Smooth Transitions: Empower nurses across the continuum through interagency teams

Presenters: Michelle George, BSN, RN, CEN, and Sarah Marotti, BSN, RN, CEN

ST. ELIZABETH YOUNGSTOWN HOSPITAL
Caring together. MERCYHEALTH

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

CLINICAL PROBLEM/SIGNIFICANCE

In 2011, St. Elizabeth Health Center (SEHC) Emergency Department (ED) and community extended care facilities (ECF) had poor communication during transfer of patients between facilities. Poor handoff communication resulted in:

- Delays of implementing care
- Safety concerns
- Unwanted interventions due to unknown code status
- Duplicate or unnecessary testing
- Increased length of stay in ED
- Inappropriate level of care
- Negative relationship between SEHC ED and ECF's

SETTING

St. Elizabeth Health Center is an urban, tertiary level 1 trauma center located in Northeast Ohio with 45,000 patient visits annually in the emergency department.

BACKGROUND

Surveys were distributed to a sample of community ECF's and ED staff regarding continuity of care and transferring patients to and from the ED. Results of a 4-week audit of ECF patients transferred to SEHC ED from community ECF's:

- 38 patients arrived with no report:
  - One cardiac arrest with no code status
  - One trauma activation
- Of the 71 telephone reports audited, only 39% included the necessary criteria for reporting to provide safe patient care:
  - Name
  - Contact person
  - Reason for transfer
  - Isolation
  - Age
  - Allergy
  - Code status
  - Wounds
  - Transferring physician
  - Current vital signs
  - Baseline mental status
  - Incontinence

Community extended care facilities collaborated with the ED to establish the elements of reporting initially through monthly meetings.

INITIAL CORE GROUP

- Representatives from 10-14 ECFs
- Lean Six Sigma facilitators
- ED educator
- ED physicians
- ED staff nurses
- Pre-hospital care providers

CLEAR GOALS DEFINED

- To improve transfer and continuity of care
- Not to find fault or assign blame in any one person or organization

EACH FACILITY VERBALIZED

- Individual transfer process
- Identified areas needed for improvement with most common:
  - Anxiety (especially in time-sensitive transfers)
  - Multiple tasks at once
  - Fragmented processes
  - New or inexperienced staff

Each facility was encouraged to use Lean Six Sigma tools to identify areas for improvement within their individual processes:

- Mapped process flow of ED and several ECFs
- Fishbone diagram – (cause/effect) excellent vs. poor handoffs
- PDSA (Plan Do Study Act) – change implementation

ECF representatives requested education for their staff on assessment or data collection for reporting to ED:

- Education day with continuing education for ECF staff was held at our hospital
- Emergency nurses and physicians presented on:
  - Falls
  - Stroke
  - Sepsis
  - SBAR (Situation Background Assessment Recommendations) for handoff
  - Case studies
  - Wound care
  - Malnutrition

RESULTS/OUTCOMES

- An audit of telephone reports verified improvement
- Since the collaborative, a monthly average of 83% of pertinent information is included in the report
- Using SBAR format has improved the quality of reports to the ED

IMPLICATIONS

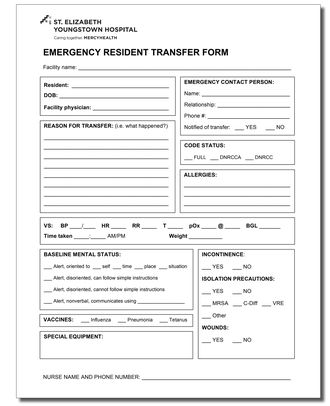
- Smoother transition by improving the communication between ED and ECFs
- This directly reflects on the quality of care provided to the patient
- Establishing a non-threatening forum has laid the groundwork for future collaboration

DEVELOPMENT OF INTER-PROFESSIONAL TRANSFORMATION TEAM

- Meets quarterly
- Members have expanded to include:
  - Inpatient nurses
  - Case management
  - Social workers
  - ED
  - ECF
  - Home health
  - OT/PT
  - Infusion center
  - Dietary services
  - KePRO
  - Area Agency on Aging

PROJECT WORK

- Inter-facility transfers
  - Between ED and ECF
  - Inpatient to ECF
- Readmissions
- Appropriate level of care
- Utilization of outpatient hospital services
- Direct admission from ED to ECF
- Continue to offer yearly education day on topics established by the collaborative



ST. ELIZABETH
YOUNGSTOWN HOSPITAL
Caring together. MERCYHEALTH

EMERGENCY RESIDENT TRANSFER FORM

Facility name: _____

Resident: _____
DOB: _____
Facility physician: _____

EMERGENCY CONTACT PERSON:
Name: _____
Relationship: _____
Phone #: _____
Notified of transfer: ___ YES ___ NO

REASON FOR TRANSFER: (i.e. what happened?)

CODE STATUS:
___ FULL ___ DNRCCA ___ DNRCC

ALLERGIES:

VS: BP ___/___ HR _____ RR _____ T _____ pOx _____@ _____ BGL _____
Time taken _____:_____ AM/PM **Weight** _____

BASELINE MENTAL STATUS:
___ Alert, oriented to ___ self ___ time ___ place ___ situation
___ Alert, disoriented, can follow simple instructions
___ Alert, disoriented, cannot follow simple instructions
___ Alert, nonverbal, communicates using _____

INCONTINENCE:
___ YES ___ NO

ISOLATION PRECAUTIONS:
___ YES ___ NO
___ MRSA ___ C-Diff ___ VRE
___ Other

WOUNDS:
___ YES ___ NO

VACCINES: ___ Influenza ___ Pneumonia ___ Tetanus

SPECIAL EQUIPMENT:

NURSE NAME AND PHONE NUMBER: _____

4734YOUPST (8/15)