# Care transfer: perspective and practice of nursing in an emergency care service

## Transferência de cuidados: olhar e prática da enfermagem em um serviço de pronto atendimento

## Transferencia de cuidado: perspectiva y práctica de la enfermería en un servicio de atención de urgencia

**RESUMO**

Objetivo: analisar a transferência de cuidados realizada pelos profissionais de enfermagem em uma unidade de pronto atendimento. Métodos: Pesquisa qualitativa, descritiva e de caráter retrospectivo do período de setembro a dezembro de 2017, por meio de consulta a documentos e entrevistas com roteiro semiestruturado. Entrevistas realizadas com oito enfermeiros e três técnicos de enfermagem, foram transcritas e submetidas à Análise de Conteúdo e análise secundária dos dados. Resultados: Emergiram três categorias analíticas, e os achados revelam problemas associados a comunicação durante a passagem de plantão, como: sobrecarga de trabalho, número de pacientes, diferentes níveis de gravidade, dinâmica do setor, transferências intra e inter-hospitalar, local da passagem de plantão, uso de instrumentos de registro. Os profissionais expressaram potencialidades e fragilidades do processo. Conclusão: Sugere-se que a transferência seja estruturada e com informações precisas para reduzir erros assistenciais, perda de dados, eventos adversos, e consequentemente melhorar a segurança do paciente.

**DESCRITORES:** Transferência da responsabilidade pelo paciente; Equipe de enfermagem; Comunicação em saúde; Serviços médicos de emergência.

**ABSTRACT**

Objective: to analyze the transfer of care performed by nursing professionals in an emergency care unit. Methods: Qualitative, descriptive and retrospective research from September to December 2017, through consultation of documents and interviews with a semi-structured script. Interviews conducted with eight nurses and three nursing technicians were transcribed and submitted to Content Analysis and secondary data analysis. Results: Three analytical categories emerged, and the findings reveal problems associated with communication during the shift change, such as: work overload, number of patients, different levels of severity, sector dynamics, intra and inter-hospital transfers, place of change on duty, use of recording instruments. The professionals expressed strengths and weaknesses of the process. Conclusion: It is suggested that the transfer be structured and with accurate information to reduce care errors, data loss, adverse events, and consequently improve patient safety.

**DESCRIPTORS:** Transfer of patient responsibility; Nursing staff; Health communication; Emergency medical services

**RESUMEN**

Objetivo: analizar la transferencia de cuidados realizada por profesionales de enfermería en una unidad de atención de emergencia. Métodos: Investigación cualitativa, descriptiva y retrospectiva de septiembre a diciembre de 2017, mediante consulta de documentos y entrevistas con guión semiestructurado. Las entrevistas realizadas con ocho enfermeros y tres técnicos de enfermería fueron transcritas y sometidas a Análisis de Contenido y análisis de datos secundarios. Resultados: surgieron tres categorías analíticas y los hallazgos revelan problemas asociados a la comunicación durante el cambio de turno, tales como: sobrecarga de trabajo, número de pacientes, diferentes niveles de gravedad, dinámicas sectoriales, traslados intra e interhospitalarios, lugar de cambio de guardia , uso de instrumentos de grabación. Los profesionales expresaron fortalezas y debilidades del proceso. Conclusión: Se sugiere que el traslado sea estructurado y con información veraz para disminuir errores de atención, pérdida de datos, eventos adversos y consecuentemente mejorar la seguridad del paciente.

**DESCRIPTORES:** Transferencia de la responsabilidad del paciente; Personal de enfermería; Comunicación sanitaria; Servicios médicos de urgencia

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## INTRODUCTION

Patient Safety is one of the global strategies for effective and risk-free health care. In 2004, the World Health Organization (WHO) expressed concern about the situation and established the World Alliance for PatientSafety. (1) In Brazil, strategic actions aimed at this field have also received attention in recent years. For example, Ordinance No. 529, of April 1, 2013, which creates the National Patient Safety Program (PNSP), in which it highlights the essential points for patient care, communication in the environment of health services and the transfer of care, with the implementation of basic health care protocols [2].

