Introducing an individualised 'plan for the day' in the NICU

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infant PATIENT SAFETY Working together

It is widely recognised that clear, effective communication, especially at handover, is essential to ensure patient safety in the hospital environment. It helps the neonatal intensive care unit (NICU) team prepare for the day ahead, improves morale and reduces errors. This article describes the development and implementation of 'plan for the day,' a handover tool that is individualised for each baby.

Identifying the problem

Nursing and medical staff at a tertiary neonatal unit at University Hospital Wales, Cardiff, were surveyed over a three-month period on their thoughts regarding patient safety and communication following ward rounds. Handover was highlighted as a principal area of concern with reports of uncertainty surrounding the tasks planned for each patient, their priority, and the member of staff responsible. Alarmingly, over 60% of nursing staff were uncertain of whether any changes had been made to the prescription chart (**FIGURE 1**).

Methodology

Using the Institute for Healthcare's *Model for Improvement*,[1] a handover tool originally developed by two neonatal units in Bristol[2] was adapted for local use and initially trialled for one month. The tool contains:

- a job list for each shift
- clear identification of who is responsible for each task
- safety prompts
- nursing safety checks.

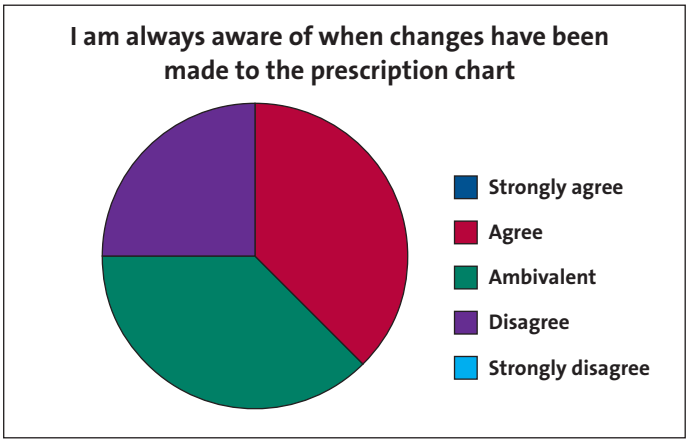

FIGURE 1 Nursing staff response to one of the questions in the survey: over 60% of nursing staff were uncertain about changes to the prescription chart.

Prior to the introduction of plan for the day, parents were surveyed for their preference; it was welcomed by 83% but some parents raised concerns regarding confidentiality and were worried they would not understand what was written, potentially leading to anxiety. These concerns were addressed during the implementation period of the plan.

Regular feedback was sought via 'plan-do-study-act' (PDSA) cycles (**FIGURE 2**); the tool was modified between cycles before being re-implemented in the NICU.

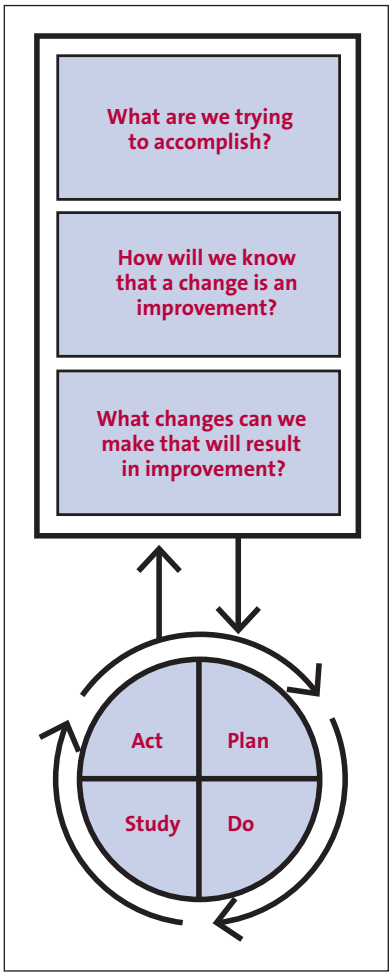

FIGURE 2 PDSA cycles.

PDSA cycles

Some problems were encountered during the trial period, these included staff awareness and acceptance, and issues regarding patient confidentiality. The problems were addressed in four PDSA cycles over a six month period.

PDSA 1: Staff reluctance to change

Action 1: Education and promotion of the importance of the plan for patient safety by various methods including posters in the doctors' office and staff room, and reminders at the daily team briefing meeting.

