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Decreasing Delayed Patient Transfers Prior to Shift Change

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Clinical Leadership Theme

This project focuses on the CNL competency leadership theme of *Clinical Outcomes Manager. "*Clinical Outcomes Manager uses data to change practice and improve outcomes" (AACN, 2013). With the assistance of my preceptor, lean team members, department managers, and administration, this project will aim to reduce delayed patient transfers times between the emergency department and inpatient units by 50%. This project goal will be achieved by writing and setting in place a new guideline for 45 minute black-out transfer times. The anticipated goal date for this project is set for mid-August, 2015. As the CNL, I will be leading the project and utilizing internal, as well as, external resources to help implement this course project.

Statement of the Problem

Ideal patient transfer times, from the emergency unit, to the inpatient unit is an important component of any patient's health outcome. When a patient transfers to the inpatient unit prior to shift change, the probability of delayed care increases; therefore, a patient's health status can decline quickly. Transfer times, prior to shift change, also increases the workload for the nurse; which leads to nurse frustration, and declined care for their other patients. One of the most significant reasons for this project is related to the increase in rapid response pages placed for newly transferred patients.

The purpose of this project is to: prevent delayed care, Rapid Response Team (RRT) alerts, fatalities, nurse frustration, work-overload, decline in overall patient care, and nurse dissatisfaction. Furthermore, because the primary purpose of this project is to decrease delayed patient transfer times by 50%, patient care will ultimately improve upon arrival, nurse

satisfaction will improve, and expected patient outcomes will be ensured. Beneficially, the new guideline demonstrates best practice for transfer times and the prevention of delayed care. Upon the established guideline and brief in-services, staff member compliance will be expected.

Project Overview

For this course project, data will be obtained from Lean Team members, department managers, my preceptor, internal EPIC data, as well as, external research. Computer data will allow me to investigate charting times, hand-off reporting times, and transfer times between the two units – emergency department & inpatient units, specifically.

Throughout the day and night, patients are transferred to the inpatient units from the emergency department. However, a problem with delayed patient transfer times, prior to shift change has been noted. The objective is time management and the goal is to decrease delayed patient transfer times by implementing a new *black-out window* of 45 minutes. During the black-out time frame, ED patients will be blocked from inpatient transfers, and will not be allowed on the inpatient units until next shift has arrived. If transfer time is greater than 45minutes prior to shift change, the transfer will be accepted. This solution will rectify the above problems and allow for a better, efficient, patient transfer experience.

Once data is collected and analyzed, meetings, project implementation and guideline brainstorming can begin. The administrative team, physicians, the lean team, relevant unit managers, house supervisors, unit educators, and one housekeeping rep will be involved. Thereafter, upon guideline establishment ED nurses will become aware of the change, as well as, in-patient nurses. Quarterly assessments will be conducted to confirm adherence.

Rationale

To identify the needs and contributing factors that have led to delayed patient transfer times, a cause and effect analysis was conducted. Based on nursing reports, observation, emergency and inpatient unit assessments, ICU data, EPIC data, patient and family surveys, RRTs alerts, and fatalities were gathered to conduct this cause and effect analysis for this problem. According to the data collected, unfortunately, some of the contributing factors are rooting from the inpatient units themselves, but also, the emergency department.

For example, data revealed some contributing factors, such as: inpatient beds are being held to avoid a new patient, inpatient rooms are not being cleaned fast enough for an early transfer, inpatient nurses are avoiding receiving report from the emergency nurse, new nurses still learning time management skills and efficiency, unhelpful charge nurses, and inpatient nurses trying to complete their shift and patient care becomes difficult when a new transfer arrives prior to shift change.

Additional contributing factors include: emergency nurses are holding onto their patient cases longer than needed, emergency nurses are attempting to complete their transfers at shift change to avoid another ED admit, Physicians are releasing their transfer orders late so the oncoming Hospitalist can assume care for the rest of the patients awaiting in the lobby. Finally, a major contributing factor are new trauma cases (Tier 1 or Tier 2) that arrive to the floor within the hour of shift change. For instance, when a trauma patient arrives to the emergency unit, the

ED nurse most likely will hold off on transferring any patients. These trauma cases will also lead to a delayed patient transfer time.

