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Effective communication between nurses in care transitions

Comunicação eficaz entre enfermeiros nas transições de cuidado

Comunicación eficaz entre enfermeras en las transiciones de cuidados

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ABSTRACT

Objective: To map scientific knowledge about effective communication between nurses during the transition of care between urgent and emergency services. **Methods:** This is a scoping review, using the theoretical-methodological framework of the Joanna Briggs Institute (JBI), which included eight articles. These articles were analyzed on the methods used for communication between nurses during the transition of patient care between the mobile pre-hospital services and the fixed urgent and emergency care unit, which were dedicated to transitional care in fact, through the presentation and/or implementation of communication tools, indication of essential characteristics during the case hand-over process and the perspective of the professionals involved in the transition and knowledge gaps. **Results:** Safe communication for the transition that dedicated to actual transitional care, through the presentation and/or implementation were communication tools, indication of indispensable characteristics during the case passing process and the perspective of the professionals involved in the transition. **Final Considerations:** Future studies with more robust designs are needed to improve the prevention of failures and omissions with a thorough understanding of their origins. Investigate sources of system-related failures in the emergency context, such as excessive work fatigue, fast pace, overtime, high staff turnover, among others, to improve the quality of communication.

Keywords: Health communication, Patient safety, Emergency medical services**.**

RESUMO

Objetivo: Mapear o conhecimento científico sobre a comunicação eficaz entre enfermeiros durante a transição do cuidado entre serviços de urgência e emergência. **Método:** Trata-se de uma revisão de escopo, utilizando o referencial teórico-metodológico do Joanna Briggs Institute (JBI), que incluiu oito artigos. Esses artigos foram analisados sobre os métodos utilizados para comunicação entre enfermeiros durante a transição do atendimento ao paciente entre os serviços pré-hospitalares móveis e a unidade fixa de atendimento de urgência e emergência, que se dedicavam ao cuidado de fato transicional, por meio da apresentação e/ou implementação de ferramentas de comunicação, indicação de características essenciais durante o processo de passagem do caso e a perspectiva dos profissionais envolvidos na transição e lacunas de conhecimento. **Resultados:** A comunicação segura para a transição que se dedicou ao cuidado transicional real, através da apresentação e/ou implementação foram ferramentas de comunicação, indicação de características indispensáveis durante o processo de passagem do caso e a perspectiva dos

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profissionais envolvidos na transição. **Considerações Finais:** Estudos futuros com desenhos mais robustos são necessários para melhorar a prevenção de falhas e omissões com um conhecimento profundo de suas origens. Investigar fontes de falhas relacionadas ao sistema no contexto emergencial, como cansaço excessivo no trabalho, ritmo acelerado, horas extras, alta rotatividade de pessoal, entre outros, para melhorar a qualidade da comunicação.

Palavras-chave: Comunicação em saúde, Segurança do paciente, Serviços médicos de emergência.

RESUMEN

Objetivo: Mapear el conocimiento científico sobre la comunicación efectiva entre enfermeras durante la transición de la atención entre servicios de urgencia y emergencia. **Método:** Se trata de una revisión de alcance, utilizando el marco teórico-metodológico del Instituto Joanna Briggs (JBI), que incluyó ocho artículos. Estos artículos fueron analizados sobre los métodos utilizados para la comunicación entre enfermeros durante la transición de la atención al paciente entre los servicios prehospitalarios móviles y la unidad fija de urgencia y emergencia, que de hecho fueron dedicadas a la atención de transición, a través de la presentación y/o implementación de herramientas de comunicación, la indicación de características esenciales durante el proceso de entrega del caso y la perspectiva de los profesionales involucrados en la transición y las lagunas de conocimiento. **Resultados:** Comunicación segura para la transición que se dedicó a la atención transicional real, a través de la presentación y/o implementación fueron herramientas de comunicación, indicación de características indispensables durante el proceso de paso del caso y la perspectiva de los profesionales involucrados en la transición. **Consideraciones Finales:** Se necesitan futuros estudios con diseños más robustos para mejorar la prevención de fallas y omisiones con un conocimiento profundo de sus orígenes. Investigar fuentes de fallas relacionadas con el sistema en el contexto de emergencia, como fatiga laboral excesiva, ritmo acelerado, horas extras, alta rotación de personal, entre otros, para mejorar la calidad de la comunicación.