Dentre essas estratégias, as relacionadas a transferência do cuidado ganha destaque neste estudo. Nas instituições de saúde a transferência do cuidado refere-se conjunto de ações articuladas que possibilitam a continuidade do cuidado ao paciente. É também realizada quando se necessita transferir o paciente de um setor para outro no mesmo serviço ou para níveis diferentes de cuidado à saúde, como no caso dos serviços de referência ou para a assistência domiciliar[3].

Among these strategies, those related to the transfer of care are highlighted in this study. In health institutions, the transfer of care refers to a set of articulated actions that enable the continuity of patient care. The moment of transferring information between nursing professionals can be conducted using forms, passometers and transfer notes, or verbal guidelines in emergency or urgent situations. [4] It is understood, however, that this moment is crucial in the team's communication process, as it provides focus and direction to the professionals who will take care of the patient, in addition to directly influencing the quality and continuity of care provided. [5]

> It is also performed when it is necessary to transfer the patient from one sector to another in the same service or to different levels of health care, as in the case of reference services or for home care. [3]

It is understood that the quality of the information depends on the ability of the person transmitting it, the mode selected, the time spent and the team's engagement in recording information that reports the complications with the patient. Therefore, the success of the shift change depends on articulated teamwork, creating alternative and effective ways to transfer consistent and quality information. [6] However, health care professionals have difficulties maintaining communication that favors teamwork and the continuity of intra- and extra-hospital health care, either due to lack of time, shortage of personnel, lack of standardization, incompetence or ignorance of the importance of such action. [7-8]

In the context of urgency and emergency units, complex services with a high degree of immediacy in care, there is some difficulty in communication between professionals, which occurs, in part, due to the proliferation of specialties that provide patient care. [3,9] In addition, these services have as inherent characteristics unrestricted access, excessive number of patients, extreme diversity in the severity of the initial condition, critical patients,

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scarce resources, overload of the team, insufficient number of professionals, predominance of young and inexperienced professionals, inadequate supervision, discontinuity of care and lack of appreciation of the professionals involved. [3,7]

Faced with this problem, it recognizes that knowledge about carrying out the transfer of care allows the identification of strengths and weaknesses, which can contribute to rethinking forms of management, adoption of work improvement measures and reduction of risks to the patient's health. Thus, the objective of this study was to analyze the transfer of care (shift change) performed by nursing professionals in an emergency care unit.

## METHOD

This is a single case study [10], descriptive, of a qualitative nature. The case study refers to an investigation in which there is little control over the events and seeks to understand in depth the holistic and significant characteristics of a phenomenon, especially when they are not clearly evident. [10]

The choice for the case study is justified by the possibility of investigating contemporary phenomena, in their real context and allowing broad and detailed knowledge about them. [10] In this study, the case refers to the transfer of patient care performed by health professionals in an urgency and emergency service of a public hospital.

The research scenario was the emergency room (ER) of a public hospital in Belo Horizonte/MG, with high general and teaching complexity. The study sample consisted of 08 (eight) nurses and 03 (three) nursing technicians working day and night shifts, randomly chosen from the available work schedule.

Considering the complexity of transferring care to patients in the context of emergency care, it was decided to use the semi-structured interview, consultation of documents about the hospital and observation of the transfer of care, also called shift change, as sources of evidence.

To maintain the anonymity of the study participants, the interviews were identified by codes, followed by the interview number, that is, identification codes ENF1, ENF2, [...] were used to present the nurses' speeches; TEC1, TEC2, [...], for the speeches of nursing technicians.

After transcribing the interviews in full, thematic content analysis was performed for data processing, using the MAXQDA software version 2020. Thematic Content Analysis was performed, based on Bardin's framework. [11]

The project was submitted and approved by the ethics committee of the Federal University of Minas Gerais (COEP/UFMG), opinion number 1,519,784. And also, by the ethics and research committee of the hospital where the study was conducted by opinion, number 1,559,717.

## RESULTS

The data sets will be discussed in three thematic categories that emerged from the data analysis: Transfer of care by the nursing team; Nursing work in an Emergency Care unit and The importance of communication in the transfer of care.

