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The relationship between the level of knowledge, documentation, and communication of nurses with the intra-hospital transfer process: A literature review

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Abstract

Background: The intra-hospital transfer process is the transfer of patients while being treated in hospital from one service or from one inpatient unit to various other service units.Transfer is the transfer of a patient within the same facility for diagnostic procedures or transfer to another room to receive additional treatment.
Purpose: This literature review aims to review previous research regarding the relationship between the level of knowledge, documentation and communication of nurses with the intra-hospital transfer process.
Method: This literature review uses electronic databases such as PubMed, Google Scholar, Wiley Online Library, and Springer Link, which are journals published for the period 2016 to 2023. Articles were filtered using prism diagram rules, the keywords used in the literature search were "patient transfer" AND “intra-hospital” OR “intra-hospital patient transfer”.
Results: There were 9 pieces of appropriate literature, which were then analyzed and the results showed that the importance of the role of nurses in patient safety during the transfer phase of patient care includes policies, clinical processes, quality of information, accuracy and coordination of nurses, doctors and other staff in filling out transfer forms and communication in internal so that it can affect quality in terms of accuracy.
Conclusion: Implementation of a good transfer process is influenced by several factors, including pre-transfer preparation and stabilization, knowledge and skills of transfer accompanying nurses, necessary equipment and monitoring, patient documentation and handover, effective communication and having transfer guidelines. The patient transfer process can run smoothly, but poor implementation of nurses' knowledge, documentation and communication regarding patient transfers can hamper the transfer process which can result in morbidity, mortality and patient safety incidents.
Suggestion: The transfer process can threaten patient safety, this is because the transfer situation is prone to incidents due to the duration of the transfer, severity of illness, lack of experience of accompanying health workers, and communication gaps. So effective communication, collaboration, standardization and implementing appropriate care are needed. This emphasizes the important role of nurses in patient safety during the transfer phase of patient care.

Keywords: Communication of Nurses; Documentation; Intra Hospital; Knowledge; Patient Transfer.

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INTRODUCTION

Hospitals provide comprehensive and most complex services compared to other health service facilities (Wahyuni, Setiatin, & Susanto, 2021; Patel, & West Jr, 2021; Kim, Lee, & Ryu, 2017). In providing health services, hospitals must pay attention to quality and patient safety (Minister of Health of the Republic of Indonesia, 2022). Intra-hospital transfer management is a form of nursing service that is closely related to patient safety. Intra-hospital transfers are also included in the 2019 National Standards for Hospital Accreditation as an assessment standard for the quality of health services, especially nursing services. The intra-hospital transfer process is the transfer of patients while being treated in hospital from one service or from one inpatient unit to various other service units.

The patient transfer process can threaten patient safety, this is because the transfer situation is prone to incidents due to the duration of the transfer, severity of illness, lack of experience of accompanying health workers, and communication gaps (Bressan, Mio, & Palese, 2020; Bergman et al., 2020). Hospitals and staff are responsible for providing effective and safe patient care and services, this requires effective communication, collaboration, standardization and implementing appropriate care. This emphasizes the important role of nurses in patient safety during the transfer phase of patient care (Berry et al., 2020; Azyabi, Karwowski, & Davahli, 2021).

Patient safety in a system to make patient care safer, includes patient risk assessment, incident reporting and analysis, the ability to learn from incidents and follow up and implement solutions to minimize risks and prevent injuries caused by errors due to carrying out an action or not taking action which should be taken (Minister of Health of the Republic of Indonesia, 2017; World Health Organization, 2020). Based on the problem above, many studies have studied itlevel of knowledge, documentation and communication of nurses with the intra-hospital transfer process.This research needs to be summarized and analyzed using a literature review.

RESEARCH METHOD

This research method uses studies literature review by analyzing previous research that has been systematically collected from several databases so that it becomes a new idea. Appropriate journals are then analyzed using the PRISMA diagram. Journal searches were carried out in September 2023 using the keywords:“patient transfer” AND “intra-hospital” OR “intra-hospital patient transfer”.Journals are collected through several electronic databases, including:PubMed, Google Scholar, Wiley Online Library, and Springer Link which are journals published for the period 2016 to 2023with the following criteria using English or Indonesian, not being experimental in terms of effectiveness or nursing actions, the journal can be accessed in full text and free of charge.

