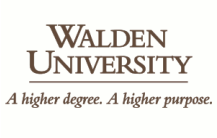

2016

Using SBAR to Decrease Transfers from the Long-term Care to the Emergency Room

Phyllis Marie Bowers Garrett
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Phyllis Garrett

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Mary Verklan, Committee Chairperson, Health Services Faculty
Dr. Geri Schmotzer, Committee Member, Health Services Faculty
Dr. Barbara Niedz, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2016

Abstract

Using SBAR to Decrease Transfers from the Long-term Care to the Emergency Room

By

Phyllis M. Bowers Garrett

Project Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May, 2016

Abstract

Care of the elderly, long-term care resident in the emergency department is an issue of importance because of the overall impact on healthcare costs, potential for negative outcomes for the resident, and the loss of revenue. The purpose of this project was to decrease avoidable transfer of residents to the Emergency Department. Using the Antecedent, Target, Measurement logic model, poor quality assessment data was deemed the antecedent of the avoidable transfer. The goal of the project was the implementation of a standardized process of assessment that would have decreased avoidable transfer of the resident. The project would have involved training of the nursing staff in the use of the Situation Background Assessment and Recommendation tool for collecting and communicating pertinent data. The tool would have been completed at each acute complaint and would have indicated disposition. Data would have been collected by the Education Coordinator and organized for review and comparison with preintervention data. Social change implications would have included enhanced communication, potential for increased nurse and physician satisfaction which could have potentially increased job satisfaction, and improved recruitment and retention. Autonomy and self-pertinence empowers the nurse to be a stronger advocate. Positive outcomes increase when care is provided by those familiar with the patient norms and the setting. Financial savings can have an impact on the cost of healthcare. This project would also have allowed for and encouraged internal review of process and practices. This project was not implemented and so remains inconclusive.

Using SBAR to Decrease Transfers from the Long-term Care to the Emergency Room

by

Phyllis M. Bowers Garrett

Project Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

May 2016

Dedication

This work is dedicated to all the teachers, mentors, and educators who have always encouraged me to be the very best that I can be. This work is also dedicated to the memory of my parents, who while possessing only a third grade education recognized the benefit of higher education and to my beautiful sister Linda Bowers who engaged me in learning the basics of education.

Acknowledgments

I would like to acknowledge first and foremost my Lord and Savior Jesus the Christ, who loves me before, beyond, and past myself. I thank my parents who gave me life and taught me the basics of life; love and respect for the differences that exist in us all.

I would like to acknowledge all of the key educators in my student life from early childhood until now; with a special acknowledgement of Aaron A. Granberry, Peggy Ranew Durden, and Gene Walton; all who recognized potential in me before I saw any in myself. Lastly but certainly never least I acknowledge my beautiful mother who taught me more about nursing during her illness and death than I learned during my previous 30 years of nursing.

Table of Contents

Section 1: Overview of the Evidence-Based Project 1

Introduction 1

Problem Statement 7

Purpose Statement and Project Objectives 9

Significance/Relevance to Practice 13

Project questions 16

Evidence-Based Significance of the Project 17

Implications for Social Change in Practice 19

Definitions of Terms 21

Assumptions and Limitations 23

Summary 26

Section 2: Review of Literature and Theoretical Framework 27

General Literature 27

Section 3: Methodology 38

Design and Methodology 38

Section 4: Findings, Discussion, and Implications 52

Introduction 52

Section 5: Professional Scholarly Product 68

References 69

Section 1: Overview of the Evidence-Based Project

Introduction

This project, to introduce the use of the communication tool called SBAR (Situation, Background, Assessment, and Recommendation), was not implemented but would have taken place in a long term care facility in a rural setting in Jackson County FL. The facility has 180 beds capacity, employs 10 Registered Nurses (RN), 15 Licensed Practical Nurses (LPN) fulltime, and they also have three RNs and two LPNs who work on an as needed basis. The site of my projected project was a long-term care facility associated with a trifold healthcare system, which included the local hospital and a private physician's office practice. These three facilities were located on the same grounds within walking distance and privately owned (personal communication, S. Lowery, APN; March 1, 2014). This facility was faced with financial concerns like many other long term care (LTC) facilities. Medicaid and Medicare pay for more than 60% of LTC and resident stays. LTC facilities may lose money based on empty beds. Any initiative to maintain residents in the LTC setting has potential benefit to the organization long term and to residents (Intrator, et al., 2006).

Although the project was not implemented, the LTC facility was prepared to embrace the project proposal as a needed change to meet the needs of the residents and the organization. The facility was equipped with the necessary human resources, as evidenced by an adequate staffing of capable LPNs and RNs on each shift, to accommodate the needed change (verbal communication T. B, Director of Nursing,

2015). In the assessment of the motivation for change the facility demonstrated readiness and willingness for change. The facility seemed to be driven to implement a program of quality assurance that affects patient outcomes and prevents transfer of the LTC resident to the ED, from a financial standpoint as well as a desire to survive. Like many other LTC facilities in the nation, the organization was placed in an unavoidable position to find means to decrease costs, especially in areas related to care provided (Diachun, Charese & Lingard, 2012). This cost of this project proposal was nominal when compared with alternatives to improve process and decrease costs associated with transfer of the elderly LTC resident to the Emergency Department (ED). No resident assessments would be outside the scope of practice for the RN. Avoidable ED transfers had been identified by this facility as an area of concern and needed strategic focus (personal communication T. Brown, DON, 2015). This was an issue addressed initially by my preceptor, who was a provider in the ED. It was noted that more than 36 avoidable visits were accounted for over a 3 month period reviewed. These visits were noted in a log book that had only been initiated with the new nursing management. They were identified as avoidable because in each case the resident was seen in the ED and transferred back to the facility for care and treatment of the issue. Upon further review, there was not enough documented data present to offer a longer trend. My preceptor, along with the other providers, and the nursing staff in the ED all provided verbal reports of the avoidable transfer as an issue of concern. They further supported any efforts of improvement in this area.

Continued financial constraints caused so much stress on the organization that key stakeholders were lost and focus was shifted to keeping the facility open and functioning.. Employees were engaged in providing day to day care for the patients rather than implementing the SBAR project. This notwithstanding, this DNP project has the potential for providing any LTC facility with guidance regarding the usefulness, relevance and methodology for implementing an SBAR project to reduce avoidable transfers to the ED.

The emergency department (ED) is a busy clinical arena where highly technical procedures and treatments occur. Congestion in the emergency department affects the overall operation of the healthcare organization financially as well as patient flow through the ED (Ouslander et al, 2011). Research has identified the avoidable visits of the elderly to the ED as an issue of concern (Nelson, Washton, & Jeanmonod, 2012; Ouslander et al., 2011). Nelson and colleagues (2012) described a study completed in the ED of a primary teaching hospital that served 15 LTC facilities within a 10 mile radius. The study found that the residents transferred to the hospital from the LTC settings were predominantly brought to the ED with inadequate health information pertinent to the current complaint (Nelson et al., 2012). Less than one third of the residents were able to provide adequate history and the information provided in transfer was either missing or nonessential to the treatment of the presenting problem (Nelson et al., 2012). The residents often endured testing and diagnostic procedures that had little to do with the current complaint and were not relevant to the visit complaint but entailed what was essential for a basic evaluation (Nelson et al. 2012). More than 70% of the residents often

had radiological studies, electrocardiography, and basic laboratory testing (Nelson et al., 2012). Use of the SBAR as a standardized tool for collecting and sharing assessment data would offer a format to ensure that essential data has been provided for review in caring for the resident in the ED.

The resident complaint must be adequately assessed to triage the urgency and convey the nature of urgency in hand-off. For the purpose of this paper, it is considered a preventable transfer to the ED if a resident is transferred to the ED is returned to the LTC facility without interventions or with interventions that could have been provided in the LTC setting. If the visit is deemed necessary but could have been avoided with interventions occurring at an earlier interval this is considered an opportunity for training and instruction without fear of negative retaliation. An example of an avoidable visit could include a resident who complains of chest discomfort is immediately transferred to the ED only to discover upon assessment in the ED that the chest pain was actually epigastric pain accompanied by a burning sensation in the throat. Use of the SBAR through the assessment process would also have revealed that the resident also had a history of chronic GERD, had not taken the prescribed medication intervention prior to meals for several days, and had been put to bed shortly after a large meal. The vital signs, lab, and EKG were all negative, and the intervention ordered for GERD relieved the complaint. This transfer was considered a preventable transfer.

The concerns in these avoidable transfers was relative to the well-being of the elderly patient, the ED providers who often do not have adequate time to dedicate to this complex patient, and for the organizational costs incurred in providing care for this

patient population in the ED (Ouslander et al., 2011). The patient assessment and interview performed by the nurse and the presentation of information gathered during the initial triage assessment in the ED are often the establishment for the track through the healthcare system for the patient. This encounter alone holds the potential to set the platform for the patient outcome of each visit or encounter.

Communication between nurses and physicians after hours is a common area of information transfer and a common reason for avoidable transfer of the long term care (LTC) patient to the ED. Coley (2015) reminds us that the effectiveness of communication in this exchange is dependent upon the relevance of the information shared. Significant information is often gathered during the during the assessment phase and not shared or simply overlooked during the assessment of the situation (Coley, 2015). The omission of essential information during the assessment process is a key factor in the avoidable transfer of the elderly LTC resident to the ED. For example, a resident was assessed for reported changes in mental status and was immediately transferred to the ED. Upon presentation to the ED the resident was noted to have stable vital signs and was able to be aroused to full alertness but fell asleep intermittently during the interview. This resident might correctly have been considered to be suffering from altered mental status. However, using the SBAR protocol would have revealed that this resident was recently started on a routine sedative hypnotic at hour of sleep. The medication administration record reveals that the medication was given at 1930 and the resident also received an analgesic at the same time. The assessment of altered mental status then changes and the nurse might favorably have decided during the recommendation phase

that the resident does not need to be transferred to the ED. The nurse might decide that closer observation and intermittent vital sign monitoring might be more appropriate. The transfer would then be considered avoidable.

Failure to assess the event of resident complaint or status change, precipitating factors, current resident status, and formulation of what the nurse feels should happen to rectify the situation often lead to premature transfer to the ED. Close attention to the Situation, Background, Assessment, and Recommendations (SBAR) can prevent overlooking simple and easily resolved issues or the beginning manifestations of a more severe underlying issue. The consistent use of the SBAR protocol can serve as a mental aid for rapid triage of the event to ensure that the resident who does need to get to the ED for further evaluation is transferred as soon as possible (Coley, 2015). Avoidable transfers were determined by a review of the treatments provided in the ED. If no treatment was provided in the ED or the treatment could have been provided in the LTC setting, such as enemas, vital sign monitoring frequency, or medications by mouth, the visit was considered avoidable. Upon review of past resident visits from the LTC setting to the ED it was noted in several instances that the resident was examined, received no treatment procedures and returned to the LTC facility with written orders for monitoring interventions at the facility(ED log book 2015). This visit would meet the criteria for an avoidable visit.

This section of the paper presents a statement of the identified practice problem, address the purpose and significance of the evidence based project (EBP), and the specific measurable objectives to meet the goals of the project. The paper further

discusses the evidence-based relevance of the project to practice and the implications for social change in practice. The paper defines terms and provides clarification of the concepts. The paper also offers any assumptions and limitations associated with the project. Section 2 of the paper provides general and specific information from the literature along with conceptual models/ theoretical frameworks used in this project. Section 3 of the paper discusses the design and methodology of the project, methods of data collection and the analysis of the data. Section 3 also offers a plan for evaluating the project and a discussion of the population and sampling.

Problem Statement

Transfer of the LTC resident to the ED for avoidable visits is a costly practice that can be positively impacted. Visits of the elderly to the ED can be essential and lifesaving because of advanced technology and skills of the staff in the ED but some of these visits are for non-urgent health issues such as simple UTI, constipation, changes in mental status associated with medication side effects or response to therapy, and effects of aging. Some of the ED visits may actually be urgent but could easily have been managed in the LTC setting and then there are those visits that could have been avoided with timely management of precipitating factors (David, Gunnarsson, Saynisch, Chawla & Nigram, 2015).

