

# Every Patient, Every Experience, One Team



Improving Transfer of Care from the ED to Inpatient Unit

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# Emergency Department Throughput Performance Improvement Project



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System Director, Emergency Services


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## Project Leadership


- Deb Cronin-Waelde, RN,MSN,NEA-BC,ONC  
System Director, Emergency Services
- Judy Thorpe, RN, MS, NEA-BC  
Associate Chief Nursing Officer
- Steven Sbardella, MD, FACEP  
Chairman, Emergency Medicine  
System Medical Director, Quality
- Ori Litvak  
System Director, Process Improvement

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- Hallmark Health – Community Hospital System North of Boston
  - Non-academic, Non-profit
  - 2 acute care facilities
    - 234 licensed beds MWH
    - 134 licensed beds LMH
  - HHMA: multispecialty practice
  - Cancer Center
  - Hybrid medical staff model
  - Hospitalists
  - 70% admissions arrive through the ED
  - 65,000 ED visits per year
  - Meditech IS base system

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“66% of medication errors occur during transitions in care”



“Aim to decrease errors during transitions of care by 20% by the end of 2013”

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“If running relays were like patient handoffs, 4 in ten teams drop the baton”\*



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## Medicare: 6600 Preventable Deaths, Monthly!



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80% med errors are related to communication and transitions



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## What happened your second day on the job?

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### ■ Definitions and Metrics: "the negotiation"

- What does "ready" for admission mean?
- What information is necessary transfer of care?
- Is there a standard practice?
- Who is responsible to transfer the patient?
- What does the patient really need during the first 8-12 hours?
- Are we transferring to a higher level of care?
- How often does a patient transfer to a higher level of care w/in 24 hrs. of inpatient arrival?
- What is the focus?
- What are we trying to accomplish?

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## Change of Shift Report ("before")



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## Facility handoff – (“before”)



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## ED admissions project (“before”)



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## Warm Handoff



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## ED Admissions Project – “after”



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## ED Admissions Project – “after”

- 100% at the patient’s bedside in the ED
  - Physician/ Physician Assistant
  - ED Nurse
  - In-patient primary care nurse
  - Patient
  - Family

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## Monitoring and Mentoring

Direct observation +  
Data Collection

Real time feedback



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**STANDARDIZED REPORT HAND-OFF**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Observer: \_\_\_\_\_ Place patient sticker here

**HAND-OFF AUDIT TOOL**

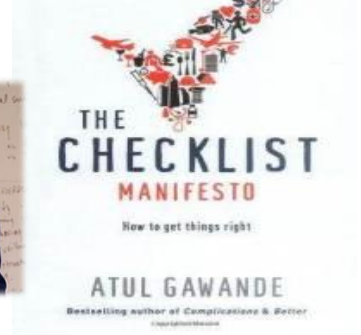
\*This HFO is not a complete guide. If you need additional information, please refer to the HFO manual. If you find a need for additional information, please refer to the HFO manual.

Introduction of Team	ID Band Check/2 Patient Identifiers	Review of Patient Identifiers	Review of Patient Status	Code Status	Diagnostic Tests/Results	Positive feedback given	Constructive feedback given	Comments
<input type="checkbox"/> Introduction of Team	<input type="checkbox"/> ID Band Check/2 Patient Identifiers	<input type="checkbox"/> Review of Patient Identifiers	<input type="checkbox"/> Review of Patient Status	<input type="checkbox"/> Code Status	<input type="checkbox"/> Diagnostic Tests/Results	<input type="checkbox"/> Positive feedback given	<input type="checkbox"/> Constructive feedback given	<input type="checkbox"/> Comments

3/1/13 Part of Payment Record - Do Not Discard



“Checklists defend anyone, even the experienced, against failure”



Do you want to make a mark on someone's life, or just do the tasks the rest of your career?  
~Steve Jobs~



Thank You!  
? Questions?