RESEARCH RESULTS

Based on search results in several online research databases, 2,935 articles were found using related keywords. A total of 937 articles came from Google Scholar, 602 Wiley Online Library, 320 Springer Links, and 1,076 others came from Pubmed.In the next selection stage, it was found that several articles were excluded because their titles and abstracts did not match, the topics were unrelated, and they could not be screened, totaling 2,508 journals. Several articles with appropriate criteria were found in 427 journals. Several articles were removed after duplicate elimination and experimental exclusion for 399 journals. The next screening was the use of language and accessibility of articles, so 36 articles were excluded, and 28 articles remained, 12 of which were treatment studies. The final stage of selection, 9 articles were accepted.

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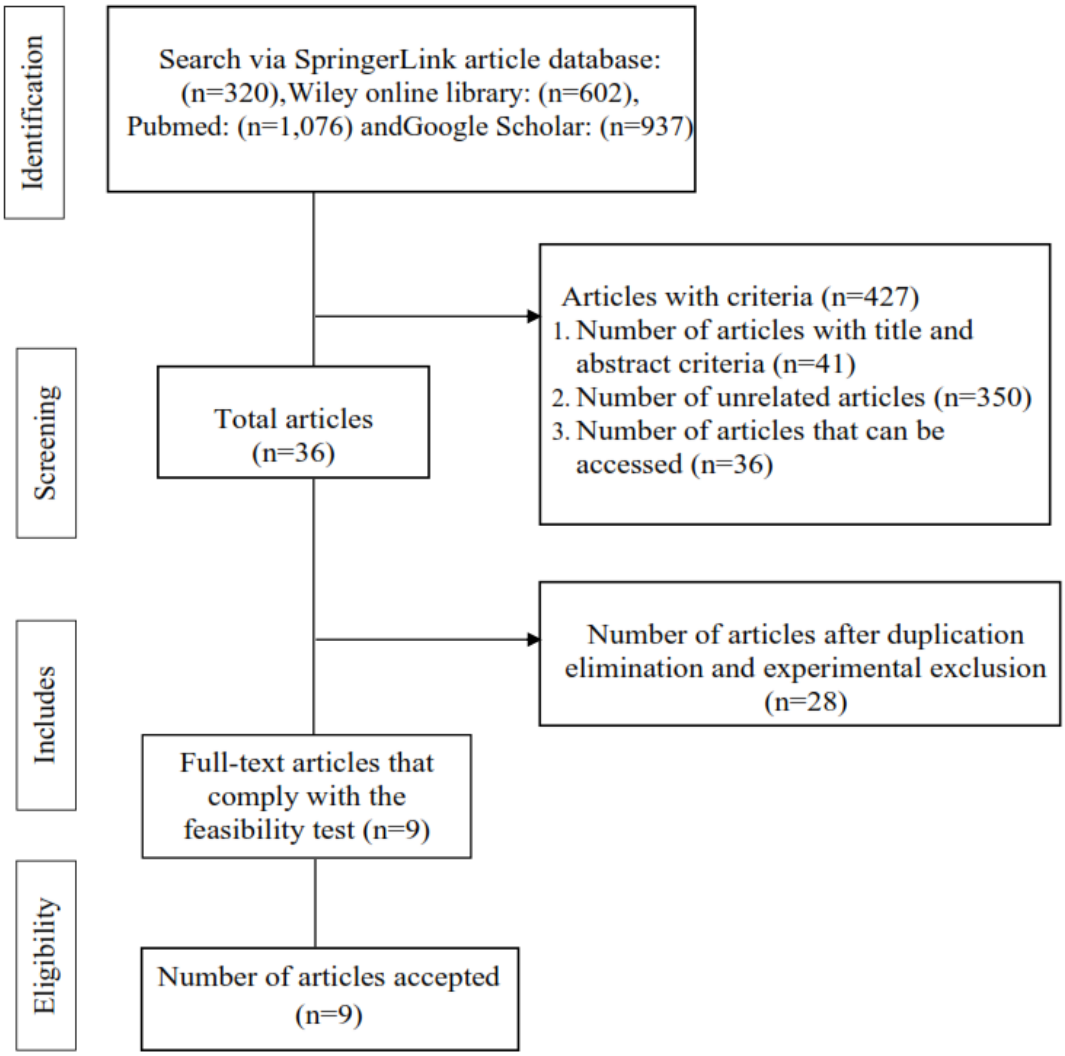