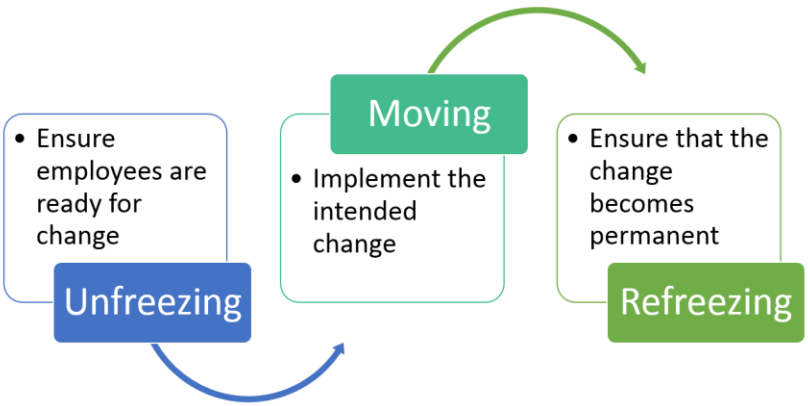
Estimated costs contribute from the staff RNs, unit educators, unit managers, Lean Team members, working time, and myself. The 220 clinical hours, and course work hours that is required are accounted for; the hospital does not lose or gain revenue in that regard. By transferring patient's earlier from the emergency department, patient cases will increase in the ED. Therefore, revenue may increase. In value, given a 45 minute black-out timeframe, inpatient nurses will become more equipped/prepared to care for their transferred patient. Therefore, the chances of nurses leaving on time or losing time on the floor will improve.

Nursing educators assume the role as *thee* educator. Therefore, time & money spent to educate and help implement this new project guideline is financially minimal. Every unit has a mandatory, quarterly, staff meeting. For example, the next mandatory staff meeting for my unit is August 18th. Absences from these staff meetings result in write-ups and can even affect your raises. Staff meetings are held in the morning and late afternoon. A staff member can join the staff meeting live or via phone. Therefore, the turn-out for these staff meetings is usually 100%; and costs are previously budgeted.

Unit Managers work on a salary basis at Sutter Memorial Hospital, though their time is just as valuable, the cost however, is minimal. Adversely, too much time spent on this project, could potentially take away from other project focuses.

Methodology

Lewin's theory of change includes three stages: unfreezing, moving, and refreezing. This theory is also known as the force field model. This theory is significant when attempting to change or support any change, because its purpose is to focus on improving or strengthening those forces, or factors that can support change and restrain those forces that interfere with change. In regards to this project, I will use Lewin's theory of change to guide me. When including Lewin's theory of change, this theory will teach me to increase the number of strengths that drive positive forces, and decrease the number of restraining forces within my project. By viewing the graph below, I had a better understanding of how to incorporate Lewin's theory into my project to decrease delayed patient transfers, prior to shift change, as well as implement a 45 minute black-out window time frame for ED transfers.



This change concept will help in guiding the implementation of my course project by providing me with a systematic approach. During the *unfreezing* stage, I will gather all my data thus far, and ensure all staff members involved are ready for change (or in my case, my project's aim). Setting up meetings and discussing with higher leaders will also ensure absolutely everyone is ready for the imminent change, too. Additionally, driving off any negative forces that could potentially affect my project's aim will be addressed as well. Then, in step two,

the *moving* stage, my preceptor & I will finalize our objective and implement the intended change. Finally, in step three, the *refreezing* stage, to ensure the change remains permanent, quarterly assessments will have to be conducted to confirm incorporation. Without reading and learning about this particular theory, I perhaps, would have been less organized. I feel this theory and its mapping allows me to approach what has been assigned to me systemically.

To assess project effectiveness, EPIC notes and data can be easily attained by the internal IT Registered Nurse, ED Manager, Unit Managers, and Nursing Supervisor. Once attained, reading nursing notes and noted transfer times will ensure my project plan is being produced. Completed surveys will also be collected amongst the emergency room and inpatient nurses to ensure colleagues are complying with the project's aim. My predictions are promising and quarterly assessments will be performed to assess effectiveness and continued compliance.

