Caring for the Post Operative Bypass Patient
An ICU Nursing Perspective

DATE: October 2017 PRESENTED BY: Heidi Paulson, BSN, RN, CCRN and Tanya John, BSN, RN, CCRN

Objectives

• Describe our previous transition of care process from the OR to the ICU for a CBP patient
• Review our current transition of care process from the OR to the ICU
The Old Days

Remembering Our Past

• One verbal report from the OR
• A chaotic process of transition in the ICU
• Multiple providers in the hallway giving report to the ICU staff without nursing present
• Loud environment, many people talking and nobody listening
• No specific assignment of tasks leading to duplications and omission of important details
Patient Safety

• Unfortunately there were consequences related to our transition of care
• Patient safety was compromised and we had an adverse event
• A change was necessary

“In 2006, The Joint Commission mandated that all hospitals develop a standard approach to handoff communications.” (1)

Ineffective care transition processes lead to adverse events. (The Joint Commission, 2014).

“Despite recent efforts to promote clinical integration, the US Health Care System remains highly fragmented. From it’s earliest days, the patient safety field identified transitions of care as an important latent condition for errors and harm.” (1)

Our Goal

• To provide the safest transition of care possible between the OR and the ICU

“The process of transferring care from one team to another should be sacrosanct.”

—Michael Hutchens, MD. Anesthesia and Critical Care Attending 2006-2016, Quality and Safety Director for the CVICU 2015-2016
The Process

• Multidisciplinary collaboration
  – ICU Intensivist Team, Anesthesia, CT Surgery, ICU and OR Nursing
  – Leadership and staff support
• Identify strengths and vulnerabilities in the patient care transition
• Create an atmosphere where the transition of information could occur in a calm, well coordinated environment

“Great patient care is carried out quietly.” Dr. Michael Hutchens

The Result

• Improved OR to ICU communication
• Delineation of rolls for the ICU staff upon patient arrival
• One report is given to the whole team in the patient room
• Development of a predetermined “Anesthesia Script” for every patient
OR to ICU Communication

- Three reports from the OR to the ICU
  - First report: written note in EHR
  - Second report: phone call from OR nurse to ICU nurse, usually when the patient is coming off bypass
  - Third report: “rolling call” from the OR to the ICU to indicate that the patient is en route

Communication in the ICU

- ICU RN delegates predesigned responsibilities to two RN helpers
- Upon patient arrival in the ICU, a page is sent to the ICU providers and Respiratory Therapist
Communication in the ICU – The Anesthesia Handover

• One report to be heard by all care providers
• Report will begin when
  – ICU provider (PA, NP, and/or Attending), anesthesia resident, anesthesia attending, primary RN are all present at bedside
  – The patient is safely hooked up on monitor and patient stability is established

The Anesthesia Handover

• Procedure performed.
• Airway complexities.
• Line complexities
• Bypass and aortic cross clamp time.
• Pre and post procedure TEE findings.
• Arrhythmias and treatments pre and post bypass.
• Current intravenous infusions
• Epicardial pacer wires and current settings.
• Short term treatments for electrolyte imbalances.
• Last neuromuscular blockade and medication for pain.
• Last antibiotic given.
• Last dose of immunosuppression.
• Any evidence of pulmonary hypertension.
“My patient is now your patient.”

—Anesthesia provider to the ICU team

Published Results

A before and after retrospective study of 1127 post operative cardiac surgery patients, a structured transfer of care process was associated with a reduction in preventable complications.

Remember this?

Our process now
Thank You