A LTC resident who has had more than 5 days without a bowel movement, has had a gradual decrease in oral intake, and has refused oral medications that include stool softeners and fiber is taken to the ED with nausea, vomiting, and possible bowel obstruction. This ED transfer is perhaps unavoidable but could potentially have been

avoided at first notice of decreased intake followed by a thorough abdominal assessment. The findings of the assessment in combination with review of the situation and background might have prompted early intervention and even if the physician had to have been called the recommendations might have included encouragement of increased fluids, rectal suppositories and even digital exam for impaction. These are interventions easily and often routinely managed by the LTC nurse.

For the purpose of this project avoidable visits are classified as visits that are nonemergent, where immediate medical care is not required or emergent, where care is indicated but could have been provided safely and effectively in the LTC setting (David et al., 2015). According to David et al. these avoidable visits to the ED not only increase health system spending but also may lead to excessive or unnecessary treatment and testing in order to support a baseline assessment of the resident complaint. A study performed by Weinick, Burns, and Mehrotra (2010) calculated that between 13.7% and 27.1% of all ED encounters were for conditions that could have been addressed in healthcare settings other than the ED with an overall savings of approximately $4.4 billion each year.

Thorough assessment and relay of pertinent information of the LTC resident can decrease the need for unnecessary interventions and avoidable transfer to the ED. The assessment of the patient and the event complaint should be thoroughly evaluated and then effectively communicated to pertinent parties to prevent the resident from receiving avoidable interventions, interruption in continuity of care, or avoidable transfer to the ED for further evaluation and or even more invasive and avoidable interventions such as

venipuncture for intravenous medications and fluids, blood gases, and possibly placement of intrusive tubes.

Purpose Statement and Project Objectives

The purpose of this project was to develop a standardized assessment approach to be used by nurses in the long-term care setting during an acute event and then to evaluate its effectiveness for decreasing avoidable transfer of the elder LTC resident to the ED. It was anticipated that this intervention would decrease the number of avoidable transfers to the ED for further assessment and avoidable interventions by prompting the nurse to gather pertinent information during assessment of the event. Renz, Boltz, Wagner, Capezuti, and Lawrence (2013) performed a study using a repeated measures design where the SBAR tool was instituted as a clinical communication improvement tool. Renz et al. found that the tool served much more than to simply enhance communication but also served as a tool to enhance anticipation of critical information required from the assessment. This enhanced anticipation prompts the nurse to gather data and perform specific assessment details in accordance with the current complaint (Renz et al. 2013). The SBAR tool prompted the nurse to ascertain what the exact situation or concerns the nurse had about the patient. The assessment portion prompted the nurse to assess current medications, vital signs, intake and output, bowel sounds, weight, and pertinent labs. The recommendations portion of this tool empowers the nurse to actually formulate a recommendation of perceived best interventions based on assumptions made from the assessment data collected. The enhanced assessment skills garnered through the use of this standardized process is then used to further promote positive outcomes, specifically a

decrease in the number of nonemergent transfers to the ED through early recognition and early intervention and enhanced monitoring. The resident may simply need to have more frequent vital signs and more frequent monitoring. Another finding from such studies indicated increased satisfaction of providers with information received (Tjia, et al., 2009).

Another purpose of this project would have been to improve communication of assessment findings through an organized and orderly process which can subsequently improve the outcomes for the resident of LTC. This project implementation phase would have provided education and instruction for LTC nurses in the use of the SBAR tool. Taking advantage of teaching opportunities also strengthens and enhances the practice of other nurses and improves the outcomes for LTC residents. The improvement and standardization of the assessment process would have facilitated communication between disciplines, improved patient outcomes, and decreased the incidence of the elderly resident being transferred from long-term care to the ED. The project would also have provided education and instruction for long term care nurses in the use of the SBAR tool as a standardized prompt for gathering pertinent information during the assessment process. Materials for training and instruction sessions were to be provided by the project planner and implemented by the education director and the project planner.

The first objective of this project was demonstrated proficiency in the use of the SBAR tool by the nursing staff as evidenced by participation in training and instruction followed by accurately completing an SBAR form for each resident event. The SBAR tool would act as a prompt for the nurse in this LTC facility to make a thorough assessment of the patient. The tool would have then served as a communication tool to

ensure that all pertinent information would be conveyed to the physician with recommendations for care and treatment. If it was determined that a resident needed to be treated in the ED the tool would have then serve as communication between the nurse from the LTC facility and the ED nurse for continuity of care.

Though the program was not implemented the training and instruction in use of the tool was paramount to the success of the project. Arford (2005) warned that the SBAR alone cannot fix broken communication. The degree to which the tool improves the assessment process and communication is heavily dependent upon the consistency in use of tool. Coley (2015) stresses the importance of understanding that the relevance of information strongly affects the effectiveness of the communication process. The SBAR protocol, though unable to fix all communication issues, has the potential for being a tool to facilitate the gathering and exchange of quality information that can significantly influence patient outcomes (Klaasen, Lamont, & Krishnan, 2009; Coley, 2015). “The SBAR tool helps the user to anticipate information needed and encourages the assessment skills; and using the SBAR prompts staff to formulate information within the right detail” (Coley, 2015 p. 202).

The second objective of this project would have been to ensure that the that the SBAR protocol would be used in this LTC setting over a twelve-week period for each resident incident requiring assessment for an acute event or complaint. The form would have been used whether a call is made to the medical provider for directives or not. The SBAR protocol sheets would be used to complete the assessment. The nurse would have documented the specifics of the current complaint or event using the SBAR tool. The

SBAR tool would have also been used to document assessment and recommendations from the nurse as well as the outcome of the event. The nurse performing the assessment of a resident is often the person who makes the call to the physician with recommendations for transfer or treatment in the LTC facility.

The nurses were allowed the option of sending the resident to the ED without calling the physician to prevent delays in care. A specific instance occurred when a nurse assessed a resident who had a temperature greater than 101.5. The nurse decided the resident should be transferred to the hospital ED immediately. Using the SBAR protocol as a prompt during the assessment might have shown that the resident had a gradual increase in body temperature for several days, decreased urinary output and oral fluids. The background revealed a history of benign prostatic hyperplasia (BPH) with retention treated with terazosin and consistent B/P within the limits noted. The assessment when performed revealed an elevated temperature, normal pulse, low B/P, and a distended and tender lower abdomen. An alternate outcome to sending the resident to the hospital would have been a recommendation from the nurse for urinalysis with culture and sensitivity (C&S) if indicated and other labs, hold the terazosin, and encourage oral fluids and possibly administration of oral antibiotics. When presented with the findings in a concise format the physician might feel comfortable the nurses' recommendations for care.

The third and last objective would have been the notable reduction in the number of residents transferred to the ED for avoidable visits that do not result in treatment other than assessment and return to the LTC facility. Over the course of the DNP project a notable decline of at least 20% in the number of transfers for visits would have been

construed as a positive impact and would have offered evidence that this would have been an effective intervention to standardize the assessment process of the LTC resident and thereby reducing avoidable transfers of the resident to the ED.

At the time of the development of the project proposal the LTC setting had documented evidence that greater than 75% of the transfers from the LTC facility to the ED resulted in an evaluation and return to the LTC facility (personal communication, Lowery APRN, 2015). The residents were often ordered to have increased monitoring and simple treatments such as enemas, and monitoring of intake and output for a specified time period. The residents who were admitted were those who developed some advanced symptomology stemming from a chronic condition that worsened without intervention and then required in-hospital care (personal communication R. Grubbs, RN Education Coordinator, May 09, 2015).

Significance/Relevance to Practice

The frail elderly require a particular skill set to adequately meet the challenge of providing quality and compassionate care (Lamb et al., 2011). In the long-term care setting this care is primarily delivered by the LPN, who often calls for the RN to assess the resident during an acute episode or exacerbation of an issue (Lamb et al., 2011). Registered nurses are accountable for the assessment, planning, implementation, and evaluation of nursing care for the residents in the LTC setting and this presents a challenge for the often sole RN to facilitate this role (Lamb et al. 2011). It becomes even more important to perform the steps of assessment outlined in the SBAR protocol to become familiar with the specifics of the newly introduced situation for development of

nursing diagnoses and a strategic plan of care and for possible communication of key information to the physician for direction beyond the scope of the nurse.

According to Juthberg, et al., (2010) the LTC registered nurse may be called upon to assess a resident with whom they are unfamiliar and therefore must respond to the situation equipped solely with information provided from the report given by the LPN and the nursing assistants in order to make interventional decisions for the resident. Equipped with data from the certified nursing assistant (CNA) and the LPN, decisions may be made to treat and or transfer based on insufficient assessment data. This situation promotes the notion that improving the assessment abilities of the nurse will improve outcomes and prevent unnecessary interventions and transfers. Klaasen, Lamont, and Krishnan (2009) offered evidence that improved assessment and interventions have the effect of decreasing costly and often painful interventions for the elderly population. In their study, nurses were provided guideline training in areas such as bowel assessment/management and other issues pertinent to the elder LTC population (Klaasen et al. 2009). This training would have offered the nurses the information needed to adequately assess the residents, implement interventions, and to make autonomous decisions based upon assessment findings to transfer the resident to a higher level of care. Noticing changes in the health status of the long term care (LTC) resident is essential for appropriate nursing interventions to take place. It is therefore important that the assessment process be purposeful and goal directed. When the assessment follows a set and purposeful process the result would be improved practice and improved outcomes for patients (Watson & Rebair, 2014).

A cross-sectional prospective study conducted by Intrator, Zinn, & Mor, (2004), examined 663 facilities using the Minimum Data Set (MDS) to determine the impact that changes in skill sets had on the number of residents transferred to the ED for avoidable care. Avoidable care is defined in this study using the ambulatory care sensitive (ACS) diagnoses to determine which could have been avoided through the provision of care within the facility (Intrator et al. 2004). ACS diagnoses are complaints that can often be managed on an outpatient basis and generally do not result in hospitalization if managed properly. The list of ACS diagnoses may vary, however, these diagnoses often include angina pectoris; asthma; cellulitis; chronic obstructive pulmonary disease; congestive heart failure; dehydration; diabetes mellitus; gastroenteritis; epilepsy; hypertension; hypoglycemia; urinary tract infections; pneumonia; and ear, nose, and throat infections (Intrator, 2004). The study concluded that LTC facilities in which the staff received additional and ongoing training had fewer incidences of hospitalizations for residents (Intrator, 2004). The training for the staff included early recognition of emergent situations. The premise of the study by Intrator and colleagues (2004) was that the characteristics of a LTC facility such as regulatory restrictions and financial conditions may precipitate resident transfer to acute care settings for avoidable visits. Inadequate staffing and minimal funding to institute new protocols and processes were additionally cited as contributing factors (Intrator et al., 2004) The occurrence of the avoidable visits can be positively impacted by the institution of clinical protocols to prevent or treat episodic events before hospitalization is required (Intrator, Zinn, & Mor, 2004).

When adequate information is not gathered during the assessment phase of an acute event, the ability to determine the true urgency of the situation can be impeded. Often the end result is an unnecessary intervention, omission of adequate follow-up monitoring, or the patient is transferred to the ED for a more thorough evaluation (Bernstam et al., 2007). David et al. (2015) and Ouslander et al. (2011) have identified avoidable tests and visits of the elderly to the ED as an issue of concern for the wellbeing of the elderly patient as ED providers do not often have adequate time to dedicate to complex patients and for the associated costs organizations incurred in providing care for this patient population. These patients often require baseline testing to adequately assess the complaint and potentially provide treatment.

The SBAR tool has the potential for being an aid in schematic development which enhances the nurse's ability to make rapid decisions in determining and providing patient care interventions. Usage of the SBAR tool has also shown positive potential for the social advancement of the nurse through the developmental stages from novice to expert nurse (Narayan, 2013). The SBAR protocol also contributes to the standardization in nursing practice (Vardaman et al., 2012). The SBAR protocol provides a framework for sharing pertinent clinical information across professional disciplines in a manner that can significantly decrease incidents, adverse events, and enhance patient outcome potential (Joffe, et al., 2013; Narayan, 2013).

Project questions

The following questions were considered during the development of this project:

1. Can the nursing assessment in the LTC setting be standardized using the SBAR protocol?
2. Can avoidable transfer of the LTC resident during acute events be decreased using the SBAR to standardize the nursing assessment?
3. Can the use of the SBAR protocol improve patient outcomes through standardization of the assessment process improve patient outcomes through enhanced continuity of care?