Data Source/Literature Review

The aim of my project is to improve time management by decreasing late patient transfers prior to shift change, between the emergency department and inpatient units by 50%, with a goal date of August 2015. "Patient turnover during change of shift was more disruptive than during medication administration. Nurses from both units often expressed that patient turnover during shift change was very disruptive, especially near the time of shift report" (Jennings, B.M. et al. 2013).

Research articles relevant to my project included: Improving patient flow from the waiting room to the inpatient; A systematic review of time studies to assess the impact of patient transfers on nurse workload; Implementation of an Emergency Department Sign-Out Checklist Improves Transfer of Information at Shift Change; How to improve change of shift

handovers and collaborative grounding and what role does the electronic patient record system play?; Emergency Department Staff Planning to Improve Patient Care and Reduce Costs; Turning Over Patient Turnover: An Ethnographic Study of Admissions, Discharges, and Transfers; Developing a framework for nursing handover in the emergency department: an individualized and systematic approach; Synching ED and Inpatient Nurses to Streamline Patient Flow; Emergency department lengths of stay: characteristics favouring a delay to the admission decision as distinct from a delay while awaiting an inpatient bed; & When place and time matter: How to conduct safe inter-hospital transfer of patients.

PICO allows Clinical Nurse Leaders to focus in on the main areas of a problem and search based on that specifically.

P: Patients transferred from ED to the inpatient units prior to shift change.
I: Time Management.
C: 45 minute blackout times.
O: Improved patient care.

Timeline

This project began in early June 2015 and is currently in the conclusion phase. This improvement project is expected to end mid-August 2015. However, quarterly assessments will be conducted to review data and ensure project adherence. Some potential challenges that can impede the timeline process include: negative forces from staff members, resistant staff members, time allotted, an increase in trauma cases, an increase in newly hired RNs, or extended education maybe required for healthcare providers.

Expected Results

My expected results focuses between the emergency department and inpatient units. The expected outcome is to decrease late patient transfers, prior to shift change, by 50%. The anticipated timeframe goal is set for mid-August 2015. The expectations to achieve this goal is aided by the 45 minute black-out guideline.

Previous to this intervention, patients were being transferred and brought up to the inpatient units at any time. The expected goal is to set in place a black-out window of 45 minutes, where ED patients are not allowed transfer until after shift change, or no less than 45 minutes prior to shift change. I imagine a positive and surprising outcomes once the written guideline is enforced and results are evaluated – next quarter. This new project supports optimal patient care, time management, communication between the units, hospital revenue, and takes into account the dangers of transferring a patient to the inpatient units prior to shift change.

Nursing Relevance

Decreasing late patient transfers, between the emergency department and inpatient units, by implementing a 45 minute black-out guideline will have numerous significance to Sutter Memorial Medical Center and its culture. This study will increase staff awareness within the emergency department and inpatient units. With heightened awareness, patient health outcomes can improve during transfer time & admission onto the floor. Time management and nurse satisfaction will improve, hospital revenue will increase, and overall patient care will not be delayed.

