Improving OR → PICU Handover
“Did I Miss Anything?”

Background
At BC Children’s Hospital PICU, a standardized OR → PICU process was developed 10 years ago
- Cumbersome
- Confusing
- Staff began noting safety concerns relating to handover

Defining the Problem: Handover Audits:
- Patient not stabilized on arrival to PICU
  - Handover commencing with no monitoring or with ongoing management by bedside RN
- Team members missing or unknown to one another
- IV site to source checks missed
- Lack of coordination
  - No clarity on order of speakers
  - No defined opportunity for questions

Aim Statements
1) Reduce safety concerns to zero. Reduce PSLS events related to handover by 50% in first 6 months after roll out (10 in 12 months prior)
2) Increase compliance with all 6 steps in the mechanics of handover for 100% of OR to PICU admissions

Implementation
- Project team worked to create a mnemonic and visually appealing tool.
- Used a “runner” from the project team to obtain feedback on tool from relevant departments.
- ´All teams present?’ was changed to ´All teams ready?’ after PDSA #1 (being present was not the same as being ready to listen and participate in handover).

Results
- Patient stable and monitored improved: 73% → 100%
- ´Are all teams ready?’ improved: 69% → 80%
- IV site to source checks improved: 73% → 100%
- Any Safety concerns? Improved: 69% → 20%
- PSLS in 12 months since roll out of tool: 10 → zero!
- Staff also report a much higher level of communication and confidence when sending and receiving a patient from OR → PICU.

Lessons Learned
- Use a simple tool (easy to follow).
- Address a real world problem that staff are invested in improving.
- Advantage of using a “runner” – member of project team that presented the problem/change to each group of stakeholders and brought feedback back to the core project team. Change is easier and quicker when not having to gather a large project team.

Strategies for Change
1) Create handover standard (see PATH Qs visual tool)
2) Gather feedback from stakeholders
3) Test the tool – PDSA cycles
4) Have champions in the PICU during roll out

Next Steps
- Celebrating the success of the early results with all HCPs.
- This work has been shared with the trauma steering committee to explore handovers for trauma patients from ER to PICU.
- This work is being adapted for receipt of transport patients in the BCCH PICU.

Spread
Each iteration of the process has incorporated learnings from previous QI work: OR → PICU → OR → NICU → NICU → OR → ER → PICU → OR → PACU

Liz Lambb, Jamie Wlodarczaka, Gordon Krahna, Lisa Lupienb, Mona Patela
aDepartment of PICU, British Columbia Children’s Hospital, Vancouver, Canada
bDepartment of Procedures & Surgical Services, British Columbia Children’s Hospital, Vancouver, Canada