IMPROVING ADVANCE PRACTICE NURSE (APN) TO APN HANDOFF COMMUNICATION IN THE EMERGENCY DEPARTMENT EXTENDED CARE UNIT - AN APN QUALITY IMPROVEMENT PROJECT

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AIM
70% of 3pm APN to APN Handoffs will occur in the EDECU with team & family updates by end of fiscal year 2019.

BACKGROUND
APN to APN Handoff Characteristics identified consistency in format & location as areas for quality improvement

DETAILS OF INNOVATION
- APN, Nursing & Attending Stakeholders Identified
- Process Maps Standardized Practice
- Test & Implemented APN to APN Rounds Process
- Targeted Feedback & Education
- QI Outcome tied to APN group Incentive

OUTCOME
- 3pm APN hand-off location goal observed at or above 70%
- Results validated by study observer

CONCLUSION
Constant practice modeling, mentoring and education will be required to sustain practice and culture change.
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Advance Practice Nurse (APN) to APN handoff characteristic data identified that structured multidisciplinary unit/bedside handoffs can promote more accurate communication and contribute to the quality handoffs in the Emergency Department Extended Care Unit (EDECU). Last year the Emergency Department APN group at an urban pediatric tertiary care hospital identified characteristics of APN to APN communication requiring requirement within the context of an overall hospital initiative to improve transfer of care communication. Unlike the Emergency Department (ED) where a variety of clinicians including physicians, nurses, nurse practitioners, residents, and students treat, discharge, or admit patients the 14-bed short stay / EDECU is managed exclusively by the ED APN’s.

Process maps identified several areas for improvement including the need for consistency in location and content. Handoff location was determined to be the first goal quality improve actionable attribute as it is completely APN driven. It was determined that to improve multidisciplinary collaboration and increase family inclusion handoffs needed to occur within the unit rather off unit. Family and patient inclusion was fostered by a shared exchange of information with the bedside nurses. As a team, the APNs and bedside nurses were present for the care transition and jointly updated the bedside communication board.

The aim for this project was that 70% of rounds would occur in the EDECU. During the test and implement phase, reminder emails were sent and monthly feedback was delivered to APN's. From April 2018 to June 2018 APN to APN unit sign out communication occurred within the unit >75% of the time. In the Fall when an APN office space became available, handoffs in the EDECU fell from 81% to 46%. The ED APN Quality Improvement (QI) group focused on education and awareness through a campaign of daily targeted emails to the daily EDECU APN. Weekly hospital email blasts and monthly staff meeting updates kept further attention focused on the importance of this culture change. Additionally, financial incentive was offered by the enterprise if this goal was obtained. All results were validated by a co-op student and entered into the survey database. By the end of the fiscal year, the group goal was achieved with at least 70% of EDECU APN to APN handoffs occurring within the EDECU.

Creating process maps allowed for identification of different APN practices. Sharing these process maps helped staff understand the need for group standardization of APN to APN communication at transfer of care. Providing sustained feedback to staff enforced accountability and awareness to help drive culture change. Receiving buy-in from APN leadership to make this QI project part of the yearly group goal with an attached financial incentive program also attributed to project success. Similar techniques can be applied to other units and hospitals looking to improve APN hand off skills. Next steps in this project is focused on sustaining this practice change and improving other hand off attributes.

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