Palabras clave: Comunicación en salud, Seguridad del paciente, Servicios médicos de urgencia**.**

INTRODUCTION

Encouraging a culture of safety by reducing and preventing the risk of unnecessary harm and recognizing the occurrence of healthcare-related incidents and adverse events at an early stage have become goals of the World Health Organization (WHO). In view of this, the World Alliance for Patient Safety program was created in 2004 (WHO, 2006).

In addition, six international patient safety targets have also been drawn up, including basic protocols in the following priority areas: patient identification, communication between healthcare professionals, safe prescribing, use and administration of medicines, hand hygiene and minimizing the risk of falls and pressure injuries (GERÔNIMO AGS, *et al.,* 2020; AMAYA MR, *et al.,* 2016).

In Brazil, in 2018, according to the Patient Safety and Quality in Health Services Bulletin No. 20: Incidents Related to Health Care, according to the National Health Surveillance Agency (ANVISA), there were 103,275 notifications of incidents by category of services, of which 96,113 came from hospitals, and 2,077 from urgent/emergency services, both representing 95.08% of notifications. When considering the number of health-related incidents reported by hospital unit, urgent and emergency services came third (7.45%) (ANVISA, 2018).

Effective communication is especially evident when it promotes a direct connection between patient and professional, making it an increasingly dynamic process that is inherent to care (SOUZA MMD, *et al.,* 2020). It should be noted, however, that one of the main factors determining the occurrence of incidents related to health care is a failure in communication between health professionals (OLINO L, *et al.,* 2019; CHLADEK, MS, *et al.,* 2021).

Interprofessional communication is understood as the ability for people from different professions to communicate effectively with each other in a reciprocal manner (COIFMAN, AHM, *et al.,* 2021). A well-articulated communication process between health services is essential to guarantee coordination, systematization and continuity of care between the different levels of care (MIORIN JD, *et al.,* 2020).

The care transition process is complex and dynamic as it involves multiple functions that ensure the coordination and continuity of care (SANJUAN-QUILES Á *et al.,* 2019). This scenario becomes more critical when the transition occurs between emergency services, with a number of challenges, especially for nursing professionals, where the environment has a high turnover of patients, a lack of physical space and equipment, added to an overload of work and also associated with a high level of noise pollution in parallel with continuous interruptions in care (ASHEIM A, *et al.,* 2019; NASCIMENTO KCD, *et al.,* 2022).

The establishment of an efficient and effective communication process depends on the insertion of technology, the evaluation of logistics and the implementation of protocols, but above all on people willing to dedicate themselves to the purpose of sharing information centered on the patient and family (MIORIN, JD, *et al., 2020).* The gaps left in the communication of patient information during the care transition process are internationally known as one of the roots of a significant proportion of avoidable deaths, often associated with adverse events (FITZPATRICK D, *et al.,* 2018).

Considering the magnitude of the issue, some authors highlight the great challenge of using and creating care technologies as tools that give new meaning to the dimensions of professional nursing practice and benefit interprofessional relationships (NIETSCHE EA, *et al.,* 2005). In view of the above, the aim of this study was to map scientific knowledge about effective communication between nurses during the transition of care between urgent and emergency services.

METHODS

This study is a scoping review aimed at synthesizing the available scientific knowledge on effective communication between nurses during the transition of care between urgent and emergency services. Conducted using the theoretical-methodological framework proposed by the Joanna Briggs Institute (JBI), the scoping review was operationalized in the following stages: 1- Identification of the research question; 2- Identification of relevant studies; 3- Selection of studies; 4- Data mapping and grouping; 5- Presentation of results (JBI, 2006).

