Transferring Patients to a Higher Level of Care from an Ambulatory Setting

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ABSTRACT

Purpose:
To investigate barriers to effective handoffs, as well as develop and implement evidence-based guidelines and an electronic Situation Background Assessment and Recommendation (SBAR) tool for patients transferring from ambulatory clinics.

Relevance/Significance:
Patient handoffs are improved by implementing standards and practices. There is limited research discussing handoffs in the ambulatory areas, with the exception of the emergency departments to inpatient units. This lack of research is problematic, considering the number of patients who are treated in ambulatory clinics and procedural areas need transfers to areas in which they can receive a higher level of care. A clinical handoff is required in order for these patients to transfer safely.

Strategy and Implementation:
A multidisciplinary workgroup investigated barriers to effective communication, developed a guideline, and an SBAR. An aggressive education plan led to an awareness of the guideline and high competency rates through meetings with stakeholders, workgroups to develop tool and guidelines, as well as training and monitoring of implementation.

Evaluation:
145 patients were transferred from ambulatory clinics during the initial 30 days of implementation. Nurses documented on the SBAR for 84.1% of transfers, verbal handoff occurred for 62% of transfers, and documentation of transfer occurred for 68.3%. Documentation of all three components was 70%. No reports of ineffective handoffs were reported during the evaluation period.

Implications for Practice:
Involving the interdisciplinary team in developing guidelines and standard tools supported effective implementation of strategies for patients' safe handoffs. Providing an electronic modality and resources for nurses from different clinical areas to solve communication issues may increase patient safety.

BACKGROUND

- Safe patient handoffs are used to transfer information and responsibility (Strople & Ottani, 2006)
- Two-thirds of sentinel events are the result of ineffective communications (Effken, Gephart, Brewer, & Carley, 2013)
- Communication failures during handoff account for the majority of adverse outcomes in hospitals (Halm, 2013)
- Lack of a consistent standard for transferring patients from the ambulatory setting: Some clinics used a paper SBAR, and called report, others did not
- The processes among the clinics and team members were different
- The expectations from the emergency room (ED) and inpatient units varied
- Patient safety became an increasing concern; the ED provided evidence of 19 failed handoffs
- Patient handoffs are negatively affected by a lack of standards (Abraham, Kannampallil, & Patel, 2014)
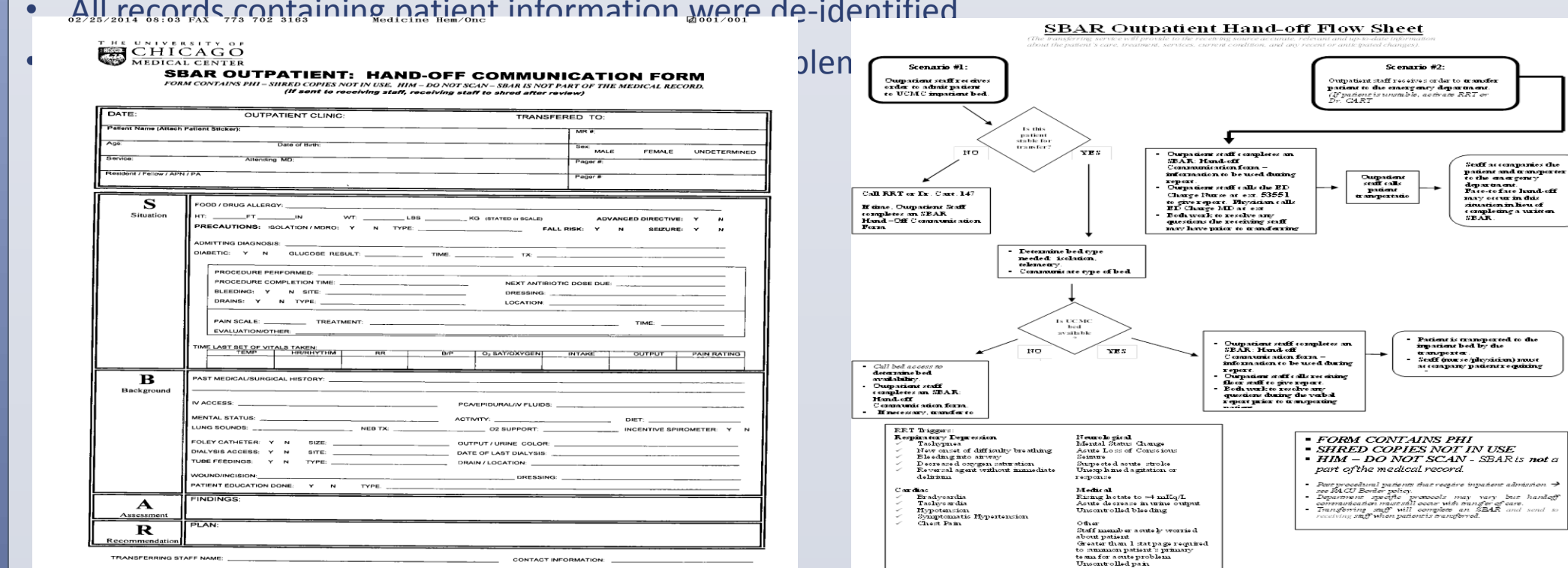
OBJECTIVES

