Implementing and Evaluating a Standardized Perioperative Process to Reduce Errors and Improve Patient Safety in Surgical Neonates/Infants

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Disclosure Information
Speaker:

• Recipient of the Children’s Hospital of Philadelphia Patient Safety Award

Objectives

• The learner will be able to discuss the current gaps in knowledge, the background and significance and the purpose of this evidence based practice project.
• The learner will be able to describe the implementation and measurement plans of this evidence based practice project.
• The learner will be able to summarize the preliminary findings of this evidence based practice project intended to improve provider satisfaction, increase information sharing, reduce errors and improve patient safety in surgical neonates/infants.
Team Members

- Tamara Meeker, MSN, CRNP, NNP-BC
- Melissa Duran, MSN, CRNP
- Natalie Rintoul, MD
- Kathleen Abel, RN-C
- John Chuo, MD, MS
- Kevin Dysart, MD
- Jacqueelyn Evans, MD
- Holly Hedrick, MD, FACS, FAAP
- Lynne Maxwell, MD
- John McCloskey, MD
- Michael Padula, MD, FAAP
- Laura Schleelein, MD

Purpose

The purpose of this project is to implement and evaluate a standardized perioperative process to improve provider satisfaction, increase information sharing, reduce errors and improve patient safety in surgical neonates/infants.

Background and Significance

- Practice variation and deviation for neonatal/infant perioperative patient care high.
- Suboptimal communication between team members identified.
Background and Significance

• Clear and effective communication essential to safe patient care
• Ineffective communication cited as most frequent root-cause category of sentinel events
• Handoffs known to be vulnerable to communication failures

Implementation Plan

• Study design: Prospective, unmasked study using pre-post intervention design to evaluate perioperative process
• Hypothesis: implementation of perioperative handoff tool, standardized order set and clinical pathway will:
  – improve provider satisfaction
  – increase information sharing
  – reduce errors
  – improve patient safety and outcomes in surgical neonates/infants

Implementation Plan

• Needs assessment:
  – Current practice and barriers to improvement
  – Need for standardized, stepwise framework
  – Enormous education initiative
    • Implemented in intensive care unit with 300 nurses and 100 clinicians
Evaluation

- Outcome metrics defined
- Process metric evaluating efficacy: number of uses of order set and clinical pathway
- Measurement process: postoperative handoff tool completed by FLC
- Balance metric: number of OR case delays related to errors in perioperative ordering and/or preparation

Implications for Practice

- Process translated universally
  - To be used in other areas of our institution
  - PICU
  - To be used in institutions throughout country and world
  - CHNC

References

References


Runy, L. (March 5, 2008). The pitfalls and solutions of transferring patients safely from one caregiver to another. Hospitals & Health Networks, 82(5), 1.
