Evidence Summary with Practice Recommendations Regarding Communication During a Transition in Patient Care: Recommendations for Healthcare Providers in Polytrauma System of Care

Sue Biggins MBA, BSN, RN, CRRN; Brenda French, MSN, CRRN, CBIS, VHA-CM, RN-BC;
Sherry Hopkins, MSN, BSN, RN, CRRN, CCM; Patricia D. Jackson, MS, RN, CRRN; Constance R. Uphold, ARNP, PhD, FAAN
Polytrauma Field Advisory Committee (PFAC) / Office of Nursing Service

VA NURSING
Excellence in Patient-Driven Care

Purpose:

- To establish a safe, patient-centered, standardized set of communication actions designed to ensure critical coordination, continuity, and optimal healthcare outcomes for Active Duty Servicemembers (ADSM) and Veterans as they transition from one care site or level of care to another.
- To provide a standardized two-way dialogue approach for communicating patient information between health care providers during the transition of care from one care site or level of care to another.
- To ensure more effective communication by utilizing a method for communicating this critical information which provides the opportunity to ask and respond to questions by the transferring and receiving parties in real time.
- To promote the concept that discharge planning begins at admission and this transition plan also begins at admission

Clinical Problem:

- Discharge communication between care sites or levels of care can be complex for any patient.
- For the severely impaired ADSM or Veteran who might need to transition between multiple levels of care during a recovery period, this communication involves detailed, individualized information pivotal to quality clinical outcomes and patient/family satisfaction.
- These complex cases include multiple family members involved in the communication process.
- The use of the Interdisciplinary Team (IDT) and a standardized set of communication actions is recommended as a way to improve this communication.

Key Clinical Question: (Using PICO format)

P = regarding the patients who are discharged from a rehabilitation environment

I = will utilizing an IDT communication written format in addition to verbal communication

C = (versus only verbal communication to the receiving party)

O = result in improved critical outcomes and satisfaction (regarding the transfer) for the ADSM, Veteran, family support system and the receiving facility?

History of the Project
<u>June 2011</u>
PFAC asked to develop improved process for "transitions" handoff – Acute Care to Community Living Center
Consider standardizing a template
Identifying the complexity of the transitions
Make the acute template accessible to all
Make an ideal handoff procedure

Objective: To ensure a seamless transition between care settings to meet the bio-psycho-social and functional needs of patients and their families.

Define Polytrauma complexity

Describe multiple levels of care/different options for continued care

Communication modalities: V-Tel, Tele-conference with interdisciplinary team, patient/family, RN to RN POC

Documentation to include realistic goals, expectations, recommendations and F/U needs

Discharge planning begins at admission

Upon identification of next appropriate level of care, transfer facility begins coordinating transfer to next level of care.

Current Status Reviewed

Collected data from PRC sites

Each facility had own processes

Reviewed various documentation templates and tools

Noted commonalities among processes

<u>November 2011</u> – first draft developed

Incorporated ISBAR concept -(Identification, Situation, Background,

Assessment, and Recommendation

Utilized San Antonio PRC transfer communication template

EBP

Literature search, article reviews

Published to the ONS page

Literature Search - Used 29 search terms resulting in 19 articles for review.
In addition:

- Expert opinion (as a source of evidence) regarding this *transition* topic was sought which included a clinical panel of experts chosen from the Polytrauma/Rehabilitation Advisory Committee.
- Survey was sent to other VA rehabilitation/polytrauma nurses inquiring about strategies used to assure effective handoffs at time of discharge/transfer to another level of care

The overwhelming recurrent theme throughout the literature reviewed (See Appendix A) suggests **communication** is the key element in any successful patient hand off. This communication includes <u>active listening</u>, <u>thorough documentation</u>, and <u>very detailed verbal communication</u> directly to/among involved care providers. Numerous situational strategies are described in the literature, which have been effective in certain environments. The literature supports that these communication formats and processes need to be discipline-specific and specialty-specific to be sure all details are included in the transition handoff.

This evidence summary with practice recommendations intends to serve as a tool for use during transitions in a rehabilitation environment, and includes use of both written and verbal communication strategies supported by moderately strong evidence.

<u>Practice Recommendations</u>

1. Communication
2. Hand-off communication is required for transitions within the Polytrauma System of Care including discharges to different rehabilitation centers, long term care facilities, assisted living facilities, community living centers, hospices or homes. This includes discharge to Polytrauma Network Site Teams, Polytrauma Support Clinic Teams, and / or Point of Contact Staff when the discharge plan is to home with follow up care at the local VA Medical Center.
3. At each transition in care, active patient/family involvement is essential. The patient's and family's short and long term goals should be identified and communicated to the receiving team / care entity. Every effort should be made to assure that these identified goals are realistic and can be implemented in the future.
4. The standardized POLYTRAUMA -TBI INDIVIDUALIZED REHABILITATION REINTEGRATION PLAN OF CARE written format should be utilized. Nursing information should be integrated into this interdisciplinary document. Responsibility for completing this document often falls to the Case Manager. Additional nursing discharge documents (site specific) may also be used to include more detailed information.
5. A patient must have all follow-up outpatient clinic appointments scheduled with this information provided to the patient/family and receiving facility prior to discharge from the hospital.
6. "Rehabilitation Nursing Report Outline" is suggested format for nursing to nursing communication during a transition process.
7. It is expected that discharge planning begins at admission and this transition plan also begins at admission

Information has been disseminated by way of

- ONS Nurse Exec call
- PFAC SharePoint https://v6infoshare.v06.med.va.gov/programs/polytrauma/default.aspx
- Polytrauma Nurses National Live Meeting May 2013

Evidenced Base Practice document can be found on the ONS Products Page, under Polytrauma:

http://vaww.va.gov/nursing/cppProducts.asp