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Effective communication on temporary transfers of inpatient care

Comunicação eficaz nas transferências temporárias do cuidado de pacientes hospitalizados

Comunicación eficaz en las transferencias temporales del cuidado de pacientes hospitalizados

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ABSTRACT

Objective: To describe the implementation of a standardized process of effective communication for the temporary transfer of inpatient care.

Method: Experience report of the implantation of a process of temporary transfer of care between professionals of the hospital wards and areas of diagnostic-therapeutic procedures of a university hospital in the south of Brazil. The process began in 2015 involving adult wards and radiology, being expanded to other areas of the hospital in 2017. The construction of the form was done through meetings and training with the professionals involved in order to contemplate the specificities of care.

Result: The elaborated form contemplates relevant aspects about the patient, subsidizing the professionals during the transitions of the care, transportation and accomplishment of procedures.

Final considerations: Its implementation added security and strengthened the process of effective and structured communication among nursing professionals.

Keywords: Patient safety. Nursing care. Patient-centered care.

RESUMO

Objetivo: Descrever a implantação de um processo padronizado de comunicação eficaz para transferência temporária do cuidado de pacientes hospitalizados.

Método: Relato de experiência da implantação de processo de transferência temporária do cuidado entre profissionais1 das unidades de internação e áreas de procedimentos diagnóstico-terapêuticos de um hospital universitário do sul do Brasil. O processo iniciou em 2015 envolvendo unidades de internação adulto e radiologia, sendo expandido para demais áreas do hospital em 2017. A construção do formulário se deu por meio de reuniões e capacitações com os profissionais envolvidos, visando contemplar as especificidades do cuidado.

Resultado: O formulário elaborado contempla aspectos relevantes sobre o paciente, subsidiando os profissionais durante as transições do cuidado, o transporte e realização de procedimentos.

Considerações finais: Sua implantação agregou segurança e fortaleceu o processo de comunicação eficaz e estruturada entre profissionais de enfermagem.

Palavras-chave: Segurança do paciente. Cuidados de enfermagem. Assistência centrada no paciente.

RESUMEN

Objetivo: Describir la implementación de un proceso estandarizado de comunicación eficaz para la transferencia temporal del cuidado de pacientes hospitalizados.

Método: Relato de experiencia de la implementación del proceso de transferencia temporal del cuidado entre profesionales de las unidades de internación y las áreas de procedimientos diagnóstico-terapéuticos de un hospital universitario del sur de Brasil. El proceso inició en 2015 involucrando unidades de internación de adulto y radiología, siendo ampliado a otras áreas del hospital en 2017. La construcción del formulario se dio por medio de reuniones y capacitaciones con los profesionales involucrados con el objetivo de contemplar las especificidades del cuidado.

Resultado: El formulario elaborado contempla aspectos relevantes sobre el paciente subsidiando a los profesionales durante las transiciones del cuidado, el transporte y la realización de procedimientos.

Consideraciones finales: Su implementación agregó seguridad y fortaleció el proceso de comunicación eficaz y estructurada entre profesionales de enfermería.

Palabras clave: Seguridad del paciente. Atención de enfermería. Atención dirigida al paciente.

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INTRODUCTION

In hospitals, patients travel long distances to perform diagnostic tests or specific treatments[1]. In this context, the patient is assisted by several health professionals, and it is necessary to transmit information effectively, to ensure that their care is continued[2].

Data from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) revealed that about 65% of adverse events are caused by communication failures between professionals[3]. Against this background, in 2005 JCAHO and the *Joint Commission International* (JCI) have partnered with the World Health Organization to drive strategies, prioritizing solutions to risk situations for patients in health settings. Thus, they defined the six International Patient Safety Goals for the purpose of promoting specific improvements in the main incident-related care processes to avoid them[4-5].