Evidence-Based Significance of the Project

An elder resident sent to the ED from the nursing home presents a significant issue in the ED. There is often a limited amount of information that accompanies the resident to the ED which results in longer ED stays and higher rates of diagnostic testing (Samaras, Chevalley, Samaras, & Gold, 2010). This delayed discharge can cause congestion in the ED and loss of revenues from repetitive testing to properly evaluate the elderly resident unknown to the provider.

Acute events that occur in the LTC setting often result in an initial autonomous nursing assessment of the resident by the LPN and then a conferral with the RN who may perform an in-depth assessment of the resident and issue. These incidents present a unique clinical scenario in which the nurse has the dilemma of making a decision to call the physician on call or transfer the patient to the ED. The phone communication often takes place in a setting where human resources are scarce and fatigue is common (Bernstam et al., 2007). The call is often placed to convey concern over the status of a patient or to report results. It is most often an assumed acute situation and the patient

outcome is dependent upon the effectiveness of the assessment findings and how they are communicated (Bernstam et al. 2007). If the information is inadequate this greatly impedes the ability of the physician to determine the true urgency of the situation and often the end result is that the resident ends up in the ED for a more thorough evaluation (Bernstam et al. 2007).

Research has identified nonemergent visits of the elderly to the ED as an issue of concern for the wellbeing of the elderly patient, for the ED providers who often may not have adequate time to dedicate to this complex patient, and for the associated costs organizations incurred in providing care for this patient population in the ED (Ouslander, et al., 2011). The report to the physician from the nurse is often a translation or recital of the orders received from the physician covering the LTC facility. According to Nelson, Washton, and Jeanmonod (2013), this communication is vital to the care of the patient and yet is often insufficient. The loss or omission of valuable information becomes the catalyst by which the patient is transferred to the emergency department (Nelson et al. 2013). The care provided in the ED is often fragmented and tedious for the patient and the provider (Nelson et al., 2013). More importantly is that the transfer for care is often avoidable; the care could have been performed in the LTC setting or the resident received only an assessment with facility treatment and monitoring recommendations upon return to the LTC facility. The SBAR protocol has the potential of decreasing the incidence of patient transfer to the ED through the increase in the significance of information garnered from the assessment and the transference of the information from nurse to provider (Vardaman et al., 2012).

The SBAR protocol has proven effective as a common language between clinicians and a tool to improve communication. Vardaman et al. (2012) argues that it can be used as much more than a common language tool. SBAR has the potential for being an aid in schema development that enhances the nurse's ability to systematically assess a situation and make rapid decisions and promotes standardization in nursing practice (Vardaman et al., 2012).

According to Arford (2005) the use of SBAR alone cannot fix broken communication. SBAR provides a framework for collecting and sharing pertinent clinical information across professional disciplines in a manner that can significantly decrease spiraling of incidents, adverse events, and enhances patient outcome potential (Joffe, et al., 2013; Narayan, 2013). Substantial negative outcomes and even threats to longevity and quality of life can be the results of ineffective communication of assessment findings (Joffe et al. 2013). Hospitals and other healthcare providers have subsequently been placed in an obligatory position for pursuing and implementing techniques designed toward assuring effective communication skills (Eggertson, 2012; Robinson, Gorman, Slimmer, and Yudkowsky, 2010). The pursuit of improving communication is in the best interest of the patient.

Implications for Social Change in Practice

The need for change in this environment is relative to the population served in the LTC setting. The elderly population is considered vulnerable in healthcare. Zimmer and Martin (2007) reported that the aging population is rapidly becoming the largest segment of the population in developed countries. The complexity of healthcare demanded by this

population places a drastic demand upon available financial and human resources (Zimmer & Martin, 2007). Organizations are compelled to develop and implement programs to effectively meet the needs of this population while monitoring budgetary constraints and considerations for the entire organization (Zimmer & Martin, 2007). The activities involved in implementation assist change agents to become more skillful and consistent in use of innovations to effectively manage change. Though the long term health care system was driven by the financial and patient safety needs, consideration of the need for effective management of changes was pronounced. Effective change implementation requires consistently high evidence to support change (Stonehouse, 2012). Although the project was not implemented the organization was positioned and eagerly willing to embark upon the initiative. The financial burdens of the facility became so massive that they consumed all energies of key players. My preceptor and many others eventually left the facility to find more stable income.

According to Zimmer and Martin (2007), the growth of the aging population, whether it be from compression of the mortality rate through advances in medicine or the increased number of births during an era, will bring about the implications of increased morbidity and increasing disability. This phenomenon can cause devastating socioeconomic issues, not to mention the burden placed on the already strained healthcare system to provide the complexity of care with limited resources (Zimmer & Martin, 2007). In the nursing home setting of the evidence based project there is a tendency for the LPN to defer assessment in acute issues for the resident to the RN and the RN oftentimes will defer the assessment to the APN in the ED or to the physician

rather than assess the situation autonomously within the limits and scope of practice for the ward LPN or RN (personal communication May 29, 2015, R. Grubbs, RN). Klaasen, Lamont, and Krishnan (2009) offered reference to similar findings in the long term care setting and attribute this to lack of empowerment and ownership of the situation.

A resident who is reportedly lethargic can and should receive a thorough assessment by either the LPN or the RN as this lies within their scope of accepted practice. If the assessment is not thorough and completely documented and relayed to the attending physician or APN, the patient may be transferred to the ED for avoidable or nonemergent care. Taking advantage of the opportunity to present the nurses in the LTC setting with a standardized tool that that not only enhances communication of the event but also facilitates and prompts the nurse to gather information in an organized manner is a teaching opportunity that would have strengthened and enhanced the practice of these nurses and improved the outcomes for LTC residents.

Definitions of Terms

Defining the concepts of this discussion will serve to ensure the objectives are clearly understood and applicable in connection.

Avoidable ED: Visits that were nonemergent where immediate medical care was not required or care was indicated but could have been provided safely and effectively in the LTC setting (David et al., 2015).

Avoidable interventions: Interventions provided in the ED that would not have been provided had the resident not been transferred to the ED, (David et al., 2015).

Communication: is defined as the essence of human interaction and learning. The very nature of communication is dependent upon interaction between two or more individuals (a sender and a receiver) and understanding is constructed through that interaction (Schaefer & Ruxton, 2012). The information can be exchanged verbally or nonverbally.

Effective communication: When the receiver gets the exact message that the sender intended (Schaefer & Ruxton, 2012).

Medical errors: The failure of a planned action to be completed as intended (an error of execution), or the use of a wrong plan to achieve an aim (an error of planning), an unintended act (either of omission or commission), or one that does not achieve its intended outcome. Deviations from the process of care, which may or may not cause harm to the patient (Grober & Bohnen, 2005).

Nursing Assessment: "an identification by a nurse of the needs, preferences, and abilities of a patient. Assessment includes an interview with and observation of a patient by the nurse and considers the symptoms and signs of the condition, the patient's verbal and nonverbal communication, the patient's medical and social history, and any other information available. Among the physical aspects assessed are vital signs, skin color and condition, motor and sensory nerve function, nutrition, rest, sleep, activity, elimination, and consciousness. Among the social and emotional factors included in assessment are religion, occupation, attitude toward hospital and health care, mood, emotional tone, and family ties and responsibilities. Assessment is extremely important because it provides

the scientific basis for a complete nursing care plan" (Mosby's dictionary of medicine, nursing & health professions, 2009).

Protocol: The collective set of rules and formalities that govern procedures and processes (The Concise Oxford Dictionary, 1991)

Situation, Background, Assessment, and Recommendation (SBAR): The SBAR is a format for improving communication of pertinent information from one person to another. It is used as a form of communication between nurse and other professional disciplines to improve communication, (Dunsford, 2009)

Standardization: An attempt to create uniformity in processes to reduce the potential for error by commission or omission of act, (Mosby's dictionary of medicine, nursing & health professions, 2009)

Assumptions and Limitations

The SBAR protocol is a form of communication between nurse and other professional disciplines; it is used to improve communication and has become widely used as a tool to improve communication (Narayan, 2013). SBAR has been concluded to be effective in improving patient outcomes (Narayan, 2013). Consistent use of the SBAR has also been shown to improve clinician satisfaction through clearly defined expectations from both the nurse and the physician (Narayan, 2013). The SBAR communication tool can in some cases assist with decreasing avoidable hospitalizations and thereby help to decrease the overall spending of healthcare dollars (Narayan, 2013). The SBAR communication tool has also shown to improve communication by creating a

common language between nurses and physicians and may aid in the development of the mental acumen needed for critical thinking and rapid action (Narayan, 2013).

Standardizing the assessment process and using the SBAR protocol to guide the collection of the patient assessment during an acute complaint can have the effect of enhanced development of the mental processing that occurs with critical thinking and increased positive patient outcomes (Narayan, 2013). This developing of a mental plan of action assists the nurse in making the assessment and intervening rapidly. Rapid intervention can prevent worsening of the issue and can assist in developing a plan of care that eliminates unnecessary and potentially hazardous interventions. One such intervention includes the frequent transfer of the elderly to the ED (Dunsford, 2009; Vardaman et al., 2012).

The SBAR protocol would have provided an outline for performing the patient assessment during an acute complaint or event in the LTC setting. The protocol would be presented in a concrete, concise format that would have been easy to remember and to implement during the assessment process when there is so much critical information to be assessed and noted. The SBAR protocol would have allowed the nurse to proficiently gather data in a concise and standardized format and then present the information in a usable format for ease of review (Heinrichs, Bauman, & Dev, 2012). Using the SBAR protocol would have provided a guideline for the nurse performing the assessment during the acute phase of a complaint and then the same guideline would have served as a tool of empowerment where the nurse can systematically impart the information to the physician in a general format. This format would include recommendations from the nurse. The

physician would have expected the nurse to offer recommendations supported by findings from the assessment.

Watson and Rebair (2014), concerned with the issues of noticing, offered further support that the SBAR can prompt the long term care nurse to notice certain factors in the evaluation of acute process that might be otherwise overlooked. Watson and Rebair (2014) related the process to use of the GPS by a driver who would rarely notice the roads; they stated there is no need to notice the roads as the GPS will lead one to the destination (p. 515). The SBAR would have served as a marker suggesting that which has most significance for particular incidences. Watson and Rebair, (2014) state that marking will not only make the nurse notice but will more specifically make mention of things noticed. It is only through noticing and reporting changes in the healthcare status of the elderly that appropriate care can be given.

Limitations to the SBAR protocol exist. It is important to be conscientious of the fact that the use of SBAR would not have made every nurse proficient in patient assessment or effectively remedy communication issues. The SBAR would simply have provided a framework for collecting, analyzing, and sharing pertinent clinical information (Joffe et al., 2013). The consistent use of the SBAR protocol can significantly decrease the spiraling of incidents, aid in the avoidance of adverse events, and enhance patient outcomes; it must be noted this improvement can only be attained through consistent use and evaluation of the protocol use (Joffe et al., 2013; Narayan, 2013).

Summary

The role of the nurse has evolved to one of active participant in ensuring the safety and efficacy of service delivery, (Haig et al., 2006). The nurse has the primary responsibility for assessing patient complaints and then providing some intervention to relieve the complaint or notifying the physician for further evaluation (Klaasen et al., 2009; Lamb et al., 2011). The role of the nurse is vastly important for the collection of data surrounding the issue. The nurse would have used the SBAR protocol to paint a picture of the situation and arrive at the conclusion that no further intervention was required. Implementation and consistent use of the SBAR protocol in the long-term care setting has definite potential for decreasing the incidence of avoidable interventions and visits to the ED for the elderly patient. The SBAR has also been shown to be effective as a pneumonic that may prompt the nurse to look closer, notice more and seek information that may lead to decreased visits to the hospital ED.

Section 2: Review of Literature and Theoretical Framework

General Literature

The purpose of this project would have been to have nurses in the long term care setting adopt a standardized approach for assessment of the long term resident during an acute phase and to improve the assessment process with an increase in positive patient outcomes. This intervention could have potentially decreased the number of avoidable transfers to the ED for interventions in nonemergent situations. The SBAR tool would have provided a standardized process for information gathering and presentation.

