A Process to Support an Evidence-Based Guideline and Electronic SBAR for Ambulatory Departments Transferring Patients to a Higher Level of Care

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Objectives

• Discuss the evidence supporting intraprofessional communication and collaboration in enhancing patient care safety and outcomes.

• Learners will describe the process implemented to improve communication for patients transferring from ambulatory to the ED and inpatient settings.
Background/Evidence

• Safe patient handoffs are used to transfer information and responsibility (Strople & Ottani, 2006).

• 2/3rds of sentinel events are the result of ineffective communications (Effken, Gephart, Brewer, & Carley, 2013).

• Communication failures during handoff account for the majority of adverse outcomes in hospitals (Halm, 2013).
Background/Evidence

• 20% of ambulatory malpractice claims are the result of failure to communicate effectively during patient handoffs (Donnelly, Clauser, & Weissman, 2012).

• Poor handoff processes are known to cause delays to access and effective care (Bloutin, 2011).

• In a systematic review of 36 studies, Abraham, Kannampallil, & Patel, (2014) stated patient handoffs are negatively affected by a lack of standards and handoffs should be evaluated for their effect on patient outcomes.
Statement of Problem

• Lack of a consistent standard for transferring patients from the ambulatory setting: some clinics used a paper SBAR and called report, others did not.

• The processes among the clinics and team members were different.

• The expectations from the emergency room (ED) and inpatient units varied.

• Patient safety became an increasing concern; The ED provided evidence of 19 failed handoffs.

• Patient handoffs are negatively affected by a lack of standards (Abraham, Kannampallil, & Patel, 2014).
Statement of Problem

• There is limited research discussing handoffs in the ambulatory clinics (Donnelly, Clauser, Weissman, 2012), and (Solet et al., 2005).

• This lack of research is problematic, considering the potential numbers of handoffs in ambulatory settings.

• This project focused on taking existing evidence based research regarding communication and the use of SBARs and implement it in the ambulatory clinics.
Objective and Aims

**Objective:** To improve the handoff process for patients in ambulatory clinics who transferred to a higher level of care

**Aims:**

- Investigate the barriers to effective handoff communications by physicians, nurses, and transporters when transferring patients from ambulatory clinics to the ED

- Develop a standard guideline for use by ambulatory nurses that detailed the process for effective handoffs

- Design and implement an SBAR tool to serve as the standard tool for communication of clinical information and provide clinical decision support

- Reduce the occurrences of patients transferring from the clinics to the ED without an effective handoff including transportation
Evidence to Support Innovation

- Effective handoffs include face-to-face, two-way communication, structured written forms, templates, or checklists that encourage clinicians to agree on minimal data that create a shared mental model (Halm, 2013)
Evidence-based Research to Support Innovation

• In a literature review of handoffs between acute care nurses, Halm (2013) recommended organizations should proactively address cultural aspects of the organization to facilitate effective handoffs.

• In an observational study, improving nursing handoffs during report using a standard (SBAR) protocol has made handoffs concise (Cornell, Gervis, Yates, & Vardaman, 2013).

• In an observational, multi methods study, standardized handoff processes increases communications and correlates with positive outcomes such as easily extracted patient identifiers, medications, allergies from the health record making it easy to communicate (Donnelly, Clauser, Weissman, 2012, and Solet et al., 2005).
Setting

• The clinical setting is an academic medical center’s ambulatory clinics
• There are 629,269 ambulatory visits and 74,359 ED visits annually (Health.usnews.com, 2013)
• 19 clinics with over 80 specialties
Project Methods

• The Iowa Method was adapted by the organization as the clinical guideline for nursing Evidence Based Practice Projects

• The model highlights the importance of considering the healthcare system (Doody, 2011)

1. Identify Problem
2. Review Literature
3. Identify research that support the innovation
4. Implement change and monitor the outcomes
Project Methods

• A Request for assistance to improve the communication and process for handoffs by the Medical Director and the Nurse Manager of the ED initiated an investigation.

• A multidisciplinary stakeholder group representing ambulatory, nursing shared governance council, ED, inpatient, transportation, risk management, patient logistics, and professional development who met and worked together over several months.

• A summary of 19 failed handoffs from ambulatory clinics to the ED, seven of them should have been RRT calls.

• The evidence and stakeholder’s feedback provided the compelling case that supported the need to develop a transfer guideline and SBAR with clinical decision support.

• The project plan and work groups were created using project management, change management, and lean process improvement tools.
Project Methods

• Support was provided for EPIC analyst to put the SBAR into the EMR

• An educational plan was developed and implemented

• Collaborated with EPIC Training Manager to develop training and support tools

• HIM Security approved a request for the SBAR report containing PHI to measure outcomes

• Measured all transfers from clinics to determine number of effective handoffs

• Monitored and controlled project for four weeks
Handoff Process

• A process map was developed over several meetings by the workgroup to ensure that all elements were considered in the guideline and SBAR
  – Should the patient wait in the clinic for bed assignment?
  – What happens if the patient is unstable?
• Two scenarios developed
  – Admit to inpatient bed
  – Unstable patients to the ED
• RRT criteria used to determine the stability
Evidence-based Guideline

The University of Chicago Medicine
Ambulatory Services Clinical Guidelines for standard communication when transferring patients to other clinical areas

**Purpose:** To provide guidelines for standardizing the way ambulatory services communicates patient condition, care, and status to other care areas.

