

THE INTRODUCTION OF A PATIENT TRANSFER FORM FOR THE TRANSFER OF CRITICALLY ILL PATIENTS FROM THE EMERGENCY DEPARTMENT (ED) TO THE INTENSIVE CARE UNIT (ICU)

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OUTLINE



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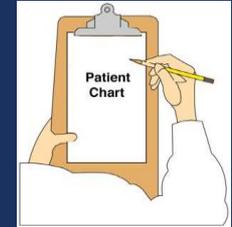


INTRODUCTION



- The number of critically ill patients requiring treatment in EDs has increased by over 25% (Varndell *et al.* 2015). EDs, however, were designed for rapid triage, stabilisation and initial treatment (Cowan *et al.* 2005).
- The intra-hospital transfer of critically ill patients is unavoidable in emergency practice - It is reported that critically ill patients transferred from the ED represent a significant proportion of the total number of patient transfers (ICS 2011).

PATIENT TRANSFER: A CRITICAL EVENT



- It is recognised that any transfer of the critically ill patient puts them at increased risk of significant mortality (Pakula *et al.* 2016). Transfers in care have been acknowledged across the literature as **danger points** in the patient care process.
- Droogh *et al.* (2015) best describes the transfer of critically ill patients as following Murphy's Law – *'if anything can go wrong, it will'*.
- Adverse events have been reported in up to 70% of intra-hospital transfers with problems categorised as patient, equipment related or environmental (Lovell 2001). Adverse events occurring during patient transfers may result in harm to the patient, distress to staff, increased financial costs for the hospital and additional worry for relatives
- Despite the existence of guidelines, the transfer of the critically ill patient is still linked with avoidable incidents (Droogh *et al.* 2015). One study reported that up to 91% of incidents were avoidable (Flabouris *et al.* 2006).

WHY PATIENT TRANSFERS?



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- Why not! In the UK, guidelines for the transfer of the critically ill adult remarked how critically ill patients were transferred in an “*ad hoc* manner” potentially putting patients at risk of serious complications (ICS 2011).
- Lack of research in Ireland and in the UK – My qualitative descriptive research study in 2017 is the **first** Irish/UK study to ever examine, in detail, Irish emergency nurses’ experiences regarding the transfer of critically ill patients from the ED to ICU.
- There are many hospitals where transfer guidelines are not used in everyday practice and transfer policies are not developed. There remains a lack of structure, and documentation associated with patient transfers and this can result in a lack of accountability.
- Why, despite the existence of international and national guidelines on intra-hospital transfers, do adverse events continue to occur? In addition, a lack of reporting adverse events.
- Transfers are often made out of normal working hours, and the patient may be accompanied by junior staff, leading to a high rate of critical incidents.

FINDINGS

- Caring for the critically ill patient in ED
- Arrival of the patient to ICU
- The need for clear transfer processes
- Improvements suggested for patient transfers



CARING FOR THE CRITICALLY ILL PATIENT IN ED

- Delays in transfer of patients to the ICU, resulted in these patients being managed in the resuscitation area of the ED, often for up to 24 hours.
- These patients were described as the “**sickest of the sick**” (Participant 1) and had a higher acuity that warranted complex and ongoing 1:1 care.
- Participants referred to the 1:1 care that the critically ill patient requires and how difficult it was to provide such care properly in an ED.
- By not being able to provide this care, both patients and staff were put at risk: ***“You’re constantly prioritising patient care when you have multiple critically unwell patients...it’s like a juggling act...only it’s people’s lives at stake”*** (Participant 9)

ARRIVAL OF THE PATIENT TO ICU

- All participants described the moment they arrived in ICU with the patient and some of the challenges they encountered trying to give handover.
- Participants described as feeling intimidated by the number of ICU staff and that ICU staff wouldn't typically approach them to identify themselves.
- Individuals described the struggle they associated with the transition between the life-saving part they played in the ED to almost feeling invisible on arrival to ICU.
- The ED nurses referred to a loss of control in the management of the patient at this point: ***“You might have been looking after the patient all day...helped to save them...then all of a sudden you're on the outside looking in”*** (Participant 8)

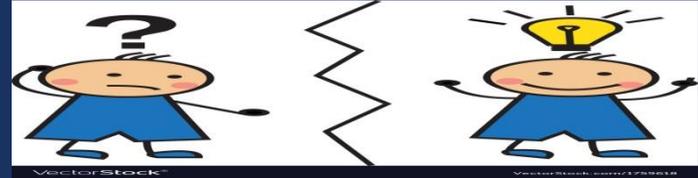
THE NEED FOR CLEAR TRANSFER PROCESSES

- Transporting a critically ill patient within the hospital creates a challenging and highly stressful work environment. Transfers were described as rushed. Participants found they rarely had time to undertake a proper safety check.
- All participants reported experiencing an adverse event and it was remarked “***if your patient is going to crash they will do it in the area where you are least prepared to handle it***” (Participant 2)
- 0% of the participants had any knowledge of the existence of national or international guidelines on the transfer of the critically ill patient or were aware of the local hospital policy on transferring patients.
- The hospital site where this study was carried out, had no framework to assist in patient transfer.

