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Improving Hand-off Communication Between the Skilled Nursing Facility and the Emergency

Department

Dubravka Labovic

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## Improving Hand Off Communication Between the Skilled Nursing Facility and the Emergency Department

California Department of Veterans Affairs (CalVet) is a 396-bed long-term care facility, located on the same campus with Federal Veterans Affairs Medical Center (VAMC). Residents at the CalVet receive primary care and minor nursing care, but are often transferred to Emergency Department (ED) on campus for further evaluation. It is important to mention that CalVet is a relatively new facility, built in 2010, still working on filling job positions, beds and creating steady policies and procedures. Frequent changes are common. The geriatric population has high rate hospital transfers and if information is not appropriately relayed to ED, it can cause unnecessary tests, early discharge or unnecessary observation time spent in ED, therefore it is imperial that leadership implements changes that will improve hand-off communication during transfers.

Reducing unnecessary hospital transfers from SNFs is a national priority stated by Centers of Medicare and Medicaid Services (CDC, [2016]). Increased complains, frequent re-hospitalization, early discharge and poor patient satisfaction rates are just some of the reasons that triggered the need for this project. Agency for Healthcare and Research Quality (2015) lists care coordination as part of the program that focuses on improving primary care practice. This is important because the Institute of Medicine identified care coordination as one of the strategies to improve effectiveness, safety and efficiency of the American Healthcare system (2001). This site reveals valuable information and tools for measuring quality of care; it also gives the updated Care Coordination Measures Atlas. It is the ultimate goal of CalVet team to improve overall communication between these two facilities.

### **Clinical Leadership Theme**

The aim of this project is to improve the hand off procedure between the skilled nursing facility (SNF) and ED. Even though, the problem is multidimensional the clinical leadership theme specifically for this project, is Leadership Outcomes Manager with the focus on improving communication. Communication is an important part of clinical nurse leader role within the microsystem. According to American Association of Colleges of Nursing (2013), clinical nurse leaders, at the point of care among other competencies, focus on interprofessional communication and team leadership, which is the framework of this project.

The leadership expects to see the improvement of communication by measuring lower readmission rates and lower percentage in poor hand-off communication by the end of first quarter. Poor hand-off communication means that pertinent information was not received at the ED at the time of transfer. Ultimately, the goal of this project is to see improved communication practices on one unit, which would then lead to implementation of evidence based practice facility wide.

### **Statement of the Problem**

The Joint Commission Center for Transforming Healthcare (2014) presented solutions for transforming healthcare into high reliability industry. The Joint Commission guidelines and tools are used in this project to create a sense of urgency as the collected data proved that SNF has poor communication practices. Poor communication was listed by Joint Commission as one of the major reasons for cause of adverse effects in healthcare these tools are beneficial for creating a successful hand-off a priority in the organization. Additionally, Griffiths, Morphet, Innes, Crawford and Williams (2014) performed literature review of sixty-nine relevant studies

confirming that communication deficit arises from insufficient transfer of information from long-term care to emergency department upon patient transfer.

It is important to mention that the Federal VA and the State VA do not share the same electronic health record system. The problem is encountered when break in communication causes inability to treat due to lack of information or ineligibly handwritten orders. CalVet used to employ physicians from VAMC that had dual access to electronic health record system. In January of 2017, the contract ended leading to a total chaos in continuity of care for CalVet residents. After analyzing only one unit with 84 residents in this specific microsystem, it was discovered that 70% of residents who transfer to the ED either do not have medical records delivered with them or have the records that are insufficient for appropriate care. The problem identified at the SNF microsystem is the lack of proper hand-off procedure during ED transfers. Geriatric population has high rate hospital transfers and if information is not appropriately relayed to ED, it can cause unnecessary tests, early discharge or unnecessary observation time spent in ER, therefore it is imperial that leadership implements changes that will improve hand-off communication during transfers.

### **Project overview**

In the fourth quarter of 2017, unit A had 32 transfers to ED of which 22 had to be followed up with a phone call due to missing hand off upon patient arrival. The goal of this project is to improve consistency of hand off procedure on the current unit, lower the incidence of missing hand-off from 70% to at least 40% by the end of March, 2018. The leadership plans to implement evidence-based practice, to work with clinical nurse leader and support the change in the microsystem with the ultimate goal to implement change and improve practice facility-wide.

The first step in implementing change in communication process is collecting data for the previous quarter, that is October 1<sup>st</sup> – December 31<sup>st</sup>, 2017. The collected data will tell us how many residents were transferred to ED, how many of those were transferred with proper hand off communication, how many of those returned prematurely and were sent back to ED for the same reason.

The clinical nurse leader is to track each hospital transfer on the unit A for the duration of the fourth quarter of the previous year and the first quarter of the current year. Additionally, clinical nurse leader will 1) attend daily huddles with charge nurses and collect data of hospital transfers, 2) create a one-page spreadsheet for each resident that contains essential transfer information (ETI) and will be kept in the transfer envelope for each resident, 3) add SBAR communication tool to the transfer envelope and 4) provide in service to all charge nurses and licensed nurses that arrange transfer of residents to ED. The SBAR tool can be found in Appendix A. The specific aim statement of this project is to improve hand-off communication between SNF and ED, which has an ultimate purpose of improving quality of care and decreasing unnecessary transfers to ED and therefore, increasing patient satisfaction.

