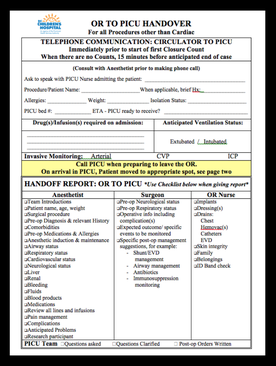
Improving OR → PICU Handover

"Did I Miss Anything?"

Background



OR TO PICU HANDOVER
For all Procedures other than Cardiac

TELEPHONE COMMUNICATION: CIRCULATOR TO PICU
Immediately prior to start of first Closure Count
When there are no Counts, 15 minutes before anticipated end of case

(Consult with Anesthetist prior to making phone call)

Ask to speak with PICU Nurse admitting the patient: _____

Procedure/Patient Name: _____ When applicable, brief Hx: _____

Allergies: _____ Weight: _____ Isolation Status: _____

PICU bed #: _____ ETA - PICU ready to receive? _____

Drug(s)/Infusion(s) required on admission:	Anticipated Ventilation Status:
	Extubated / Intubated

Invasive Monitoring: Arterial CVP ICP

Call PICU when preparing to leave the OR.
On arrival in PICU, Patient moved to appropriate spot, see page two

HANDOFF REPORT: OR TO PICU ***Use Checklist below when giving report****

Anesthetist	Surgeon	OR Nurse
☐Team Introductions ☐Patient name, age, weight ☐Surgical procedure ☐Pre-op Diagnosis & relevant History ☐Comorbidities ☐Pre-op Medications & Allergies ☐Anesthetic induction & maintenance ☐Airway status ☐Respiratory status ☐Cardiovascular status ☐Neurological status ☐Liver ☐Renal ☐Bleeding ☐Fluids ☐Blood products ☐Medications ☐Review all lines and infusions ☐Pain management ☐Complications ☐Anticipated Problems ☐Research participant	☐Pre-op Neurological status ☐Pre-op Respiratory status ☐Operative info including complication(s) ☐Expected outcome/ specific events to be monitored ☐Specific post-op management suggestions, for example: - Shunt/EVD management - Airway management - Antibiotics - Immunosuppression monitoring	☐Implants ☐Dressing(s) ☐Drains: Chest Hemovac(s) Catheters EVD ☐Skin integrity ☐Family ☐belongings ☐2 Hand check

PICU Team ☐Questions asked ☐Questions Clarified ☐Post-op Orders Written

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

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