Action 2: Regular feedback was sought from staff to help improve the plan and therefore enhance staff participation. The weekly

unit teaching sessions were used as an opportunity to remind staff to complete daily plans for each patient and listen to any concerns, which sometimes led to further PDSA cycles.

PDSA 2: Nursing staff using a separate safety checklist
Action: A nursing checklist was added to the plan for the day creating a clear, unified checklist and minimising paperwork.

PDSA 3: Shortage of space on the plan for the day for jobs for more complex babies
Action: A 'Plan for the night' was included on the back of the plan for the day.

PDSA 4: No specific place for the plan at the bedside
Action: Clipboards were placed at each bed space specifically designated for the baby's plan for the day. The clipboards minimised the risk of lost paperwork.

The plan for the day tool

The plan for the day tool can be seen in **FIGURE 3**. It is placed on a clipboard at a designated space at each baby's bed space. To protect patient confidentiality sensitive information is not included on the plan, instead a highlighted note indicates that more information is included in the patient's notes.

The plan is updated during every ward round/handover and throughout the day by the doctors and nursing staff when the plan changes or jobs are completed.

The tool contains prompts for:

- X-ray review
- antibiotic levels
- blood glucose/bilirubin levels
- prescribed drugs/fluids
- parenteral nutrition
- central line checks
- pain scores
- naso- and orogastric tubes
- cot space safety check and cleaning
- badgernet updates.

The plan itself has been extremely well-received on the neonatal unit at University Hospital Wales and positive feedback has been received from all members of the multidisciplinary team. It is currently being used on a daily basis. It is difficult to measure specific improvements in patient safety, but feedback indicates that staff feel better-informed, can plan ahead for the shift in a more organised manner, and perceive that handovers between shifts are more efficient. The safety prompts, in particular, ensure that important points are discussed and documented at every handover. The plan helps eliminate uncertainty about the tasks planned for each patient, their priority, and the member of staff responsible and in doing so improves communication between the team and prompts the delivery of safe, optimal levels of patient care.

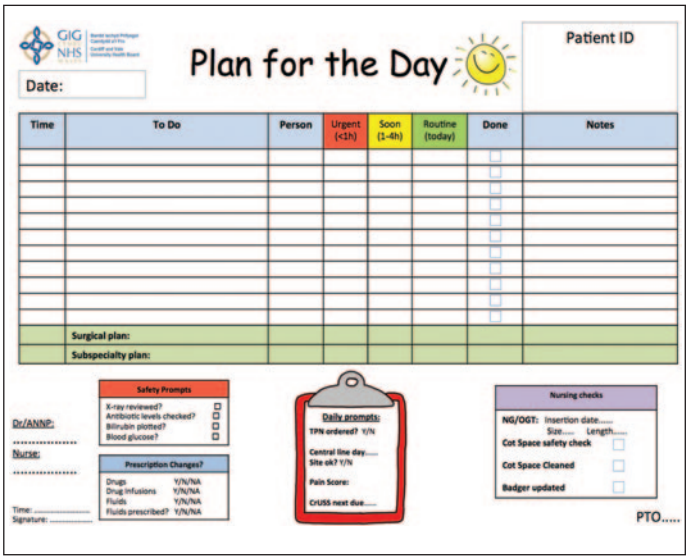

FIGURE 3 The plan for the day tool situated at each baby's cotside. The reverse side includes a similar 'plan for the night' (not shown).

Following the success of the plan for the day for NICU babies, it is intended that a similar plan will be implemented for babies on the high dependency unit – the 'plan for the week'.

Acknowledgement

The authors would like to thank all the staff and parents of the neonatal unit at University Hospital Wales. The project was inspired by the Bristol *My Plan for the Day*,[2] which was designed and introduced in Southmead Hospital and St Michael's Hospital in 2014 by Elizabeth Osmond, Alexandra Doerr, Katherine Burke and David Evans.

References

1. **Institute for Healthcare Improvement.** *Model for Improvement.* [Online]. Available at: www.ihi.org/resources/Pages/HowtoImprove/default.aspx [accessed 11 September 2017].
2. **Osmond E., Doerr A., Burke K. et al.** 'My Plan for the Day': improving handover in the neonatal unit. *Arch Dis Childhood Fetal Neonatal Ed* 2014;99:A73.