## **Methodology**

### **Rationale**

To identify the need of the project the assessment data of the microsystem was completed. Tracking system for all transfers to ED was started on unit A in October 2017. The total number of hospital transfers for the fourth quarter, October, November and December was 32, including repeat transfers (see Appendix B). This tracking system was able to identify the reason for transfer, admission rates, readmission rates, and a complete hand off. To follow up with this tracking system, monthly meetings with ED medical director were held to compare the

data. It was identified that 70% of transfers were completed without hand-off or minimal information provided to ED staff. The leadership team found the need for improvement after the data was presented in January 2018.

SWOT analysis was used to identify the strengths and weaknesses regarding hand off communication on the unit A (see Appendix C). Strengths of the microsystem consist of the multidisciplinary teamwork and the sense of urgency, which leads to buy-in for change. Weaknesses include lack of interoperability due to different electronic health record systems at these two facilities, as well as, high staff turn over rate. Opportunities include minimal cost to implement change and the eagerness to implement practices that will bring about improved care coordination. A major threat is the incomplete transfer of patient information to the ED, which could lead to delayed or inappropriate care in emergency situations.

Additionally, a fishbone diagram was utilized to determine the causes for missing hand-off (see Appendix D). Possible causes include professionals, policies/procedures, equipment and communication. Contributing factors to the professionals cause include that there is a high turn over rate of staff, heavy workload for short staffing and the recent loss of VA employees who used to have access to communication with ED. Contributing factors to policies/procedures include inconsistent leadership and lack of written procedures. Inconsistent leadership in administration has caused difficulties in developing relationship with the federal VA in general, leading to difficulties in developing strong hand-off procedures for CalVet. Contributing factors to equipment include the lack of interoperability via electronic health record which makes transfer of information more difficult. Contributing factors to communication include handwritten orders that are sometimes illegible, hard copy of medical record and phone calls. These factors make communication difficult because medical records do not always get handed

over to ED when patients are transferred via third party transportation. Also, phone calls do not always go through in the busy ED.

### **Cost Analysis**

The cost analysis indicates positive outcomes as a result of this project, because it brings both financial savings as well as non-monetary savings. The overall cost of implementing this project is minimal as it utilizes the resources that are already in place and new financial investments are not necessary. Per the State of California Office of Statewide Health Planning & Development 2015 report, each ED visit costs \$1,800. It is important to add the additional cost of non-emergent medical transport of \$400, or in case of the emergency the Los Angeles Fire Department medical transportation cost is anywhere from \$1,030 to \$1452 plus \$19 per mile. By preventing unnecessary transfers to ER and preventing unnecessary trips back and forth, to and from ED these expenses could be significantly lowered by improving communication between SNF and ED .

### **Change Theory**

Kotter's theory of change was used to facilitate this project and implement the change in the microsystem. Kotter, (2015) identified eight stages of change and explained that it is important to use these eight steps in the right order to successfully implement a sustainable change . The first and most important step in the process of change is creating a sense of urgency (Kotter, 2015). Kotter's theory of change consists of these eight steps: creating a sense of urgency, forming powerful guiding coalitions, developing a vision and a strategy, communicating the vision, removing obstacles and empowering employees for action, creating short-term wins, consolidating gains and strengthening change by anchoring change in the culture (see Appendix E for Kotter's 8-step model).



First, Charge nurses on the unit were given the data collected from the fourth quarter in 2017, which created a sense of urgency and clear understanding of the project need. Then the guiding coalitions were made with the unit supervisor, director of nursing and the quality assurance nurse, who all agreed to attend meetings and support the project to improve the process of hand-off. Next, the goal was created collectively to decrease the rate of poor hand-off in the first quarter of 2018 on the unit. The next step, communicating the vision, was achieved by conducting morning huddles on the unit, giving a quick report and sharing literature related to transition of care. Together, we created a vision that was set forward by the clinical nurse leader and the quality assurance nurse, but then adjusted to more realistic goals due to the valuable input from charge nurses who run the floor and experience the challenges of hand-off daily. Even though, the barriers of using paper charting to communicate with ED, charge nurses were empowered to creatively implement the change to the best of their knowledge and ability, based on the resources they were given; to communicate this change with the rest of the floor staff, and to take the input from medication nurses who may also be involved in transferring residents to the ED. Next, weekly and monthly meetings are conducted to discuss progress, which created opportunity to celebrate short term wins, and discussions regarding barriers to success. The final step in Kotter's theory of change is to ensure that there is a change of culture within the microsystem. More time is needed to assess the culture change.

### **Data Source/Literature Review**

Multiple scholarly articles supported the need of this project, as well as, literature reviews, statistics and rules and regulations set forth by government agencies. PICO search statement was developed to help find the supporting evidence to implement the change that will improve communication practices between SNF and ED. The initial PICO statement "Long term

care hand off procedure for emergency room transfers and patient satisfaction.” The population is geriatric, long-term care, Intervention statement is implementation of SBAR, creating a hospital transfer packet and weekly follow up to discuss barriers with charge nurses. The comparison statement is poor hand-off procedure or completely missing hand-off at the time of transfer from SNF to ED. The outcome statement is improved hand of procedure for emergency room transfer.

Griffiths, Morphet, Innes, Crawford and Williams (2014) reviewed literature to explore different communication practices between residential aged care facilities and emergency department. They reviewed sixty-nine articles that were published between 2000 and 2013, so that their evidence remained current. The authors also reviewed data to identify records and key information that should accompany patients when transferred. They concluded that standardized forms show limited improvement in the quality of communication and that more research is needed to improve the transfer of information from SNF to ED. This literature review was significant for the project as it relates to barriers encountered for proper hand-off. Nurses continue to struggle with paper documentation and lack of interconnectedness via electronic health record.