Among these goals, it is important to highlight that it aims at improving the effectiveness of communication in the transitions of patient care among health professionals, to ensure that care and the therapeutic plan are followed by all the teams involved in their care, regardless of the area of the institution[6]. Part of these care transition communications, among professionals, occurs when hospitalized patients are moved to sectors where examinations or procedures are performed, and care is taken by other teams. This process can be called communications in the temporary transfer of care, an important security strategy that still deserves to be better explored.

In Brazil, the literature on strategies to qualify communication in the transition of patient care among hospital units is scarce[7-8], demonstrating an important knowledge gap. At the study site, it was identified that the patients' movement occurred without planning the continuity of care among the professionals, failing to comply with the safety recommendations. The professionals involved in transportation were unaware of the clinical characteristics and the care of the patients who would be transported and there was no process of transmission of this information by the nursing team of the hospitalization unit. The results of the implantation can collaborate to qualify this practice, contributing to the adoption of a routine that promotes patient safety. Thus, the central question of this report was: how does the implementation of a standardized process of communication, among professionals, for temporary transfers of care, promote patient safety in health institutions?

Considering the above, this article aims to describe the implementation of a standardized process of effective communication for temporary transfer of care of hospitalized patients.

METHOD

This is an experience report of the implantation of the standardized process for effective communication in temporary transfers of care among nursing professionals in the hospitalization units and the sectors of diagnostic-therapeutic procedures of a large university hospital in southern Brazil.

The design of the new work process started in 2015 with the observation of the work of the nursing technicians who work in the patient transportation team for the Radiology sector, being coordinated by the nurse of the institution's Quality and Health Information Management Program (QUALIS). Subsequently, a working group was formed to identify and discuss possible improvements in care transfers. To this end, two adult hospitalization units (clinical and surgical) and Radiology were chosen, which were represented by two professionals from each area (a nursing technician and a nurse), as well as the leaderships of these nursing services and the coordinator of the Nursing Process Commission.

In these discussions, it was defined that the effective and safe transmission of patient information will be verbal and also in writing, through the preparation and completion of a printed form that accompanies the patient during his or her journey to other sectors, since the patient's medical record in the institution is electronic and there are no access points available during the trip for immediate consultation of the data, in case the professional does not memorize some information verbally given. The form will also be used by the different nursing professionals to support the transition of care in the sectors of diagnostic-therapeutic procedures.

The initial construction of the form required six meetings where the items that would be included were defined: registration of the conditions of the patient, the essential information that should be included and which is the best *layout* to facilitate the filling, access and visualization of the information. At these meetings, besides the items to be included in the form, it was also discussed how the process of verbal communication between the nursing teams of the different areas in the care transition would occur.

Throughout this trajectory several versions were elaborated and improved together with the professionals in-

volved seeking to qualify the exchange of verbal and written information during the transfer of care.

The implantation of the process began between clinical / surgical areas and Radiology unit. Subsequently, it was expanded to all areas of the hospital demanding the inclusion of specific care in some areas such as pediatrics. Inclusion was also suggested of space in the form to record sequential transfers of care, when the patient is moved to other sectors, before returning to the unit of origin.

Thus, this process was followed over two years and allowed the standardization of effective communication in temporary transfers of care. It should be emphasized that the use of the form also supports the verbal transmission of information about essential patient data among nursing professionals, so that their care can be continued safely according to JCI concepts and recommendations[6].

Currently, the process of temporary transfer of care is standardized and started to be used in all transitions of care of patients between the teams of the hospitalization units and the diagnostic-therapeutic sectors of the institution. It was established that the form will be completed by the nursing staff at the patient's exit from the unit of origin and complemented by professionals from the unit of diagnostic-therapeutic procedures at the time of their return. The purpose of the instrument is to provide quick access to the patient's clinical information by the professionals who accompany him during his or her stay and stay in the target areas, prioritizing patient safety so that their therapeutic plan is followed by other professionals.

In order to enable its implementation, several educational actions were necessary to raise the awareness of the nursing team about the importance of this new process and the appropriate use of the form to effectively ensure continuity of care.