Nursing professionals from the hospital's emergency room participated in this study, directly involved with the care and transfer of care to patients, totaling 11 participants, including nurses [8] and nursing technicians [3].

Regarding the nurses, the age ranged between 29 and 40 years. Of the 8 (eight) participants, there were only 2 (two) males and 5 (five) were married, 2 (two) single and one in a stable union. Of the participants, education ranged from Undergraduate, specialization and Master's, with 4 (four) Emergency Nurses and of these one with training in Obstetric Nursing; one with training in Intensive Care and Master's; and a Resident in Urgency and Emergency. Also, one participant was a specialist in Management and Public Health and one participant was a specialist in Intensive Care.

Training time (graduation) ranged from 1 year and 12 months to 12 years. The time of experience in the health area varied between 1 year and 12 months and 16 years. Finally, the time of experience in Urgency and Emergency in the study scenario ranged from 8 (eight) months to 12 years.

Regarding the nursing technicians, the age ranged between 30 and 41 years. Of the 3 (three) participants, all were female: one has only trained as a nur-


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sing technician, 02 (two) have trained as a technician and graduated, one technician, graduated in Biomedicine and the other, graduated in Social Work. Training time as a nursing technician ranged from 8 to 19 years; with experience in the health area, 6 (six) and 19 years; and, with experience in Urgency and Emergency, from 2 (two) years and 4 (four) months to 19 years.

**The transfer of care performed by the nursing team**

In this category, aspects of the findings that reflect on the transfer of care performed by the nursing team are presented. The professionals expressed the strengths and weaknesses of the process and about how the dynamics in the hospital's ER have been, as a form of care. The way in which the exchange of information between work shifts in health services is structured can avoid the fragmentation of care, between shifts and patient care.

> *I think that the transfer of care is very important because whether it is a doctor or a nurse, care has to be continued. If you are in the emergency room and go to another sector, you will continue the treatment. So when you transfer care, it has to be clear, objective so that the professional can continue the patient's treatment, otherwise information will be lost. (TEC 1)*

The reports on the transfer of care for nurses focus on the continuity of care and point out that it should be clear and objective and involve doctors and nurses. It is clear about the terminology and associates it with the shift change, as a moment of care transfer.

> *I understand that "care transfer" is about how we should take care of the patient, providing more care, working with the patient, discovering their needs inside an emergency room or in the corridors. I understand that we need to aim more at this. (ENF 12)*

> *"Transfer of care" I understand when I know what I need to do for that patient, I know what is best for him, but I am not willing to do that. Then I meet another professional who sometimes does not have the technical skills or knowledge to know the risks and benefits and I tell him what I could be doing, I see a transfer of care when you omit something that you would be able to do. (ENF 16)*

Regarding the means used during the shift transfer and the implications that it is not done properly, the nurses show confidence and clarity about how the transmission of information should be carried out, in addition to sensitivity in relation to the work of the colleague, who takes over the shift.

> *You must be very careful with what you are passing on to your colleague, because you have to pass on information quickly, accurately, but that addresses the main aspects of the patient, then it is with that information that your colleague will take care of that patient. If you are not objective and do not have a global view of the patient, putting the main points, your colleague will not be able to handle this care properly. (ENF 9)*

> *[...] If the patient is allergic to a certain medication, if it was not registered and passed to the other employee upon his arrival, he may administer the medication again and the patient goes through the whole process again. (ENF3)*

The reports indicate what to inform, not the pathology, but the patient and the ways of passing on information, that is, the passometer, the visit to the bed and the recognition that nursing holds relevant information for the team and other professionals.

> *When you have a transfer of information and more detailed care, better done, looking at the patient not as that pathology, but looking at him as a whole, right? [...] You have to be very confident, objective, with as much information as possible, especially what the patient needs.*
> *(ENF 11)*

> *And another issue is that the nurses have their own Passometer for nurses, which we use for this shift change and sometimes we go from bed to bed and I see that here, I'm not talking because I'm a nurse, okay? [laughs] but here the best shift handover is from the nurses, including some residents [doctors] come to us to take the shift because we are aware of everything that is happening. (ENF 16)*

In the following reports, the participants pointed out the importance of a well-established work process, in which the intra- and inter-hospital transfer can follow well-established methods, so that there are no errors, difficulties and discontinuity in care.