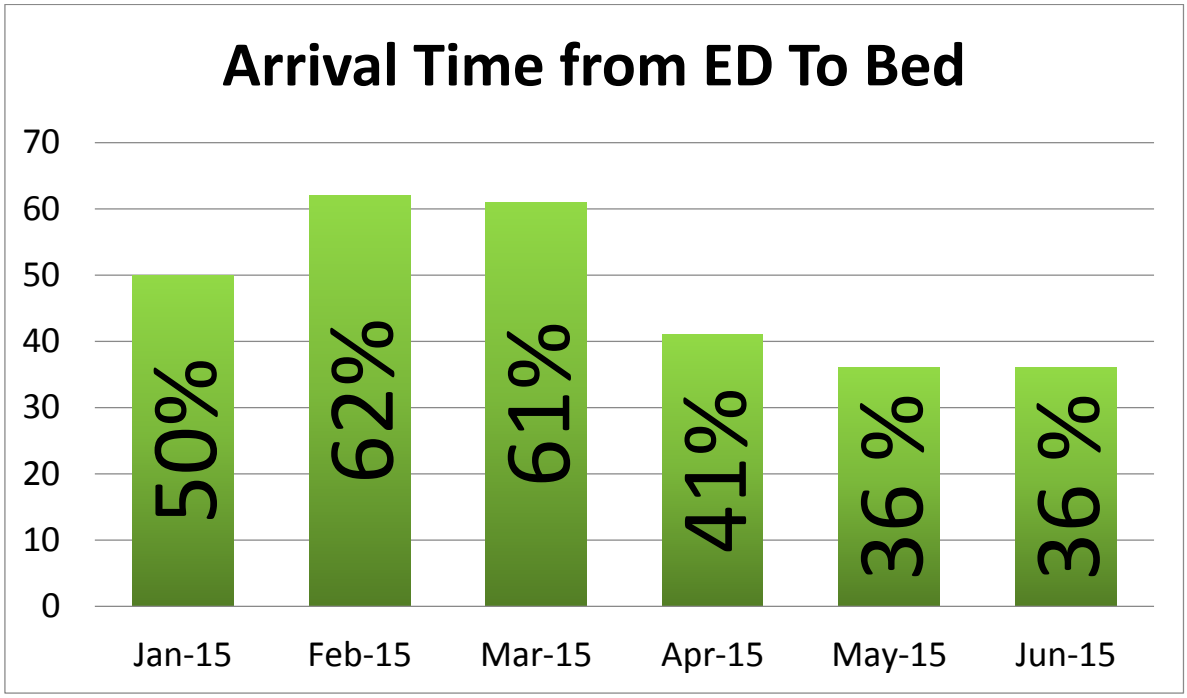
SUMMARY REPORT

Throughout the course of this final semester, I have learned an immense amount of Clinical Nurse Leadership knowledge. The attained CNL knowledge has heightened my professional awareness within two different healthcare settings and has given me the ability to create a guideline and implement my improvement project. This master's prepared CNL program has taught me quality material that helped influence the generation of my final project, for example: articulate the need to find data, predict barriers, and set a timeframe before starting my quality improvement project, helped distinguish between a quality improvement project vs. only research, showed reasoning to analyze the need(s) within a microsystem - PICO, defined the SWOT analysis, FMEA, RCA, fishbone diagram, or cause-in-effect analysis to a project, helped improve my communication skills/interdisciplinary skills with other team members, explained the importance of creating a sense of urgency, promotion, sustainability, and change theories. This program has additionally advanced my project by giving me the information to understand literature review, project costs, outcome measures, benchmarking, and the PDA cycle.

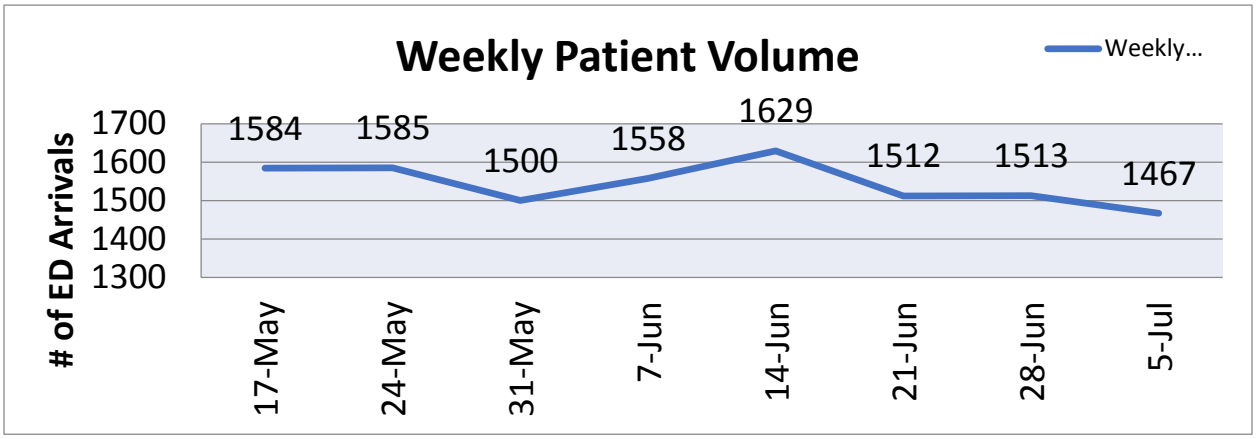
By creating a written guideline, the aim of my project focused on the emergency department and inpatient units. The goal is to decrease delayed patient transfers prior to shift change by 50%, with a goal date set for mid-August, 2015. The methods used to implement this course project includes: participating in multidisciplinary meetings with unit managers, lean team members, my preceptor (also known as the Nursing House Supervisor), and members of the administrative team. Assessing and evaluating lean team and EPIC data were also conducted. Reviewing the process of how to create an internal guideline was studied and then created.

