Objectives: The objective of the study was to describe the process of transferring patients from the Department of Emergency Medicine (ED) to the Radiology department.

Methods: Prospective observational study. 160 patients scheduled for transfer to the Radiology Department were observed over a six month period. Observations were performed by three trained observers (including the author). Observers noted all activities, verbal exchanges, use of equipment and the period of time at which they occurred. Each observation began when the physician ordered an x-ray and ended on the patient's return to the ED. All observations were performed during day and evening shifts (8 AM to 11 PM). There was one observer per transfer.

Results: Only 3 transfers were conducted according to the procedure protocol. No incidents of patient harm were recorded. 62% of patients left the ED not according to the protocol. In 16% of transfers there was an extreme problem in the process of leaving the ED and 13% had extreme problems on the stage of arriving to the Radiology Department. 43% of patients returned to the ED without an escort. ED nurses were aware of the returning of 22% of patients who left the ED.

The average delay time outside the ED was 33 minutes. 20% of patients were
out of the ED over 45 minutes.

50% of patients with trauma returned to the ED unescorted.

**Conclusions:** There is a lack of a safety atmosphere in the ED Mt, Scopus. There is a great need for an intervention program that would increase the safety awareness and cooperation between the various human factors, in order to prevent the next event before it occurs.
Bibliography:


5. הרווח המשרד הבריאות 90/57/90 קולה וחולים במעבון


7. Morrissey J. Patient safety proves elusive. Five years after publication of the IOM’s ‘To Err is Human,’ there’s plenty of activity on patient safety, but progress is another matter. Mod Healthc. (2004) 1;34(44):6-7, 24-5, 28-32

8. See Joint Commission on Accreditation of Healthcare Organizations, “Sentinel Events Policy and procedures” online at:
http://www.jointcommission.org/Sentinel_Event_Policy_and_Procedures/