**Supportive Data:** The purpose of an effective handoff is to meet the need to convey essential information to the person(s) being communicated with. Standardized handoff tools such as the SBAR have been shown to increase patient safety, provide more comprehensive and consistent information, decrease patient safety events, decrease handoff time, increase collaboration amongst disciplines, and increase both patient and employee satisfaction.

**Content:**

I. **In-Patient Admission**
   1. **Process:**
      1. The outpatient staff receives an order to admit the patient to an inpatient bed.
      2. The outpatient staff determines if the patient is stable for transfer
         i. If not stable, the outpatient staff calls a RRT or Dr. Cart
            a. The outpatient staff completes a SBAR handoff communication tool and provides a verbal report to the RRT or Dr. Cart team member
            b. The patient is transported to the receiving unit by the RRT or Dr. Cart Team
         ii. If stable, the outpatient staff determines the bed type needed and communicates this to bed access.
            a. If a bed is available:
               i. The outpatient staff calls the receiving floor staff to give report.
               ii. The outpatient staff completes a SBAR handoff communication tool
               iii. The outpatient staff requests transportation in TeleTracking or call 55537
               iv. The patient is then transported to the inpatient bed by the transporter.
                  i. Should the patient require telemetry or advanced care, the RN/MD must accompany the patient.
            iii. If a bed is not available
               i. The outpatient staff calls bed access to determine timely bed availability
               ii. If necessary, a transfer to the Emergency Department might be indicated. (See ED Transfer # II Below)
SBAR

- Provided on-going updates to all stakeholders through various meetings
- Gained support for EPIC Analyst
- Converted paper SBAR and Guideline into an EPIC Documentation tool that crossed ambulatory encounters into the ED and inpatient chart
Electronic SBAR
**Education Implemented**

- Communicated education plan and go-live schedule via meetings, email, flyers, rounding, super users from Ambulatory Shared Governance Council, EPIC Team Memo
- Education on the Ambulatory Guideline and hands-on completion of the SBAR using ambulatory scenarios from the clinics

**Scenario #1 – Transfer to ED**

Your patient is present for a routine appointment. When taking the patients vitals, you note that his blood pressure is 200/110. He states that he is dizzy and just hasn’t been feeling well lately. You notify the provider who assesses the patient and decides that the patient should be taken to the ED. An order is placed for a saline lock and orthostatic vital signs. You arrange for transportation to take the patient to the ED. You also initiate the SBAR form in Epic. The provider places an MD to MD call to the ED which is followed by you calling RN to Charge nurse report.

**Scenario #2 – RFA order placed**

Your patient presents for his scheduled appointment. While being triaged, the patient states that he has a rash on his torso that has become increasingly painful. You notify the provider who determines that the patient needs to be admitted to Mitchell for treatment of Disseminated Zoster. An RFA order is placed. An order is also placed for a saline lock. You place the saline lock and initiate the SBAR form in Epic. Once a room has been procured, you call the assigned floor and give a nurse to nurse report. You arrange for transportation to take the patient to the floor.
Education Implemented

- Wrenching in the Ambulatory SBAR
- Epic Tip Sheets developed and disseminated for three areas
- A training webinar was developed and provided on two different days before go-live
- CBT assessment required
- Go-live
- Elbow support provided for 2 weeks post go-live
Education Implemented

• Super users completed training two days before one-on-one hands on training began

• Ambulatory trainers provided one-one training to 91 RNs using scenarios with work stations on wheels

• Mandatory Assessment was completed by 82% of RNs
Educational Support Tools

**ED Clinicians**

Wrenching the Ambulatory SBAR Hand-Off Report (ED)

Summary

The Ambulatory SBAR Hand-off Communication report is now available in the Emergency Departments. Previously a paper document, the SBAR form is now completed by clinicians in Epic, where this and other information is electronically gathered into the report. ED users should manually “wrench” the report button to the ED Track Board.

**Step-by-Step**

1. Single-click a patient on the Track Board to display the report toolbar. Click the Wrench icon.

2. The Add or Remove Buttons window opens. Click a blank row. In the Report field, type amb shr and click the Search icon.

**Ambulatory Clinicians**

SBAR Communication Form

Summary

SBAR stands for Situation, Background, Assessment and Recommendation. When a clinic patient is admitted to an inpatient unit or the ED, the Ambulatory SBAR form facilitates prompt and appropriate reporting of the patient’s status and the clinical recommendations. Previously a paper document, the form is now available in Epic, where this and other information is electronically gathered into the Ambulatory SBAR Hand-off Communication Report.