- The primary goal of this project was to improve the handoff process for patients in ambulatory transferring to the ED.
- Investigate the barriers to effective handoff communications by physicians, nurses, and transporters when transferring patients from ambulatory clinics to the ED
- Develop a standard guideline for use by ambulatory nurses that details the process for effective handoffs
- Design and implement an electronic SBAR to serve as the standardized tool for communication of clinical information
- Reduce the occurrences of patients transferring from the clinics to the ED without an effective handoff

EVIDENCE TO SUPPORT INNOVATION

- Effective handoffs include face-to-face, two-way communication, structured written forms, templates, or checklists that encourage clinicians to agree on minimal data that create a shared mental model of the patient (Halm, 2013)
- Organizations should proactively address cultural aspects of the organization (Halm 2013) .
- Improving nursing handoffs during report using a standard (SBAR) protocol has made handoffs concise (Cornell, Gervis, Yates, & Vardaman, 2013)
- Standardized handoff process increases communications and correlates with positive outcomes (Donnelly, Clauser, Weissman, 2012, and Solet et al., 2005)

METHODS

- The clinical setting is an academic medical center's ambulatory clinics
- There are 629,269 ambulatory visits and 74,359 ED visits annually
- 19 clinics with over 80 specialties
- Multidisciplinary stakeholder groups from ambulatory shared governance, Mitchell ED, inpatient units, transportation, risk management, patient logistics, electronic medical record software electronic medical record software , and professional development worked together
- Support provided by electronic medical record software analyst to put SBAR into electronic medical record software
- Education plan developed and implemented
- Collaborated with the electronic medical record software Training Manager to develop training plan and support tools
- Handoff Process: process map was developed to ensure all elements of a safe handoff were in place.
- An ambulatory transfer guideline was developed to support the process
- The investigator retrieved reports from the following four sources (ED): 1) Teletracking, 2) electronic medical record software , 3) the Rapid Response Team, and 4) the ED triage nurse report.
- Communicate Status updates on compliance and education to departments
- All reports were retrieved electronically directly from electronic medical record software and Teletracking and/or email
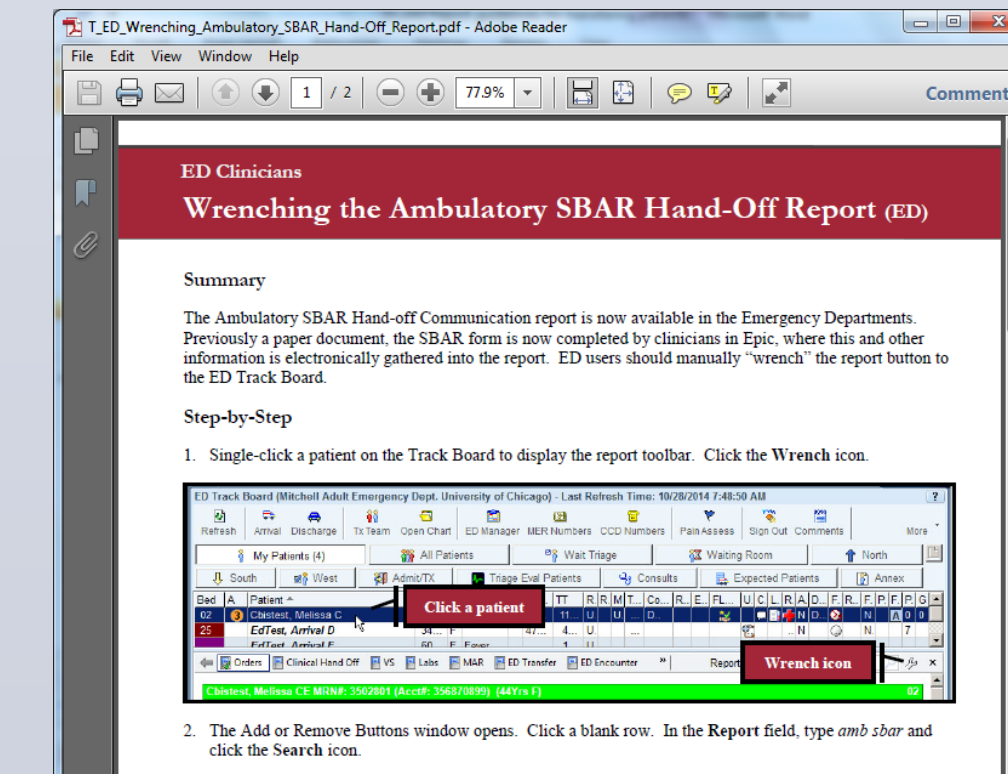- All records containing patient information were de-identified

