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RESEARCH PAPER

Shortfalls in residents' transfer documentation: Challenges for emergency department staff

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Residential aged care facility;
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Summary
Background: Increasing numbers of residents are transferred from aged care facilities to emergency departments. Frequently, residents arrive with inadequate documentation regarding their presenting complaint or medical history, making it difficult for emergency department staff to make decisions about care.
Methods: A retrospective review of emergency department records was undertaken for residents transferred from residential aged care facilities to two emergency departments in Melbourne, Victoria in 2012.
Results: 2880 resident transfers were included in the sample, of which 408 transfers were randomly selected for documentation review. Clinically important documentation was frequently absent including: the reason for transfer to the ED ($n = 197$, 48.2%); baseline cognitive function ($n = 244$, 59.7%); and vital signs at time of complaint ($n = 285$, 69.9%). When the reason for transfer was absent, residents with an altered conscious state had more investigations and spent longer in the emergency department than when the reason for transfer was recorded.

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Conclusion: Inadequate documentation negatively impacted the resident's journey through the emergency department. There is evidence that inadequate documentation contributes to poor patient outcomes. To minimise the gaps in the transfer documentation regular staff development and quality assurance programs may be required in residential aged care facilities.

What is known

- The international literature reveals that many residents are transferred to ED with inadequate documentation about their medical history.
- Any gaps in resident documentation have implications for both ED efficiency and the quality of care provided.

What this paper adds

- There are no Australian studies that attempt to identify and explain the relationship between RACF transfer documentation and care provided within the ED.
- This study examines the resident journey within the ED, and compares the journey for residents who arrived with essential transfer documentation, to residents who did not have essential transfer documentation with them.

Introduction

In 2010 there were approximately 182,825 people living in residential aged care facilities (RACF) in Australia, 75% of whom were in high level care.[1] Older people have a greater need for emergency medical care than others in the community, and the number presenting to emergency departments (ED) from residential aged care is increasing,[2–5] with at least 30 transfers from RACF to ED per 100 RACF beds per year.[6]

In order to adequately care for residents, ED staff require accurate and complete health information. Yet many residents are unable to provide a coherent medical history or describe their medication regime.[7,8] As a result, the documentation accompanying these residents provides the critical link between RACF and ED staff to enable optimal decisions to be made about care. Many residents are transferred to ED with inadequate documentation about their medical history.[9–13] When relevant information is absent, quality of care may be negatively impacted. Incomplete documentation makes it difficult for staff to make informed decisions, which may result in inefficient resident management, including service duplication, inappropriate or unwanted care[14] and extended ED length of stay (LOS). Service duplication and delays in ED care increase demand on ED services and costs to the health care system.

Australian EDs are committed to the 'National Emergency Access Target' (NEAT), whereby patients depart the ED, either via hospital admission, transfer or discharge, within 4 h of arrival.[15] Insufficient communication between RACF and ED hinders resident management, increasing length of ED stay,[12,13,16] and making the NEAT difficult to achieve. Further, extended length of ED stay increases the risk of delirium,[8] nosocomial infections[17,18] and increases inpatient length of hospital stay.[19]

To address the gaps in documentation accompanying residents transferred to hospital, the Australian Commission for Safety and Quality in Health Care introduced the Transfer-to-Hospital envelope (the Envelope) in 2007 as a way to improve communication between RACF and ED.[20,21] The Envelope is an A4 size, bright yellow envelope designed to contain residents' medical documents and other key information, when the resident is transferred to hospital. A checklist of key clinical information is provided on the outside of the Envelope, for RACF staff to complete prior to resident transfer.[21] The Envelope is then returned to the RACF with discharge information, when the resident is released from hospital. There is evidence that the Envelope improves the transfer of information between RACFs and ED, and is frequently utilised in Melbourne, Australia.[22]

There are no Australian studies that attempt to identify and explain the relationship between RACF transfer documentation and care provided within the ED. Any gaps in resident documentation have implications for both ED efficiency and the quality of care provided. The aim of this study was to investigate the documentation that accompanies resident transfers to ED, and the effect transfer documentation had on the resident ED journey.

Method

The setting for the study was two EDs in a large Victorian health care network. The two EDs treated over 132,000 presentations in 2012. Ethical approval was obtained from both Monash University and the health care network prior to undertaking this study.

A retrospective review of ED records was undertaken over a twelve month period in 2012 (January 1 to December 31, 2012). All residents transferred from residential aged care facilities to the EDs were included in the study. A computer program was used to uniformly extract a range of data fields from the electronic ED record. Data collected from the ED record included the resident's time of arrival to ED, presenting complaint, allocated triage category, investigations and procedures within the ED, diagnosis, length of ED stay, and disposition.

Following extraction of data from the ED record, 14% of the total sample was randomly selected for review of the transfer documentation which accompanied the resident to the ED. This ensured that more than 400 patient histories were reviewed. For the purpose of this paper, this