Results The most commonly identified low-dose medication was rectal Diazepam. Our baseline rate of low-dose prescriptions using data was 3.5%. Interventions targeting efforts to eliminate low-dose prescribing resulted in a centerline shift from a baseline of 3.5% to 2.8% in January 2016. There was a second centerline shift to 1.59% in September 2017.

Conclusions Using quality improvement methodologies, the team substantially decreased low dose rescue medication orders by an average of 54%. We are currently developing a tool within our EMR to auto-calculate the correct rescue medication dose for each patient.

IHI ID 16

MOVING FROM PARALLEL TO SERIAL PREOPERATIVE PROCESS FLOW UTILIZING MULTIDISCIPLINARY BEDSIDE HANDOFFS IMPROVES PREOPERATIVE TASK COMPLETION

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10.1136/ihisciabs.16

UCMC Same Day Surgery → Operating Room Handoff Checklist

SDS Room #:	SDS RN:	ASCOM Phone #:
Task	Task Completed	Not ordered / Not applicable
Patient ID Bracelet on	☐	☐
Allergy Bracelet Needed? Yes ☐ No ☐	☐	☐
Consent complete (procedure to be performed matches consent, site, laterality, signatures, dates, times)	☐	☐
History and Physical with Update complete	☐	☐
Site Marking complete	☐	☐
Pregnancy Waiver Signed or β-HCG is Negative	☐	☐
Chlorhexidine wipe complete	☐	☐
Nasal iodine treatment complete	☐	☐
Preoperative medications administered		
Antibiotics (available at bedside)	☐	☐
Subcutaneous heparin	☐	☐
Acetaminophen	☐	☐
Gabapentin	☐	☐
Celecoxib	☐	☐
Immunosuppressants (transplant)	☐	☐
Other:	☐	☐
SCDs in place on patient	☐	☐
Implanted metal devices? Yes ☐ No ☐	☐	☐
Isolation? Yes ☐ No ☐	☐	☐
Patient belongings / clothes off and secure (dentures, glasses, contacts, etc.)	☐	☐
Surgeon available (surgeon head in Epic)	☐	☐
What interventions (if any) were required at the time of the handoff to complete tasks? None ☐		

Same Day Surgery RN: _____ Circulating RN: _____
Anesthesia Team Member: _____

DO NOT PLACE IN PATIENT CHART (not part of the medical record)
(Please return to Same Day Surgery Front Desk)

Abstract IHI ID 16 Figure 1 Process flow chart and bedside handoff checklist

Abstract IHI ID 16 Figure 2 Days-between preoperative task completion failures

Individuals (XMR) chart depicting the days between preoperative task-completion failures that resulted in incident reports. The chart is annotated for important time points in the study. Special cause is illustrated by points/connectors in red and by points above the upper control limit. Dashed red line = upper control limit; Light blue line = Centerline depicting the mean for each value

Abstract IHI ID 16 Figure 3 First-case start times

Individuals (XMR) chart depicting the average start time for first cases in the operating room. The chart is annotated for important time points in the study. Special cause is illustrated by points / connectors in red and by points above the upper control limit. The shift upward of the centerline after special cause was met in the upper chart illustrates the average start time becoming significantly later after 'Go-Live' of the new handoff process. The widening control limits illustrate increased variation in the start times after introducing the new process. Dashed red line = upper control limits (UCL) and lower control limits (LCL); Light blue line = centerline depicting the mean for each value

Abstract IHI ID 16 Figure 4 Pareto charts of issues identified by qualitative bedside handoff data

Panel A: Tasks requiring completion that were caught by bedside handoffs prior to transferring patient to the operating room. Green bars represent categories requiring surgeon presence to complete

Panel B: Issues that interfered with or needed completion at the time of bedside handoffs. Red bar and orange bars identify the issues with the highest count. Yellow bars represent categories related to nurse availability

Background Incident reports suggested that patients were reaching the operating room (OR) without completion of necessary preparatory tasks. Incidents included Near Misses with potential for harm. Parallel processing and inadequate communication among preoperative nurses, anesthesia providers, and OR nurses were determined to be root causes of many of these failures.

Objectives Significantly increase the number of days-between preoperative task-completion (PTC) failures.

Methods Incident reports were analyzed for root causes. Pre-operative process flow was mapped. Process flow at other institutions was observed. Multidisciplinary bedside handoffs utilizing a task-completion checklist were tested, adapted, and adopted as a new preoperative process (figure 1). Days-between PTC failures were plotted on an XMR chart as the primary metric. First case procedure start times were plotted on XMR charts as a balancing measure. Qualitative data were collected about process issues identified by the handoff process.

Results After introduction of bedside handoffs days-between PTC failures reaching the OR increased from every 5 days to >40 days (figure 2). The average procedure start time was delayed by 8 min (figure 3). A majority of PTC failures that were stopped from reaching the OR were surgeon-specific

(figure 4A). Unavailability of nurses was a reported barrier to process success. (figure 4B).

Conclusions Bedside handoffs inclusive of preoperative nurses, anesthesia providers, and OR nurses increased the days between PTC incidents reaching the OR. This safety intervention had the tradeoff of a slight decrease in efficiency as measured by procedure start times. Interventions targeting nurse availability and earlier surgeon task completion are still necessary to optimize efficiency.

IHI ID 17 IMPROVING TIMELY RECOGNITION OF SEPSIS IN PEDIATRIC INTENSIVE CARE UNIT PATIENTS

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10.1136/thiscabs.17

Background Sepsis is a leading cause of pediatric mortality. Prior research shows that patients who receive antibiotics within 6 hours of sepsis recognition have decreased in-hospital mortality. While we had demonstrated improvements in recognition of sepsis for newly admitted patients, delayed