Doctor of Nursing Practice Projects   School of Nursing

Spring 5-2023

Enhancing Communication Pathways Between Care Environments to Improve Patient Outcomes

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<center>**Executive Summary**</center>

Introduction

Electronic communication supports the transfer of information in healthcare using the electronic health record (EHR). Patient care transitions may result in adverse safety events, such as medication errors, hospital readmissions, and unnecessary emergency department utilization when healthcare teams lack communication and patient hand-off. This project aimed to enhance communication through electronic communication methods between acute care and primary practice nurses at the time of patient discharge from the hospital setting.

Literature Review

Communication between the acute care and community setting is substantially important to prevent adverse outcomes, promote safety in care transition and ensure quality outcomes. Adverse events occur in approximately 20% of patients experiencing a transition of care (Baxter et al., 2020). Discharge communication is often automated but limited to review by the primary care physician only, excluding the remaining care team that is involved in the patient's care delivery. Communication relay must occur among all care team members, including nurses (Camicia et al., 2021). Nurses serve as fundamental partners in communication pathways, adding value and enhancing outcomes in critical situations for patients in care transitions (Acosta et al., 2018).

Ensuring enhanced communication in healthcare is a focused initiative in quality to prevent undesired outcomes such as adverse events, hospital readmissions, and unnecessary emergency department visits. Tsilimingras et al., (2019) reported that 47% of adverse events are preventable with 87% of adverse events related to medications. Baxter et al. (2020) shared that 20% of patients experience adverse events when transitioning from acute care to a community

setting. Pre-existing relationships among healthcare teams should be leveraged to prevent adverse events. Hospital readmissions effect approximately two million Medicare patients annually. Streelman & Staffileno (2021) reported hospital readmissions cost more than $25 billion annually.

Open communication and collaboration will strengthen rapport and care coordination between care environments (Lundereng et al., 2020). Absence of communication between care entities is directly linked to cause of readmission (Patel et al., 2019). In addition, poor discharge planning and absence of quality care coordination precedes hospital readmission (Christiansen et al., 2017). Healthcare operational differences adds a level of complexity to communication challenges as it related to diagnoses, diagnostic findings, medication reconciliation, and plans of care (Rattray et al., 2017). Care gaps can be closed by enhancing communication pathways between care environments (Baxter et al., 2020).

Communication should be standardized when used between care environments to avoid information omission and prevent adverse events (Streelman & Staffileno, 2021). Standardizing communication among nurses at the time of care transition is recommended. When communication at the time of care transition is shared in an inconsistent format, clinical information can be inadvertently omitted, leaving the patient at higher risk for adverse events (Yu et al., 2022). Communication utilized at the time of discharge should include direct observations from the hospital stay and comprehensive assessment of the patient (Rattray et al., 2017).

Project Methods

Following approval from the Institutional Review Board at Southern Illinois University Edwardsville, an electronic communication process within the EHR was developed to provide

efficient and detailed information from the acute care and primary practice nurse following patients being discharged from the hospital. Acute care and primary practice nurses received education related to purpose of the project as well as focused teaching to properly utilize the electronic communication tool. At the time of patient discharge, the acute care nurses completed the electronic communication tool within the EHR. The electronic communication tool included the most recent complete nursing assessment using a SBAR technique, post-acute care orders, follow-up expectation with the primary care practice, ancillary service needs, and an opportunity for the nurse to free text any additional concerns at the time of discharge.

Evaluation

The focus of this project was to utilize an electronic standardized hand-off tool within the EHR for patient discharges during the implementation period to reduce information omission and prevent hospital readmission. Ninety-six patients were discharged during project implementation. Forty-two of the ninety-six patients followed up with their primary care provider upon discharge. Successful EHR transmission of the standardized handoff tool occurred in 86% of the patients during the implementation period. Of note, the readmission rate of the patients during the project implementation was 2.3%, which was down from 7%-13% in 2021.

Acute care and primary practice nurses completed pre and post-surveys following project implementation. Nurses were asked to evaluate current communication methods and perceptions regarding patient handoff between the two care environments. In the pre-survey results, the acute and primary practice nurses shared concerns regarding the lack of hand-off between the practice environments following patient discharge from the hospital setting. Post-survey results reflected positive perception of the electronic communication tool within the EHR. Both acute care and primary practice nurses noted in the post-surveys that the new electronic communication method

for patient hand-off helped with continuity of care. Most surveyed nurses agreed the electronic communication tool at patient discharge improved patient outcomes, enhanced patient hand-off, decreased hospital readmissions, and reduced medication errors.

Impact on Care

A standard, electronic communication tool was provided within the EHR to support communication between care environments at the time of hospital discharge. Communication shared between acute care and primary practice nurses enhanced the care of the patient by eliminating otherwise absent communication regarding the patient's hospital admission. Primary practice nurses were able to gain knowledge regarding the patient's hospital admission from the electronic communication tool to benefit follow-up within the primary practice team. Policy development at the unit level will be developed. Organizational use of the electronic communication tool is being evaluated. Communication tool automation will require further investigation with process review involving the EHR information technology team.

Conclusion

Communication is imperative to successful care transitions. When communication is absent between care teams at the time of transition, gaps in care can occur and adverse outcomes can result. Nurses play a pivotal role in communication to the patient but also to one another during the transition from acute care to community environments. Using an electronic standard, handoff tool during care transition can improve outcomes and probability of care transition success for patients. Handoff tools should include a current assessment of the patient in addition to identified care needs and discharge medications to support the transition back into the community. Communication between acute care and primary practice nurses can prevent or reduce hospital readmissions and adverse events.