As it is an experience report, it does not require the approval of the Research Ethics Committee. However, it is noteworthy that the authors followed the good practices preserving the identity of those involved and the confidentiality of institutional data.

RESULTS

The result of this study was a product called Patient Summary for Care Transfer, which complies with the literature on the subject and can be visualized in Figure 1.

The form is completed by the nurse or nursing technician who is caring for the patient in the hospitalization unit and is completed whenever he or she performs some diagnostic or therapeutic procedure scheduled in another area of the hospital.

The completion of the form occurs when the patient leaves the hospitalization unit, when the meeting of the nursing professionals of the unit with the professional that will carry the patient's transportation to the procedure area takes place. Now, whoever is caring for the patient verbally transmits the information contained in the form to the carrier, allowing the review of care to be continued in the other sector, facilitating transportation planning and anticipating possible intercurrences or the possibility of discontinuity of care.

The professionals who carry out the patient's transfer to the procedure are responsible for verbally relaying the information and revising the form completion for caregivers, which is the link in the information and care chain.

DISCUSSION

Patient safety is understood as the reduction to an acceptable minimum of the risk of unnecessary damage associated with health care[9]. The continuity of care when the patient leaves their unit of origin is an important factor to be observed to ensure safety in their care. Teamwork requires effective communication that takes place when a security culture is established in health organizations and is valued as an institution's equity[10].

In this sense, the implantation of the standardized process of effective communication in the transfer of care contributed to good safety practices, since it is known that communication failures among professionals are among the main causes associated with adverse events or errors in patient care and , consequently, to the decrease of the quality of care[8].

In the same way that it was implemented in the study institution, in the United States, a hospital introduced a case summary form to accompany patients from the inpatient unit to the examining areas and to return to the unit of origin. This summary included a pre-transport checklist and assessment completed by the unit of origin, the transport team and receiving unit, as well as a message to be read to the patient explaining the purpose of safe transport and inviting to participate[11].

The adoption of standardized processes for verbal and written communication in moments of transition of care has been encouraged by international organizations as a means of reducing the possibility of occurrence of adverse events in hospitals. The study points out that these strategies minimize the variations and standardize the type of information relevant at the time of transfer, allowing the systematization of the entire process, resulting in an increase in safety, accuracy, efficacy and quality of care[12].

SUMÁRIO DO PACIENTE PARA TRANSFERÊNCIA TEMPORÁRIA	cole aqui etiqueta de identificação do paciente (nome completo e n° de prontuário)	Localização do paciente: Leito: _____

PREENCHIMENTO A SER REALIZADO NA UNIDADE DE INTERNAÇÃO:

Diagnóstico Atual / Motivo da Internação: _____

Procedimento Planejado: _____

Alergia: ( ) Não ( ) Sim a que: _____

Prótese dentária ( ) Sim ( ) Não

( ) Termo Cirúrgico ( ) Termo Anestésico

Tipo de Transporte: ( ) Cadeira ( ) Maca ( ) Berço ( ) Berço com cinto de segurança ( ) Carrega Bebê

Riscos e observações:

Riscos / Observações	Sim	Não	Observações
Queda			
Suicídio			
Fuga			
Agressão			
Fratura ou restrição para mobilização			
Germe multirresistente			
Precauções			
Contenção Mecânica			

Intercorrências nas últimas 24 horas: _____

Dieta: ( ) NPO ( ) VO ( ) SNG ( ) SNE ( ) Gastrostomia ( ) Jejunostomia

Acesso venoso: ( ) Periférico ( ) Central Tipo: _____

Infusões: _____

Nível de consciência:

( ) Lúcido / Alerta ( ) Desorientado ( ) Torporoso ( ) Comatoso

Suporte Ventilatório: ( ) O2 _____ l ( ) Catéter Nasal Extra-Nasal ( ) Máscara de Venturi ( ) Máscara de Hudson ( ) BIPAP ( ) Traqueostomia

Drenos e Sondas: ( ) Não ( ) Sim Qual: _____

Curativo: ( ) Não ( ) Sim Tipo e localização: _____

Alteração de Sinais Vitais: ( ) Não ( ) Sim Qual(is): _____

Observações Importantes: _____

Responsáveis (assinatura e carimbo)

Enfermeiro ou Técnico de Enf. da Unidade

Enfermeiro ou Técnico de Enf. da Unid. Procedim.