The SBAR protocol has effectively been used to improve patient outcomes; an EBP study reported by Beckett and Kipnis (2009) states that developing supportive communication can positively facilitate team work and improves quality patient care. The SBAR, when used in collaborative communication, serves to facilitate sharing of knowledge and implementation of skills into practice with an increase in positive outcomes (Beckett & Kipnis, 2009). The SBAR protocol has also been shown to significantly reduce hospital admission and readmissions thus affecting the cost of healthcare (Vardaman et al., 2011). The SBAR protocol has been accepted and used as a tool to facilitate effective communication between people who interact with various degrees of frequency but who might not necessarily communicate in the same manner (Narayan, 2013; Vardaman et al. 2011). The SBAR can further be used as a tool to assimilate the patient assessment process and gather pertinent information needed for decision making (Narayan, 2013). Ineffective communication has been cited as a primary

cause of medical errors in healthcare. These errors cost the American people in productivity, finances, life, and actual limb (Haig et al., 2006). Annually, medical errors are estimated to cause approximately 100,000 deaths and cost approximately $20 billion (Haig et al., 2006). Ineffective communication can cause additional strains on organizational finances associated with increases in length of stay and patient dissatisfaction. Both of these issues can lead to decreases in revenues (Vardaman et al., 2012).

Renz and colleagues (2013) implemented a quality improvement project in a one site facility with all nurses participating. Using a repeated measures study design Renz and colleagues (2013) provided supporting evidence that the SBAR protocol provided nurses with a sense of order and cohesiveness in gathering data associated with a particular issue of complaint. The SBAR was further determined to be useful as a tool for prompting the nurse on what information to gather and then provided a format for relating the information to the provider for further direction and guidance in caring for the resident (Renz et al., 2013). Other important findings from the project were that the nurses in the project reported increased feelings of competency and also physician satisfaction (Renz et al., 2013).

The nursing assessment and interview, when performed with some degree of standardization and then communicated to the attending physician or APN effectively, can significantly decrease the number of avoidable LTC resident transfers to the ED and improve patient outcomes. According to Diachun, Charise, and Lingard (2012), the elderly population is rapidly growing and the expertise required to meet their healthcare

needs have not yet been made evident. The growth of this population places a burden on healthcare organizations to implement practices that are specifically geared towards preventing errors and improving outcomes for this patient population (Diachun et al., 2012). Diachun and colleagues (2012) offered the opinion that healthcare administrators must rise to the occasion and ensure that healthcare practitioners and services available be adjusted to suit the needs of the elderly population. Renz and colleagues (2013) stress that the nurse in the LTC setting has a large impact on resident outcomes not just during after-hours but 24 hours per day. The findings offer supporting evidence for other literature findings that suggest that the quality of the nursing assessment is an important aspect of the process that determines what the disposition for the resident will be. The manner in which the data is gathered and then presented to the physician has vast influence in the decision of and disposition of the resident. This section of the paper discusses the specific and general literature pertaining to this project. Conceptual models and theoretical frameworks used to address this topic are discussed in this section as well.

Specific Literature

Gruneir et al., (2010) performed a cohort study with data from all LTC facilities in Ontario, Canada. They evaluated all LTC residents who visited the ED over a 6 month period and identified potentially preventable visits (those for any ambulatory care sensitive conditions that resulted from an exacerbated issue) and low acuity or preventable visits (those triaged in the ED and determined as non-urgent and then returned to the LTC facility) using the National Ambulatory Care Reporting System (Gruneir et al., 2010). Gruneir and colleagues (2010) concluded that one fourth of all

LTC residents in Ontario made at least one visit to the ED. Of these visits to the ED the number of low acuity and potentially preventable visits indicated that there are opportunities to prevent ED transfers of the LTC resident (Gruneir, 2010). They suggest that early recognition of status changes and management of symptoms may be beneficial in decreasing the incidence of LTC resident transfers to the ED (Gruneir et al., 2010.

LTC residents are hospitalized or transferred from the LTC facility to the ED each year. Ouslander et al. (2011) performed a quality improvement project and attempted to enroll 30 LTC facilities in three different states. In this study by Ouslander et al., all levels of staff were involved. Findings supported the assumption that approximately 50% or more of the admissions and transfers to the ED from the LTC settings were potentially avoidable. Ouslander and colleagues (2011) found during this quality improvement project that implementing the InterActII SBAR protocol was successful in decreasing avoidable hospital transfers of the LTC resident. Ouslander and colleagues (2011) did not offer a clear definition of the avoidable visits; however they did offer that the administration will review each transfer to determine the appropriateness of the transfer. Many of these transfers included diagnosis and treatment of clinical conditions that could have been adequately managed in the long-term facility. Examples may be patients who have history of congestive heart failure, early urinary tract infection, or patients with chronic constipation. These conditions may manifest early signs and symptoms that with early identification and appropriate interventions can be clinically managed while remaining in a nonemergent environment such as the LTC setting.

Ashcraft and Champion (2012) performed a retrospective chart review in a 120 bed LTC facility. The goal of their study was to identify and describe the common diagnoses and symptomology that precipitated transfer to the ED from the LTC setting. What they found was the most common reasons for transfer included alterations in mental status, fatigue, weakness, and shortness of breath (Ashcraft & Owen, 2014). They concluded that strategic planning with attention to noticing changes in resident status and communication of findings had excellent potential for decreasing the incidence of preventable ED transfers (Ashcraft & Owen, 2014). The use of the SBAR protocol has the potential for providing a standardized method of collecting and disseminating the information obtained from the assessment of the LTC resident during issues of acute complaint or episodic status changes (Ashcraft & Owen, 2014).

Ashcraft and Owen (2014) used a descriptive survey design to identify the signs and symptoms common to ED transfer of LTC residents and to identify strategies used to prevent ED transfer. In this study they included 100 LTC facilities to participate in the survey. Ashcraft and Owen (2014) identified nurses as a key decision maker in the LTC setting. The nurse typically makes the decision of whether a resident will be transferred. These decisions were made based on recognizing the importance of changes in the resident's status and how they can potentially impact quality of life. Ashcraft and Owen (2014) concluded that strategies to prevent avoidable transfers should include education focused on early recognition and communication. The SBAR protocol would standardize the process and provide prompts in the assessment process and would provide a reporting format that improves communication.

In a mixed methods analysis involving 26 LTC facilities Lamb et al.,(2011) noted that staff deemed transfers unavoidable for reasons beyond their control such as family insistence, acute changes in resident status, or a physician's order. The nurses felt the transfer was out of their control and reported feeling powerless to change the outcome. It was estimated that 40-67% of all transfers are avoidable. In this particular study the staff rated greater than 75% of the transfers made by facilities involved in the study as unavoidable (Lamb et al., 2011). There was ambiguity in many cases; however in some instances, the nurses rated the transfer as avoidable while in others they rated a similar change in patient status as unavoidable. Lamb et al (2011) reported that

> "the most common reasons for transfers that were rated avoidable or possibly avoidable were in the categories of missed opportunities for preventing the transfer before or after the onset of symptoms (31.9%); resident or family insistence on transfer (13.9%); communication gaps between nursing staff, families, Primary Care Providers, specialists, and outside facilities (13.0%); advance directives and end-of-life care not in place or not followed (11.1%); and gaps in staff knowledge or skill (9.7%) (p.1668).

Although some issues beyond the control of the nurses constituted the greater incidence of avoidable transfers; the study by Lamb et al., (2011) provided supporting evidence of the need for a standardized process to decrease avoidable transfers to the ED.

Watson and Rebair (2014) reported on the importance and use of noticing skills in patient care to improve outcomes and to prevent further deterioration of resident status. Watson and Rebair (2014) offer further discussion concerning the responsibility and

accountability of the nurse in the act of noticing as an essential skill for nursing interventions to take place in a manner consistent with the current status of the patient. Watson and Rebair (2014) stated that noticing must be an activity that is purposeful and specifically directed in the effort to improved practice and patient outcomes. They also pointed out the negative outcomes that might be incurred by the resident and consequently the LTC facility when there is a lack of quality noticing in resident assessment (Watson & Rebair, 2014). Surveillance is one of the major areas of missed care accompanied by others such as ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, and intake and output documentation (Kalisch, Landstrum, &Williams, 2009). Nurses have the responsibility for making opportunities to notice their patients and to take any opportunity of support to prevent missing care that could potentially impact outcomes for the patient. When completing the SBAR the nurse will be prompted to address these areas in the situation, background, and assessment. Watson and Rebair (2014) acknowledged the need to notice the slightest change in patient behavior and to evaluate the incident to ascertain the basis of the situation. This can effectively be done using the SBAR protocol as a prompting tool that might cue the nurse to notice things that might have otherwise gone unnoticed.

The SBAR protocol would have had the advantage of prompting the nurse to look for information or investigate each situation according to a standardized process. The SBAR tool would have compelled the nurse to assess the patient against a set and predetermined criteria, and would require the nurse to think and look beyond the situation. For example, a resident who is reportedly having alterations in the level of

consciousness is transported to the ED. An evaluation of the medication administration record (MAR) reveals the resident was administered a sedative hypnotic erroneously and thus induced sleep at a time when sleep was unexpected. The transfer then of this resident to the ED with a complaint of alteration in mental status, while true, would be considered an unnecessary transfer. The cause of the alteration in mental status would have been identified if the assessment had included a thorough situational, background, review along with the physical assessment. Using the SBAR protocol the nurse would be compelled to compare the level of consciousness in the resident before the incident. The nurse would question whether the patient has taken medication, and is it time for the resident to rest. The situation would be reviewed looking at all of this information. The background would include the normal hours of rest for this resident and possible medication side effect. It would also include any issues that might make this a normal or abnormal finding at this time for this resident. The assessment of the patient would be the ability to rouse the patient, to what level of responsiveness is he able to be aroused, and does he have any complaints. The assessment phase would include vital signs, a specific assessment for etiology of the change in consciousness. Using the SBAR for this example would have revealed from review of the medication record that the patient was given a medication for sleep an hour before and he also takes as a routine medication Benadryl at bedtime; the change in awareness might not then be alarming but expected. The nurse might have concluded from the assessment of the situation background, and specific assessment that the patient intervention required is putting the patient to bed and frequent monitoring through the night.

Cary and Lyder (2011) determined that when nurses collect the situation and background information it prompts the nurse to be more specific in the focus of the physical assessment. Paying specific attention or noticing assessment findings that better explain what is happening with the patient. This attention to all aspects of the event Situation, Background, and Assessment can assist the nurse to identify the true issue at hand. This finely tuned focus may have served to ensure that the appropriate interventions are implemented, increase positive patient outcomes, and prevent avoidable transfers to the ED.

Vardaman et al., (2012) performed a study to examine the additional outcomes that may be derived from the implementation of the SBAR protocol. Vardaman et al., (2012) concluded that the SBAR was effective in structuring communication between health care professionals and reducing communication errors and that the SBAR protocol was effective in the promotion of critical thinking. They concluded that use of the SBAR protocol, in addition to decreasing errors of omission in the assessment and reporting process, and increasing the effectiveness of communication, emerged as a contributor to the development of long-term social capital for nurses (Vardaman et al., 2012). Social capital is the combination of the actual and/or potential resources within an organization which are linked to ownership of a system of institutionalized relationships with mutual associations. Social capital provides a sense of self-efficacy as a product of the quality and nature of connections employees develop while interacting with each other (Tsai & Ghoshal (1998). The SBAR dictates that the nurse collect from the resident's chart a medication list, recent lab reports and code status before engaging in communication to

relay the resident status. Vardaman et al., (2012) found that the SBAR protocol encouraged the nurse to anticipate essential information needed and this encouraged a more thorough investigation for each of the four components of the SBAR protocol.

Joffe, et al., (2013) in a randomized trial using a simulated on call setting had nurses make calls to physicians with and without using the SBAR protocol. The study indicated that after-hours telephone communications were a common component of consideration in the management of long term care resident and represented a significant component in decision to transfer LTC residents to the ED (Joffe et al., 2013). Joffe and colleagues (2013) evaluated the communication of key information during after-hours phone calls and deduced that the SBAR did prompt the nurse in some cases to include specific information. Joffe et al., (2013) emphasized that the use of the SBAR form alone will did not make a significant impact. The nurse must be able to communicate essential findings to the provider. The SBAR protocol provides a standardized format for this communication (Joffe et al., 2013).

Ouslander et al. (2011) suggest that a substantial proportion of hospitalizations of LTC residents may be preventable and they estimate that of all residents in the LTC setting more than 50% of those hospitalizations are non-emergent. They do insist that not all of the avoidable transfers to the ED and hospital admissions can be blamed upon the nursing assessment. A complex blend of medical, family, systemic, and policy factors play into the rationale for the transfer (Ouslander et al., 2011). It is arguable that improvements in the nursing assessment and communication of findings can significantly reduce the incidence of avoidable hospitalizations for the LTC resident (Ouslander et al.

