Implementing the I-PASS Handover Bundle Lessons Learned

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VS.

SITUATION
What is the situation?

BACKGROUND
What is the clinical background?

ASSESSMENT
What is the problem?

REQUEST/RECOMMENDATION
What do I recommend/request to be done?

VS.

ILLNESS
Severity

PATIENT
Summary

ACTION LIST

SITUATIONAL
Awareness & Contingency Planning

SYNTHESIS
by Receiver
A Bundle!
- Faculty Development
- Core Workshop Curriculum
- Structured Implementation
medical error rate
23%
preventable AEs
30%

I-PASS
Better handoffs. Safer care.

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Handover Quality
Pediatric Residents in our NICU Setting
Handover EPA Rubric
HEAR Checklist
Handover Related Errors Questionnaire

quality measures
Quality

EPA Rubric Scores

no difference
Handover Related Errors Questionnaire

Decreased satisfaction POST (p=0.038)
Quality

HEAR Checklist

Improved read-back
Fewer distractions
Focus Groups

Residents

Longer handovers
Workshop: realistic examples
Role-modelling
Focus Groups

Resident

“We never actually saw what a real-life example would look like.”
Focus Groups

Faculty

Accuracy of information
Cumbersome assessment tools
Problem synthesis
Focus Groups

“…but the big picture about the patient… There was no headway made there.”
Focus Groups

Resident

“If it’s a complex kid, I would still go system-based. I wouldn’t use this…”
Focus Groups

Resident

“...if you go through the systems, you know that you’re not missing anything.”
Lessons Learned

Realistic Scenarios
Role Modelling
Enhance patient/problem synthesis
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