The guiding question of the research is based on the strategy used in the scoping review (Tricco *et al.,* 2018) namely: use of the PCC mnemonic (P: Population, C: Concept and C: Context). “P” refers to the population (nurses), ‘C’ to the concept of interest (communication methods in the transition of care), and ‘C’ to the context (between the mobile pre-hospital services and the fixed urgent and emergency care unit). Thus, the following guiding question was posed: What scientific evidence is available, in official publications, on the methods used for communication between nurses during the transition of patient care between mobile pre-hospital services and the fixed urgent and emergency care unit?

Data collection took place in August 2023, with searches in the following databases: Virtual Health Library (VHL), National Library of Medicine (PubMed) and the journal portal of the Coordination for the Improvement of Higher Education Personnel (CAPES), using the following descriptors: Communication Systems between Emergency Services; Transfer of Responsibility for the Patient; Emergency Nursing; Patient Safety and Emergency Medical Services, associated in pairs with the Boolean terms AND and/or OR.

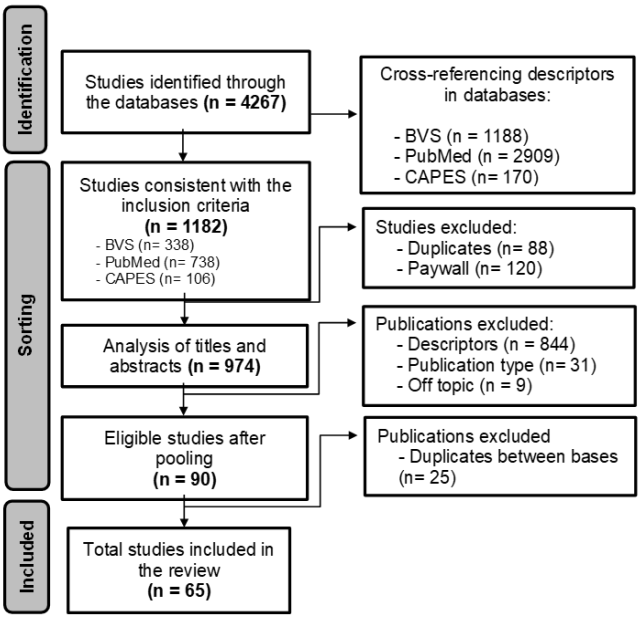
The papers included were free, available in full and published between 2018 and 2022 in Portuguese, English and Spanish. Studies that did not meet the inclusion criteria were excluded, as were duplicates, conference abstracts, annals, editorials, commentaries and reflection articles.

Rayyan® was used to store and organize the database and discard duplicate searches. In addition, the presentation of the results was guided by the checklist items of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-ScR), ensuring greater transparency and accuracy of the results found (OUZZANI M, *et al.,* 2016).

RESULTS

Initially, the database searches resulted in 4267 publications, but according to the pre-established eligibility criteria, eight articles made up this study, shown in **Figure 1**.

Figure 1 – Flowchart for the search and selection of studies for the scoping review adapted from the Preferred Reporting Items for Systematic Review and Meta-Analyses (PRISMA).



Source: Alves TM, et al., 2025.

At first, 65 studies were analyzed, of which North America accounted for 28% of the publications, with citations in the United States of America (16) and Canada (2). Similarly, the European continent also accounted for 28%, with a wider geographical distribution, including Spain (3), Norway (3), Germany (3), the United Kingdom (2), the Netherlands (2), Belgium (1), Switzerland (1), Portugal (1), France (1) and Italy (1). South America contributed 26%, with Brazil (16) and Argentina (1) standing out. In smaller but still representative proportions, 11% of the studies were carried out on the Asian continent, covering countries such as Saudi Arabia (3), Iran (1), Oman (1), Israel (1) and India (1). Oceania, represented by Australia (4), contributed 6%, while the African continent had a presence of 1% through a study carried out in The Gambia.

With regard to the concept/context of the selected studies, 73.9% of the publications concern safe communication for the transition of care. Throughout the studies, there are 12 unpublished tools built by the authors and the use in a further 13 publications of adaptations of already structured tools and strategies. The planning and promotion of a patient safety culture is the focus of 23.1% of the publications, while the identification of potential risks to patient safety during the transition of care was the focus of 3% of the studies.