2011). Use of a standardized tool can create a culture of awareness in providing a thorough assessment and then effectively sharing these findings. The increase in awareness can decrease the incidence of avoidable interventions that are performed in the ED in an attempt to identify the issues associated with each resident presentation (Watson & Refair, 2014 & Vardaman, et al., 2012).

Summary

The SBAR protocol structures communication around four components Situation, Background, Assessment, and Recommendations. In the first component the sender acknowledges their name and the current resident status or what concerns them about the resident. The background provides information about the resident's admitting diagnosis and pertinent history to this event, any treatments or interventions successful or not and any noted changes. The assessment component includes the patient's vital signs and a comparison to past vital signs, any current ongoing medical devices such as oxygen, and pain and the level. Lastly a recommendation from the nurse as to what she thinks should happen is given.

The SBAR holds potential for decreasing ED visits by creating a standardized format for documenting and reporting changes in resident status and conditions. The SBAR protocol also serves as a mental mantra for developing and conditioning the nurse to predict what information and assessment data will be required by the physician or clinician to make a decision regarding disposition of the resident for care. The prescriber is often an on-call physician who does not know the resident and is aided in the decision

of whether to transfer the resident or not by the information collected and communicate by the nurse.

Section 3: Methodology

Design and Methodology

The purpose of this project was to develop and implement the use of a standardized approach for the assessment of the long-term resident during an acute phase to improve patient outcomes. The project was not implemented due to continued financial issues that caused a massive shift in available staff to care for the residents and patients in the ED. The organization was no longer interested in projects. They were simply struggling to meet financial obligations. My preceptor was one of the key stakeholders in this project. When the facility was unable to meet financial obligations to their employees for two consecutive time periods many of the employees were forced by financial obligations of their own to find employment elsewhere. My preceptor was included in this number. Though the project was not implemented, this intervention would potentially have decreased the number of transfers to the ED. The enhanced assessment skills would have been used to further promote positive outcomes. Positive health outcomes would have been achieved through shared information for follow-up care or recommendations for transfer to a higher level of care. The use of the SBAR protocol would also serve to ensure that the residents whose conditions required more in-depth assessment and intervention would receive transfer to prevent further delay in treatment.

The nursing assessment and interview when performed with some degree of standardization and then communicated effectively could decrease the number of

avoidable transfers to the ED. Improved outcomes associated with the use of the SABR protocol might be attained by ensuring that the resident whose condition requires further investigation would not be overlooked due to poor quality of information and transference of the information to the provider.

There are commonly encountered complaints assessed in the elderly. These complaints may not be vocalized but may be noted upon manifestation of some sign or symptom noted by the staff and assessed by the nurse. Some of these complaints include abdominal pain, agitation, confusion, or altered mental status, high blood pressure, low blood pressure, chest pain, constipation, diarrhea, dizziness or unsteadiness, dyspnea or shortness of breath, fall, and elevated temperature. These complaints are well within the scope of the nursing assessment, planning and implementing of care. However, this may necessitate a call to the physician (Tjia, et al., 2009; MERCK Manual, 2014). This call should follow a thorough assessment of the current situation, including the background of the resident, the current problem, medications, and diagnostic tests. The assessment should also include findings from the nurse, and recommendations of what the nurse suggests should be done next or at the least the nurse must have formulated some expectation from the physician. The SBAR protocol would have provided a structured means for prompting the collection of pertinent data to assess the situation and then communicated to other disciplines. This section of the paper discusses the design and methodology of the project. This section also includes the methods of data collection and the analysis of data. This section also includes a plan for evaluating the project and a discussion of the population and sampling.

Project Design and/or Methods

This evidence-based quality improvement project was not implemented but would have been carried out in a single-site LTC setting. The project would have been carried out over a 3 month period/12 week period. The organization was engaged with the SBAR project and made a commitment to implementing this throughout the organization in an attempt to institute a quality improvement initiative geared towards decreasing spending. The project would have been implemented in a 160-bed skilled long term care facility which is a part of a multicare primary setting. This care setting included a physician's practice, LTC facility, and local small-town hospital. The physicians in the primary care office provide coverage for all three settings.

The facility chosen for this project was staffed for three shifts, days, evenings, and nights for the LPNs. The RN's work 12 hour shifts with the exception of the DON, Education Director, and the wound care nurse, who all work 5 days per week. There are 12 LPNs on the full time day shift, six on the evening shift and four on the night shift. The facility also had five LPN's who work as needed. The RN staff consisted of three fulltime day shift (admin nurses) and 2 on both the early and late shift (7a-7p and 7p-7a) respectively. Day shift RN's and all staff nurses, RNs and LPNs would have been eligible and would have been required by the facility to participate in the project. A quantitative design with pre and post measurements would have been utilized for this project proposal development.

Focusing on the question for this EBP project: Will the use of the SBAR protocol decrease the incidence of avoidable transfer of the elderly LTC resident to the ED? A

logic model approach was used to frame this project. The logic model allowed a conceptual plan to clearly visualize the expected outcomes from the proposed intervention. The logic model also provided a systematic process to illustrate how the key elements of program planning, development, implementation, and evaluation are connected and how they demonstrate factors relevance to produce good outcomes (Page, Parker, & Renger, 2009).

The logic approach used was the Antecedent, Target, Management (ATM) approach. The Antecedent Target Measurement (ATM) logic model assisted me in identifying antecedent conditions on the problem's underlying rationale and to determine why the problem existed. The ATM identifies antecedent conditions to be targeted by program activities and determines what outcomes are reasonable to include in the evaluation of the program considering timeline restraints (Kroeger, Borders, & Webster, 2013).

The impact of the SBAR on the learning for the nurses would have been measured by the evaluation of SBAR completion by the Education Coordinator. Retraining of nursing personnel would have occurred as indicated by incomplete forms, inaccurate data noted, and verbalized need from the nurses. Training for the nurses had been determined as paramount to the success of the project. Consistency of uses and accuracy would have been the goals for meeting the training objective.

The organization had committed to common use of the SBAR tool for documentation of all acute issues and changes in health status of the LTC resident. The completed forms were to be included in the daily reporting and reviewed by the

Education Coordinator for completion and disposition of the resident. The incidents which did not have a completed form documenting the specifics of the current complaint or issue would have required reeducation and training. The return information from the ED would be included in the review to determine if the transfer was avoidable or one necessary for the safety of the resident. The nurse would at the review have been allowed to discuss alternatives to transfer when it was determined the transfer was avoidable.

The Education Coordinator would be responsible for collating the data for review and analysis for decline in number of transfers. It was determined at the outset that over a 3 month period more than 20% of the LTC facility residents were seen in the ED. We would have expected at least a 20% decrease over the first three month period and a continual decline as the comfort level and use proficiency increased.

Step I: Identify the Antecedent

This is a three-step process that first addresses antecedent conditions. While working in the ED and the physician clinic with my preceptor I was able to appreciate firsthand how frustrating the transfers from the LTC facility were for all involved. The residents showed up in the ED with little or no information to highlight the current issue. Often the presenting issue was totally different from the issue discussed over the phone. This immediate contact with the ED staff and the discussions with the physicians allowed me to quickly identify the antecedent as the assessment before transfer and then communication of findings.

Addressing the antecedent assisted me in developing a visual map of the transfer of the elderly to the ED and the relationship of this problem to the assessment process

and communication of resident needs. Other associated issues that lead to nonemergent transfer of the elderly LTC resident to the ED were identified using this process as well. In the first step of the ATM approach the targeted antecedent was identified as the lack of a standardized assessment process and the absence of a standardized communication tool for sharing assessment findings.

Step II: Targeting the Antecedent

Having identified the antecedents, the next step involved the development of strategies targeted towards improving the process. A strategy for targeting the antecedent was then developed. The SBAR protocol was identified as a tool to approach the standardization for patient assessment and effectively communicating findings. The SBAR protocol would have addressed the antecedent. The organization was currently seeking a strategy to standardize the assessment process and it was agreed upon that the use of the SBAR INTERACT tool (Appendix1) would be appropriate for this process. A protocol for using the SBAR protocol was developed by the DON, physicians, and the Education Coordinator. Using the ATM logics program design ensured that the energies consumed by the project actually addressed the identified issue of avoidable transfers to the ED. This program design allowed the project to focus on standardizing the assessment process in an attempt to decrease the transfer of the elderly LTC resident to the ED. The final step in the ATM logic model is the measurement.

Step III: Measurement

The final step in this design would have been determining whether change had occurred. This change would have been indicated by a decrease in the number of

residents transferred to the ED for nonemergent care (Page, Parker, & Renger, 2009). The measurement of the outcome was to have been a straight forward comparison of the ED transfers 3 months before and 3 months after the intervention. A decrease of 20% of transfers would have provided support that this intervention had shown positive outcomes. The measurement phase and assuring the sustaining of the intervention would be beyond the scope of my project.

Population and Sampling

The population for the project would have been the RNs and LPNs who work in the LTC facility. This facility has the capacity for 160 residents. All of the nurses would have participated in the project. The facility was staffed for three shifts, days, evenings, and nights for the LPNs. The RN's who work the floor as leaders work 12 hour shifts with the exception of the DON, Education Director, and the wound care nurse, who all worked 5 days per week. There are 12 full time day shift nurses who are LPN's, six LPN's on the evening shift, and four LPN's on the night shift. The facility also had five PRN nurses who are LPN's.

The LPN primarily provides care with supervision by the RN. The Education Coordinator and the Lead Nurse who are both Registered Nurses also staffed the day shift. The staff had a variety of nursing longevity and years of experience. The Education Coordinator had 15 years of nursing experience. LPNs assume the lead roles on each ward during the evening and night shifts with an RN who assumes the role of house supervisor or in-house supervisor. There was collectively greater than 150 years of long-term nursing experience amongst the entire nursing staff. The nurses on the night shift

had the longest tenure within the facility. The nurse with the shortest tenure on the night shift was an LPN who had been there for less than 5 years. The majority of the day shift nurses had been with the facility for a diverse number of years ranging from less than 1–10 years.

The educational experiences were uniquely similar. The staff RNs all held an Associate's degree in nursing. The Director and the Education Coordinator are the only two nurses who possessed degrees past the Bachelors level. There were two other nurses with education preparedness to the level of Bachelor of Science in Nursing (BSN). The LPNs are all graduates from certificate programs of study.

Data Collection

The SBAR communication tool provides the nurses with a systematic approach for the assessment, recording, and reporting changes in the resident status. The SBAR protocol addresses the (1) Situation: this section includes symptoms, onset, duration, aggravating and or relieving factors, and other observations, (2) Background: history or story of the change in patient status, primary diagnosis, pertinent history, vital signs, functional and mental status changes, medications, pain, laboratory studies, allergies, and advance directives, (3) Assessment: or description of appearance as it is allowed within the scope of practice for the individual nurse, and (4) Recommendations: requests for action as suggested by the assessor. The nurses would have received training on the purpose and use of the tool, using clinical case scenarios that would have demonstrated data collection and communication techniques for a change in resident condition.

These educational sessions were to be approximately one hour long with questions and interactive participation allowed and encouraged. The facilitator would have used case scenarios from previous transfers with all demographic identifiers removed. The educational sessions would have been provided at the LTC facility of this proposed project and led by the education director and the project leader. Each nurse would have been required by the facility to participate in the training on the use of the SBAR and would use the SBAR Communication Form and Progress Note (Appendix A) during each acute incident with a resident. The residents that have chronic issues with standing orders to cover the issue would not have required an SBAR form. The SBAR INTERACT II form had recently been adopted by the facility for use. Each nurse would have been provided a pocket copy of the tool. Additional copies of the SBAR tool would have been placed on each unit for nurses to use for incidents requiring a patient assessment. The Education Coordinator (EC) assumed responsibility for assisting with the training current nursing staff and any new hires. The EC would have also been responsible for tracking the data via a collection log prepared by the nurse on duty for each shift, and review the communication progress notes. The data collection logs would also indicate which resident complaints included a completed SBAR protocol sheet.

This LTC facility had embraced the use of the SBAR protocol for resident assessment with any new onset or episode of complaint and for all status changes noted by the nurse. The INTERACT II SBAR tool that had been agreed upon for use would have become a part of the resident record and would contain documentation of resident complaints and status changes. The SBAR protocol was introduced by the LTC facility.

