EXECUTIVE SUMMARY

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Improving Communication Between the Emergency Department and Inpatient Units

Background

The Joint Commission defines handoff as "a transfer and acceptance of patient care responsibility achieved through effective communication," in which they stipulate that "The organization's process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information" (The Joint Commission, 2017, p. 1).

The gold standard for handoff is face-to-face, bedside handoff (Gettis, Dye, Williams, Frankish, & Alvarez, 2019). This is echoed in our own policy. However, both our policy and the Joint Commission recognize that this is not always possible, especially if it incurs other safety deficits (Elsevier Inc., 2020, The Joint Commission, 2017)). One of the only transfers that does not include verbal handoff is the ED to inpatient units transfer. Our own policy, which is now guided by Elsevier's Clinical Skills library (2020), directs that if face-to-face handoff is not possible, then verbal is the next best option and to not solely rely on electronic or paper communication. Currently, after the unit charge nurse is notified of the incoming patient's name, social security number and diagnosis, the only report form the emergency department is in the form of an often incomplete or inadequate transfer note, that is rarely audited.

Finally, communication and transfer errors are two sources of medical errors, which have been documented as mortally and fiscally unsafe. The cost of medical errors is estimated to be $20.8 billion, nationally (Bos, Rustagi, Gray, Halford, Ziemkiewicz & Shreve, 2011).

Objective

To increase nurse efficacy and safety through initiation of verbal report between the emergency department and inpatient, medical/surgical wards.

Evidence Informing Project

- Personal experience
- Questionnaire data
- Literature review
- Interview

Methods

This project took place at the Portland Veteran's Administration Health Care System, specifically among nursing staff in inpatient units and the emergency department. This project started November of 2019 and completion is to be determined. One facet of this study included an extensive literature review on evidence-based handoff and implementation. Aside from the literature review, clinical nurse specialists within the Veteran's Administration, across the nation, were interviewed via email for their knowledge and experience. A pre-intervention questionnaire was created, approved by the American Federation of Government Employees, and distributed to available inpatient registered nurses. The results are as follows.

Results

The response rate for the preintervention questionnaire was 45.7% (N=86) of all the inpatient registered nurses. The nurses that did not participate did not opt out, but rather were unavailable at the time of questionnaire administration. There were four question posed on the questionnaire. A majority of responses indicate that not only did inpatient nurses find the transfer process inadequate, but that the addition of a verbal modality is preferred.

Conclusion

Due to the current COVID-19 situation, the project was put on hold indefinitely, therefore our conclusions are limited. However, the literature review that we completed indicates that a verbal, interactive component to handoff increases safety, completeness and nurse efficacy. Also, the preliminary questionnaire that was administered shows a glaring need for change. Overall, receiving nurses indicated that they feel underprepared to assume care of incoming patients and that there is room for improvement. Nurses responded to the questionnaire emphatically and continually wrote in comments. Overwhelmingly, responding nurses indicated that they believed there needs to be a verbal component.

There is a safety and cost piece to this project that could not be measured of the time of completion. For example, an ill-informed nurse may not have the appropriate safety supplies for an incoming patient, such as a suction set-up. Also, resources could be mismanaged if a patient had to reassign a room.

This might occur if the patient required a negative pressure room due to their condition.

Recommendations/Next Steps

We recommend that a more in-depth cost and benefit analysis be completed. This would require more resources and time and fell outside of the scope for this portion of the project. However, we believe including verbal report, something that has almost no cost, would reduce costs of mismanaged resources down the line.

Also, we were limited in our ability to view and codify medical error data within the hospital due to limitations in the reporting system. However, communication errors are a major cause of medical errors. Ergo, poor communication likely has measurable consequences that could be more thoroughly explored.

Reference List

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