Intra Hospital transfer of patient care from the emergency department to an inpatient setting

Carly Hawkins

CNS, Emergency Department, Dunedin Hospital

Introduction

A routine aspect of care for any hospitalised patient includes physical movement from one area to another. This can include movement from the point of entry, which is often the Emergency Department (ED), to radiology, inpatient wards and operating theatres. Patient transport may involve movement by wheelchair, on hospital trolley or ward bed. It may also require escort by a range of hospital personnel, such as orderlies, nurses, doctors and at times include accompaniment by friends or relatives. The time spent being transported within the hospital environment can constitute a significant part of the patient's journey, their acuity and their overall experience of their hospital stay.

Policy Review

In order to better understand the needs of a patient during the process of intra hospital transfer, a policy review was carried out to identify any existing best practice policies or guidelines. These could provide guidance for emergency nurses when making decisions about the level of care required for patients who are being transferred within hospital areas. The review was undertaken with reference to New Zealand Health Board (NZ DHB) policies relating to intra hospital transfer and has the aim of identifying similarities and differences amongst national policies.

Which patient to escort

Senior Registered Nurse's (RN) working in an ED are regularly approached by nursing colleagues, orderlies, and other healthcare team members with the question such as "**does a nurse need to go with the patient" or "do I need to go with the patient**?" This raises the issue of how such questions should be answered, including whether there is an agreed rationale or protocol to underpin such decision making. It is important to consider why nurses are asking such questions. It could be that ED staff feel pressured to remain in the ED and therefore unable to accompany a transferring patient. It could also be a result of a lack of knowledge and understanding of the patient's condition and the impact that the process of transfer could have. Finally, difficulty in making transfer related decisions could relate to a concern by ED nurses about who will assume responsibility for their remaining patients should they leave the ED. Long stays in ED's are linked to overcrowding of the ED, negative clinical outcomes and compromised standards of privacy and dignity for patients (Ministry of Health, NZ [MoH] , 2013). Less time spent waiting to receive treatment improves the patient's outcome and also prevents "bottlenecks" that lead to ED overcrowding which slows the flow of patients through the ED resulting in other patients in the waiting room wait longer for treatment (MoH, 2013).

Implications of ED patient transfers

ED patients who are waiting for transfer to an inpatient area for admission or further investigation may have higher acuity that requires complex and on-going care. This can be challenging for nursing staff and needs to be taken into account when making the decision as to individual patients' escort requirements to other inpatient areas.

The challenge for nursing staff is to ensure and maintain safe and effective care for other remaining or new ED patients (ENA, 2006). Time away from the ED, for example while escorting patients, is time away from other patients already within the nurse's care. Such competing demands on nurses can impact on their ability to attend to other clinical responsibilities, (Kelly, Kerr & Lin, 2007). If an ED nurse is required to leave the department to escort a patient to another area this increases the workload on the remaining ED staff. This means the safety benefit gained for the patient being transported can thus be offset by a decrease in safe care for those patients left behind (Gilboy & Tanabe, 2006). When an ED nurse is escorting a patient on an intra hospital transfer this person is unable to hold the clinical risk and responsibility for the other patients who were in their care prior to them leaving the ED with the transferring patient. This ethical dilemma is further complicated by consideration of who holds the clinical responsibility for the patient during transfer if the decision is made for that person to be transferred without an RN in attendance. It has been acknowledged that clinical emergencies can and do occur during transfer. Crawford, Howick and Lucero (2004) for example commented, "**if your patient is going to crash they will do it in the area where you are least prepared to handle it**", (Crawford, Howick & Lucero, 2004, p80).

