

ICU discharge; improving patient safety through handoff improvement and increased awareness

Inleiding	Reduction of human error associated deaths in modern healthcare is a globally recognized goal since it involves around 210.000 people yearly in the US alone. The contribution of communication failures is estimated at 60% and is thought to be even higher for the perioperative and ICU settings. Evidence suggests handovers are an effective tool in improving patient safety through reduction of communication failures.
Doel	This study aims to analyze and improve current ICU discharge practices in the ... hospital.
Methode	<p>A clinical audit was performed consisting of a week-long baseline measurement in which all 31 ICU discharges were monitored and checked against current local discharge agreements. Also patient sex, age, admission reasons were noted. This week-long survey covered logistics, handover incidence, and content topics. Handover failures were then analyzed, involving stakeholders, yielding possible improvements.</p> <p>A checklist was implemented to list current discharge agreements both official and not-yet official. Also exemptions were explicitly stated. It further contained tips on verbal handover topics like, patient history, clinical course, medication and prescient issues.</p> <p>After implementation the effectiveness of said intervention was assessed using a 3 week period. Primary outcome was handover incidence defined as being ICU initiated verbal handovers congruent with current agreements.</p>
Resultaten	A group of 31 patients was followed and compared to a group of 60 patients post-intervention. The handover success rate at baseline was 61 % compared to 89% post-intervention. The relative handover incidence is raised 46% compared to baseline. Total handover incidence (including non-ICU initiated verbal handovers) was 96%. Least reported items were 'medication' and patient history (50-65 % respectively). Both 'clinical course' and 'current issues' were reported in 85% of cases.
Discussie & Conclusie	The discharge process marks an important transition of both responsibility and information. Post implementation handover incidence rose from 61% to 89%, with a total of 96% successful handovers. Interdisciplinary (i.e. nurse – doctor) communication is key in securing timely handover initiation. Hospital-wide implementation of SBAR would raise the bar in professional communication.