IMPROVEMENTS SUGGESTED FOR PATIENT TRANSFERS

- An absence of training , education and structure was prevalent in the data. It is recognised that patient transfer is a **clinical skill** like placing an intravenous line and requires a training process (ESICM 2011).
- All individuals involved in the transfer of critically ill patients should be suitably competent, trained and experienced.
- It was suggested that the provision of an ED to ICU patient transfer form had the potential to improve the current transfer process.

WHAT HAPPENED NEXT?



- Presented findings to ED and ICU
- ICU communication workshop
- ICU audit
- Development of an ED/ICU working group
- Development of an ED/ICU patient transfer form
- 6 week pilot
- Post pilot audit

ICU AUDIT



- Two weeks – Survey Monkey – questions devised from findings of my research (Opportunity to give ICU a voice regarding patient transfers)
- 35 responses from ICU
- 69% of ICU staff rated the handover process between ED and ICU as inadequate
- 94% of ICU staff felt a specific document would improve the handover process
- ICU reported the biggest challenges encountered regarding the ED to ICU handover were;
 - *Inadequate information handed over / Missing information / Unsure regarding dose / rate of IV medications*
 - *Handover not detailed enough*
 - *No proper flow / Not chronologically concise / Rushed*
 - *Time Consuming ‘Having to rifle through notes’*

INTRODUCING CHANGE



- Leading the change and motivating others *‘Leadership is not about being the best, but promoting a culture and environment where others can be their best’*
- Challenging! *“More paperwork!!?”*
- Followed up on every ICU transfer
- Regular team meetings in ED and ICU

DEVELOPMENT OF AN ED TO ICU PATIENT TRANSFER FORM

- User Friendly
- Regular ED and ICU input
- Multiple drafts
- Cost Effective
- Needed to be adaptable to other hospitals



ED/ICU PATIENT TRANSFER FORM (SJH)

EMERGENCY DEPARTMENT TO INTENSIVE CARE UNIT/HIGH DEPENDANCY UNIT HANDOVER DOCUMENT

Place patient addressograph here

Diagnosis: _____

Past Medical/Surgical Hx: _____

Adverse Events ED: _____

AIRWAY & BREATHING	CIRCULATION	NEURO	INVESTIGATIONS	ACCESS	PERSONAL
Self-ventilating <input type="checkbox"/> Non rebreather 100% <input type="checkbox"/> Venturi Mask <input type="checkbox"/> Non Invasive <input type="checkbox"/> Cpap <input type="checkbox"/> Bpap <input type="checkbox"/> Intubated <input type="checkbox"/> Time & Date _____ Tied at: _____ Airway Grade _____ Ventilated Patient Ventilator mode _____ PRVC <input type="checkbox"/> PS/CPAP <input type="checkbox"/> Volume support <input type="checkbox"/> TV 6ml/kg _____ Fio2----- _____ PEEP----- _____ ABG <input type="checkbox"/> Time _____ Cuff Pressure _____ Closed Suction <input type="checkbox"/> Continuous Waveform Capnography <input type="checkbox"/>	Weight kg _____ Temp: _____ BP: _____ Resp: _____ HR: _____ Spo2: _____ BSL: _____ Noradrenaline <input type="checkbox"/> Dosage _____ Adrenaline <input type="checkbox"/> Dosage _____ If >5mcg/kg then: _____ Y connector <input type="checkbox"/> 2nd Drug syringe <input type="checkbox"/> IV Fluids given <input type="checkbox"/> Volume & Type _____ Blood Products <input type="checkbox"/> RCC <input type="checkbox"/> Platelets <input type="checkbox"/> Plasma <input type="checkbox"/> Fibrinogen <input type="checkbox"/>	GCS: _____ Pupils: <input type="checkbox"/> Time _____ Size _____ Equal <input type="checkbox"/> Reactive <input type="checkbox"/> Sedation-please state _____ Paralysis <input type="checkbox"/> Time administered _____ Spinal precautions <input type="checkbox"/> Log roll _____ C-collar <input type="checkbox"/> VAC Mattress <input type="checkbox"/> Time commenced _____ Skin integrity intact? <input type="checkbox"/> if no specify: _____ Braden Score value _____	Blood Cultures <input type="checkbox"/> Urine <input type="checkbox"/> Sputum <input type="checkbox"/> Wound swab <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> ECG <input type="checkbox"/> Pregnancy Test <input type="checkbox"/> Toxicology Screen <input type="checkbox"/> CT/MRI <input type="checkbox"/> Bloods <input type="checkbox"/> FBC <input type="checkbox"/> U&E <input type="checkbox"/> COAG <input type="checkbox"/> LFT <input type="checkbox"/> CRP <input type="checkbox"/> GROUP & HOLD <input type="checkbox"/> OTHER _____ TIME _____ Additional Info _____	Central Line: <input type="checkbox"/> Date & Site: _____ Arterial line: <input type="checkbox"/> Date & Site: _____ Peripheral Cannula: <input type="checkbox"/> Date & Site: _____ Chest drain <input type="checkbox"/> site _____ Suction _____ Drains Urinary Catheter: <input type="checkbox"/> Nasal Gastric Tube <input type="checkbox"/> Fine bore <input type="checkbox"/> Ryles <input type="checkbox"/> Insertion date: _____ Colostomy <input type="checkbox"/> Ileostomy <input type="checkbox"/> Urostomy <input type="checkbox"/> OTHER DRAINS Please specify _____	Next of Kin informed <input type="checkbox"/> Next of KIN details in patient chart _____ Dentures <input type="checkbox"/> Glasses <input type="checkbox"/> Valuables _____ Allergies _____ Isolation Reason <input type="checkbox"/> Transfer Events _____ Time admission to ICU requested _____ Actual time of admission to ICU _____

