Improving Handovers Between Emergency Department and In Patient Cardiac Units

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Improving Handovers Between Emergency Department and In Patient Cardiac Units

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Purpose and PICOT Question

The purpose of this quality improvement project is to improve handovers from the Emergency Department (ED) to the cardiac telemetry floor which consists of two nursing units (6th floor). The PICOT question is, will nurses consistently performing identified roles compared to current process, improve nurse satisfaction for 6th floor nurses so that they get what they need to safely care for patients from the ED?

Background

The 6th floor nurses expressed concerns about not getting what they need in handovers from ED to safely care for patients they receive.

In reviewing the literature, Abraham, et al (2011) stated that handovers in healthcare refer to the transfer of care from one clinician to the next and involve a transfer of information, responsibility and authority for patient care. In addition, handoffs are often considered error-prone affecting the continuity, quality and timeliness of the patient care process.

Holly and Poletick (2013) reported that nearly 70% of sentinel events can be traced to breakdowns in communication. This finding led to the development of a patient safety goal to improve communication among caregivers using a standardized approach to handover communication.

Baseline Assessment

A survey was administered to 6th floor nurses, who could best evaluate whether the documentation from the emergency department provided has the necessary information to provide safe care, with the following questions: 1) what type of patient do you feel requires a bedside handover? 2) what type of patient do you feel requires a phone call? 3) thinking about the last patient you received, what information on the Professional Exchange Report (PER) was missing for you to safely care for the patient? 4) what other information do you need from the ED to care for the patient safely? The three most common items identified as lacking were items provided in a standardized text-based “dot phrase” which includes items such as mobility language barriers or special considerations. Second was not enough or recent vital signs and third was lack of documenting intake and output (I’s and O’s). Table 1 shows frequency before and after the intervention regarding these items.

Intervention

The intervention was education provided at start-of-shift huddles for one month to each department about Electronic Health Record (Epic) documentation. Emergency nurses received education about documenting the dot phrase information more completely, vital signs, and Intake and output. Cardiac staff were educated about how to find the dot phrase in the electronic documentation and the transportation policy, which speaks of when a nurse would need to accompany a patient from the emergency department to the cardiac unit.

The survey was repeated right after the education period of one month, to measure the effectiveness of interventions. Chart audits consisted of 20 random charts prior to education were reviewed for dot phrase completeness, vitals updated within one hour prior to admission, and documentation of intake and outtake and again 20 charts after education were reviewed for the same. The results are shown in Figure 1.

Table 1. Cardiac telemetry nurses’ survey responses.

<table>
<thead>
<tr>
<th></th>
<th>Baseline Survey</th>
<th>Post Intervention Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dot Phrase Requested</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Vitals Requested</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>I’s &amp; O’s Requested</td>
<td>8%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Figure 1. Chart Review Results

<table>
<thead>
<tr>
<th></th>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
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<tbody>
<tr>
<td>% Documented in Epic</td>
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<td></td>
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<td>65%</td>
</tr>
<tr>
<td>Dot Phrase Compl.</td>
<td>30%</td>
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<td></td>
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<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Vitals Updated</td>
<td>5%</td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>I’s &amp; O’s Completed</td>
<td>60%</td>
<td></td>
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Results

The baseline survey in Table 1 indicates the percentage of 6th floor staff that reported insufficient documentation of the dot phrase (50%), vitals (33%) and I’s and O’s (8%). The post-intervention survey demonstrates improvement in that none of the three items were requested in the post survey. The response rate from the post survey was low as there are over 100 nurses that work between both cardiac units.

Conclusion and Next Steps

The results of the education is promising in that the post survey rates being low, could indicate the 6th floor nurses are getting what they said they wanted, which was better information including the more complete dot phrase, current vitals and documented intake and outtake. These are what the 6th floor nurses indicated they wanted to safely receive patients from the ED.

Future research would include improvement in the electronic health records so that nursing documentation is aligned between ED and patient units. Another key element is getting real time feedback from the 6th floor if and when the documentation slips or parameters are not in line for example: expectation of last vitals one hour verses 10 minutes prior to departure.

References