RESULTS

- 145 patients in ambulatory clinics transferred to a higher level of care.
- The SBAR was completed 84.1% of the time
- A verbal handoff was completed 62% of the time
- Documentation of patients accompanied for transportation was completed 68.3%, unknown was 16.6%, and other was chosen as an option for 15.2% of the time
- There were six occurrences of patients transferring to the ED as a result of Rapid Response Team (RRT) calls. Verbal handoff was given five out of the six times, but the SBAR was not completed
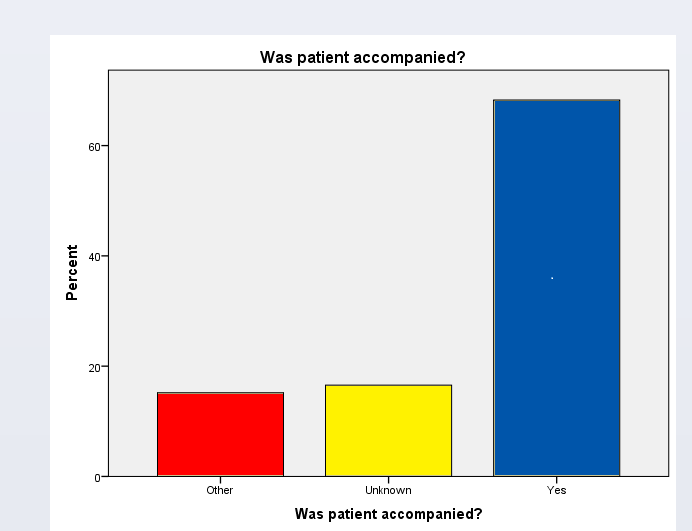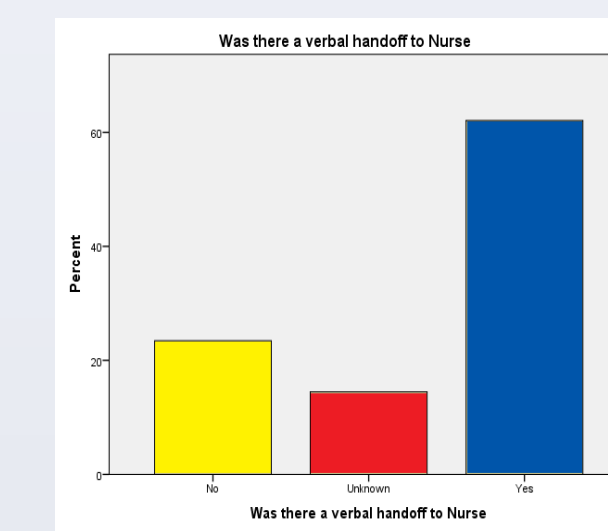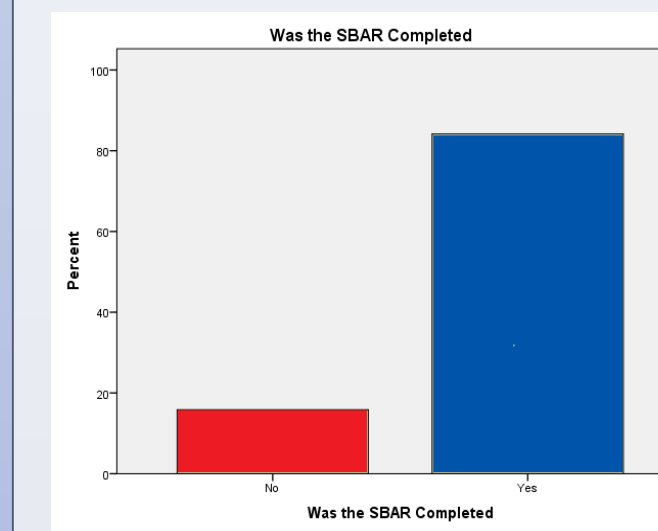
DISCUSSION