Another relevant aspect concerns the care setting. The studies reviewed indicated that 29.3% involve urgent and emergency services, 23.1% take place in Intensive Care Units, 21.6% were developed in the Medical Clinic, 10.8% cover the Surgical Center, 6.1% relate to Pediatrics, 4.6% are dedicated to Geriatrics, 3% focus on Obstetrics Units and 1.5% are in Psychiatry services.

In view of the above, when the analysis of studies that simultaneously addressed the categories of nursing and/or multi-professional teams working directly in the urgent and emergency care setting was carried out, a final number of 15 studies was stipulated. Thus, the other 50 became ineligible at this stage of the process, because they only involved the medical category and/or had research settings that did not include urgent and emergency services.

It should also be emphasized that of these 15 studies, because they did not have a direct correlation with the object under study, articles that discussed the identification and assessment of potential risks to patient safety in urgent and emergency care services were excluded. In addition, those that explained the culture of patient safety, presenting strategic plans to encourage safe care, and those that presented only the personal perceptions of professionals in relation to patient safety in the urgent and emergency sectors were also discarded.

In view of this, eight studies were part of this study, characterized in **Table 1**, which were dedicated to de facto transitional care, through the presentation and/or implementation of communication tools, the indication of essential characteristics during the case transition process and the perspective of the professionals involved in the transition.

Table 1 – Categorization of studies by author, title, country, year, objective and main findings.

Author	Objective	Key findings
Tortosa - Alted R, *et al.* (2021)	To study the emergency passage of critically ill patients between two emergency critical care wards carried out by emergency nurses around the world and to identify the characteristics of these processes.	This integrative review shows the clear need for improvement in emergency transfers. It is essential to begin by standardizing the concept of emergency transfer, using the available literature to describe and confirm the ideal method for effective and safe action. The following factors were identified as aspects requiring improvement: standardization, identification, professional behaviour, location, environmental factors, patient participation, clinical records, education/training, responsibility and communication.
Bagnasco A, *et al.* (2019)	To investigate emergency room nurses' perceptions of the handover in a children's ER, as a basis for future research into how to develop future practices in this area.	The standardization of the communication process during the handover could be effectively resolved with the use of a mnemonic tool adapted for the handover in a paediatric emergency department. Standardizing the language of communication would not only improve the daily planning of their clinical practice but could prevent them from mentioning irrelevant items and help them focus on key points for effective and efficient care.
Schorr V, *et al.* (2020)	To find out the multi-professional team's perspective on the change of duty in the emergency department of a university hospital.	The results show that the multi-professional team makes little contribution to the shift handover, which may be related to the organizational culture. Therefore, the shift handover involves improving communication skills linked to the standardization and systematization of the shift handover.
Costa JWS, *et al* (2020)	To verify the main barriers and strategies inherent in the Nursing handover to the critically ill patient in the scientific literature.	This integrative review identified, in the articles selected, six main situations These were: communication problems, lack of standardization, human and environmental factors, time and equipment used in the transition. Among the strategies involving mnemonics, ISBAR, I-SBAR-Q, "I PASS THE BATON", PACE, STICC and GRRRR were cited.
Alves M e Melo CL (2019)	To understand the view of nursing professionals in an emergency room on the transfer of patient care.	The professionals mention fragmentation in the transfer of care, related to communication, teamwork and person-centered care, but show commitment to continuity of care, focusing on the transfer of duty and internal and external transfers of patients. The nurse is a reference for the nursing team and in the transfer of care, being a key professional for the work of the multi-professional team and reported using the PASSOMETER and ISBAR as communication tools at times of handover.
Chladek MS, et al (2021)	Improve the quality of transfers in the emergency department by establishing compliance with the I- PASS transfer tool.	I-PASS is an applicable tool for handovers in the emergency department and contributes to a perceived culture of safety. Successful implementation depends greatly on the diversification of educational modalities, the support of key stakeholders, personal accountability and the encouragement of participants.
Nascimento KC, *et al* (2022)[i]	To build and validate a safe communication checklist tool for the transition of care for patients treated by the out-of-hospital service in the hospital emergency unit.	The instrument is considered validated, providing an option for standardizing communication at the interface between pre-hospital and emergency hospital care, using the ISBAR tool. The tool enables professional nurses to carry out this important stage of their work process in a standardized, simplified and objective way.
Castro CMCSP, *et al* (2022)	To find out what nurses think about the transition of care when changing shifts in the emergency department and to understand their knowledge of patient safety.	The use of a standardized document based on the ISBAR methodology, which improves the quality of nursing care, is fundamental to patient safety.

