One of my colleagues, Stephanie Baker, wrote a Studer Group insight about the importance of hardwiring bedside shift report. In it, she shares the benefits and impact that handovers can have for patients and caregivers. Effective and safe patient handovers (also called care transition) are critically important, not only between shifts on the same unit, but also between departments. Emergency Department (ED) to Inpatient (IP) handovers are essentially the same concept as bedside shift report but require some additional training and steps to effectively implement the process.

Before we discuss the “how and why” of ED to IP handovers, let’s address some of the barriers or concerns you may be thinking. We don’t want to impede the flow of patients arriving to the inpatient unit or have caregivers waiting for a nurse to come and get the patient. Caregivers are busy and may not be able to stop their work to transfer patients from one unit to the next. Also, the geography or location of the ED may be too far away for in-person patient handovers. In either case, we have seen organizations implement the process in a way that works best for their team.

For example, try using Skype or another video chat method through a laptop. If technology is a barrier, the ED caregiver can also call the inpatient nurse and discuss pertinent patient information over the phone. Information can also be faxed if that’s the only means of communication. Whatever means necessary, and within the allowed avenues of the organization, caregivers should ultimately have the opportunity to ask questions and involve the patient in this process.

Why are safe care transitions so important – for both patients and caregivers?

Care transitions are focused on the safe transfer of patients from one department or unit to another, and positively benefits both the caregivers and patients. When transitioning care from the ED to IP, the ED caregiver can ensure the patient’s needs were taken care of in the ED. The ED and IP nurses have the face-to-face chance to discuss exactly what took place in the ED and what the plan of care will look like now in inpatient.

For the inpatient caregiver, the nurse is able to confirm exactly which medications were given, what procedures were completed and that proper documentation is provided. This also improves the relationship between ED and IP caregivers.

For the patient, they become a critical part of their care plan by being involved in all discussions about their care. Caregivers reiterate that safe and quality care is their number one priority, and patients gain the opportunity to ask questions. This not only increases patient compliance with areas such as proper medication dosage, it also reduces potential sentinel events.

What does the process look like?

It’s important to remember that through ED to IP patient handovers, we don’t want the process to hinder the flow of the patient reaching their final destination. It should be a streamlined process so caregivers aren’t waiting for the IP Charge Nurse to come get the patient or waiting for the patient to be delivered by the ED nurse. Once a plan is in place, we recommend starting with the most critical patients. Some organizations implement a “swoop” mentality to transfer patients as soon as they are deemed critical. The “swoop” team will immediately identify whether the ED nurse is bringing the patient to IP or visa-versa. Then the care transition should occur at the bedside and involve the patient.

How to implement ED to IP handovers?

First we suggest starting with a team of caregivers tasked with rolling out this tactic, with the end goal of all handovers occurring at the bedside, both from ED to IP and from shift-to-shift. This team is in charge of communicating this new process with staff prior to rolling it out, which allows everyone to become familiar with the tactic and understand why it’s so important. Leaders should be involved in the process but we recommend Charge Nurses own the rollout and training since they are responsible for completing the process.

Prior to rolling out this tactic organization-wide, try piloting it with just critical patients. This allows caregivers to test the process, identify opportunities for improvement, and harvest best practices to demonstrate the effectiveness with other departments. One organization coached by Studer Group, UConn Health, recorded a webinar on this topic which outlines the steps they took to hardwire this process.
INSIGHT:

SAFE CARE TRANSITIONS: BEST PRACTICES FOR EMERGENCY DEPARTMENT TO INPATIENT HANDOVERS

By: Angie Esbenshade, RN, MSN 2015

How do we measure success?

Leaders can identify successes during huddles with the core team to identify what worked well and what needs improvement during care transitions. Leaders can also ask targeted questions during Leader Rounding on Patients to see how the handover went, what they found most beneficial about the transition of their care and so on. This allows leaders to reward and recognize caregivers who are doing it well, as well as provide immediate service recovery with the patient if they didn’t feel the handover went as planned.

Another way to track effectiveness is by tracking incidents. Have you seen a decrease in incidents/sentinel events? Increase in patient safety measures? Higher levels of patient perception of care? It may not be immediate, but you should start to see some correlation in results.

When we focus on building collaboration and partnership between ED and IP caregivers, we in turn create better environments for our patients to receive care. It also generates evidence that we’re able to adapt to change for the better of our patients and organization as a whole. As difficult as it may seem at times, we must constantly strive to deliver the highest levels of quality and safe care.

ADDITIONAL RESOURCES

Learn about this and other tactics in “Partnering Effectively with Inpatient Leaders for Improved Emergency Department Throughput” published in Advanced Emergency Nursing Journal, January 2015.

Attend emergency department focused tracks at Studer Conferences to learn how to overcome obstacles such as flow and throughput, overcrowded waiting rooms, and misalignment between physicians and staff.