"/> Approach
<input type="checkbox"/> Dressings & closure device: ___sutures___staples___glue
Wound vac settings _____
<input type="checkbox"/> Assess pulses with receiving RN if applicable
<input type="checkbox"/> Complications:
<input type="checkbox"/> OPS or admit status
<input type="checkbox"/> Additional pertinent information:

Appendix B: OR RN Hand- off Report

OR RN Hand-off Report
<input type="checkbox"/> Procedure
<input type="checkbox"/> Position Bovie pad site/ skin issues
<input type="checkbox"/> Implants/ allograft charted/ in Trackcore
<input type="checkbox"/> Medications given (joint block or local infiltration) @ _____ ____ mL 0.5% ropivacaine ____ mL Toradol ____ mL epinephrine ____ mL Lidocaine ____ mL Marcaine
<input type="checkbox"/> Catheter/ Ostomies / drains (placed &/or removed, straight Cath, difficult to place?) -Type and location
<input type="checkbox"/> EBL: ____ mL
<input type="checkbox"/> X-rays done in OR
<input type="checkbox"/> Dressings & closure device: ___sutures___staples___glue
<input type="checkbox"/> Bladder scan if IV fluids > 1L. or case \geq 4 hrs Bladder scan results: _____ mL at _____
<input type="checkbox"/> Other pertinent info (diet, positioning, restrictions):
<input type="checkbox"/> Adverse events/ equipment issues

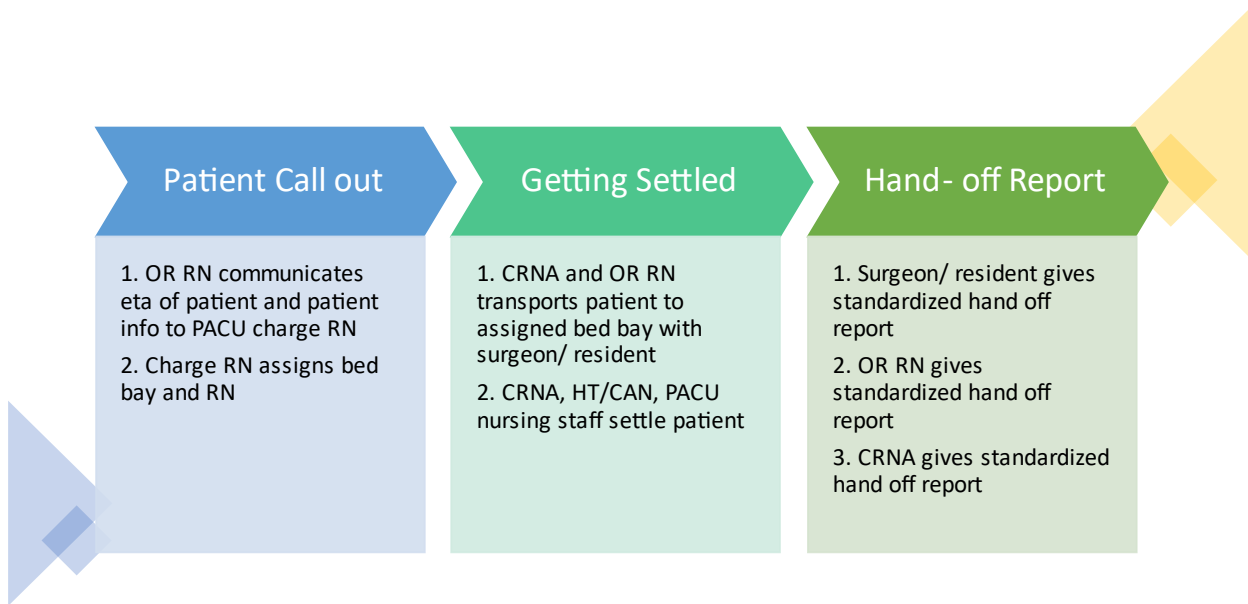
Appendix C: Anesthesia/ CRNA Hand-off Report

Anesthesia/ CRNA		
Surgical Procedure _____ Allergies _____		
Age _____ General – SAB – MAC – Local _____ Reversal Y/N _____		
Nerve Block site _____ time placed _____ & will last _____ hrs.		
Vol. injected _____ mL 0.50% bupivacaine, 0.25% bupivacaine, 0.50% ropivacaine, 0.20% ropivacaine _____ mL 2% lidocaine, Exparel _____ mg Decadron		
EBL _____ Crystalloid _____ Colloid _____ Blood _____ Urine _____		
Fentanyl _____	Zofran _____	Tylenol _____
Versed _____	Reglan _____	Celebrex _____
Dilaudid _____	Decadron _____	Gabapentin _____
Morphine _____	Zantac _____	Oxycodone _____
Propofol _____	Ketamine _____	Vicodin _____
Precedex _____	Toradol _____	Meloxicam _____
Heparin _____		
Antibiotics _____		
Diabetic yes/ no _____ Pre-op FSBS _____ Intra-OP _____ Insulin _____ PACU _____		
OSA yes/ no _____ cpap yes/no _____		
Isolation _____		
BladderScan _____ _____ _____ _____ _____ _____		
Disposition	CRNA	MDA