> *What I see as difficult is even on the part of the technician, when we are going to transfer. We arrive at the sector and there is no one to welcome you and there is no one to pass on the case and sometimes the technician who receives you at that moment does not even receive you well. So this is a difficulty for you to give or receive information. (ENF 7)*

> *When they go to the ICU or to an external intensive care bed, that patient [...] is picked up by the ASU [Advanced Support Unit] of the SAMU. There is a team meeting, the*

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*doctor here makes the report and passes it on to the SAMU doctor. [...] the patient is formalized by the medical team and there is no formalization in relation to the nursing part [...] the nursing process is not carried out, only a medical report is made that accompanies the patient to the destination unit. (ENF 8)*

The transfer of care between sectors, institutions and the health transport network are portrayed by the study participants. The ineffective transfer of information carried out by professionals from the Mobile Emergency Care Service (SAMU) in the dynamics of the ER often leaves the shift without information, which requires energy expenditure by professionals in surveying records that should have been passed on.

*They passed at the exact moment we were receiving a SAMU patient, in an ASU [advanced support unit], with a diagnosis of SAH [subarachnoid hemorrhage] was verbally and the information: patient with a diagnosis of SAH, a tomography was performed, his name is such and the family is outside and that's it. The afternoon team left the shift and we on the night shift were trying to find out the name of the patient who had CRA [...] so the shift change was tumultuous, lack of information, lack of humanity, lack of care, patient safety. (ENF 12)*

The reports point out the lack of registration and transfer of information, the use of instruments for recording and transferring information about care and the difficulties in daily work to ensure adequate care for the patient.

*I think that a lot of important information is not recorded, is not passed on, sometimes vacancies are lost because of this, exams are missed due to poor transfer due to lack of instruments or overwork. Sometimes an event happens and the nurse doesn't even know about it, they don't get to him. (ENF 8)*

I believe that in the observations of the sector it is more the passometer and it does not have details, it is not an ISBAR [Introduction, Situation, Background, Assessment, Recommendation]. There are many patients, so there is no way for us to start describing the patient's history, something more complete. In the observations it is the passometer. (ENF 3)

**Nursing work in anemergency care unit**

In this category, the work of nursing in a HR unit is discussed, in which the team assists patients, generally, in critical conditions, 24 hours a day and articulates with different sectors and intra and inter-hospital services.

The workers' reports showed how they are inserted in the institution, work overload, little dialogue with the coordination, insufficient human and material resources and investment in training that affect the quality of care, despite the experience in the sector that influences the work process.

*In some shifts, the scale is complicated because some employees are not skilled here in the emergency room and it affects the shift. We have a way of working and if the employee doesn't have experience, sometimes he stops doing something or does it more slowly, it takes time to prepare a drug and suddenly we need a certain agility during the process. I think it's the experience of urgency. (ENF 3)*

*We have excellent technicians, very good, but there are some here who are problematic, who are here for the emergency allowance. (ENF 16)*

*The fact that the team was working under stress made it a little difficult, people are, as they say, "on the edge of their skin", so this makes dialogue in the team difficult. (TEC 1)*

*Communication, due to the volume of patients, number of tasks, the dynamics of the work, patient entry and exit and overload and the number of professionals, I think, you only communicate with the other what is impossible. He doesn't have time to discuss a situation, get an opinion, or make suggestions for better conduct. This affects the emergency room. (ENF 11)*

*I pass the patient on when changing shifts, for example, I pass that patient on to my colleague, but many times you don't find out how that care was carried out, precisely because of this transfer and you are absent after you hand over that patient. (TEC ENF 2)*

The workload in nursing is seen as a critical node in patient care, given that the increased workday does not cause negative reflexes only for professionals, but it can also interfere with the quality of care provided, in a way that affects users with high risks.

