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## Continuity matters: Examining the ‘information gap’ in transfer from Residential Aged Care, ambulance to emergency triage in southern Tasmania

Briony Campbell<sup>a,b,\*</sup>, Christine Stirling<sup>a</sup>, Elizabeth Cummings<sup>a</sup>

<sup>a</sup> University of Tasmania, Hobart, Tasmania, Australia

<sup>b</sup> Royal Hobart Hospital, Emergency Department, Hobart, Tasmania, Australia

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### ABSTRACT

**Background:** Transfer of older people from Residential Aged Care Facilities to Emergency Departments requires multiple comprehensive handovers across different services. Significant information gaps exist in transferred information despite calls for standards.

**Aim:** To investigate: (1) presence of minimum standard elements in the transfer text written by RACF nurses, paramedics and ED triage nurses, and (2) the transfer documentation used by services.

**Methods:** We analysed retrospective cross-sectional transfer narratives from the digital medical record system of an Australian tertiary referral hospital using the mnemonic SBAR (Situation, Background, Assessment Recommendation) as the measure of comprehensiveness. Transfer documents from 3 groups were also reviewed.

**Findings:** Inclusion of elements from SBAR was inconsistent across transfer. Rather, the written narratives focused on concerns relevant to the immediate priority, the type of information imposed by the document(s) in use, and clinical role of the author.

**Conclusion:** Transfer documentation from Residential Aged Care nurses, paramedics and ED triage nurses do not contain comprehensive information of older persons complex conditions. Better communication between non-affiliated organisations is needed to improve timely appropriate care for RACF residents.

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### Introduction

Individuals from Residential Aged Care Facilities (RACFs) frequently live with complex multisystem disease including cognitive impairment (Dwyer et al., 2014; Arendts et al., 2010; Australian Institute of Health and Welfare, 2013). They are often transferred to hospital for a variety of reasons (Ingarfield et al., 2009; Arendts et al., 2010) via ambulance (Dwyer et al., 2014; Arendts et al., 2010) unaccompanied by anyone who knows them well. Multidisciplinary services are expected to share complex health histories efficiently and accurately during transfer (Coleman, 2003; Iedema and Merrick, 2008). This is particularly important for the cognitively impaired who may not be able to provide accurate information themselves (Kessler et al., 2013). However, providers do not always transfer quality information in cases of acute illness and out of hours care (Coleman, 2003; Cwinn et al., 2009;

Arendts et al., 2010; Kessler et al., 2013; McMurray et al., 2013; Griffiths et al., 2014; Morphet et al., 2014). This ‘missing’ information creates challenges for timely, appropriate clinical decision-making and care delivery in the ED (Dwyer et al., 2014) and increases the risk of adverse outcomes (Cwinn et al., 2009; Arendts et al., 2010; Morphet et al., 2014), and longer ED lengths of stay (Dwyer et al., 2014; Street et al., 2012).

Transfer from RACFs involves handover of verbal and documented information from RACF nurses to ambulance paramedics to ED hospital staff (Belfrage et al., 2009). While policies advocate for coordinated hand over of accountability, responsibility and information for patients (Australian Medical Association, 2013; Coleman, 2003; The Joint Commission, 2012), there is no agreed consensus on what amounts to essential information for transfers from RACF to ED (Griffiths et al., 2014). Recent studies have found RACF documents frequently have missing or incomplete information (Cwinn et al., 2009; Kessler et al., 2013; Morphet et al., 2014; Arendts et al., 2010; Hoare, 2009) and that information gaps also occur during transfer (Coleman, 2003). In one study, patients with complex comorbidities were described as challenging to

\* Corresponding author at: Private Bag 135, Hobart, Tasmania 7001, Australia.

E-mail addresses: [Briony.Campbell@utas.edu.au](mailto:Briony.Campbell@utas.edu.au) (B. Campbell), [Christine.Stirling@utas.edu.au](mailto:Christine.Stirling@utas.edu.au) (C. Stirling), [Elizabeth.Cummings@utas.edu.au](mailto:Elizabeth.Cummings@utas.edu.au) (E. Cummings).

hand-over at triage. These patients were also at risk of lack of appropriate attention when their symptoms were non-specific and they were perceived as not to be in need of advanced care (Bruce and Suserud, 2005).

Standardised transfer forms are recommended as a means to improve information quality and continuity across services/providers (Pearson and Coburn, 2013). One transfer form commonly used in Australian RACFs is a Yellow Envelope (YE). The YE was designed to function as a receptacle for documents, with check-boxes for key clinical and basic information printed on the exterior. Additionally, the YE may support verbal handover (Belfrage et al., 2009). Studies of transfer forms, including the YE (Cwinn et al., 2009; Pearson and Coburn, 2013; Belfrage et al., 2009) found they led to an improvement in the organisation of RACF documents and handover. However, 3 months after YE implementation in Australia, usage had decreased by 23%, and gaps in transfer content remained even though the volume of documents included in transfer had increased (Hoare, 2009).

