Patient Safety Tip of the Week

February 11, 2014

Another Perioperative Handoff Tool: SWITCH

Handoffs have been the topic of some of our most popular columns (see the list of all our handoff-related columns at the end of today's column). Handoffs, of course, are key links in the patient safety continuum and faulty handoffs are a major root cause in many untoward incidents in any industry, not just healthcare. Doing the handoff in a setting that promotes communication and allows the recipient ample time to ask questions and get clarifications is critical. But having a standardized format is also very important. Our February 14, 2012 Patient Safety Tip of the Week "Handoffs – More Than Battle of the Mnemonics" discussed several handoff tools and corresponding mnemonics which may be very helpful in your handoffs. The key message is that you need to implement tools that address the needs of each particular type of handoff that occurs in your organization. Though using a structured communication format or tool is important, the exact tool or format needed will vary by the nature of the handoff so "one size does not fit all".

In the perioperative setting, the nature of handoffs is often very different from the resident-to-resident or nurse-to-nurse handoffs done on a medical unit. We highlighted the AORN toolkit in our December 2011 What's New in the Patient Safety World column "AORN Perioperative Handoff Toolkit" and several abstracts presented at the 2011 American Society of Anesthesiologists annual meeting dealt with perioperative handoffs/handovers. And in our March 2012 What's New in the Patient Safety World column "More on Perioperative Handoffs" we highlighted a multidisciplinary and interdisciplinary handoff process developed at Hopkins designed for transfers of patients from OR to PACU or PACU to ICU, etc. (Petrovic 2012a, Petrovic 2012b).

But even within the perioperative area there are a variety of handoffs that occur between different personnel and these need to be customized for the context of those interactions. A recent article in the AORN Journal (Johnson 2013) described the development and implementation of yet another standardized format for perioperative handoffs: **SWITCH**. They describe a quality improvement project at Provident St. Vincent Medical Center in Portland, Oregon that began with analysis of barriers to effective communication in the perioperative setting. One of their findings was that a standardized tool was needed for

their handoffs and that it needed to be tailored to the needs of those involved in the handoffs. So they developed their own tool that goes by the acronym "SWITCH" which stands for:

S Surgical procedure
W Wet (i.e. fluids)
I Instruments
T Tissue (eg. specimen)
C Counts
H Have you any questions?

Their initial implementation was aimed toward handoffs between RN circulators or between scrub persons. The article provides a sample of the tool in checklist format with boxes for the various subitems under each category. For example, under W (for wet) they include IV fluids, medications, blood loss and blood products available, urine output, drains, etc.

They nicely describe the rollout and implementation of the SWITCH program. They used multiple venues for inservicing and learning and obtaining feedback as the tool developed. Laminated forms were available in several locations, including a pocket card that could be worn behind staff nametags. The article provides examples of what a handoff would sound like between two RN circulators or between two scrub persons.

Based on positive feedback on the SWITCH tool they recognized the need for similar tools to be used by OR front desk/scheduling nurses, or by OR charge nurses. So they developed handoff tools for these, again using the SWITCH acronym but with different items for the specific handoff. For example, for the front desk handoff:

S Staff issues (eg. overtime, sick call)
W What still needs to be done (eg. rooms running, those needing setup, etc.)
I Items (eg. loaned items, items needing repair, etc.)
T Time (eg. time available, gaps in schedule)
C Cases (eg. cancellations, add-ons, etc.)
H Have you any questions?

And then the anesthesia department got into the mix, modifying the tool for it's own needs. The article provides an example of the much more complicated tool developed for the anesthesia handoff, still using the SWITCH acronym.

While the authors don't report any metrics on actual use of the tool or impact on patient outcomes, they did find that very high percentages of staff surveyed felt that the tool was important and easy to use. The fact that so many other providers wanted their own version of the tool is a further testament to its utility.

Read the Johnson article and see the sample checklist versions of the SWITCH tools. You will find them very helpful. This once again emphasizes a point we've made over and over: while a standardized format for handoffs is very important, the format must be

customized for the nature of the handoff and its participants and "one size does not fit all".

Read about many other handoff issues (in both healthcare and other industries) in some of our previous columns:

May 15, 2007	"Communication, Hearback and Other Lessons from Aviation"
May 22, 2007	"More on TeamSTEPPS™"
August 28, 2007	"Lessons Learned from Transportation Accidents"
December 11, 2007	"Communication…Communication…Communication"
February 26, 2008	"Nightmares….The Hospital at Night"
September 30, 2008	"Hot Topic: Handoffs"
November 18, 2008	"Ticket to Ride: Checklist, Form, or Decision Scorecard?"
December 2008	"Another Good Paper on Handoffs".
June 30, 2009	"iSoBAR: Australian Clinical Handoffs/Handovers"
April 25, 2009	"Interruptions, Distractions, Inattention…Oops!"
April 13, 2010	"Update on Handoffs"
July 12, 2011	"Psst! Pass it on…How a kid's game can mold good handoffs"
July 19, 2011	"Communication Across Professions"
November 2011	"Restricted Housestaff Work Hours and Patient Handoffs"
December 2011	"AORN Perioperative Handoff Toolkit"
February 14, 2012	"Handoffs – More Than Battle of the Mnemonics"
March 2012	"More on Perioperative Handoffs"
June 2012	"I-PASS Results and Resources Now Available"
August 2012	"New Joint Commission Tools for Improving Handoffs"
August 2012	"Review of Postoperative Handoffs"
January 29, 2013	"A Flurry of Activity on Handoffs"
December 10, 2013	"Better Handoffs, Better Results"

References:

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