*I think teamwork works, but it is more visible in closed sectors, pediatrics and emergency rooms, environments with fewer professionals and patients. In open sectors, people move around more, patients are spread out over a wide physical area. The nurse moves from one side to the other all the time. The technicians are in several sectors, you don't interact much with them during the shift, there are more demands for intercurrences. We can concentrate, dialogue and discuss what is happening. (ENF 11)*

*I realize that teamwork in the emergency room is bad. Today, the*


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*emergency room professionals at the hospital are tired, they are exhausted, they are sick, because there is a lot of service, a lot of care and there are few professionals for many patients. (ENF 12)*

Regarding coordination, workers point out distancing, demands to improve occupancy indicators, returns only when they request some material or need.

*I only see the boss asking for the case from outside, trying to empty as much as possible, transferring these patients, right? In the sense that they give an answer [...]. (ENF 10)*

*When we communicate difficulties or lack of some material, then we get some feedback on what we are asking for, it never comes back spontaneously. Before, we had feedback and we didn't have to keep asking. The coordination, the leadership already saw what was needed in the sector, that patient, that employee, so we always had feedback. Today we have to go after what we really need, to get that return [...]. There are experienced professionals, there are good professionals, but it is getting lost and I think that comes from the coordination. If there is coordination and organization, then there is communication, it is a team. (ENF 12)*

Regarding training, the team points out that they do not exist as they would like them to be or that those that exist are open to the entire hospital, not contemplating the emergency room.

*There are open trainings on transferring care to the hospital, not the ER,*
*for people to take responsibility and put themselves in the other's shoes [...] so I don't know if I could discuss it in an open group because it becomes more petty than training that would bring benefits. If it is open, it brings benefits to the hospital and to people, as most are statutory and have the view that nothing happens to me and this can greatly impact care. (ENF 16)*

*Professionals have to be more up-to--date, there has to be more courses, debates, because it's getting worse, both in terms of care and transfers. There should be a course once a month, on care, transfer, medication and how to deal with patients and colleagues. In the private sector, there are always courses, there are dynamics, there are works, but in the public body I have never seen them. (ENF 11)*

**Health communication**

In this category, workers show difficulties in transmitting clear and objective information, especially when the team receives transfers from outpatients and SAMU. They indicated the need that effective communication requires knowledge, competence, empathy and instruments that can improve patient safety, considering that it involves writing, observation, perception and interpersonal relationships.

*This transfer cannot be delayed. Sometimes we have to be concise in what we are going to say, because it becomes demotivating for those receiving it, tiring. So, you have to pass on cases of 10 patients, or in the observations, of more patients, it is still tiring for whoever is receiving the information. (ENF 8)*

*In the same way that they gave me the shift, my obligation is to pass the patient on to whoever is outside in the same way in here, talking about the attacks, medications that were taken, his case and that sometimes does not happen. (TEC 6)*

The shift change should be seen as a moment for education, reflection and team integration, under a multidisciplinary approach, with the aim of reassessing conduct, providing growth among workers and improving work development.

*This transfer does not happen based on an instrument, this harms because it directs the most important information that you must pass on. The porter takes the patient and this is negative in the transfer of care. The technician does not transfer the case to the technician upstairs, and the transfer of the patient from the emergency room is deficient. The Nurse tries to make contact to have an effective transfer, sometimes not. This impairs the transfer of care. (ENF 8)*

It is seen that the emergency room must be informed about the patients, but in the hospitalization sector communication is sometimes lacking, which, considering the number of critically ill patients, ends up generating several problems.

*The nurse manages this. He is the one who tells the doctor if he can go upstairs, the doctor discharges him, transfers the patient internally through the system. If the patient goes to the ward, it is usually the technician who takes them. (ENF 3)*

Even in nursing there is no joint passage, technician passes to technician and nurse to nurse, making a fragmented action.