Additionally, Samal, Dykes, Greenberg, Hasan, Venkatesh, Volk and Bates (2016) performed a qualitative study in regards to health information technology and how it can improve coordination of care and interoperability. This study aimed to determine how care coordination is accomplished across the Unites States from a clinician perspective, and how much HIT is used during this process. The authors conducted six focused interviews with Information Technology (IT) professionals as well as with medical professionals from six different regions of the United States. In addition to interviews they reviewed literature in search

for studies that were already looking at improving transfer of information during transfer of care (Samal et al., 2016). They concluded that one of the largest gaps was the transfer of information. This study was relevant for this project because it discussed important issues regarding care coordination and it served as evidence that further supported our need for change.

Curry (2013) published an article that encourages utilization of SBAR tool to improve communication and prevent hospitalizations from the home health nursing perspective. Nevertheless, this tool can be linked to other healthcare settings and used to improve patient outcomes. The author explores the miscommunication between physicians and nurses or lack of thereof; she also addresses national reports in regards to improving communication. The most valuable information from this article is that it explores SBAR as a tool for communication between physicians and clinicians in different settings and it shows that Situation – Background – Assessment – Recommendation proves to be efficient and effective. This article was used as the evidence to support implementation of the SBAR tool for CalVet transfers as well. Even though, nurses are provided with the tool for in-house communication, this project revealed inconsistencies with the use of SBAR, especially for the transfers outside the facility. The biggest strength of this article is that it provides us with the simple evidence based practice that is supported by variety of examples from literature and national guidelines, which makes it ultimately easier to utilize.

Ouslander, Naharci, Engstrom Shutes, Wolf and Alpert (2016) presented a randomized control trial that focused on exploring the need of transfers from skilled nursing facilities to emergency department. This study identified areas of improvement in education department as well as in process improvement. It enrolled two hundred and sixty-four SNFs from across the United States who submitted their RCAs on hospital transfers in the INTERACT (Interventions

to Reduce Acute Care Transfers) program and randomized them all in three groups of eighty-eight (immediate intervention, contact comparison group, and usual care comparison group). Ouslander et al. (2016) also state SBAR as a useful tool for improving intercommunication. Additionally, this study provides insight about areas for care process improvement, using RCA as part of QI program and it was closely related to executing this project, as it also required a root cause analysis.

Gleason, McDaniel, Feinglass, Baker, Lindquist, Liss, and Noskin (2010) conducted a MATCH study (Medication at Transitions and Clinical Hand-offs). The study was designed to analyze the incidents of medication errors during transitions of care. Medication reconciliation is an important factor that relates to the project of improving hand-offs because, medication errors are just one of the events that could have harmful deadly effects for patients. Gleason et al., (2010) used a sample size of 651 patients with 5,701 medications and found that one third of patients in this study experienced medication errors. They also stated that the older population is at the higher risk of suffering from medication errors due to higher number of medication on their medication lists. Specifically to this project, CalVet had an incidence of sending a patient to ED with the printed list that was placed in the envelope more than 30 days ago. The dose of Carvedilol was changed two weeks prior to transfer, from 50mg to 25mg, and the medication list did not reflect the change. This article was utilized for improving documentation package during transfers to ED from SNF. It served as a tool for in-servicing licensed staff of the importance of providing the correct medical list upon transfers to ED.

Naylor, Aiken, Kurtzman, Olds, and Hirschman (2011) summarized twenty-one clinical trials and wrote a literature review concerning the importance of transitional care and how it relates to the Affordable Care Act. The new healthcare reform has preventing hospital

readmissions at the forefront of the quality improvement plan. This literature review was relevant for project implementation because it represented a big picture and a better understanding and the purpose for implementing change. Even though, this review focuses on interventions for lowering readmission rates within 30 days of discharge, it also brings about the significance of improving hand-off, cutting healthcare costs and improving the quality of care. Interestingly, one of the goals from this literature review, as supported by evidence is that “investments should be made to promote the endorsement and widespread adoption of effective interventions as best practices by private and public organizations” (Naylor et al, 2011, pp. 752).

### **Timeline**

The project is set for the time frame from January 1<sup>st</sup>, 2018 until March 31<sup>st</sup>, 2018; a Gantt chart was created that outlined the time frame (see Appendix F). The project begun with the assessment of the microsystem based on the data from the previous quarter, October 1<sup>st</sup>, 2017 – December 31<sup>st</sup>, 2017. Data was collected from patients’ charts, nursing documentation, and daily census report. First meeting with charge nurses was held on January 29<sup>th</sup>, 2018 to discuss data from the previous quarter and set the goal for the current quarter. The implementation of SBAR and EPI forms started on the unit on January 1<sup>st</sup>, 2018. Follow up meetings were set for February 20<sup>th</sup> and March 26<sup>th</sup> to discuss barriers. Additionally, clinical nurse leader attended daily huddle at 08:30 with charge nurses and other floor staff, which helped gather more information regarding successes and barriers to hospital transfers. The final data is to be collected during the first week of April followed by the discussion meeting with charge nurses, director of nursing and quality assurance nurse, which is scheduled for April 27<sup>th</sup>.

