CLINICAL GUIDELINE	
Cardiac: Post-Operative Handover	
Scope (Staff):	Nursing and Medical Staff
Scope (Area):	NICU KEMH, NICU PCH, NETS WA

Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

This document should be read in conjunction with this DISCLAIMER

Most babies undergoing cardiac surgery will have their immediate post-op care in PCC with most returning to NICU as early as 24 hours later. This Guideline applies whether the baby returns from cardiac catheter, PCC or directly from Theatre.

Prior to Arrival

Set up the bed space with appropriate monitoring equipment and drug infusions and ventilator settings as notified by theatre/ PCC.

Handover

Handover must follow the **iSoBAR** format.

The anaesthetist and NICU consultant and/or senior registrar, registrar and appropriate neonatal nurses should be present. All non-essential staff should move away and everyone should listen carefully and quietly to the handover.

Prior to handover:

- Patient is transferred onto a NICU ventilator with immediate assessment of chest movement, air entry, end-tidal CO_2 and SaO_2 by anaesthetist.
- Chest drains should be connected to suction (15-20cm H_2O).

The anaesthetist remains in charge of the patient until handover is completed.

Identity	Patient name and UMRN.
Situation	Describe the reason for handover.
Observations	TPR, BP, CVP, blood gas and haemoglobin. Ventilation settings and current infusions.
Background	Brief salient pre-op status. **Surgery** • Intra/post op echo details (if done). • Details of procedure. • Intra-operative surgical problems/complications. **Anaesthesia** • Itemise any ETT, vascular and surgical drain manipulations and difficulties. • Analgesia. • Blood losses and Fluid/blood product administration. • Any arrhythmia details.
Agree a plan	Given the situation agree what needs to happen.
Read back	Confirm shared understanding.

Following Handover

- Transfer transport monitoring to bedside monitoring. Invasive systemic BP and CVP monitoring is recommended.
- Review infusion concentrations. If changing inotrope infusion use the 'double pumped', i.e. the original infusion should only be stopped once the new infusion has 'hit'. You will be able to tell this when the BP rises.
- Medical and nursing staff should thoroughly examine the patient.
- ABG should be taken within 10-15 minutes of admission.
- FBC/ U+E/ Ca/ Mg/ coagulation profile should be checked.
- X-ray to check ETT, NGT, drain and line positions and lung and heart status.
- An ECG should be considered.

Parents

Once surgeon has spoken to the parents and if patient is stable enough parents should be encouraged to see their child as soon as possible.

Registrar or Senior Registrar should write all the above details in notes.

Related CAHS internal policies
CAHS • Communicating for Safety Neonatology • Clinical Handover

References and related external legislation, policies, and guidelines
DoH: MP0095 Clinical Handover Policy

Useful resources (including related forms)
NSQHS Standard 6 Communicating for Safety

This document can be made available in alternative formats on request for a person with a disability.

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Reviewer / Team:	Neonatal Coordinating Group /PCC/ Anaesthetics		
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