*Communication, here, is very different and because the work process has been broken a little bit, I see that it has been harmed. Nowadays you have a piecemeal handover; the technician passes to the technician, the nurse to the nurse, the doctor to the doctor, and the ideal would be a*

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*joint shift change. (ENF 9)*

*It often happens, due to the demand, to forget to pass something that will harm the patient [...] like a probe that has not been tested and you don't pass it on to the colleague, because you think she has already been tested and can already start a diet, but he will stop checking. (ENF 10)*

*It fails a little, too, when the hospitalization sector passes a vacancy, but when you call the sector, regarding bed 20 in the medical clinic, there is no such bed. Then the communication fails. Or the coordinator says that an intubated patient will come, but sometimes the patient arrives and is not intubated, it is a different diagnosis. It does have some flaws. (ENF 3)*

Professional-family and professional-professional communication can be influenced by the overcrowding of emergency services and the overload of professionals. However, the time factor, communication skills and technical language often make it difficult to communicate with family members and patients to provide information and clarify doubts.

*Communication is a little tumultuous, because the number of patients is very high. Sometimes they want to talk to us, but now there's no time, they have to see a patient here, there's a demand for another one there. Communication with the family is hampered by the very high demand for the service, the amount of service. (ENF 10)*

We have little contact with the patient's family member who is there in the emergency room. Outside the emergency room, we have direct contact with family members.

> So, I see that communication is good, I never had a problem with any family member about communicating, explaining, guiding the patient's questions.

Regarding external transport, the participants highlighted the relationship with the SAMU, which frequently takes patients to the ER and does not always inform that it will take the patient or their condition. At the same time, the nursing team also does not always transfer care, making reporting information unavailable to the SAMU when they are going to take patients to other health units.

*When they [SAMU] arrive, they usually pass the case on to us in a bad mood, and sometimes they don't even know how they found the patient, so it gets tumultuous. Even when the SAMU comes to pick up a patient, not always, we in the team pass on the information to them, who read the reports that we leave in the medical record. I don't think there is a good fit. (ENF 3)*

*SAMU often gives distorted information. Sometimes the patient needs an emergency room, sometimes not, but they give a distorted view. When the doctor collects the patient's history with the family, I don't know if the family misinforms or what happens, but when they collect the history, sometimes it is different from what they told. (TEC 1)*

The institution's workers are concerned about the timing of pre-hospital care transfers, revealing the loss of significant clinical information, failures related to the use of confusing language or jargon, unidirectional transfers that are often inaccurate, incomplete and not relevant to the patient's conditions.

## DISCUSSION

The study's findings demonstrate the perspective of nursing professionals who work directly with patient care and transfer of care. Some strengths and weaknesses of the care transfer process are highlighted.

Among the potentialities in this process, the shift change (handover) presents itself as a possibility to establish objective and clear communication, regarding the intercurrences with the patients, in addition to issues


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related to nursing management, which is generally supported by protocols that organize this process and provide security. [12] The literature recommends that handover be a standardized process, so that all those involved can understand and play their roles with the aim of improving patient care and, this standardization can be carried out through the use of instruments, which work as memory aids so that the professional contemplates all the information relevant to care. [13]

Teamwork and efficient communication are another potentiality. To ensure the quality of care and patient safety from admission to discharge, teamwork and efficient communication between professionals and health services are required, in addition to expertise in care. [14] That is, the transfer of care must be related to professional training and collaborative work, which causes responsibility for their care, it can be during the assistance provided by the professionals and during shift changes, aiming at the continuity of care and patient safety.

In this work process in health, nursing intervenes on an object by the human being with the intention of modifying it. In this context, the main work processes of nurses are care and management. Specifically, in the context of urgency and emergency, care is considered complex and dynamic, including technical, operational and evaluative aspects, permeated by the characteristics of the environment and determined by the clinical profile of the patients. Therefore, it constitutes a complex and adaptive system, in which individual and collective behavior transforms, adapts and organizes itself at a microscopic level, forming macroscopic networks. [14]

In addition, in this context, the pre-hospital care service is often faced with little information and limited time to act, which has implications for patient and professional safety. To make this process safe, one must invest in risk prevention through some basic patient safety strategies, such as professional training for safety, organizational and institutional awareness, allocation of resources and effective communication among health professionals[15], that is, establishing effective communication between the hospital institution and the mobile service leads to better relationships and patient care.