The proposition of the lean team is to expedite patient transfer times (lean team's goal for ED to bed transfers is 75% on time after MD orders are released), oversee cost, and ensure quality care is given. When viewing patient transfer times, the lean time oversees times from direct admits, patient's transferred from another hospital, inpatient to inpatient transfers, and in this case, ED to inpatient beds. A description of their unmet goal, baseline data and

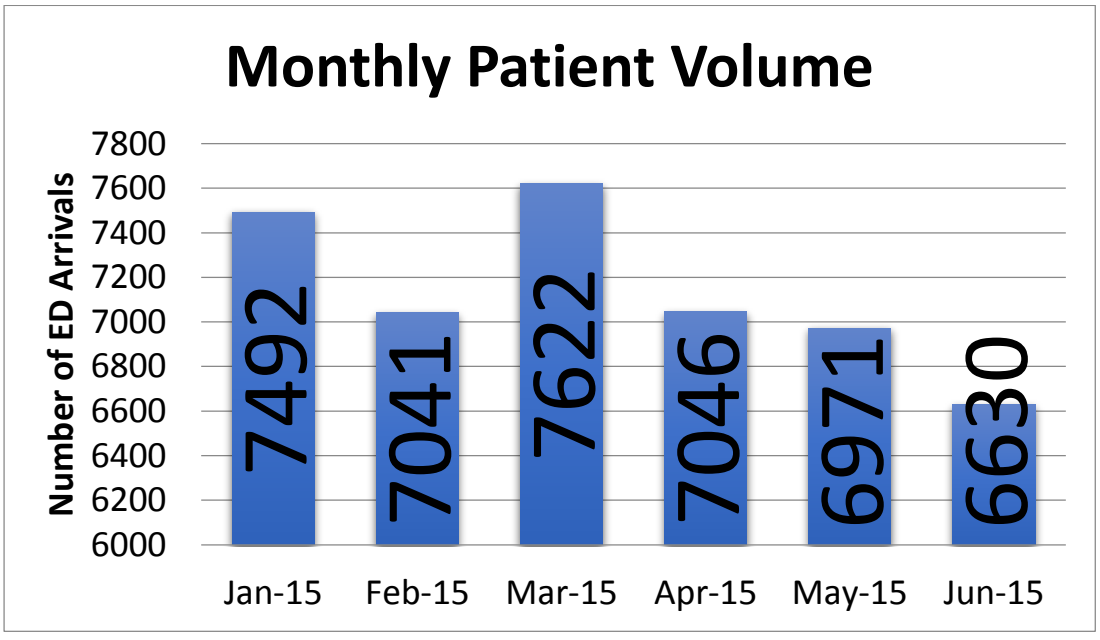
external benchmark data were also obtained and shared with amongst the team to validate the need for my improvement project.



For example, the data acquired for my project included several graphic charts, estimated and factual transfer times, and benchmark data. "The average transfer rate of 4.0% for rural emergency departments is more than double the 1.8% transfer rate reported in the 2007 CDC study" (Vantage, 2013, p. 5). Per the R3 report provided by the Joint Commission, standards LD.04.03.11 and PC.01.01.01 are revised standards that address an increased focus on the importance of patient flow in hospitals. Boarding (also known as patient transfer times) represents a particular type of problem in patient flow that can result in heightened risk for patients and inefficiencies for staff. R3 report states, the Joint Commission should recommend a time frame in the definition of boarding/patient transfers (p. 2).