Efforts to improve verbal handover have also been widely addressed through mnemonics and minimum data sets (Wong et al., 2008). The existence of numerous mnemonic variations (Riesenberg et al., 2009) has led to flexible standardisation becoming widely supported in order to improve consistency of information during handover in different areas of practice (ACSQHC, 2012; WHO Collaborating Centre for Patient Safety Solutions, 2007). The mnemonic SBAR (Situation; Background; Assessment; Recommendation) is one version inclusive of a base minimum dataset recommended for handover in Australian health service organisations (ACSQHC, 2012).

Transfer to hospital via ambulance requires creation of a Patient Health Care Record (PHCR). The PHCR is a legal record of the patient's personal health information (Lang, 2012). Ambulance services in the Eastern Australian states and territories use a 'standardised' electronic record known as the Victorian Ambulance Clinical Information System (VACIS) for this purpose (Ambulance Victoria, 2012). The PHCR enables entry of an open written narrative on the transfer event. However the majority of information requirements in the PHCR are headed under set fields, which align with assessment, treatments and outcomes (Lang, 2012). Whilst it is not designed specifically for handover the record can be printed and retained by the ED. Internationally, similar requisite transfer documents exist. In her qualitative study on Nursing Home transfer to ED, McCloskey (2011) found paramedic records tended to be limited to the resident's primary complaint.

Arrival in ED via ambulance necessitates paramedic handover to the triage nurse. A common electronic data management system used for capturing triage data in Australia is the Emergency Department Information System (EDIS) (OAG, 2013). The EDIS triage document is designed for documentation of clinical acuity and urgency. Urgency is categorised by applying the nationally accepted Australasian Triage Scale (ATS), which is tiered 1 through 5 (Australian Government, 2009). The ascribed numerical value corresponds to degree of clinical urgency; where 1 requires immediate time critical attention, and 5 may wait two hours prior to medical assessment (Australian Government, 2009). In addition to the ATS, triage documentation requires patient identification, mode of arrival, concise description of the primary complaint and free text that enables entry of other relevant information. Additional administrative data must be inserted separately (OAG, 2013).

For the vulnerable and often cognitively impaired older person transfer necessitates shared communication across a range of settings, between multidisciplinary healthcare workers, using numerous information systems. Despite attempts to improve quality and safety, transfer of information from RACF to ED using transfer documents have had limited sustained improvement

(Hoare, 2009; Cwinn et al., 2009; McCloskey, 2011). Few studies have specifically included paramedics in reviews of RACF to ED handover, nor explored for usage of a minimum standard.

## Aim

The primary aim of this study was to explore for elements of a minimum standard in the written transfer narratives of RACF nurses, paramedics and ED triage nurses.

## Method

### Study design

Whether it's the use of checklists, flow-charts, templates, headings or mnemonics, healthcare communication and documentation is formalised and guided by the use of tools. This study, which represents the first stage in a larger study exploring RACF to ED transfer, examined retrospectively collected, cross-sectional dataset of transfer records from three organisations.

### Setting and sample population

A tertiary hospital in southern Tasmania was the setting for data collection. The hospital provides services that are inclusive of, but not limited to: midwifery, neonates and paediatrics, surgical specialties, neurosurgery, cardiology, oncology, stroke, rehabilitation, psychiatric, and emergency care. It is the principle referral and university teaching hospital for the state with 550 beds, and an approximate catchment population of 240,000 people (Department of Health and Human Services, 2015). Lower triage categorisation of patients from RACF was acknowledged (Ingarfield et al., 2009; Arendts et al., 2010) in the study design. In keeping with the time-constraints and available resources of the study, data collection was limited to residents triaged as category 3, 4 and 5. The timeframe of interest was the period from December 1st, 2013 to January 31st, 2014. Data for this time period was retrospectively extracted from the hospital-wide Digital Medical Record system (DMR) between February and July 2014.

Eighty-nine episodes of transfer for ATS triage categories 3, 4 and 5 were available for review from the 2-month data collection period. After application of the exclusion criteria (see Table 1), eighty episodes of transfer were included. However, information scanned from RACF and some ambulance PHCR were missing or incomplete. In total data were collected for 80 ED triage, 72 ambulance and 46 RACF transfer episodes.

The DMR is the scanned digital record collated for each patient, containing copies of all documents relevant to the patient's episodes of care received by, and conducted at the hospital. The DMR enabled ease of access to documents from each of the three groups of interest. However, the RACF YE system incorporates a return to RACF checklist on its reverse side. As the intention is to use the YE to return information to RACF's it was not routinely scanned into the DMR. A separate data collection recruited the hospitals ED nurses to collect, de-identify and photocopy the YE

**Table 1**  
Exclusion criteria.

Age	<65 years
Level of care	Self-contained residential accommodation
Mode of transport to ED	Public transport Privately arranged family transport Community car
Triage category	Category 1 Category 2
Presentation	Direct admission to a ward

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