- Including key stakeholders from various departments was seen as a success factor to keeping the organization engaged and supportive of the change in patient hand-offs.
- The comprehensive educational plan contributed significantly to the awareness, engagement, and competency of the staff in completing the SBAR
- Gaining the support of electronic medical record software resources increased the engagement of the ED and inpatient staff
- Further evaluation and education was required to assess the specific needs for documentation on the SBAR after the RRT team arrived, as we found the verbal communication occurred without the SBAR documentation
- The Ambulatory Transfer Guideline was instrumental to supporting the process and was later
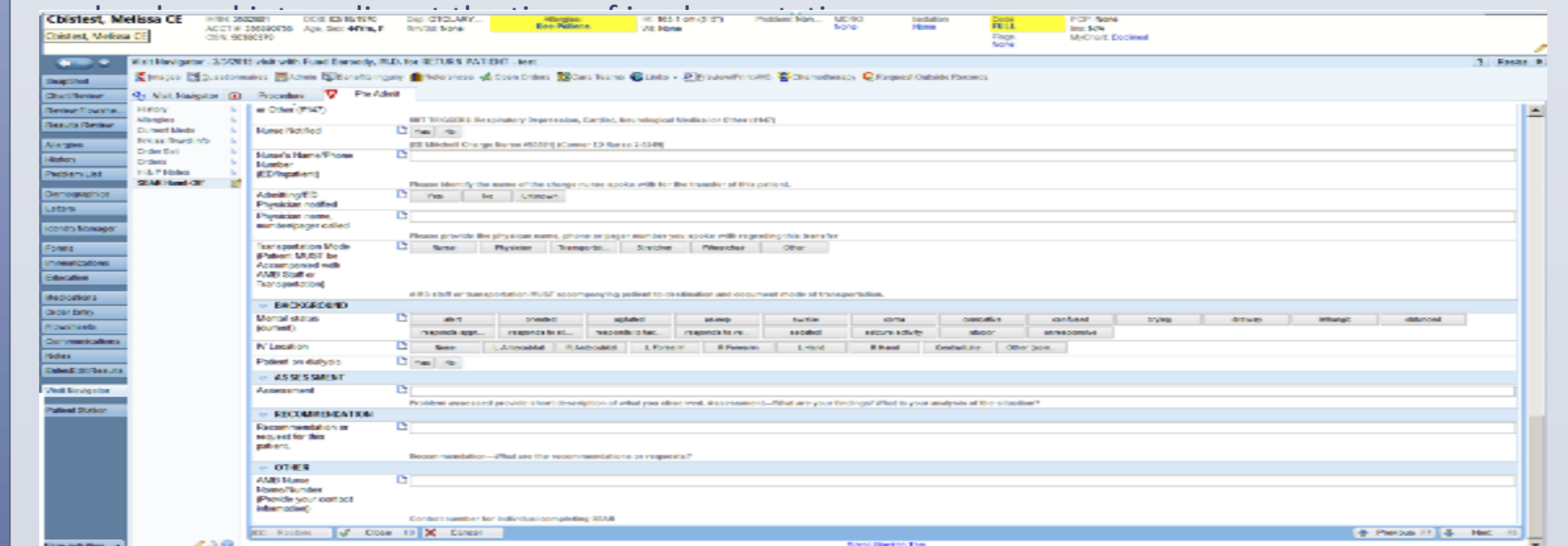
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