The added value of this project is incomparable to any potential costs. Per in-house data, financially, delayed patient transfers have affected monthly, ED patient volumes. For example, a decline in ED arrivals went from 7,492 to 6,630 last quarter. The value of ideal transfer times, for instance, would result in an increase in ED arrivals. Therefore, an increase in hospital revenue will occur. Furthermore, rapid response events do strike on the inpatient units when patients immediately arrive from the emergency department. Many of these events happen because patients are waiting too long in the ED, transfer orders are being placed too late, or ED nurses are not releasing the ED Physician orders within an ideal timeframe, and then patient's crash once they are transferred to the unit.



When the Rapid Response Team (RRT) is activated, it involves a group of specialist: 1 or 2 ICU RNs, Respiratory Team, additional staff members, and then of course, the physician(s). In terms of cost, currently, RNs can make anywhere from $45.00/hr-$80.00/hr at Sutter Memorial in California. So, when ICU RNs and staff RNs have to engage in an RRT prior to shift change, those nurses will most likely earn overtime if the event continues past their scheduled time.

In regards to the utilization of published material, in my literature review, I was able to acquire 10 studies that supported and helped implement my project. My project's objective is setting in place a new guideline for improved time management, and the goal is to decrease delayed patient transfers, between the ED unit and inpatient, prior to shift change, by 50%. Goal achievement will be accomplished by setting in place a "*black-out*" window of 45 minutes prior to shift change. My research findings helped me initially envision my project because I began realizing the severity of the problem. Not only have I witnessed delayed patient transfers prior to shift change, but other nurses, in other states, were experiencing this same issues, too. As I continued my evidence-based search, it became very apparent that this problem can be possibly corrected.

Article 1 and 6, supports the need for better time management and patient flow. Article 2, assesses how patient transfers can affect a nurses workload on the floor. Article 3, gave insight about an implementation strategy to improve patient transfers between the emergency department and transfer unit at shift change. Article 4 and 7, supported the need for optimal communication during change of shift report. Article 5, reviews the importance of costs and staffing within the emergency unit. Article 8, supports the synchronization and camaraderie between ED nurses and inpatient nurses. Article 9, reviews the effects of delayed inpatient admissions. Article 10, supports the importance of safe patient transfers. The external resources supported my CNL project in terms of improving time management, patient transfer times, nurse communication, and the workload of a floor nurse.

A SWOT analysis was conducted to analyze and evaluate the strengths, weaknesses, opportunities and threats involved in this project.

- **Strengths** - Project strengths include: receptive leaders/board members who invite suggestions or thoughts for the hospital. Unit managers also invite new ideas for their units. Excellent Nurse Educators who can educate the new guideline to the units. Also, patients will arrive on the unit sooner; less wait time on an ED bed or waiting room. Quality, efficient care will be implemented as soon as patient arrives to the unit.
- **Weaknesses** - Some project weaknesses include: ED nurses becoming potentially resistant to the new change. Physicians having to work more efficiently to finalize an appropriate transfer time. General non-adherence. Also, the possibility of method-regression. Finally, the ability to actually implement such a project within the time given.
- **Opportunities** - Some opportunities for improvement include: improved patient satisfaction scores, improved nurse satisfaction scores, improved report/communication between staff members, all questioned answered, improved productivity, and an increase in patients choosing this hospital; thus, an increase in revenue.
- **Threats** - Some initial potential threats aimed at my project included: executive leaders disapproving my project, executive leaders focusing on other prospects or ideas for this problem, timing, inadequate data to support this project, resistance, and especially, the fact that I am very new to this facility and I've built limited report amongst my colleagues and healthcare providers.

Project effectiveness to decrease delayed patient transfers will be evaluated quarterly. Nursing compliance will also be evaluated and audited through EPIC charting times. Factual

data will give insight to the most accurate patient transfer times and black-out compliance. Continued efforts and adherence ensures best practice per guideline.

After reviewing early audits, EPIC progress notes revealed emergency nurses are providing inpatient nurses additional time to ask questions prior to transfer. For example, emergency nurses are now charting “Report given. Opportunity to ask questions prior to patient transfer allowed”. Earlier transfer times were also noted per EPIC charting. Although, this is the beginning of the guideline implementation stage, current results are rewarding. Upon the commencement of this project, early data demonstrates the value of this improvement project. However, a more in-depth assessment and data collection will be acquired by next quarter.