### **Expected results**

The expected result for the microsystem is that there will be 30% decrease in missed hand-offs for ED transfers from SNF in the first quarter of 2018. As the problem of implementing a proper hand-off involves many parties and departments, the project aims to start small, with the nursing department and then grow bigger. With the addition of new documentation for transfers and diligent tracking system it is expected that this goal is attainable. In order to assess the effectiveness of this project it will be imperative to continue collecting daily data of hospital transfers and conduct meetings that will focus on barriers for success. As a result, possible conclusion after this project may be that there are outside factors that prevent smooth hand-off procedure. One of the barriers voiced by nurses is that paper documentation makes it harder to implement this change, and that sometimes the envelope stays with paramedics even though it was diligently prepared and sent to ED with the patient.

### **Nursing Relevance**

Transferring essential patient information from one healthcare provider to the other is an integral part of communication. The integration of two powerful communication tools, SBAR and EPI, has a potential of improving the communication with other facilities, regardless of the scarce resources at the present moment. After presenting the information that was discovered in this project, it is the hope that there will create increased awareness of the significance of proper hand-off and create a written policy that will be used facility-wide. By focusing on microsystem hand-off procedure, we also bring about issues of readmission rates and medication errors, creating the opportunity to improve the overall patient safety. Moreover, the empowerment of nurses to implement changes and develop ideas that are realistically attainable creates more productive work environment and creates opportunities for even bigger changes. Nursing

leadership hopes to bring this project to administrative review to create a better understanding of the current issues regarding hand-off procedures and the need for investment in updating communication tools.

### **Summary Report**

This project aims to improve hand-off procedure during transfers from SNF to ED by lowering the incidence of missing hand-offs to at least 40% by the end of first quarter of 2018. CalVet lost the contract with Federal VA at the beginning of 2017, which led to loss of access to electronic health record system and ultimately created a disorder in continuation of care and other problems related to communication, such as slow referrals and poor hand-off procedures. As CalVet begun to receive phone calls concerning these problems, the leadership initiated the beginning of data collection for the purpose of correcting the problem. The need for the project was demonstrated by the data indicating that on this particular unit, a total of 32 transfers to ED were completed during the last quarter of 2017 and only 10 had properly completed hand-off procedure.

To facilitate this project Kotter's theory of change was used to implement new practices at the microsystem level. Additionally, the project leader implemented tools that were published in peer reviewed articles and showed to be effective; such as SBAR and Essential Patient Information Tool. There were no changes made from prospectus.

The initial data collected showed the lack of process and procedure for CalVet nurses when transferring patients to ED. The common practice used to be that MD, contracted with both Calvet and federal VA, calls by phone and completes hand-off procedure at the time of transfer. With the lack of inter-operability, lack of common employees and lack in access to medical

records the communication worsened over the past year. The most difficult part about project implementation was changing the culture and creating a routine practice among nurses to use these two new tools introduced by the project leader. The latest data shows slow but steady improvement in hand-off procedure. In the month of March only one hand-off was incomplete, this was due to our necessity to place a staff from registry to cover the night shift due to multiple call-offs. Completion of the first quarter concluded that the new hand-off procedure lowered the incidence of missing hand-offs to 25% in the first quarter of 2018, and the goal was more than met. This new procedure was resented to leadership team on other units on April 27<sup>th</sup> for review. It was a unanimous decision to implement the same practice on other units starting May 1<sup>st</sup>. The plan is to have a designated project leader who will be responsible to attend daily huddles and collect the information. This project requires a development of routine, but does not require major changes within the system, which places it in favorable position when it comes to sustainability. Once nurses develop the routine and the procedure for transfer to ED becomes equal across the facility it is expected that this project will be self-sustainable. Until then, the project leader and the quarterly meetings with quality assurance team will be able to track and monitor the data. Lastly, the procedure for transfer of patients to the hospital will be introduced during new employee floor orientation, where new nurses will have an opportunity to understand the process from the very beginning of their employment.



### References

- American Association of Colleges of Nursing. (2013). *Competencies and curricular expectations for clinical nurse leader education and practice*. Retrieved from <http://www.aacn.nche.edu/cnl/CNL-Competencies-October-2013.pdf>
- Curry Narayan, M. (2013). Using SBAR communications in efforts to prevent patient re-hospitalizations. *Home Healthcare Nurse, 31*(9), 504.
- Care Coordination. (2015, May 01). Retrieved February 12, 2018, from <https://www.ahrq.gov/professionals/prevention-chronic/care/improve/coordination/index.html>
- Centers for Medicare & Medicaid Services (2016). "Readmissions reduction program". Retrieved from <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>.
- General Information. (n.d.). Retrieved from <http://www.lafd.org/safety/ems-billing/ems-billing-medical-records-faqs/general-information#8>
- Gleason, K. M., Mcdaniel, M. R., Feinglass, J., Baker, D. W., Lindquist, L., Liss, D., & Noskin, G. A. (2010). Results of the Medications At Transitions and Clinical Handoffs (MATCH) Study: An Analysis of Medication Reconciliation Errors and Risk Factors at Hospital Admission. *Journal of General Internal Medicine, 25*(5), 441-447.  
doi:10.1007/s11606-010-1256-6
- Griffiths, D., Morphet, J., Innes, K., Crawford, K., & Williams, A. (2014). Communication between residential aged care facilities and the emergency department: A review of the literature. *International Journal of Nursing Studies, 51*(11), 1517-1523.  
doi:10.1016/j.ijnurstu.2014.06.002