**Step-by-Step**

1. In the Visit Navigator, click the Pre-Admit tab. Open the SBAR Hand-Off section.
Data Collection

- The data was retrieved from the following four sources (ED):
  1) Teletracking,
  2) EPIC
  3) the Rapid Response Team
  4) the ED triage nurse report.

- Risk Management reports of handoff failure

- Data was collected and put into a data file for descriptive statistics

<table>
<thead>
<tr>
<th>Name of Report (RRT) report</th>
<th>Description of Data elements</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teletracking Report</td>
<td>Standardized report that contains the number of patients with MRN, department requesting transfer, department transferring to, and type of bed requested. Patient identifiers include MRN.</td>
<td>Compare the (eSBR) documentation tool to determine whether the eSBR has been completed for the patients who will transfer from the ambulatory setting.</td>
</tr>
<tr>
<td>EPIC report</td>
<td>Includes the MRN and the data elements of the eSBR, including: name of nurse, verbal report given, name of nurse given verbal report, was the patient accompanied during transfer, was the physician notified, and physician name.</td>
<td>Determines the completion of the eSBR, verbal hand off completed, and appropriate transportation provided.</td>
</tr>
<tr>
<td>Risk Management report</td>
<td>Summary of the rapid responses in ambulatory areas and whether not the patients were transferred. The MRN is required to track the patients transferred and determine if the eSBR was completed.</td>
<td>Compare the names on this report to the EPIC report to determine if the eSBR was completed and handoff for patients transferring to the ED.</td>
</tr>
<tr>
<td>ED Triage Nurse report</td>
<td>Document incidents of patients from ambulatory clinics arriving without handoffs and appropriate transportation.</td>
<td>Compare the MRN and or names to the EPIC, Teletracking, RRT, and ED Charge Nurse Report to determine handoff failure.</td>
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Post Go-Live Results

• Ambulatory staff were excited and receptive
• Unforeseen access issues for Pediatric nurses required additional work by the Epic analyst
• ED Charge Nurse and triage nurse reminders
• Rounding by the ambulatory educators 2 weeks post go-live
• Challenges identifying university staff for training
• Pediatric ED phone number was not available on SBAR
• Central line documentation not available
Evaluation

• Descriptive statistics summarized and compared data from the four reports to determine if the following criteria were met
  – SBAR Tool used to provide clinical documentation
  – Verbal handoff given
  – All patients accompanied
  – Rapid response team notified if patient is unstable (bonus)

• Communication by ED charge nurse and risk management for non-compliance
Results

- 145 patients in ambulatory clinics transferred to a higher level of care. The SBAR was completed 84.1% of the time
Results

• A verbal handoff was completed 62% of the time

• Ambulatory Nurses reported that ED charge nurses busy & not available

• Rooms not assigned
Results - Transportation

- Documentation of patients accompanied during transportation was completed 68.3%, unknown was 16.6%, and other was chosen as an option for 15.2% of the time.
Results - RRT, ED, and Risks

- There were six occurrences of patients transferring to the ED as a result of Rapid Response Team (RRT) calls. Documentation of a verbal handoff was given 5 out of the six times.

- All of these patients were accompanied to the ED, but the SBAR was not completed.
Discussion

• Including intra-professional leaders and key stakeholders from various departments on campus and taking their participation and feedback seriously was seen as a success factor to keeping the organization engaged

• The comprehensive educational plan contributed significantly to the awareness, engagement, and competency of the staff

• Gaining the support of the EPIC Team resources increased the engagement of the inpatient staff and resulted in increased interest by the inpatient and ED nurses request and use of the SBAR

• Further evaluation was required to assess the specific needs for documentation on the SBAR after the RRT team arrived, as we found the verbal handoff occurred without the SBAR documentation

• The eSBAR contains “other” as a selection for transportation in addition to transporter and staff. During development, nurses indicated this would be used for independent patients
Next Steps

- The recommendation is for “other” to be removed, and ambulatory to be added for the mode. Therefore, mode and accompanied by would be required documentation.
- Display Patient Must “be Accompanied” on the SBAR
- Add central line to accommodate a special population
- Spell out SBAR words
- Make the SBAR permanent and viewable across encounters
- Add the use of the SBAR and Ambulatory transfer guideline to ambulatory competency in the first year
Limitations

• Lack of pre-data within a specific timeline
• Inability to account for provider to provider transfers to the ED
Lessons Learned

• While this project was limited to RNs, Medical Assistants, and LPNs could have been initially included

• Ensuring active consistent participation from areas like Pediatrics and Women’s Health may have reduced last minute changes

• An updated hospital and university employee list may contribute to a faster uptake and implementation with increased communication

• Be sensitive to the change management process; it requires patience and compromise
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References


Questions