Title:
It Takes a Village: Transitional Care, an Interprofessional Collaborative Effort

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Eberhardt, S. (2014). Improve handoff communication with SBAR. *Nursing, 44*(11), 17-20. DOI: 10.1097/01.NURSE.0000454965.49138.79


Abstract Summary:
The Joint Commission (2012) estimates that approximately 80% of serious medical errors involve miscommunication among healthcare providers when patients are transferred or handed-off; thereby resulting to delay or inappropriate treatment, omission of care. A standardized hand-off tool unique in the acute care setting was created through inter-professional collaborative effort.

Learning Activity:

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<th>LEARNING OBJECTIVES</th>
<th>EXPANDED CONTENT OUTLINE</th>
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<td>The learner will be able to explain the importance of effective communications as an integral component in transitional care or patient hand-off.</td>
<td>Ineffective communications between healthcare providers during transition of care or hand-off may result to delay or inappropriate treatment, omission of care; the likelihood of inconsistent information being provided to healthcare practitioners, patients and their family is high.</td>
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<td>The learner will be able to compare and contrast the use of standardized hand-off tool (such as the Targeted Solutions Tool™ [TST] suite with the newly developed hand-off tool designed by the interprofessional collaborative team at Palm Beach Children’s Hospital at St. Mary’s Medical Center.</td>
<td>Although a standardized handoff tool will aide in lost communication, nurses must be familiar with the information on the tool (Eberhardt, 2014). Efficient and effective communication is vital for nurses as healthcare today has changed to a fast paced environment (such as in the emergency room and intensive care units). Information can easily degrade when a</td>
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patient transfers. Certain information is more pertinent than other information depending on the diagnosis but all must be relayed to the nurse that is receiving the patient. A uniquely outfitted hand-off tool designed by its own primary care stakeholders between units may also promote a sense of ownership between its users.

Abstract Text:

**Background:** The Joint Commission (2012) estimates that approximately **9% in nursing; 5% in OB, and 46% within other services such as anesthesia, emergency medicine and radiology** were directly related to miscommunications among healthcare providers and healthcare consumers. The CRICO group identified 7,149 cases in which communication failures contributed to patient harm with “communication challenge” as the sentinel attribute (CRICO, 2015). That means, there is an estimated **644 medical error cases** in nursing-related services alone.

This community hospital attempted to implement a standardized hand-off tool. However, due to self-reported issues by staff such as complexity, non-customization of the tool, and inconsistency; the process caused increase anxiety and dissatisfaction among staff and patients. Tension has developed between the two units causing a distrusting relationship and sometimes an avoidance or delay in report occurs. Patient and staff satisfaction plays an integral role in patient outcome and quality of patient care. This presentation highlights the use of interprofessional collaborative effort by healthcare providers in a community hospital in South Florida in order to enhance patient outcomes and staff satisfaction.

**Method:** The community hospital is a 464 bed acute care level I trauma facility located in South Florida. Within this facility are an adult hospital and a children’s hospital. The children’s hospital consists of two pediatric floors, a pediatric oncology floor, a pediatric intensive care unit, a pediatric inpatient rehabilitation unit and a pediatric emergency room. On average, the children’s hospital admits 5,000 patients a year. Both hospitals within this facility are under the leadership of a chief executive officer, chief operating officer, chief financial officer, chief nursing officer, and a chief human resource officer.

In a recent root cause analysis, it was identified that improper hand-off between two units created a substantial patient safety events. After assessing other units and their hand-off protocols, it was determined by the community hospital leadership and staff that a unit specific hand-off tool is needed to be created for what is usually known as one of the first major transitions of care in the children’s hospital. This transition is between the pediatric emergency room to a higher level of care, the pediatric intensive care unit or PICU. Multiple surveys and meetings with the community hospital’s leaderships and stakeholders (key administrators, quality improvement team, physicians, nurses, allied health services, etc.) was required to create the **Specialty Area hand-off tool** from Peds ER to PICU. At the time of this publication, the Specialty Area hand-off tool from Peds ER to PICU is being piloted in this community hospital. A pre-/ post analysis of staff and patient satisfaction survey will determine results.

**Discussion:** Transitional care is considered a set of actions that will guarantee the coordination and the continuity of care as patients are transferred between different levels of care (Wee, et. at., 2014). A hand-off tool contributes to proper transitional care and greatly aids in providing concise and objective report on patients’ status. Inconsistent report amongst two units can have medical, nursing care (especially patient safety) and social implications. The staff in the different units may begin to feel it impacting the relationships that they have with each other. Trust can become lost during this and the satisfaction of the employees will begin to decrease (Eberhardt, 2014). Multiple research reports that hospital employee satisfaction has correlating effects with patient health and safety outcomes. Healthcare professionals
should maintain optimal working relationships at all times. Having a standardized hand-off communication will contribute to this type of relationship (Eberhardt, 2014).

**Conclusion:** Miscommunication begets misinformation. Taking into consideration CRICO’s (2015) reported data on medical error with injuries due to miscommunications within nursing services (which is 9%); hypothetically, if this concern is not mitigated, there will be 450 projected pediatric patients (pp) (out of 5,000 pp) a year who will suffer medical error related injuries from this community hospital. When adequate and concise communication occurs, important information is not missed. If a hand-off tool is not used, the missed information can lead to an extended stay in the hospital. A severe or sentinel event could occur as well. Any event that requires additional care is a financial burden to the patient, facility and community on many different levels. Extra services are needed as well as extra supplies. Depending on the severity of the event or issue that is caused, additional staff may be needed. In addition, readmissions can arise depending on the harm done. All of this is from miscommunication or lack of communication (Wee, et al., 2014).

The objective of this quality improvement project is to improve staff satisfaction and perception of patient care during the transfer process of a pediatric patient from the pediatric emergency room to the pediatric ICU by utilizing a Specialty Area hand-off tool from Peds ER to PICU. This will ultimately mitigate medical errors related to miscommunications. It is the belief of these authors that a call for research that focus on individual aspects of hand-offs (Riesenberg, 2012), as well as exploring interactions between different parts of hand-offs are integral to mitigate this phenomena. Furthermore, researchers and quality improvement teams in the healthcare industry must allow flexibility (Henriksen, Battles, Keye, et al., 2008) and take into consideration unique aspects of each specialized unit (special settings, i.e., adult vs. pediatric emergency department patients transitioning to adult ICU vs. PICU) within the healthcare institution during patient transition or hand-off. This new hand-off tool that is unique between the Pediatric Emergency Room (ER) department and the Pediatric Intensive Care Unit (PICU) may pave way to a more accurate hand-off reporting between healthcare providers, specifically nurses, during patients’ transition of care.