Figure: PRISMA Flow Diagram

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The Main Characteristics of Included Studies

(Author,Year)(Country)	Purpose	Method	Results
(Kulshrestha & Singh, 2016). (India)	As a guideline for safe patient transfer with key elements that must be followed in every transfer to prevent side effects that affect the patient's prognosis.	*Review*transfer articles and transfer guides.	Key elements of a safe transfer involve decisions in transfer, communication, pretransfer preparation and stabilization, personnel accompanying the patient, necessary equipment and monitoring, and documentation and handover of the patient at the receiving facility. These elements must be followed in every transfer to prevent side effects that could affect the patient's prognosis.
(Jones et al., 2016). (USA)	Evaluate implementation of standardized evaluation plans during intra-hospital transport to/from the adult intensive care unit. This aims to improve patient safety by reducing unexpected events during transportation.	Quantitative observational design with collection of demographic and clinical data. Qualitative with subjective data collection related to compliance with guidelines.The study was conducted at a level 1 trauma center, auditing 502 intensive care patient transports over 4 months. Faudit form developed based on ITCA (Intrahospital transport of the critically ill adult) policy/guidelines and used to measure compliance with policies/guidelines and EU (Unexpected Events) that occur during transfer.	Of the total audited transports, the majority of nurses complied with the policy, except in the stabilization process, where only 34.7% complied. Unexpected events were recorded in 8.2% of transports, of which 26.8% of these events resulted in transport being cancelled. The most common events include hemodynamic, sedation, respiratory, and gastrointestinal problems. Fewer incidents occurred when special transport teams were involved. In contrast, the incidence was higher in nurses with less than two years of experience in the intensive care unit, as well as in patients with higher APACHE (Acute Physiology and Chronic Health Evaluation) scores.

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(Author,Year)(Country)	Purpose	Method	Results
(Shah, 2023). (USA)	As a standard care system guideline for intra- and inter-hospital transfers.	Systematic review. For specialist transport systems versus standard ambulance transfers for 5 studies involving 1,334 people. For ICU transfer checklist versus no transfer checklist for 1 study involving 211 people.	The NICE guidelines for intra- and inter-hospital transfers state that a structured and systematic approach is essential to ensure the safety and quality of care of critical patients during transfer. Assessment of patient stability, a well-trained team, adequate medical equipment, effective communication, clear standard procedures, a focus on safety, and ongoing evaluation are key elements to achieving a safe and efficient transfer.
(Intensive Care Society, 2019). (USA)	Guidelines standard of care in the transfer of critically ill patients.	Systematic literature review with observational studies. Of the 266 critical care units in England, Wales and Northern Ireland that participated in the Case Mix Program between 1 April 2014 and 31 March 2017, a total of 28,418 (4.7%) patients.	Critical care patient transfers should be led by a transfer officer whose responsibilities include developing and overseeing the transfer, understanding the transfer protocol. Guidelines, staff training, competency, provision of equipment and the ability to perform resuscitation, stabilizing critically ill patients when necessary are required. The importance of a structured approach, clear standards of practice, specialized training, and use of appropriate technology in the transport of critical patients.
(O'Connor, Rawson, & Redley, 2020) (Australia)	Exploring communication between nurses about multidisciplinary care patient in the ER at the time of patient transfer.	Mixed and naturalistic methods design, observational data, audits, and interviews. Research with 38 nurses and 19 doctors in the ER. The study was conducted in August 2018 in the ER and two medical wards. With a	Comprehensive clinical handover allows for the safe transfer of responsibility and accountability for ongoing patient care. Transfer from the ER to the inpatient room is a high-risk event, especially in complex patients who require the involvement of a multidisciplinary team.