The use of the passometer is pointed out as a possible application in the context of the HR, since it is simpler and less detailed than the mnemonic for Identification, Situation, Background, Assessment and Recommendation (ISBAR). A study points out that the tool can improve the transmission of information during this process, as it presents a clear model of clinical issues and makes it possible to define pending actions and tasks to be fulfilled, improving communication between professionals. [16]

Failure to use a standardized format for presenting information shows that there is a potential for error and breach of information, with inadequate completion of handoff preparation activities, which are related to collecting data about the patient, with updating the care plan, reviewing your information and plan of care and creating the record prior to changing shifts. [3] Thus, there is evidence in the literature that the use of tools can qualify and organize this process. [12]

Among the limitations, there is a relationship with the workload of professionals, time and resources relevant to the performance in health care in the context of emergency care. Time constraints and lack of resources often make the nursing team move away from care, which may indicate quality problems and represent an imminent risk of adverse effects on patients. [17] In a study on the subject, the authors showed that the workload of nursing professionals, above the appropriate level, can increase the risk of a patient dying by 40%. Overload does not only happen because of excessive working hours, but also because of the stress associated with working conditions (excessive workload, lack of employees, material resources and lack of professional and emotional support) and routines that require emotional, cognitive skills, which cover different spheres. [18]

From these reports, it is verified that there is a need to advance in this regard, that is, it is seen that it is of paramount importance to understand the concepts of interprofessional teamwork and two other related constructs – collaboration and interprofessional collaborative practice. In addition, on the part of the nurse, as leader and manager of the team and health unit, they know how to deal with the construct team climate, since its four dimensions allow a more operational approach to teamwork in health services, configuring a work management tool. [19]

Therefore, all staff must be qualified and trained in service to perform their tasks, including training for new employees, under the coordination of the technical responsible for the training program. [20] In this sense, nursing must have a training program focused on the needs of the emergency service, aiming at greater quality and humanization of patient care. Permanent education is a facilitator for the services, however, these need a planned structure, considering that educational activities in the work sectors according to the needs of the service can facilitate changes in daily health practices, enhancing individual knowledge and attention to society according to its needs. [21]

It should be noted that communication can transform practices, especially in Nursing, through the intensive use of light technologies with both patients and professionals, expanding discussions that favor patient safety and the prevention of adverse events. [22] Still, they suggest that the transfer of care should be multidisciplinary, especially in specialty sectors where fixed teams work. [23]

Effective communication generates greater fluidity in teamwork and nursing care, and a quality shift change, in urgent and emergency units, interferes in patient care with reflections on improved communication, especially among multidisciplinary teams, aiming at user security. [22,24] In this direction, communication must be a determining instrument of quality and safety, which aims to guarantee effectiveness in care, as it is necessary for professionals to be prepared and qualified to build a structured relationship, in which an adequate set of information favors the reduction of risks and favors greater safety and quality in health, without causing harm to the patient. [25]

## CONCLUSION

The transfer of care carried out by nursing professionals in an emergency care

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unit evidenced in this study, it is presented how the transfer of information is carried out inter-hospital, intra-hospital and in the sector itself, the essential items to the act, strengths and weaknesses and the need to use an instrument.

In the item related to nursing work in the emergency room, interpersonal relationships, professional knowledge and skills, continuing education, support and performance of nursing coordination and management were demonstrated, importance of teamwork and a positive learning environment as factors that interfere with communication and continuity of care. Effective communication between the institution's professionals, with external professionals and with patients' and patients' families was considered essential for the transfer of care, although it often does not occur properly.

It is recommended to carry out care transfers with accurate information, using verbal, written and recorded means in the medical records, as a systematic communication strategy and responsibility for patient care and safety. Implementing uniform practices can improve transfers and create a culture of integrated, patient-centered care.

This study is limited by the fact that it was carried out only with members of the nursing team, when it should have been with the multidisciplinary team that, in some situations, has the physician as the main actor and with the SAMU, in which nursing has little participation. In nursing, the transfer of information from technicians to technicians and from nurse to nurse was also evidenced, which fragments the transfer processes. Studies involving a multidisciplinary team, the ER and the hospital are suggested, in addition to studies comparing different hospitals.

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