- Kotter, J. P., Abrahamson, E., Lahey, R. K., Nohria, M. B., & Linsky, R. H. (2015, August 25). Leading Change: Why Transformation Efforts Fail. Retrieved from <https://hbr.org/2007/01/leading-change-why-transformation-efforts-fail>
- Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2011). The Importance Of Transitional Care In Achieving Health Reform. *Health Affairs*, 30(4), 746-754. doi:10.1377/hlthaff.2011.0041
- Ouslander, J. G., Naharci, I., Engstrom, G., Shutes, J., Wolf, D. G., Alpert, G., Newman, D. (2016). Root Cause Analyses of Transfers of Skilled Nursing Facility Patients to Acute Hospitals: Lessons Learned for Reducing Unnecessary Hospitalizations. *Journal of the American Medical Directors Association*, 17(3), 256-262. doi:10.1016/j.jamda.2015.11.018
- Samal, L., Dykes, P. C., Greenberg, J. O., Hasan, O., Venkatesh, A. K., Volk, L. A., & Bates, D. W. (2016). Care coordination gaps due to lack of interoperability in the United States: a qualitative study and literature review. *BMC Health Services Research*, 16(1). doi:10.1186/s12913-016-1373-y
- Young, H. M., Shillam, C. R., & Reinhard, S. C. (2014). IOM Future of Nursing Report: Implications for Gerontological Nursing Science. *Research in Gerontological Nursing*, 7(2), 54-55. doi:10.3928/19404921-20140127-03

Appendix A

TOOLS

SBAR Communication tool

**Handover Communication Tool to Hospital**

<b>S</b> <b>Situation</b>	Date _____ Diagnosis _____ Attending Physician _____ Transfer Paperwork <input type="checkbox"/> Complete <input type="checkbox"/> Partially Complete <input type="checkbox"/> Not Done
<b>B</b> <b>Background</b>	Allergies _____ Code Status: DNR <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Include copy of POLST Most recent Ht: _____ Wt: _____ Infection: <input type="checkbox"/> MRSA <input type="checkbox"/> TB <input type="checkbox"/> C-diff <input type="checkbox"/> VRE <input type="checkbox"/> Other _____ History: <input type="checkbox"/> HTN <input type="checkbox"/> DM <input type="checkbox"/> CHF <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> Seizures <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Bariatric <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> MI <input type="checkbox"/> CAPB Other _____
<b>A</b> <b>Assessment</b>	<b>V/S:</b> Time _____ B/P _____ Pulse _____ Temp _____ Resp _____ SpO2 _____ Recent Pain Score _____ Last Pain Med _____ Time _____ <input type="checkbox"/> Relieved <input type="checkbox"/> Decreased <input type="checkbox"/> No Change <b>Neuro</b> <input type="checkbox"/> Alert <input type="checkbox"/> Drowsy <input type="checkbox"/> Non-responsive <input type="checkbox"/> Oriented <input type="checkbox"/> Confused <input type="checkbox"/> Combative <input type="checkbox"/> Sedated Other _____ <b>Cardiac:</b> Rhythm _____ Other _____ <b>Respiratory:</b> <input type="checkbox"/> O <sub>2</sub> via _____ LPM _____ <input type="checkbox"/> Trach <input type="checkbox"/> Cough <input type="checkbox"/> Crackles <input type="checkbox"/> Wheezing <input type="checkbox"/> SOB Last Resp. Tx _____ Chest Tube/s: _____ Suction: <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage _____ Other _____ <b>GI:</b> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting/Last Med _____ <input type="checkbox"/> Diarrhea <input type="checkbox"/> Gastric Tube <input type="checkbox"/> Ostomy Other _____ Last BM: _____ Changes in Bowel Function: _____ <b>GU:</b> <input type="checkbox"/> Voiding <input type="checkbox"/> Foley Other _____ Incontinence: _____ <b>Skin Integrity</b> (describe): _____ <input type="checkbox"/> Clean/Dry <input type="checkbox"/> Unable to address <input type="checkbox"/> Decubitus Location _____ <input type="checkbox"/> Not addressed Other _____ <b>Ortho/Mobility</b> <input type="checkbox"/> Bedrest HOB: <input type="checkbox"/> Up <input type="checkbox"/> Down <input type="checkbox"/> Amb w/Assistance <input type="checkbox"/> Splint Other _____ Fall Risk: _____ <b>Psych/Social</b> On Admission: <input type="checkbox"/> Accompanied <input type="checkbox"/> Alone <input type="checkbox"/> Deaf <input type="checkbox"/> Blind <input type="checkbox"/> Non-English Speaking <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Psychiatric Diagnosis Other _____
<b>R</b> <b>Recommendation</b>	Pertinent lab tests <u>In Progress</u> _____ Family notified of admission: <input type="checkbox"/> Yes <input type="checkbox"/> No Other _____ Nurse (Please Print) _____ Person Notified of pending Patient Arrival _____ Time _____

Appendix A

**TOOLS**

Essential Patient Information Tool

\_\_\_\_\_Patient Name and DOB\_\_\_\_\_

Baseline cognitive function (mental status) and communication ability	
Reason for transfer	
Vital signs at the time of complaint	
Current medications	
PERTINENT Past medical history	
Allergies	
Mobility/ baseline ambulatory status	
Bowel and bladder continence	
Usual functional status/ADLs	
Additional information included in this packet (Initial next to each)	1) Face sheet _____ 2) POLST_____ 3) Recent labs_____ 4) Immunization record_____

PMD: \_\_\_\_\_

Charge nurse: \_\_\_\_\_

Phone number: \_\_\_\_\_

Appendix B

**THE LIST OF TRANSFERS TO ED**

Transfers to ED – IV Quarter 2017 - OCTOBER

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000001	Fall w/injury	No	No	No
000002	COPD exacer.	No	No	Yes
000003	UTI	Yes	Yes	No
000004	Chest pain	Yes	Yes	No
000005	Fall w/injury	Yes	No	No
000006	COPD exacer.	No	Yes	Yes
000007	SOB	No	Yes	No
000008	Fall w/injury	Yes	No	Yes

