

## INTRODUCTION

- Standardized handoffs are an important national patient safety goal
- Vulnerable patients with many moving parts
- Best process not yet identified in our institution
- Ideal handoffs include:
  - Accurate, up to date information
  - Decrease cognitive load on provider
  - Allow for clarification and feedback
- Our hypothesis: a standardized computerized checklist would improve communication from the operating room to the Pediatric ICU
- Two outcome measures
  - Primary: measure effectiveness in communication during handoff of care from the OR to the intensive care unit (ICU)
  - Secondary: compare different methods of communication

## MATERIALS & METHODS

- Prospective, observational study
- 70 observed handoffs in the Pediatric Intensive Care Unit
- Data collected by a non-participating observer
- Nineteen handoff items assessed

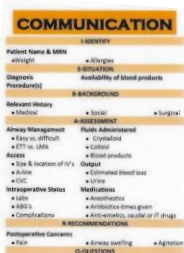


Image 1. Example of our handoff badge card.

## RESULTS

Frequency of Communication Omissions

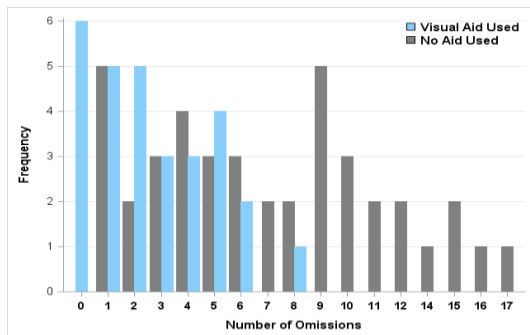


Figure 1. Number of omissions when any visual aid was used compared to no visual aid used. There was a significant decrease in the number of omissions when a visual aid was used compared to when one was not used ( $P < 0.0001$ ).

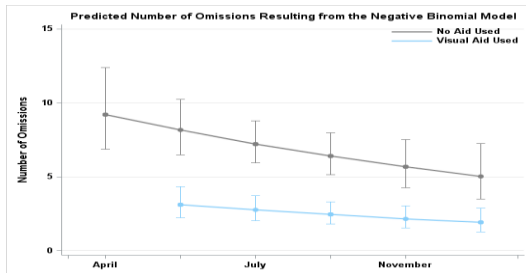


Figure 2. On average, there was a 0.96 decrease in the log count of omissions when a visual aid was used. Regardless of the use of a visual aid there was a significant decrease in the number of omissions over time ( $P = 0.02$ ).

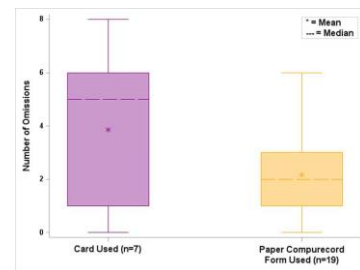


Figure 3. Number of omissions when comparing badge card and EMR handoff form.

## DISCUSSION

- Effective handoffs are crucial to the safe care of patients during transition of care
- Using a standardized handoff tool improved communication of important information from the operating room to the ICU
- The best process is institutionally dependent
- In our facility using an EMR system to facilitate handoff of care improved communication

## NEXT STEPS

- Increased compliance in utilizing the computerized checklist
- Continuing education for rotating residents and faculty
- Incorporate feedback as part of the handoff
- Expand the handoff process to include other areas

## REFERENCES

- Aron, V. and Johnson, J., A model for building a standardized hand-off protocol., Joint Commission Journal on Quality and Patient Safety. Nov 2006, 32:11, 646-655.
- Bigham, M., et al., Decreasing handoff-related care failures in Children's Hospitals. Pediatrics. August 2014, 134:2, e572-79.
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- Kaufman, J., et al. A handoff protocol from the cardiovascular operating room to the cardiac ICU is associated with improvements in care beyond the immediate post-operative period. The Joint Commission Journal on Quality and Patient Safety. July 2013, 39:7, 306-311.