"Using systems thinking to design and implement the project promotes endurance and sustainability in face of change. Systems thinking helps us anticipate and minimize barriers to change" (USF, ppt, n.d). To maintain sustainability upon practicum completion, I will follow the 5 rules of project sustainability.

- **Modification of the program:** My project has consistently been modified to fulfil the requirements of the course project, best patient outcomes, as well as, the vision of my team. Creating a guideline to prevent delayed patient transfers between the ED unit and inpatient unit by 50% is my improvement project goal for Sutter Memorial Medication Center, Modesto, California. Quarterly assessments will be conducted to ensure staff compliance and transfer time data.
- **Having a champion:** “Continuous communication and dissemination of information promotes transparency and increases trust” (USF, ppt, n.d). Within the hospital, the Lean

Team will continue to oversee transfer times/data. Quarterly in-services will be provided to re-educate and communicate the importance of guideline compliance.

- **Fit with the organization's mission/procedures:** "*Mission* - to enhance the well-being of people in the communities we serve through a not-for-profit commitment to compassion and excellence in health care services". "*Vision* - Sutter Health leads the transformation of health care to achieve the highest levels of quality, access and affordability". Lastly, "*Values* - *Excellence and Quality:* We exceed customer expectations by delivering premier clinical quality and maintaining the highest levels of safety. *Innovation:* We continually create, seek out, and adopt new ways of providing value to our customers, rapidly moving from idea to execution. *Affordability:* We deliver health care efficiently by using resources responsibly. *Teamwork:* We recognize that the power of our combined efforts exceeds what we can accomplish individually, and we are accountable to each other and to our customers. *Compassion and Caring:* We treat those we serve, and one another, with concern, kindness and respect. *Community:* We work to understand and best serve the diverse needs of our communities. *Honesty and Integrity:* We act openly and truthfully in everything we do.

(image, Sutter Health, 2013)

- **Perceived benefits of the staff/clients: Create a sense of urgency using data:**

  Our patient's ultimately benefit from this improvement project. However, increased hospital revenue is supported with the implementation of this project. Additionally, the process of patient transfers will become more efficient for ED nurses, as well as, inpatient nurses. Providing a continued sense of urgency will also maintain project sustainability.

- **Support from stakeholders:** "Project sustainability is influenced by costs and variability. Cost as an Influencing Factor centers around three areas. Cost benefit. Cost effectiveness. Cost Utility" (USF, ppt, n.d.). Sutter Memorial Medical Center is in full support of this project's efforts. Administration and Department managers are aware and agree with the

efforts of my improvement project. Although, generating a policy and procedure wasn't attainable for this project's initial goal, my preceptor has invested her time, and we both have created a guideline for my project. As previously defined, a guideline is a softer rule compared to policies and procedures. Guidelines are less difficult to write-up, and they state what is the best practice based on research & internal data.

Sutter Memorial Medical Center		
August 2015		
Patient Transfer Guideline		
Title: Decreasing Delayed Patient Transfers Prior to Shift Change		
Submitted By: Connie Marie Vazquez, MSN, RN Sutter Memorial Medical Center Medical Surgical – Telemetry Unit, Staff RN	Approved by: Alice Downs, RN Sutter Memorial Medical Center Nursing House Supervisor, Management	
Date Adopted: **08/01/2015**	**Dates Reviewed**: **06/14/2015** **07/18/2015** **07/29/2015**	**Revision Date:** **Next Quarter - 08/18/2015**

I. GUIDELINE

Sutter Memorial Medical Emergency Department shall continue to provide safe, patient handling during appropriate transfer times. A black-out window between 0615-0700 and 1815-1900 will prevent any ED patient transfers to any inpatient units.

II. PURPOSE

To implement evidence based research and practice, the purpose of this guideline is ensure adequate hand-off reports between the emergency department and inpatient nurses, help prevent rapid response alerts and/or the decline in patient health status, provide excellent care for newly transferred patients, and increase cost revenue within the institution.

III. APPLICABILITY

Registered Nurses employed within the emergency department and inpatient units.

IV. DEFINITIONS

a. RN - Registered Nurse

b. ED - Emergency department

V. REVISIONS

a. Next Quarter meeting – August 18th, 2015.

VI. REFERENCES

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