Title of Abstract:

A Multidisciplinary Approach to Improving Communication Through a Surgical Handoff Sheet

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Abstract Description:

Setting

12 bed Surgical NICU within a 67 bed level 4 regional NICU.

Problem

Lack of a structured handoff process for infants returning from the operating room (OR) to the NICU affecting patient care and safety.

Aims

To improve perioperative communications between the neonatologist, surgeon, anesthesiologist, and family by 25% by December 2016.

Interventions of Change

Plan: Working through the surgical homeroom in the VON QI Collaborative, a multidisciplinary team was established. Handoff sheet (HS) was developed and introduced in the NICU for all infants returning from the OR. (Appendix B). A driver diagram was developed. (Appendix A). Do: NICU staff was educated and HS was included in the OR package. An organized huddle with neonatologist, anesthesiologist and surgeon was held for all infants returning from the OR and the HS was jointly filled. Study: A single point was assigned to nine sections on the HS. These included preoperative communication, postoperative procedure review, plan of care, antibiotic course, pain control, extubation plan, handoff huddle, parent updated by surgeon and HS filled out. Act: Key changes during monthly PDSA cycles included assigning central location to keep HS, nursing communication during morning RN huddles, creation of super users to educate staff

and having the unit secretary page the neonatologist as infant left the OR for NICU. A section on pain control was added in HS and physician compliance issues were addressed.

Results

From a base line mean score of 4.2 in March 2016, the mean score went up to 7.45, indicating a 77% improvement in the postoperative handoff process by December 2016. With the exception of a lower score in July, the average scores for the hand off process remained between 7 and 8 the rest of the year as shown in figure 1.

Discussion

Use of a structured hand off process with HS greatly improved the multidisciplinary team hand off process. While the teams were able to organize huddles well for most infants returning from the OR (figure2), filling all sections of HS remains a problem and is being handled with reminders and education. While the surgeons have insisted that parents were updated post op, this was not always documented on the HS. Keeping the completed HS at the bedside for 24 hours has provided critical information for two nursing shifts and has led to an improved culture of communication and patient safety. Due to late assignment of patients to anesthesiologists, preop communication remains a challenge and is the subject of our new QI process.

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Nil