Source: ALVES TM, et al., 2025.

DISCUSSION

The transfer process is complex and dynamic, as it involves multiple functions that ensure coordination and continuity of care (MIORIN JD, *et al.,* 2020). In a broader context, another study considers three pillars for the care transition process, which are: communication, teamwork and person- and family-centered care (GERÔNIMO AGS, *et al.,* 2020).

This scenario becomes more critical when the transfer takes place between the mobile pre-hospital stages and the other urgent and emergency doors, both due to factors inherent in the organization of the services and the lack of information on initial care provided by the pre-hospital teams (SANJUAN-QUILES Á *et al.,* 2019;SOUZA MMD, *et al.,* 2020).

The complexity of the transition task has a direct impact on cognitive load, influencing the level of use of psychological resources such as memory, attention, perception, reasoning and creativity during the problem-solving process (Westbrook *et al.*, 2018). The use of a pre-printed sheet has proven to be highly beneficial in improving information retention during transition, virtually eliminating data loss during this process (BHABRA G, *et al*., 2007).

They highlight the importance of professionals recognizing teamwork, establishing more dialogical relationships integrated into care actions, improving communication practices and interprofessional sharing of clinical information, together with organizational management, in order to plan and carry out actions that cooperate with effective communication (COSTA JWS, *et al*., 2020; COIFMAN AHM, *et al*., 2021).

During the review of the literature on transitional care, it became clear that there is concern at an intercontinental level about the gaps that exist on the subject, highlighting the need to develop standardized communication tools for good health practices. It was possible to identify a concern related to the transition of care in multiple health environments, by revealing different care settings where the studies were carried out, covering intensive, semi-intensive, high dependency, intermediate and minimal care, showing the fragility of this issue at different levels of care complexity. In this sense, when not carried out in a systematized way, the management of information carried out in the various institutional settings sets the precedent for miscommunication during the transition of care, exposing the patient to risks (BAGNASCO A, *et al.,* 2019; ECHER IC, *et al*., 2021).

Managing patient safety in emergency services involves identifying and prioritizing risks and communicating these risks. By starting to identify risks in the emergency department, concrete contributions can be made (RAMOS DR, *et al.,* 2021). This includes the development and application of improvement plans, with an emphasis on prevention strategies and the implementation of patient safety care. It is during the provision of nursing care that the possibilities of incidents arise, highlighting the importance of this moment in the context of patient safety.

In addition, the entire health team must be involved, and it is important that they participate actively, identifying their counterparts during the transfer, taking responsibility for their respective peculiarities and behaving respectfully, assuming responsibility and ensuring continuity of care (SCHORR V, *et al*., 2020; TORTOSA-ALTED R, *et al*., 2021).

FINAL CONSIDERATIONS

The need to improve the prevention of failures and omissions requires a thorough understanding of their origins, which can be the result of faulty thinking, slips and lapses. In the context of the emergency room, several sources of system-related failures are present, such as excessive work fatigue, fast pace, overtime, work overload, high staff turnover, among others. This review mapped the available information on patient safety during the transition of care between mobile pre-hospital services and the other urgent and emergency doors, critically addressing the main contents during the provision of care and maintaining continuity of care at all levels of care. In addition, it was possible to map the growing trend towards the increased use of technologies in care practices, as a source of improving the quality, effectiveness and

safety of care, and to identify relevant issues to guide future research. Finally, the results presented are not incontestable and may change according to advances in scientific discoveries. The studies included in this review can support future research and offer opportunities to improve the quality of communication, promoting a culture of patient safety in the context of emergency care and strengthening interprofessional relationships.

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