When the primary nurse is unable to escort the patient and the duty has been delegated to another member of the healthcare team, knowing when and whom one can delegate to requires complex understanding and knowledge of the skills and existing workloads of staff available (Wheeler, 2001). This apparently 'simple' process is clearly more complex than it first appears and requires a high level of critical analysis and decision making on the part of the nurse. With increasing pressure on staffing levels within the hospital environment, decisions may be made for patients to be escorted by either a health care assistant (HCA) by a hospital orderly (also referred to a porter). While there are rationales to justify such delegation, it must be remembered that these staff members have received varied training, and may not be competent to recognise and react to either physical or mental deterioration in a patient's condition

Conclusion

An intra hospital template patient transfer policy and patient assessment tool have been developed from the policy review findings (appendix 1). This will be fed back to the contributing areas and interested Charge Nurse Managers of NZ ED's and to nursing professional bodies, along with the recommendation that the policy template and patient assessment tool be utilized by DHB's within the NZ healthcare system. It will also be recommended that position statements be released by from professional bodies within NZ should reflect and complement those already published by international counterparts.

A key recommendation of the study is the need to raise the awareness of the safe passage of patients whilst on the physical journey through the hospital environment including the intra hospital patient transport at all levels of patient conditions.

Patient Assessment Tool

Patient:
- All patients requiring admission to ICU/ HDU/CCU

Airway:
- Fluctuating conscious level or sedated e.g. seizures, recent LOC

Breathing:
- Invasive or non-invasive ventilation
- Artificial airway i.e. tracheostomy
- Chest drain in situ
- Requiring oxygen

Circulation:
- EWS equal and greater than 2
- Requiring consistent monitoring including telemetry
- Intravenous infusions via a pump
- Has received opioids or sedations within the last 30 minutes

Other:
- C- spine immobilization / spinal fractures
- Agitated / physically restrained

⇨ **Escort required: Registered Nurse**

Consider if a Medical Practitioner is required

Patient:
- EWS less than 2
- Behaviour confused / disorientated
- Requires 2 or more staff to change position
- Intravenous Infusions which do not require inistration via a pump
- Emotionally distressed

⇨ **Escort required: Enrolled nurse or Healthcare assistant on clinical assessment**

Patient:
- EWS = 0
- Mobile
- Orientated
- No interventions are required (IV or oxygen)
- Emotionally stable

⇨ **Escort not necessary according to clinical assessment**

Important notes:

The Registered nurse is responsible for the care of the patient must assess the patient's physical and mental health to determine if an escort is required and if so who should undertake this role.
Before discontinuing any transfusions or oxygen for transfer this must be discussed with senior medical staff.
It is the Registered nurses responsibility to ensure that all appropriate documentation accompanies the patient.

References

Crawford, L., Howick, T., & Lucero, D. (2004). Are you putting patients at risk during transport. *ED Nursing*, May, 80-81. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed

Emergency Nurses Association. (2006). Holding patients in the emergency department. Retrieved from: https://www.ena.org/practice-research/research/Documents/HoldingPatientsEDWhitePaper.pdf

Gilboy, N., & Tanabe, P. (2006). Transporting low risk chest pain patients – do you need an RN and a monitor/defibrillator? *Advanced Emergency Nursing Journal, 28*(3), 168-174. Retrieved from: http://www.ncbi.nlm.nih.gov/pubmed

Kelly, A., Kerr, D., & Lin A. (2007). Is cardiac monitoring during transport of low-risk patients from the emergency department necessary? *Emergency Medicine Australasia, 19,* 229-233. doi: 10.1111/j.1742-6723.2007.00966.x

Ministry of Health, New Zealand. (2013). Health targets: Shorter stays in emergency departments. Retrieved from: http://www.health.govt.nz/new-zealand-health-system/health-targets/about-health-targets/health-targets-shorter-stays-emergency-departments

Wheeler, J. (2001). How to delegate your way to a better working life. *Nursing Times, 97*(36), 34. Retrieved from: http://www.nursingtimes.net/how-to-delegate-your-way-to-a-better-working-life/200642.article

Further information Contact:
Carly.hawkins@southerndhb.govt.nz

Acknowledges
This comes from my dissertation as part of my Masters in Clinical Nursing through the University of Otago. I would like to take the opportunity to thank my colleagues on the CENNZ national committee and to all the CNM of the ED's around NZ who supported and responded to my emails by supplying their DHB policies. Also my supervisors Sandy Richardson and Bridget - Mary McGown.