Data: ____ / ____ / ____

Horário da saída da Unidade: ____ : ____

PREENCHIMENTO A SER REALIZADO PÓS-PROCEDIMENTO / EXAME:

PÓS-PROCEDIMENTO / EXAME

Realizado Procedimento / Exame?

( ) Sim ( ) Não Motivo: _____

Intercorrências: ( ) Não ( ) Sim: Qual: _____

( ) Intercorrências registradas em Prontuário

( ) Cuidados conforme prescrição / Evolução

Observações / Cuidados especiais: _____

Responsáveis de retorno (assinatura e carimbo)

Enfermeiro ou Técnico de Enf. da Unidade

Enfermeiro ou Técnico de Enf. da Unid. Procedim.

Data: ____ / ____ / ____

Horário de retorno à Unidade: ____ : ____

ENF - 276 - 256652 - OUT17

Paciente foi transferido para outra unidade após o primeiro exame / procedimento?

( ) Sim ( ) Não

Se sim, qual a unidade de destino? _____

Qual o exame / procedimento? _____

Intercorrências? ( ) Não ( ) Sim Qual: _____

( ) Intercorrências registradas em Prontuário

( ) Cuidados conforme Prescrição / Evolução

Observações / Cuidados especiais: _____

RESPONSÁVEIS PELA TRANSFERÊNCIA DO CUIDADO

DATA: ____ / ____ / ____ HORÁRIO DA TRANSFERÊNCIA: ____ : ____

Enfermeiro ou técnico da unidade de exame | Enfermeiro ou técnico de enf. da unidade

Paciente foi transferido para outra unidade após o segundo exame / procedimento?

( ) Sim ( ) Não

Se sim, qual a unidade de destino? _____

Qual o exame / procedimento? _____

Intercorrências? ( ) Não ( ) Sim Qual: _____

( ) Intercorrências registradas em Prontuário

( ) Cuidados conforme Prescrição / Evolução

Observações / Cuidados especiais: _____

RESPONSÁVEIS PELA TRANSFERÊNCIA DO CUIDADO

DATA: ____ / ____ / ____ HORÁRIO DA TRANSFERÊNCIA: ____ : ____

Enfermeiro ou técnico da unidade de exame | Enfermeiro ou técnico de enf. da unidade

Figure 1 - Patient Summary for Care Transfer
Source: Authors.

Verbal communication strategies are extremely useful but are most effective when supported by a written record, ensuring that relevant information about the patient is maintained during all care transfer opportunities. Thus, written information should present the relevant data in a systematic and orderly manner, in a list format, which reduces the possibility of information loss, helping to structure communication between professionals and, consequently, ensuring continuity of patient care[13].

FINAL CONSIDERATIONS

The implementation of the standardized process of effective communication, with the preparation of the summary form of patient information for the transfer of care, contributed to a reflection of the health professionals regarding the fragility of this moment and about the need to continue the care during transportation and patient stay in the procedures sector.

The instrument made it possible to qualify and standardize the safety items to be checked before, during and after the transfers, favoring the understanding of the necessary care for patient safety during transportation. This instrument contributes to qualify the teaching of nursing professionals and to promote research in the area of the transfer of care.

The limitations of the study include the need for a prospective evaluation of the implanted process, since the complexity of the patients is constantly changing, requiring updating of the instrument and the communication process instituted to comply with its main purpose, which is to qualify safety in care transfers.

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