**Total transfers: 8**

**Total hand-offs completed: 4**

Transfers to ED – IV Quarter 2017 - NOVEMBER

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000009	ALOC	Yes	Yes	No
000010	Fall w/injury	Yes	No	Yes
000011	Respiratory inf.	No	Yes	No
000012	Pain	No	No	No
000013	Fall w/injury	Yes	Yes	No
000014	Change in V/S	No	Yes	No
000015	SOB	No	Yes	No

**Total transfers: 7**

**Total hand-offs completed: 3**

**THE LIST OF TRANSFERS TO ED**

Transfers to ED – IV Quarter 2017 - DECEMBER

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000016	Respiratory inf.	No	Yes	No
000017	Fall w/injury	Yes	Yes	No
000018	Respiratory inf.	No	Yes	No
000019	UTI	No	Yes	Yes
000020	Fall w/injury	No	No	No
000021	Cellulitis	No	Yes	Yes
000022	CHF exacerb.	Yes	Yes	No
000023	Fall w/injury	No	No	No
000024	Respiratory inf.	No	Yes	No
000025	ALOC	No	No	Yes
000026	Chest pain	No	Yes	No
000027	Aggressive act	No	Yes	Yes
000028	Fall w/injury	No	Yes	No
000029	ALOC	Yes	Yes	No
000030	Respiratory inf.	No	Yes	No
000031	Chest pain	No	No	No
000032	SOB	No	No	No

**Total transfers: 17**

**Total hand-offs completed: 3**

**Total transfers for quarter IV: 32**

**Total hand-offs completed: 10**

Transfers to ED – I Quarter 2018 - JANUARY

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000001	Fall w/injury	Yes	No	No
000002	Fall w/injury	Yes	No	No
000003	SOB	No	Yes	No
000004	Respiratory inf.	Yes	No	No
000005	Fall w/injury	No	No	No
000006	COPD exacer.	Yes	No	No
000007	UTI	No	No	Yes
000008	Respiratory inf.	No	Yes	No
000009	Abnormal labs	Yes	Yes	No

**Total transfers: 9**

**Total hand-offs completed: 5**

**THE LIST OF TRANSFERS TO ED**

Transfers to ED – I Quarter 2018 - FEBRUARY

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000010	Edema	Yes	No	No
000011	Fall w/injury	Yes	Yes	No
000012	UTI	Yes	No	No
000013	SOB	No	Yes	Yes
000014	Cellulitis	Yes	Yes	Yes
000015	Fall w/injury	Yes	No	No
000016	UTI	No	Yes	No
000017	Fall w/injury	Yes	No	No
000018	Change in V/S	No	No	No
000019	ALOC	Yes	Yes	No
000020	Respiratory inf.	Yes	Yes	Yes

**Total transfers: 11**

**Total hand-offs completed: 8**

**MARCH**

**THE LIST OF TRANSFERS TO ED**

Transfers to ED – I Quarter 2018 - MARCH

Transfer ID #	Reason for transfer	Hand-off completed	Admitted to hospital	Readmitted – 30days tracking
000021	Fall w/injury	Yes	Yes	No
000022	Fall w/injury	Yes	No	No
000023	Respiratory inf.	Yes	Yes	No
000024	Chest pain	Yes	Yes	No
000025	SOB	No	Yes	Yes
000026	Fall w/injury	Yes	No	Yes
000027	UTI	Yes	No	No
000028	Fall w/injury	Yes	No	Yes
000029	Cellulitis	Yes	Yes	No
000030	Hematuria	Yes	Yes	No
000031	UTI	Yes	Yes	No