The teaching and briefing in use of it were to be provided by two nurses trained in use of the SBAR protocol. The participants would have been asked to complete the form during training with the information provided in case scenario. The group would then critique the completed forms as a team offering feedback and rationale for the actions or lack of action. The forms would also have been used during the handoff from shift to shift to facilitate continuity of care.

Each nurse would have been provided copies of the protocol and given group and individualized training. The nurses would have been asked to role play in the assessment of a mock patient situation followed by the completion of the protocol sheet. The trainer would have facilitated the training by assuming the role of the physician or APN. The completed forms would have been evaluated with regards to the resident complaint and would have included the resident disposition. Each participant would have been expected to provide a rationale for why the resident was being transferred to the ED or not in each instance. The nurses would have been expected to provide feedback and rationale for the decision to transfer or not to transfer during the training exercises.

A tracking log would have been maintained by the LTC facility to track resident complaints, interventions, and outcomes. These interventions would have been documented on the SBAR protocol sheet along with the outcome of the assessment and whether the resident was transferred to the ED. The data would have been collected every 24 hours and analyzed weekly. The logs were to be collected by the lead nurse from each ward at the end of a 24 hour period and given to the Education Coordinator each morning. The Education Coordinator would then have compiled the data into weekly

findings. The forms were to be assessed by the Education Coordinator to ensure completeness with all blanks filled with an answer or not applicable (N/A).

Following one month of data collection, a debriefing session was to be held for the nurses on each shift using actual data that was provided by the nurses themselves. Cases would have been reviewed and all demographic information removed to provide anonymity of residents and nurse performing the assessment. Retraining sessions were to be provided as indicated by the lack of completion of the forms or stated need for further training from the nursing staff and or administration. Though this project was not implemented it would have provided valuable information and guidance for implementation in other LTC settings. The implementation of such a project in several like facilities would also add to the validity of the use of a standardized process for data collection and improved communication of this information to providers who would make the decision of whether or not to transfer or provide care of the LTC resident in the home unit.

Data Analysis

The facility recognized the avoidable transfer of the LTC resident to the ED as an opportunity to increase the standardization of processes that might positively impact these instances by decreasing the occurrence. There were 32 visits recorded in the local ED logs from the residents in this facility for a 3-month period. Of those 32 visits only three residents were hospitalized. The current census at the time of this observation was 140 residents. The number of residents transferred totaled greater than 25% of the facility population at the time. The number of resident incidents was to be tracked by utilization

of the log book maintained at the LTC facility. The data was to be collected daily and compiled into comparative weekly numbers and graphed to provide a clear picture of the overall impact of the intervention. A pre and post project comparison of resident transfers from the LTC facility to the ED would have been performed over a period to include 12 weeks before and 12 weeks after implementation of the SBAR protocol. This comparison would have shown whether the use of the SBAR protocol would have successful in decreasing the number of avoidable transfers to the ED. The number of SBAR assessments fully completed would have been tracked as well. The number of residents sent to the ED without benefit of a completed SBAR protocol would also be tracked and compared to the number of residents with a completed SBAR protocol. Use of the SBAR would not have interfered with transfer of residents who need to be transferred. Changes in status without an identified source would have automatically been transferred in accordance with the policy of the facility (Personal communication T. Brown, DON 2015). In tracking this information evidence would have been provided supporting the use of the SBAR protocol in patient assessment during acute complaint.

Project Evaluation Plan

One of the primary purposes of the evaluation is to determine whether the program or intervention produced the desired effect (Haji et al., 2013). Haji et al., (2013) encourages us to use the evaluation process to place value on an activity or to demonstrate its merit or worth in the practice setting. Our ability to make this judgment rests primarily on the evaluation of the effectiveness of our programs and interventions. The desired effect of this project was to be standardization of the assessment process

during acute events resulting in a decrease in the number of avoidable transfers of LTC residents to the ED. A positive link between the implementation of the project and the decrease in the number of avoidable transfers to the ED would have provided supporting evidence that the project was effective in promoting the expected outcome.

The evaluation plan identified for this EBP would have been an outcome evaluation. The evaluation of this project would involve assessing the implementation and use of the SBAR protocol and then determining if there was a positive relationship between the use of the SBAR protocol and a decrease in the number of elderly resident transfers to the ED (Kettner 2013). Use of the SBAR protocol and the number of residents avoidably transferred to the ED before and after the project intervention would have served as evidence to support or deny the assumption that use of the protocol would decrease the number of transfers of the elderly to the ED. Also included in the evaluation would have been the number of residents transferred and the SBAR protocol was not completed. This comparison would be used to determine the effectiveness of the intervention.

Summary

The nursing assessment is an essential move towards ensuring the needs of the resident are met and often begins with noticing changes in resident behavior. The delivery of safe and effective nursing care lies within the capable hands of the equipped nurse. The opportunity to implement change in practice that leads to improved outcomes is an opportunity for the organization as well as the individual nurse. According to Gillespie and Peterson (2009) standardization enhances the social orientation of the nurse

and improves the critical thinking process. This improved thought process can increase patient safety and positive outcomes (Gillespie & Peterson, 2009). The novice nurse bases her decisions on textbook rhetoric garnered from school learning. The use of standardized protocols and tools such as the SBAR protocol can positively affect the nurse's ability to transition from making decisions based on simple facts to making decisions based upon critical thinking (Yoder-Wise, 2012). This transition takes place when the nurse utilizes not just the facts but inferences and assumptions based on ideas and facts compiled (Gillespie & Peterson, 2009). The nurse is now able to view the entire situation and mentally articulate a plan of care and recommend treatment initiatives to the physician. The SBAR protocol serves as a tool to facilitate this learning process.

Section 4: Findings, Discussion, and Implications

Introduction

The project was designed to evaluate the effectiveness of an organized and structured tool (SBAR), useful for gathering assessment information and communicating findings effectively, to promote resident care during phases of acute complaint. The project's goal was to decrease the number of avoidable transfers of LTC residents to the ED through the consistent use of a standardized process and use of the SBAR. Use of standardized protocols such as the SBAR protocol, can assist in meeting this goal. During the assessment period of the project it was proposed by the project director and the organizational leaders that the use of the SBAR protocol would promote a decrease in the avoidable transfer of the elderly LTC resident to the Emergency department (ED) thereby improving patient outcomes, and generally decreasing cost.

In spite of the fact that this project will not be implemented, the paper will provide a summary and evaluation of potential findings. The findings will be addressed in the context of learning evaluation, behavior and performance, and results. In this section I will also address the implications of the findings as it applies to clinical practice, future research, and social change impact. Proposed limitations and strengths of the project, along with recommendations for future studies will also be discussed in this section as well. Included in this section will also be a self-analysis as a scholar, practitioner, project developer and professional.

Summary of Findings

Learning evaluations included the participation of the nurses in an interactive training. Case scenarios were used as patient presentations with acute complaint or symptoms and the nurse used the SBAR protocol to address a resident complaint. The training would have simulated the situation and called for the nurses to demonstrate skills used to assess the situation using the SBAR protocol. The training SBAR protocols included a listing of the assessment data sought with factors being provided by the trainer. The role play training would have allowed the nurse to demonstrate understanding of the assessment process and where to gather data other than the patient complaint. Review of the completed SBAR forms on a daily basis would have allowed for assessment of the participant's ability to utilize gained skills in the clinical setting. The results then would have measured the impact that the training had on the incidence of avoidable transfers to the ED for the elderly LTC resident.

Support from the literature was used to qualify the hypothetical findings. The implementation of SBAR, an evidence-based practice, (EBP) was not implemented and therefore there are no results to validate the effectiveness of the implementation and use of the SBAR protocol to decrease avoidable transfer to the ED. The literature review presented in this paper provides information that will permit me to summarize the claims of my project query using results from previous research projects. Support from the literature will also allow me to situate my project in relation to existing knowledge and to judge the potential for my project to contribute to existing knowledge.

Implications for Policy

The project would have been instrumental in providing insight into the benefits of using a standardized process for patient assessment and communication of assessment findings in the LTC setting. The standardization of the assessment process is consistent with the development of clinical protocols such as use of the SBAR in the assessment of an acute issue or change in resident status. During the assessment of acute complaints, standardized protocols guide the nurse through the assigned process. A clinical protocol simply provides an ordered process for approaching an issue (Melnyk, 2014). An example of this would be a resident who has change in status of undetermined origin would receive an assessment according to the SBAR protocol. The situation would be evaluated and the nurse would identify why the issue is concerning. The next step would be to look at the background what other factors exist. This can be determined by using the chart and any historical information to identify associated information pertinent to the issue. The assessment would include both subjective and objective data. The use of this standardized process, the SBAR protocol, ensures that when the assessment process is complete the nurse will be more readily equipped with necessary data for assigning a nursing diagnosis (Ouslander et al., 2011). This process would have prepared the nurse for initiating appropriate interventions, or to offer recommendations for care to the physician, that would potentially increase the possibility of positive outcomes for the patient. The use of this process end result includes the decrease in the avoidable transfer of the elderly LTC resident to the ED or immediate transfer of those residents whose condition warrants transfer before further deterioration of the condition, (Hassona et al., 2012).

Healthcare systems worldwide are being challenged with the task of reducing costs while maintaining quality care (McEwin et al., 2011). Melnyk (2014) warns that the diminishing quality of healthcare and the wasteful spending that occurs will continue to be a substantial and global challenge for healthcare organizations. The cost incurred in the healthcare systems from preventable medical errors and unnecessary medical treatments could potentially save millions of healthcare dollars (Melnyk, 2014). Evidence based interventions, such as the development of standardized protocols that include the SBAR protocol, can be used to effectively combat some of the avoidable treatments and duplication of services as well as decreasing avoidable transfer of long term care residents to the ED (Lamb et al., 2011). The resident transferred to the ED for treatment of abdominal pain might receive duplicate treatment already given in the LTC facility when adequate information is not provided. The concern associated with the avoidable transfers is relative to the well-being of the elderly patient, the ED providers who often do not have adequate time to dedicate to this complex patient, and for the organizational costs incurred in providing care for this patient population in the ED (Ouslander et al., 2011). The patient assessment and interview performed by the nurse and the presentation of information gathered during the initial triage assessment can significantly impact the decision whether to transfer the patient to the ED (Lamb et al., 2011; Ouslander et al., 2011). Standardization of the assessment using the SBAR protocol can impact the decision to maintain the resident in the LTC facility for care.

The implementation of the SBAR protocol also has the potential to decrease fragmentation of care in the LTC resident population. Melnyk (2014) reports that the typical Medicare patient often sees many different providers in the same clinical setting often causing duplication of services and fragmented care. Each time a resident visits the ED, multiple additional healthcare providers in that venue intervene with the resident, adding to fragmentation of care such as incompletion of treatments and multiple treatments for the same issue. The use of the SBAR protocol could potentially impact this through shared information. This information is gleaned from the comprehensive assessment of each acute complaint of the LTC resident and then communicated to other providers in a format designed for thoroughness and clarity. This clarity in communication deters incomplete treatment interventions and ensures continuity of care (Nelson et al., 2013).

Implications for Research

The preparation for this project has provided an excessive exposure to a vast amount of information on the benefit of standardization of processes. Although the project will not be implemented, it has prompted the query into the benefit of standardization in improving patient outcomes. The project has also provided further support for use of the SBAR as a tool that has the potential for standardization of many varied processes in healthcare. The project also reaffirms the effect of enhanced communication among healthcare providers. The data from this theoretical QI project could possibly be developed into a quasiexperimental research study offering support

for use of the SBAR in standardization of nursing assessment process as well as other nursing processes.

Had this project been implemented, future research could be designed to test the theory and providing research evidence supporting the use of the SBAR protocol as an assessment tool for standardization, and prompting the nurse to gather pertinent information during the assessment phase of an acute complaint. The introduction of this project would have answered the query or prompted further inquiry. The so what according to Melnyk (2014) encourages the researcher to look for the so what when introducing evidence into practice. These types of questions include:

- What is the prevalence of the problem associated with transfer of the elderly LTC resident to the ED?
- What difference would the project have made relative to improving healthcare quality, decreasing costs, and most importantly improving resident outcomes?

The project would have answered the so what as well as offering opportunity for testing the SBAR for use in other aspects of the nursing process to improve patient outcomes and decrease spending.