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(Author,Year)(Country)	Purpose	Method	Results
		capacity of 40 beds in a tertiary teaching hospital in Melbourne, Australia. The patient's electronic medical record audit data is integrated into a formular with REDCap software. Observations and interviews by filling out forms in ISBAR format (Identification, Situation, Background, Assessment, Recommendations or Results) for information transfer.	The nurse has primary responsibility in handover communications to transfer ongoing care responsibilities when the patient is transferred from the emergency department to the inpatient ward. This research emphasizes the important role of nurses in patient safety during the transition phase of patient care. Incomplete transfer documentation during patient handover can cause problems, including medication errors, inappropriate care and delays in patient treatment.
(Minagorre et al., 2023). (Spain)	Recommendations for a standardized handoff model that uses checklists/documents to facilitate structured, comprehensive and organized management of important information.	Review articles and documents. Quality of Care and Patient Safety Committee of the Spanish Pediatric Association. Using a standardized handoff model with SBAR and IDEAS.	Handover includes a large number of actions that are critical to patient safety. Communication in handover must be clear, firm, smooth and in accordance with good practice guidelines. Communication failures can result in omission of important information regarding the patient's condition and delays in providing care. A standardized handoff system is a very useful resource in care transitions and is integrated into clinical practice. The SBAR method is applied to patient handoff in observation in the emergency unit during shift changes and the IDEAS method in telephone referrals.

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(Author,Year)(Country)	Purpose	Method	Results
(Wahyuni, Setiatin, & Susanto, 2021). (Indonesia)	To determine the effect of completing the internal patient transfer form on the quality of medical records. Optimization of filling out internal patient transfer forms is influenced by factors such as the large number of patients and weak coordination between health workers.	Quantitative design with a descriptive approach. Simple random sampling technique of 91 internal patient transfer forms. Questionnaires, observations, and literature studies.	There is an influence on the completeness of filling out the internal patient transfer form on the quality of medical records. From the observation results, it was found that 22% had not been filled in completely, especially the signature and clear name. It was found that the influence of the variable completeness of the internal patient transfer form on the variable quality of medical records was 90.1% and the remaining 9.9% was influenced by other factors. In the research, it was found that there was a lack of accuracy and coordination between nurses, doctors and other staff in filling out internal patient transfer forms, so this affected the quality of medical records in terms of accuracy.
(Germack, et al., 2020). (USA)	Collect published data on harms and adverse events that occur in critically ill children in the context of transport within medical centers. The secondary aim was to identify what interventions have been studied previously that may reduce the incidence and gather recommendations for preventing transfer harm.	Systematic Reviews and Meta-analyses (PRISMA)-Harm guide lines. 40 articles with inclusion of critically ill patients aged <18 years.	The risks associated with handover in the context of transfer of critically ill pediatric patients reviewed by Foronda et al revealed that standardized communication, dedicated teams, and better teamwork improve patient outcomes, reduce complications, and reduce costs. Standardized communication also increases officer satisfaction in handover. Transfer side effects can be reduced by patient optimization before transfer, namely: use of checklists; secure equipment attached to the patient such as IV lines, endotracheal tubes or drains; re-inspection of required equipment; and ensuring that experienced nurses/doctors accompany patients.

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(Author,Year)(Country)	Purpose	Method	Results
leephu, Arwatchananukul, & Aunsri, 2023). (Thailand)	Assess patient transfer gaps by applying the Discrete Event Simulation (DES) modeling framework to model and analyze patient transfers and evaluate the factors that influence them.	Observational study prospective. Observations on 827 transfer patients. DES Simulation Method with 4 Steps: Data collection, data analysis, algorithm design and simulation model and analysis.	Discrete event simulation (DES) models are effective for analyzing and planning queue management systems, providing optimal waiting times. This model improves the quality of healthcare services by reducing patient transfer wait times through a queue management system, selecting the most seriously ill patients to be transferred on stretchers to empty beds, and selecting the most available staff. This model reduces waiting time by 21.78% on average from 1.1751 to 0.9193 hours (70.51 minutes to 55.15 minutes), which is very important for emergency cases. Transfer of critically ill patients to hospital is associated with complications in up to 70%. Problems that can be avoided with pre-transport planning and communication the optimal one. Simulation models have proven to be an effective method for modeling processes and improve on-time service and queue management.

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DISCUSSION

Based on analysis of the literature, it was found that the key elements of safe transfer involve decisions regarding patient transfer, communication, pre-transfer preparation and stabilization, method of transfer, personnel accompanying the patient, equipment, patient monitoring, and documentation and patient handover at the hospital. receiving facility. These elements must be followed in every transfer to prevent side effects that can affect the patient's prognosis (Kulshrestha,& Singh, 2016).

