Abstract

Appropriate hand-off communication is necessary during transfers to ensure patient safety. Accurate hand-off communication is imperative to delivering high-quality, effective patient care (Muller et al., 2018). Alternatively, the absence of a standardized communication process increases the incidence of patient harm. Inadequate reporting was cited as the cause of 80% of adverse events between 2004 and 2014 (Soo-Hon et al., 2016). This quality improvement project sought to evaluate the effect of a standardized protocol on patient safety during transfers from the emergency department (ED) and inpatient unit. The developed protocol included bedside reporting, transfer times, a standardized reporting tool, early warning score (EWS), and patient visualization. A checklist was developed and used as a method of measurement to determine compliance with the protocol. Nurses working in the medical-surgical unit completed the checklists anonymously with each patient transfer. Five points on the checklists indicated 100% protocol compliance. The organization's internal dashboard was used to determine adverse patient events in the third reporting quarter of 2020, compared to the same quarter of 2021. Statistical analysis determined that 384 (N=384) checklists were completed for 411 (N=411) patient admissions. Of the 384 (N=384) checklists, 310 (N=310) received five points, indicating 100% compliance with the protocol. No adverse patient events were recorded during implementation. The quality improvement project found that using a standardized transfer protocol enhanced patient safety and created an easier workflow for nurses. Further examination is needed to determine if the protocol could be expanded to include other units in the organization.