Implications for Social Change

The role of the nurse has become one of autonomous responsibility for assuming care of patients in the acute and long-term care settings. As the largest single group of health care providers, more than three million in the United States alone,

Strech and Wyatt (2013) suggest that a greater proportion of the weight assigned for the successful application of evidence in practice belongs to nurses. Utilizing the SBAR protocol as a standardized process for the assessment and communication of problems noted in the acute assessment of the resident has the potential for increasing the overall acumen and critical thought process of the nurse. This process can be used to develop both the novice and veteran nurse in assessing the patient (Gillespie & Peterson, 2009). Use of the SBAR protocol has the potential for impacting the way nurses are trained to care for patients, in not only long-term care settings, but acute care settings as well (Gillespie & Peterson, 2009). Use of the SBAR as a standardized process for assessment of the patient with an acute complaint offers the opportunity for creating and empowering autonomous thought in the LTC nurse (Juthberg et al., 2010). This reorganized thought process and the empowerment of autonomy in practice is an essential component of social impact in the LTC setting as well. Calling upon these nurses to assume knowledge that better equips them to meet the challenge of providing quality care for the elderly is an exciting implication for social change (Juthberg et al., 2010; Klaasen et al., 2009).

Successful implementation of such a project could change the way LTC nurses are regarded by themselves and their peers. A nursing career in elder care is sometimes described as a truncated status of professional choice; described by nurses engaged in the practice of LTC, by students, and novice nurses as boring, undemanding, and non-challenging (Carlson, et al., 2014).Carlson and colleagues (2014) provide a clear understanding that such project implementation also has the

ability to provide professional self-esteem through enabling nurses' professional autonomy in terms of meeting professional standards and providing care beneficial to those patients served. The development of the professional uniqueness of the LTC nurse could have been socially erected and further developed through collaboration with other professionals deemed significant in the healthcare system (Carlson et al., 2014). The project, though not implemented, offers an opportunity and a means of gaining skills and knowledge that allows the nurse to provide input and interventions that add credibility to their practice. It also has the potential for enhancing attitudes of cooperation within a professional group that the LTC nurse seeks to become a valued member of (Carlson, et al., 2014).

Project Strengths and Limitations

Strengths

The project proposal had the support of all three entities involved, the physicians' group, the hospital administration, LTC administration, as well as the other major stakeholders, such as the director of nursing (DON) and nurses at the LTC facility. A partnership existed that included the proposed project manager as an essential team member. Strech and Wyatt (2013) stress the importance and strength of leadership in forming partnerships when implementing change in healthcare.

The project, though not implemented, presented an opportunity to positively affect the care provided in the ED and the LTC setting as well as an opportunity to improve communication between physicians and nurses in an area where the quality outcomes depend so heavily upon the communication between disciplines. Carlson et

al.(2014) noted that the LTC nurse has a special skill set that can be enhanced to ensure best CPGs for this patient population. The project initiative further implies that the nurse plays a very important role in decreasing injury and promoting safety for the LTC patient. The enhanced assessment skill learned by the nurse would have been an additional strength of this project. The nurse practices the skill of noticing and this skill becomes more finely tuned as it is practiced through the use of a standardized process (Watson & Rebair, 2014). The SBAR protocol provides standardization in the observation process. The decrease in transfers of the elderly would have resulted in a decrease in the duplication of services and resultant overall decrease in the cost of care. A decrease in the number of avoidable transfers of the elderly to the ED would serve to decrease overall costs of care. An additional strength of the project proposal is that the LTC resident receives care in an environment that is familiar to them; with providers they are comfortable and familiar with. This decreases the stress of the acute episode as well as avoiding the confusion due to changes in environment and unknown staff.

Limitations

The greatest limitation to the SBAR initiative was the financial constraints that occurred within the organization during the period of the project initiative. The hospital was in serious financial trouble at the time, and although the SBAR proposal was introduced as a cost-free initiative, it was very difficult to maintain interest when people were worried about their livelihood. The hospital was having trouble meeting its financial obligations due to low census, as well as treatments and care provided to

patients who were uninsured and or unable to pay. There were occasional weeks when the hospital was unable to make payroll for its employees (personal communication, Lowery, 2015). This was just a very difficult time for creating enthusiasm for new projects when the employees were unsure if they would be there from day to day. One day there would be rumors of the facility closing, the next a new computer system was being introduced.

Another limitation of the SBAR proposal would have been the small convenience sample which did not adequately represent the general population. The population to be used was however, similar to what one might find in any nursing home. The use of a convenience sample limits the ability to generalize the findings to the overall population. In addition, the project initiative would have included only one LTC facility. The strength of the project would have been enhanced if it had been possible to implement the original project and then replicate the SBAR project in more than one facility. The deliberate repetition of previous procedures in more than one clinical setting strengthens the evidence of project results, and has the added potential for correcting the sample size limitation (Polit & Beck, 2011). The overall results may be in favor of the query posed by the SBAR project or may have provided different results or focused attention in another direction all together (Explore.com, 2009).

Recommendations

The implementation of the project in this and other like facilities is recommended. Implementation of the project in several LTC facilities followed by an assessment of the collaborative data would offer even more supportive evidence

regarding the efficacy of standardizing the assessment process using the SBAR protocol. As stated, the inclusion of other LTC facilities would also increase the population of participants as well.

Because the project was not implemented we lose the benefit of data collection and the presentation of the same. Data presented in graphs and charts can be beneficial in bringing to life the inferences that are gleaned from the analysis of data (Vekiri, 2002). The data for the quantitative research is straight forward and direct, and the collection and analysis of the data in this project would have been an essential portion for convincing conclusions to be evident.

Analysis of Self

Scholar

Moore and Watters (2013) discuss the strategies and complexity in thought necessary for the nurse to meet the ever increasing burden of becoming a clinical scholar in today's healthcare setting. They profess that the Baccalaureate and Master's prepared nurse is more equipped to meet the demands placed on the nurse to not only recognize the need for evidence in practice, but also for the nurse to be innovative with implementing solutions to inquiry in healthcare settings (Moore & Watters, 2013). The scholarly preparation at Walden University has instilled a permanent and consistent questioning perspective. As a scholar rationales for the whys and why nots of care practices and protocols has become an innate characteristic that causes forward movement in creating and sharing visions of change.

The scholar is also prompted to motivate others and to challenge the status quo. Being prepared to lead and to be a strong follower at the same time are also achieved characteristics of the scholar. I am also empowered, through the education and training that I have received in both the MSN and the DNP program of study, to meet the challenges posed by the advances in healthcare technology, more complex medical patients, and the complexity and changing role of the nurse in the care setting.

This DNP project was proposed after spending time in the ED of my practicum setting and observing residents from the adjacent LTC facility being brought to the ED for seemingly irrelevant issues. The residents were often brought with little history or documentation of a focused assessment of the situation and or complaint. As a DNP scholar I have obtained knowledge that supports the delivery and provision of high quality, safe, cost effective, and evidence-based health care. The implementation of evidence into practice is evident of this knowledge acquisition.

Practitioner

The system changes that are necessary to sustain growth and maintenance of healthcare organizations requires changes in inputs, practices, and productivity in response to varying pressures and unsolved problems (Chase, & Pruitt, 2006). The DNP prepared nurse has the benefit of being educationally and practically trained to assess systems and processes for opportunities to implement change through evidentiary practices. Chase and Pruitt (2006) discuss that the advanced practice nurse is afforded the privilege of working in a profession where the basis is scientifically supported by research and evidence specific to the nursing profession. Dreher and Montgomery

(2009) provide an opinion that the doctorally prepared nurse is forced to think more critically about the care that they, their peers and colleagues provide. They argue that the DNP practitioner is endowed with the privilege and even the responsibility for inquiry and contributing to the advancement and development of processes to improve healthcare outcomes.

Project Developer

The DNP prepared nurse is urged to be the catalyst for change in the healthcare setting. The inquiry of why and why not are prevalent in the thought processes of this nurse. The search for the rationale for the whys and why nots in the practice setting ensures that the DNP prepared nurse often becomes the project developer for many innovative processes of change in the clinical setting (Dreher & Montgomery, 2009). The DNP prepared nurse shares the responsibility for developing and implementing practice guidelines such as use of the SBAR protocol that are based on the best evidence available. The DNP nurse is prepared to search and critique the literature in order to support best practices with scientific evidence. Practice changes today must be reinforced with sound theory and data that support innovative strategies as best methods for solving clinical problems. The doctorally prepared clinician is also able to develop programs and practices that clearly delineate a connection between the care interventions provided and desired outcomes (Glanville, Schirm, & Wineman, 2000).

A review of the literature revealed the SBAR protocol as a practical tool useful in standardizing the assessment process during the acute complaint or change in status of the LTC resident. It was noticed that the lack of information included with the

report of complaint to the provider often resulted in an order to transfer. The SBAR protocol was useful in providing a means to develop the schema for collecting and reporting quality information. As the DNP prepared nurse looking for the missing link was essential in developing and offering a proposal for solving the problem.

The DNP nurse is equipped with the training and education to assume leadership in project design and development. The IOM (2009) encourages that nurses be allowed to perform at their most optimal level of abilities. In project development the DNP prepared nurse has been equipped to lead and provide innovative change.

Professional

The IOM (2010) offers the opinion that the ever changing climate of the nursing profession demands that the practitioners within be adaptable to change and new innovations. The professional role of the nurse has become one of a partnership rather than the traditional role of taskmaster. The DNP prepared nurse is prepared to meet the challenges offered and met in the role of healthcare partner. The DNP nurse is empowered to provide autonomous practice guidelines, and develop and offer solutions to complex care issues. Yoder-Wise (2010) encourages nurses to take advantage of the support from the IOM and to take action in educating and preparing ourselves as professionals ready to meet the challenges of today's healthcare complexities.

The DNP nurse is prepared to be a leader both within the nursing profession as well as within his/her specific specialties. The DNP prepares the nurse to achieve the task of leadership within the profession through sound knowledge and judicious

utilization of scientific methods. Possessing an understanding of the importance of informed critique and synthesis of experimental evidence that is available through unwavering research prepares the doctorally prepared nurse to respond to the challenge of contributing to the growth and development of the nursing profession. As a leader in the clinical setting of individual specialties the creation of CPGs that offer direction and support in clinical decision making based on scientific data are evidence of leadership in clinical specialties. These CPGs offer evidence of a direct link to positive expected patient outcomes (Glanville, et al., 2000).

Summary and Conclusions

The objective of this project was to develop a standardized assessment approach to be used by nurses in the long-term care setting during an acute event. It was anticipated that this intervention would decrease the number of avoidable transfers of the LTC resident to the ED for further assessment and avoidable interventions. The standardization of the assessment process was to prompt the nurse to gather pertinent information during the assessment of the elderly patients' acute complaints and provide a format for the collection of pertinent data. The project question was, "Can use of the SBAR protocol decrease the incidence of avoidable transfer of the LTC resident to the ED?" The project would provide a basis for development of a CPG that would standardize the process of assessment of acute complaint in the geriatric LTC population.

The literature review provided support of the SBAR protocol as an effective tool in improving communication through a streamlining format and process for reporting

information. Standardization has proven to enhance the social orientation of the nurse and improves the critical thinking process. This improved thought process can increase patient safety and positive outcomes (Gillespie and Peterson, 2009). Each time the protocol is used the nurse will have a blueprint of the process of resident assessment and data collection.

Section 5: Professional Scholarly Product

The dissemination process will be presented in a power point. The product will serve as a compilation of this project. The power point is attached, and will include all parts of the project.

References

Arford, P. (2005). Nurse-physician communication: an organizational accountability. *Nursing Economic$, 23*(2), 72-77.Retrieved August 24, 2014.

Ashcraft, A. S. & Champion, J. D. (2012). Nursing home resident symptomatology triggering transfer: avoiding unnecessary hospitalizations. *Nursing Research and Practice, 2012*, 1-5. doi:10.1155/2012/495103

Ashcraft, A. S. & Owen, D. C. (2014). From nursing home to acute care: signs, symptoms, and strategies to prevent transfer. *Geriatric Nursing, 35*, 316-320. doi:10.1016/j.gerinurse.2014.06.007

Beckett, C. D., & Kipnis, G. (2009). Collaborative communication: integrating SBAR to improve quality/patient safety outcomes. *Journal for Healthcare Quality: Official Publication of the National Association for Healthcare Quality, 31*(5), 19-28.

Bernstam E. V., Pancheri K. K., Johnson, C. M., Johnson, T. R., Thomas, E. J., & Turley, J. P. (2007). Reasons for after-hours calls by hospital floor nurses to on-call physicians. *Joint Commission Journal on Quality & Patient Safety*, 33, 342-9.