The research highlights how complex patterns and processes impacting transfer create barriers to the use of good practice recommendations. According to the Intensive Care Society (ICS) Guidance on: The Transfer of the Critically Ill Adult (2019), critical care transfer requires guidelines, staff training, competency, provision of equipment to resuscitate, stabilize and transport critically ill patients (O'Connor, Rawson, & Redley, 2020). It requires mature readiness from the organizational structure or hospital in determining modules or guidelines related to security in intra-hospital transfers.

Joint Commission Center for Transforming Healthcare (Joint Commission on Accreditation of Healthcare Organizations, 2012) stated that a lack of teamwork was identified as the root cause of failure in transfers. Efforts to improve quality by setting goals and optimizing synergy between units can be an efficient way to strengthen the relationship between completeness of documentation, communication and knowledge of officers.

To maintain patient safety during the intra-hospital transfer process, nurses accompanying patients must be trained, competent, experienced, preferably nurses who have undergone training in patient transfer and have training in basic life support, airway management and emergencies (Kulshrestha,& Singh, 2016; Fekieta et al.,2021. In order to ensure patient safety in the intra-hospital transfer process, nurses must have the ability, competence, and be equipped with training related to carrying out patient transfers such as BTCLS (Basic Trauma Cardiac Life Support) (Kulshrestha,& Singh, 2016). In the emergency first aid process during transfer, it is expected that the experience of accompanying health workers is highly trained (Droogh et al., 2015).

Incomplete transfer documentation when handing over a patient can cause problems, including medication errors, inappropriate treatment and delays in patient treatment (O'Connor, Rawson, & Redley, 2020). In research (Wahyuni, Setiatin, & Susanto, 2021) it was found that there was a lack of accuracy and coordination of nurses, doctors and other officers in filling out internal patient transfer forms, so this affected the quality of medical records in terms of accuracy. Intra-hospital patient transfer forms are not yet optimally filled out, especially when the signature and name are clear.

The research emphasizes the important role of nurses in patient safety during the transfer phase of patient care. Research (O'Connor, Rawson, & Redley, 2020) shows that inadequate information and complicated handover processes contribute to gaps, duplication or delays in patient care in transition, thereby increasing the risk of errors and harm. The problem of transferring critically ill patients can be avoided with optimal pre-transportation planning and communication (Meephu, Arwatchananukul, & Aunsri, 2023. The communication in this transfer process must be clear, firm, smooth, and in accordance with good practice guidelines (Minagorre, et al., 2023). Recommendations for reducing handover risks during transfer include face-to-face communication at the bedside, interacting with the patient and family, reducing distractions, and following a structured process for transfer and communication (O'Connor, Rawson, & Redley, 2020). Comprehensive clinical handover allows for the safe transfer of responsibility and accountability for ongoing patient care from one clinical environment to another (O'Connor, Rawson, & Redley, 2020). Communication failures can result in the omission of important information regarding the patient's condition and delays in the delivery of care are a threat to patient safety and causes more than 70% of side effects or patient care problems (Minagorre, et al., 2023).

CONCLUSION

In the intra-hospital transfer process, the importance of the role of nurses in patient safety during the transition phase of patient care includes policies, clinical processes, and quality of information. In the research, it was found that the importance of

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accuracy and coordination of nurses, doctors and other staff in filling out internal patient transfer forms means that this affects the quality of medical records in terms of accuracy. Apart from that, good communication skills are required in handing over information regarding the patient's condition. Pre-transfer preparation and stabilization which includes personnel accompanying the patient with good knowledge, equipment and monitoring required, documentation and handover of the patient at the receiving facility, communication in this context must be clear, firm, smooth, guidelines, staff training, competence, and to carry out resuscitation, as well as stabilize the patient transfer process.

SUGGESTION

Good coordination is needed from the medical team, both nurses and doctors, in the intra-hospital patient transfer process so that all information can be communicated properly and accurately. The quality of staff in terms of knowledge, skills and communication methods is also important in carrying out a safe intra-hospital transfer process for patients. Standardized guidelines are needed in accordance with existing policies, conditions and related matters in the organization or hospital. This can be realized in the form of intra-hospital patient transfer management.

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