Appendix D: Post Heart Catheterization/ IR Hand-off Report

Post Heart Catheterization/ IR
<input type="checkbox"/> Bedrest start time: _____ Bedrest end time: _____
<input type="checkbox"/> HOB max elevation: _____
<input type="checkbox"/> Sheath: Arterial or venous
<input type="checkbox"/> Sheath location: _____
<input type="checkbox"/> Sheath size: _____
<input type="checkbox"/> Closure device: Perclose___ Angioseal___ Manual pressure___
<input type="checkbox"/> Sheath: Arterial or venous
<input type="checkbox"/> Sheath location: _____
<input type="checkbox"/> Sheath size: _____
<input type="checkbox"/> Closure device: Perclose___ Angioseal___ Manual pressure___
TR Band or PreludeSync_____cc inflated
Last ACT _____

Appendix E: Flow chart on Hand off Report in the PACU



DISTRIBUTION: Insert distribution practices here, such as, Emailed to the [Name] Distribution List on [DATE]. (This is where you will put your concurrences) SOPs are available at: [KCVA Policy Page \(sharepoint.com\)](#)

APPENDIX A

APPENDIX TEMPLATE – TITLE

1. APPENDIX USE, HEADINGS AND PAGE NUMBERS

a. Appendices is the correct terminology, not addendum or attachment. Appendices are utilized to convey detailed instructions, programmatic procedures, and implementation guidelines.

b. Insert an ODD page break on last page of document body text before the first appendix AND on the last page of each appendix that precedes another appendix.

c. If the appendix has a second page, then the header will have APPENDIX A as the next line under SOP [NUMBER].

d. The footer must have page numbers with its corresponding appendix letter as such: **A-1**. The letter before the page number must be manually entered.

e. Appendices are formatted in the same manner and structure as the body of the directive. See the next paragraphs for an example.

f. If the appendix you are attaching is a flow chart or a form you will need to provide separate documents that can be linked. Do not embed into the policy. If it is a form you are retrieving from the national forms database, please reference the form on the last page and place a link to the form. Appendix that can change or forms that may change, please provide separate from the policy. We will provide the link in the document before it is signed.

2. PARAGRAPH NAME

a. **Additional Detail.** Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. **Additional Detail.**

(1) **Sub paragraph level one.** More text here.

(a) Sub paragraph level two.

(b) Sub paragraph level two.

3. PARAGRAPH NAME

a. **Additional Detail.**

b. **Additional Detail.**

4. PARAGRAPH NAME

a. **Additional Detail.** Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. **Additional Detail.**

(1) **Sub paragraph level one.** More text here.

(a) Sub paragraph level two.

(b) Sub paragraph level two.

5. PARAGRAPH NAME

a. **Additional Detail.**

b. **Additional Detail.**

6. PARAGRAPH NAME

a. **Additional Detail.** Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. **Additional Detail.**

(1) **Sub paragraph level one.** More text here.

(a) Sub paragraph level two.

(b) Sub paragraph level two.

7. PARAGRAPH NAME

a. **Additional Detail.**

b. **Additional Detail.**

APPENDIX B

APPENDIX TEMPLATE - TITLE

1. PARAGRAPH NAME

a. **Additional Detail.** Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. **Additional Detail.**

(1) Sub paragraph level one. More text here.

(a) Sub paragraph level two.

(b) Sub paragraph level two.

2. PARAGRAPH NAME

a. **Additional Detail.**

b. **Additional Detail.**

3. PARAGRAPH NAME

a. **Additional Detail.** Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. **Additional Detail.**

(1) Sub paragraph level one. More text here.

(a) **Sub paragraph level two.** More text here.

1. No underline or bold here for headings.

2. No underline or bold here for headings.

a. No underline or bold here for headings.

b. No underline or bold here for headings.

(b) Sub paragraph level two.

4. PARAGRAPH NAME

a. Additional Detail.

b. Additional Detail.

5. PARAGRAPH NAME

a. Additional Detail. Any text that follows has the normal font style. If there is no heading, then the text is normal.

(1) Sub paragraph level one.

b. Additional Detail.

(1) Sub paragraph level one. More text here.

(a) Sub paragraph level two.

(b) Sub paragraph level two.

6. PARAGRAPH NAME

a. Additional Detail.

b. Additional Detail.