Carlson, E., Ramgard, M., Bolmsjo, I., & Bengtsson, M. (2014). Registered nurses' perceptions of their professional work in nursing homes and home-based care: A focus group study. *International Journal of Nursing Studies, 51*(5), 761-767 . doi:10.1016/j.ijnurstu.2013.10.002

Cary, M. & Lyder, C. H., (2011). Geriatric assessment: Essentials for nurses. *American Nurse Today, 6*(7). Retrieved from http://www.american nursetoday.com/geriatric-assessment-essential-skill-for-nurses/

Chase, S. K., & Pruitt, R. H. (2006). The Practice Doctorate: Innovation or Disruption? *Journal of Nursing Education*, *45*(5), 155-161.

Diachun, L. L., Charise, A., & Lingard, L. (2012). Old News: Why the 90-Year Crisis in Medical Elder Care? *Journal of the American Geriatrics Society, 60*, 1357-1360. doi:10.1111/j.1532-5415.2012.04029.x

Dreher, H. M., & Montgomery, K. A. (2009). Let's Call It "Doctoral" Advanced Practice Nursing. *Journal of Continuing Education in Nursing.40*(12), 530-531. Retrieved August, 2014.

Dunsford, J. (2009). Structured communication: improving patient safety with SBAR. *Nursing For Women's Health, 13*(5), 384-390. doi:10.1111/j.1751-486X.2009.01456.x

Eggertson, L. (2012). On the Same Team? Nurse-Physician Communication. *Canadian Nurse, 108*(5), 28-32.

Explorable.com, (2009). Replication Study. Retrieved from Explorable.com: https://explorable.com/replication-study

Florida Atlantic University (2011). InterAct SBAR Form. Retrieved from www.state.in.us/isdh/files/INTERACT_SBAR_Form.pdf

Gillespie, M., & Peterson, B. (2009). Helping novice nurses make effective clinical decisions: the situated clinical decision-making framework. *Nursing Education Perspectives, 30*(3), 164-170.

Glanville, I., Schirm, V., & Wineman, N. (2000). Using evidence-based practice for managing clinical outcomes in advanced practice nursing. *Journal of Nursing Care Quality, 15*(1), 1-11 11.

Gruneir, A., Bell, C., Bronskill, S., Schull, M., Anderson, G., & Rochon, P. (2010). Frequency and pattern of emergency department visits by long-term care residents -- a population-based study. *Journal of the American Geriatrics Society, 58(3)*, 510-517. doi:10.1111/j.1532-5415.2010.02736.x

Haig, K. M., Sutton, S., & Whittington, J., (2006). National patient safety goals. SBAR: a shared mental model for improving communication between clinicians. *Joint Commission Journal of Quality Patient Safety, 32*, 167–175.

Haji, F., Morin, M., & Parker, K. (2013). Rethinking programme evaluation in health professions education: beyond 'did it work?' *Medical Education, 47*(4), 342-351. doi:10.1111/medu.12091

Heinrichs, W., Bauman, E., & Dev, P. (2012). SBAR 'flattens the hierarchy' among caregivers. *Studies in Health Technology and Informatics*, 173175-182.

Intrator, O., Grabowski, D. C., Zinn, J., Schleinitz, M., Feng, Z., Miller, S., & Mor, V. (2007). Hospitalization of nursing home residents: the effects of states' Medicaid payment and bed-hold policies. *Health Services Research, 42*(4), 1651-1671.

Joffe, E., Turley, J. P., Hwang, K. O., Johnson, T. R., Johnson, C. W., & Bernstam, E. V. (2013). Evaluation of a problem-specific SBAR tool to improve after-hours nurse-physician phone communication: A randomized trial. *Joint Commission Journal on Quality & Patient Safety, 39*(11), 495-501.

Juthberg, C., Eriksson, S., Norberg, A., & Sundin, K. (2010). Perceptions of conscience, stress of conscience and burnout among nursing staff in residential elder care. *Journal of Advanced Nursing, 66*(8), 1708-1718. doi:10.1111/j.1365-2648.2010.05288.x

Kalisch, B. J., Landstrom, M. S., & Williams, R. A. (2009) Missed nursing care: Errors of omission. *Nursing Outlook 57*(1): 3-9 doi: 10.1016/j.outlook.2008.05.007

Klaasen, K., Lamont, L., & Krishnan, P. (2009). Setting a new standard of care in nursing homes. *Canadian Nurse, 105*(9), 24-30.

Kroeger, S., Borders, C., & Webster, K. (2013). Research Strand Evaluation. Retrieved from http://education.ufl.edu/325t/files/2013/06/ProjEval_0110.pdf

Lamb, G., Tappen, R., Diaz, S., Herndon, L., & Ouslander, J. G. (2011). Avoidability of hospital transfers of nursing home residents: perspectives of frontline staff. *Journal of the American Geriatrics Society, 59*(9), 1665-1672. doi:10.1111/j.1532-5415.2011.03556.x

McEwin, M. & Wills, E., M., (2011). *Theoretical Basis for Nursing* (3rd ed.). Philadelphia, PA: Lippincott Williams & Wilkins,.

MERCK Manual (2014). Unusual presentation of illness in the elderly. Retrieved from http://www.merckmanuals.com/professional/geriatrics/approach

Melnyk, B. M. (2014). Speeding the translation of research into evidence-based practice and conducting projects that impact healthcare quality, patient outcomes and costs: the "so what" outcome factors. *Worldviews on Evidence-Based Nursing /*

Sigma Theta Tau International, Honor Society of Nursing, 11(1), 1-4. doi:10.1111/wvn.12025

Mosby's dictionary of medicine, nursing & health professions. (2009). St. Louis, Mo.

Moore, E. R., & Watters, R. (2013). Educating DNP Students about Critical Appraisal and Knowledge Translation. *International Journal of Nursing Education Scholarship, 10*(1), 237-244 8p. doi:10.1515/ijnes-2012-0005

Narayan, M. C., (2013). Using SBAR Communications in efforts to prevent patient re-hospitalizations. *Home Healthcare Nurse, 31*(9), 504-517. doi:10.1097/NHH.0b013e3182a87711

Nelson, D., Washton, D., & Jeanmonod, R. (2013). Communication gaps in nursing home transfers to the ED: impact on turnaround time, disposition, and diagnostic testing. *American Journal of Emergency Medicine, 31*(4), 712-716. doi:10.1016/j.ajem.2012.11.024

Ouslander, J. G., Lamb, G., Tappen, R., Herndon, L., Diaz, S., Roos, B. A., & ... Bonner, A. (2011). Interventions to reduce hospitalizations from nursing homes: Evaluation of the INTERACT II collaborative quality improvement project. *Journal of the American Geriatrics Society, 59*(4), 745-753. doi:10.1111/j.1532-5415.2011.03333.x

Page, M., Parker, S., & Renger, R. (2009). How using a logic model refined our program to ensure success. *Health Promotion Practice, 10*(1), 76-82. doi:10.1177/1524839906296012

Polit, D. F., & Beck, C. T. (2011). *Nursing research: Principles and methods*. Philadelphia, PA : Lippincott, Williams, & Wilkins.

Renz, S. M., Boltz, M. P., Wagner, L. M., Capezuti, E. A., & Lawrence, T. E. (2013). Examining the feasibility and utility of an SBAR protocol in long-term care. *Geriatric Nursing*, *34*(4), 295-301 7. doi:10.1016/j.gerinurse.2013.04.010

Samaras, N., Chevalley, T.,Samaras, D., & Gold, G., (2010). Elderly emergency department patients have complex medical needs. *Annals of Emergency Medicine, 56*(3), 261-269. doi: 10.1016/j.annemergmed.2010.04.015

Schaefer, H. M., & Ruxton, G. D. (2012). By-product information can stabilize the reliability of communication. *Journal of Evolutionary Biology, 25*(12), 2412-2421. doi:10.1111/jeb.12020

Strech, S., & Wyatt, D. A. (2013). Partnering to Lead Change: Nurses' Role in the Redesign of Health Care. *AORN Journal, 98*(3), 260-266 7p. doi:10.1016/j.aorn.2013.07.006

Tjia, J., Mazor, K. M., Field, T., & Meterko, T., Spenard, A., Gurwitz, J. H. (2009). Nurse physician communication in the long-term care setting: perceived barriers and impact on patient safety. *Journal of Patient Safety, 5*(3), 145-152. doi: 10.1097/PTS.0b013e3181b53f9b

Vardaman, J. M., Cornell, P., Gondo, M. B., Amis, J. M., Townsend-Gervis, M., & Thetford, C. (2012). Beyond communication: The role of standardized protocols in a changing health care environment. Health Care Management Review, 37(1), 88-97.

Vekiri, I. (2002). What Is the Value of Graphical Displays in Learning? *Educational Psychology Review*, *14*(3), 261-312.

Watson, F., & Rebair, A. (2014). The art of noticing: essential to nursing practice. *British Journal of Nursing*, *23*(10), 514-517.

Weinick, R., Burns, R., & Mehrotra, A. (2010). Many emergency department visits could be managed at urgent care centers and retail clinics. *Health Affairs, 29*(9), 1630-1636 7p. doi:10.1377/hlthaff.2009.0748

Yoder-Wise, P. S. (2010). The Future of Nursing Begins Now. *Journal of Continuing Education in Nursing*. p. 533. doi:10.3928/00220124-20101122-02.

Zimmer, Z., & Martin, L. (2007). Key topics in the study of older adult health in developing countries that are experiencing population aging. *Journal of Cross-Cultural Gerontology*, *22*(3), 235-241.

Appendix 1 : SBAR Communication Tool

SBAR

Physician/NP/PA Communication and Progress Note
For New Symptoms, Signs and Other Changes in Condition

INTERACT II

Before Calling MD/NP/PA:

- ☐ **Evaluate the resident** and complete the SBAR form (use "N/A" for not applicable)
- ☐ **Check VS**: BP, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated
- ☐ **Review chart**: recent progress notes, labs, orders
- ☐ **Review relevant *INTERACT II Care Path or Acute Change in Status File Card***
- ☐ **Have relevant information available when reporting** (i.e. resident chart, vital signs, advanced directives such as DNR and other care limiting orders, allergies, medication list)

S SITUATION

The symptom/sign/change I'm calling about is _____

_____

This started_____

This has gotten (circle one) worse/better/stayed the same since it started

Things that make the condition worse are _____

Things that make the condition better are _____

Other things that have occurred with this change are _____

B BACKGROUND

Primary diagnosis and/or reason resident is at the nursing home _____

Pertinent history (e.g. recent falls,fever, decreased intake, pain, SOB, other) _____

_____

Vital signs BP_____/_____ HR _____ RR _____ Temp _____

Pulse Oximetry _____% On RA_____on O2 at _____L/min via_____ (NC, mask)

Change in function or mobility _____

Medication changes or new orders in the last two weeks _____

Mental status changes (e.g. confusion/agitation/lethargy) _____

GI/GU changes (circle) (e.g. nausea/vomiting/diarrhea/impaction/distension/decreased urinary output/other)

Pain level/location_____

Change in intake/hydration_____

Change in skin or wound status _____

Labs _____

Advance directives (circle) (Full code, DNR, DNI, DNH, other, not documented)

Allergies _____ Any other data _____

A ASSESSMENT (RN) OR APPEARANCE (LPN)

(For RNs): What do you think is going on with the resident? (e.g. cardiac, infection, respiratory, urinary, dehydration, mental status change?) I think that the problem may be _____***-OR***

I am not sure of what the problem is, but there had been an acute change in condition.

(For LPNs): The resident appears (e.g. SOB, in pain, more confused) _____

R REQUEST

I suggest or request **(check all that apply)**:

- ☐ Provider visit (MD/NP/PA)
- ☐ Lab work, x-rays, EKG, other tests
- ☐ IV or SC fluids
- ☐ Other (specify) _____
- ☐ Monitor vital signs and observe
- ☐ Change in current orders _____
- ☐ New orders _____
- ☐ Transfer to the hospital

Staff name _____**RN/LPN**

Reported to: Name _____**(MD/NP/PA) Date**____/____/____ **Time**_____**a.m./p.m.**

If to MD/NP/PA, communicated by: ☐ Phone ☐ In person

Resident name _____

(Complete a progress note on the back of this form)

Updated January 2011