Date: _____ Emergency Nurse: _____ Intensive Care Nurse: _____

POST- IMPLEMENTATION AUDIT



- Eight weeks post Implementation of form
- 30 Responses (?Form Fatigue!)
- 91% of ED and ICU staff felt the document useful
- 100% of both ED and ICU staff felt the document improved the handover process and that it contained all the relevant information required to give and receive handover on a patient
- Other responses included;
 - *Reduced handover times*
 - *Time saving; reported more time for patient care*
 - *Reported reduction in adverse events 'Stop and think' / Greater awareness of risk management 'Am I happy to transfer'*
 - *Reduction in duplication of handover or paperwork*
 - *Provides a visual teaching aid for all staff especially new and junior staff*

BENEFITS

Benefits for Patients

- Increase in quality of care provided to those patients requiring transfer
- Improved safety; Decrease in potential risks associated with transfers
- Providing an accurate, up to date and complete patient information as required by ICU

Benefits for Nursing Staff

- ED reported decreased stress and increased confidence
- Improved ED staff experiences of transfers
- Increased preparation – Providing a risk management tool
- Improved communications between clinical staff
- Improvement in the quality of ED nursing handovers to ICU (as reported by ICU)
- Reduction in errors due to illegible records
- An improved nursing process that releases time to care
- Time saving due to availability of clear concise records with reduced duplication of data entry
- Teaching Aid for Junior and new staff

Benefits for the Organisation

- Potential financial savings to the hospital in the reported reduction in adverse events
- Encourage reporting of adverse events – which can be used as a marker of transfer quality and to identify risks in the clinical area
- Decrease in potential harm to both staff and patients (and additional worry for relatives)
- Provides a KPI for measuring outcomes of patient transfer – ability to audit ED to ICU patient transfer times
- Promotes further quality improvement initiatives surrounding patient transfers
- Time Saving – reduction in handover time – releasing staff to provide patient care

PATIENT TRANSFERS: THE FUTURE



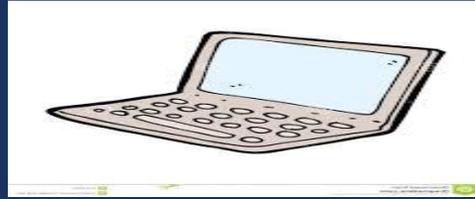
- A year of research and it ...suddenly became the norm! “*Did you fill out the transfer form*”
- Roll out of Electronic Patient Transfer Form in SJH in November 2019
- It is **recommended** that every ED involved in the transfer of critically ill patients to ICU implement this patient transfer form which provides a foundation for safe patient transfers.

CONCLUSION



- It is clear that the majority of Irish ED's currently fail to meet the standards and recommendations made by the ICS (2011) and AAGBI (2009) for the transfer of critically ill patients.
- Each hospital needs to take responsibility for the quality of care received in patient transfers, and this should include documentation.
- ***'Checklists are boring, but death is worse'*** (Atul Gawande 2017)

CONTACT



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