**Total transfers: 11**

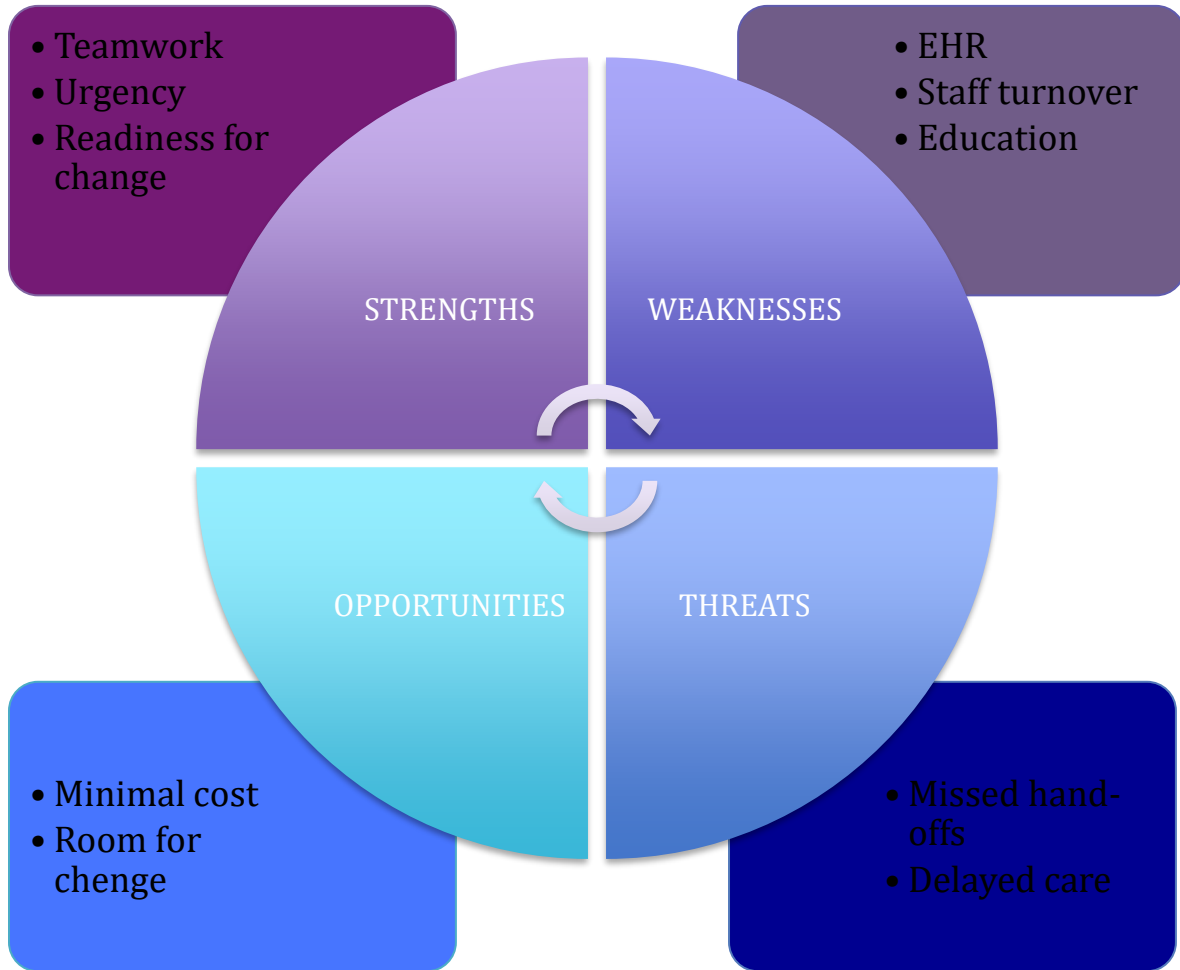
**Total hand-offs completed: 10**

**Total transfers for quarter I: 31**

**Total hand-offs completed: 23**

Appendix C

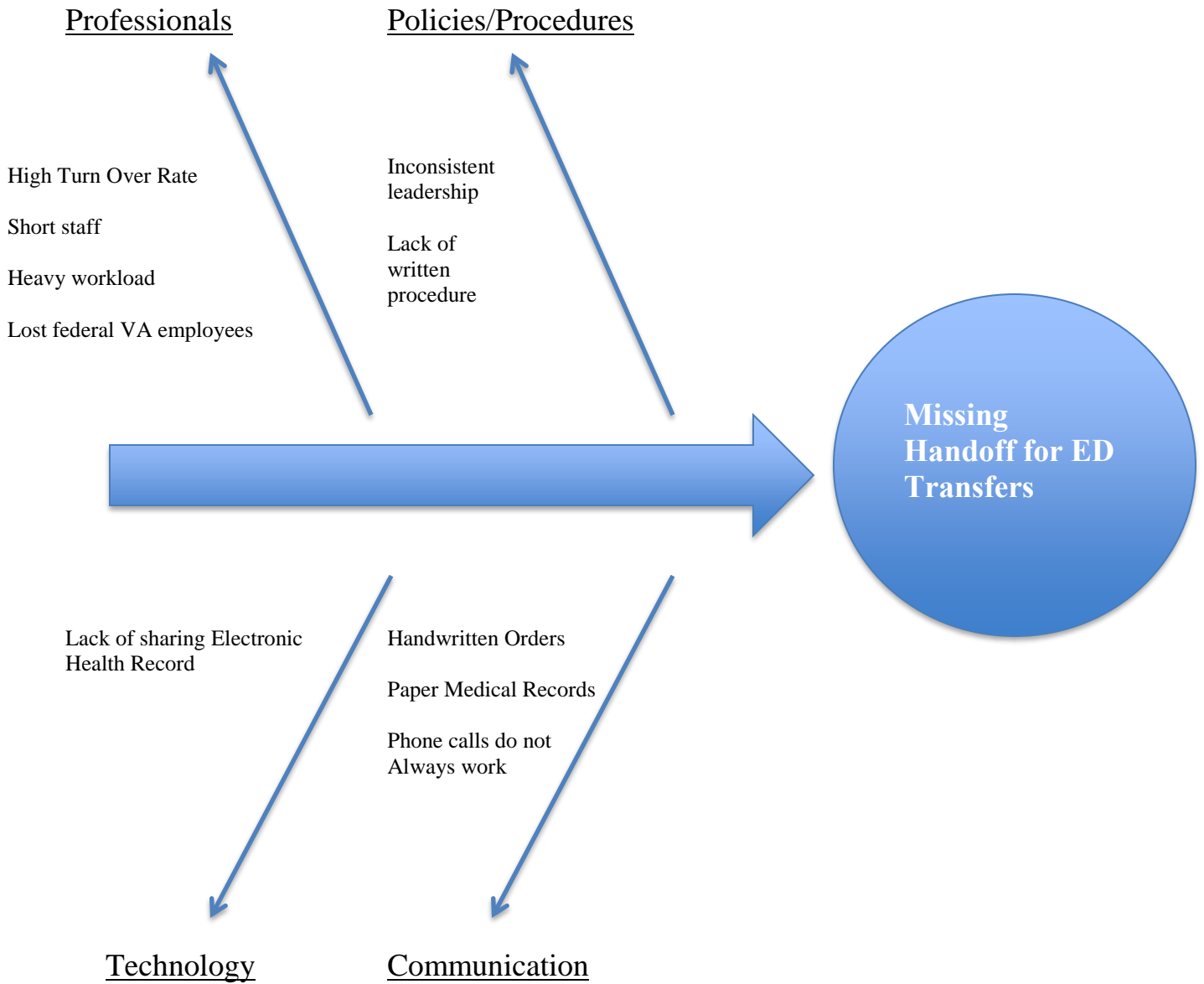
**SWOT ANALYSIS**





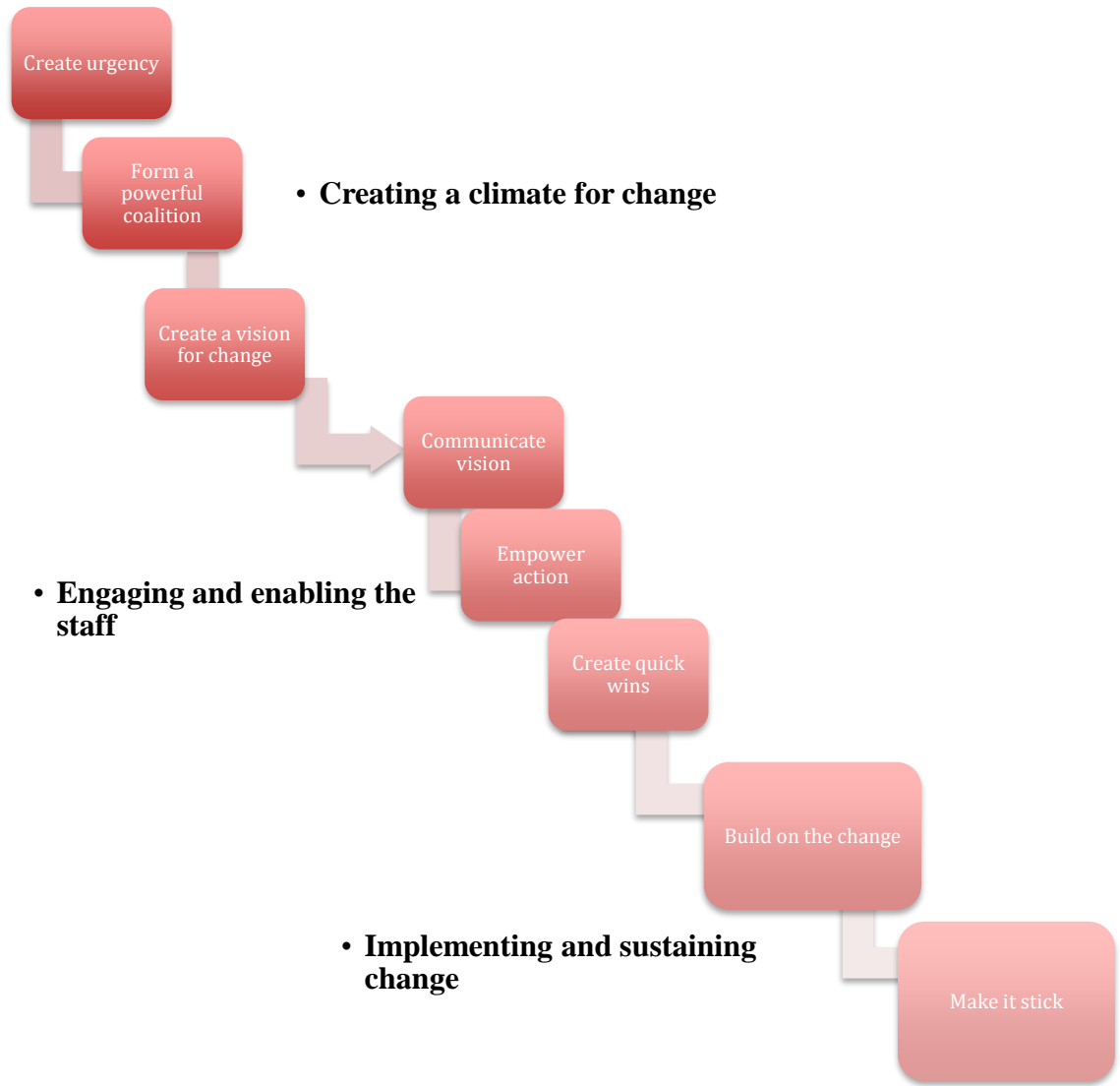
Appendix D

**FISHBONE DIAGRAM**



Appendix E

**Kotter's Theory of Change**



Appendix F

**GANNT CHART**

Action	January 2018	February 2018	March 2018	April 2018
<b>Diagnosing problem - assessment of the microsystem: review of data from previous quarter, implement new tools.</b>				
<b>Creating a sense of urgency and recognizing the need for change, share the vision with the participants.</b>				
<b>Recruit leaders in the microsystem, including director of nursing, quality assurance nurse and charge nurses.</b>				
<b>During daily huddle, address any concerns or barriers to nurses implementing change.</b>				
<b>Monthly meeting #1, data collection and discussion about addressing barriers.</b>				
<b>Monthly meeting #2, data collection and discussion about addressing barriers.</b>				
<b>Monthly meeting #3, data collection and discussion about addressing barriers.</b>				
<b>Data analysis and evaluation of the project.</b>				

