

A standardized patient handover process: Perceptions and functioning

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What is a handover? In health care?

"The primary objective of a 'handover' is to provide information about a patient's care, treatment and services, current condition and any recent or anticipated changes"

(FP7-HEALTH-2007-B, 2008)

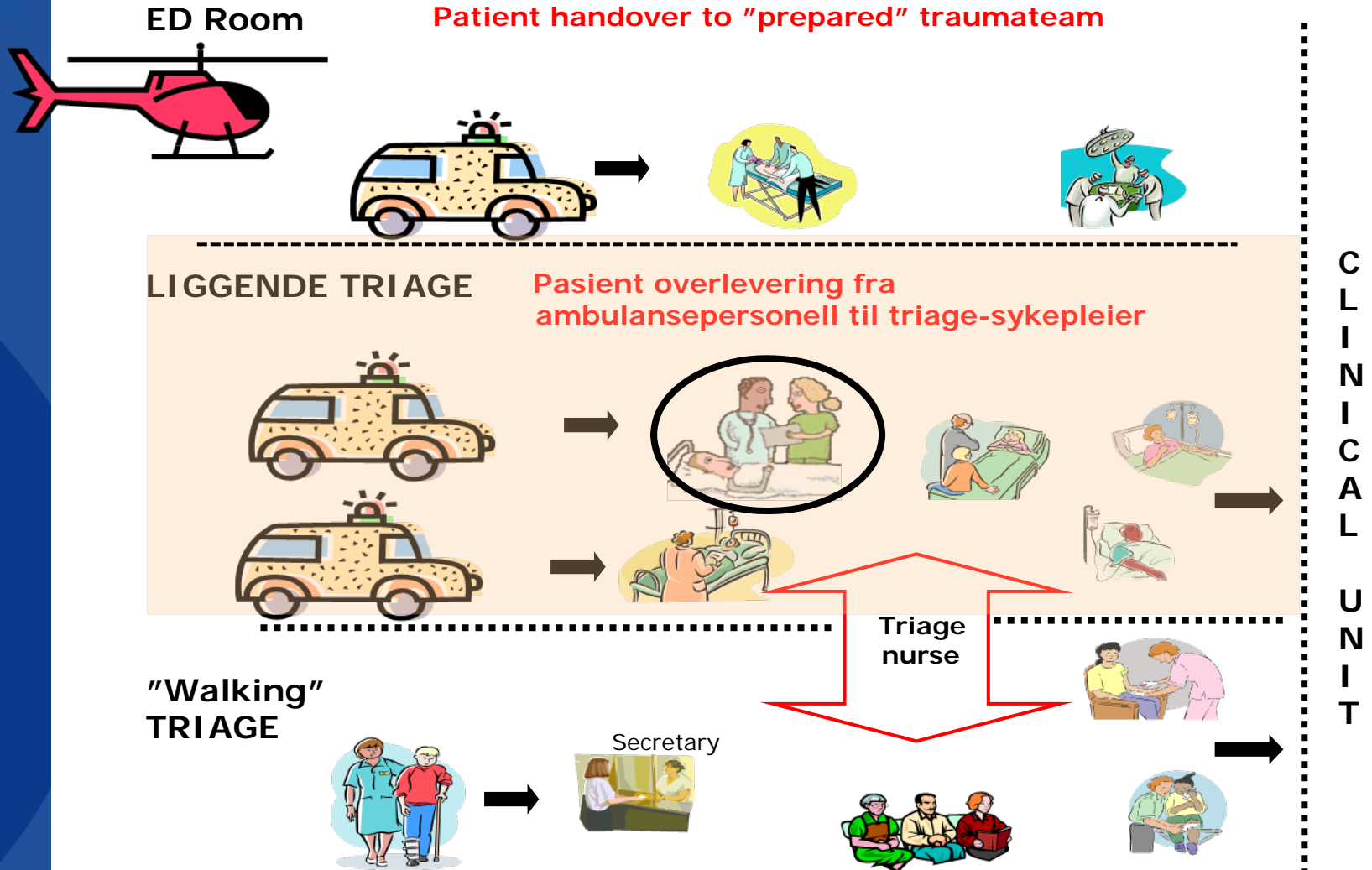


Study context

Implementation of an interdisciplinary standardized
patient handover protocol
in an
emergency department (ED) of a regional Norwegian
hospital
with an
exploratory qualitative study two years after
implementation

*Interdisciplinary meaning same
protocol to be used by both
ambulance personnel and ED nurses*

Empirical context





Study objective

To identify ambulance personnel's and ED nurses' perception of the handover process, and the functioning of the handover process two years after the implementation of a standardized protocol

Background – a joint handover protocol



Introduction of a joint protocol



Primary patient examination



Patient handover in ED



Simulation debriefing



Sound interdisciplinary handover processes? Success factors from the literature

1. Structuralization (interaction, communication)
2. Formal protocol (specific patient cases)
3. Design and implementation adapted to local conditions
4. Focus on communication training and management in clinical teams
5. Focus on active listening
6. Common language for all disciplines involved
7. Mutual understanding of each others roles and tasks
8. Managers to map, improve, ensure quality, plan for monitoring/evaluation

Findings – different attitudes

- *"A handover is from the moment we see them [ambulance personnel] in the door until they go out the same door"* (ED nurse)
- *"We come from pre-hospital to the ED to do the handover in the Triage. We should make sure all relevant information follows the patient in relation to what we have observed out there, the treatment measures we have taken, and the results of the measures taken"* (ambulance worker)

Findings – level of respect

- *" I feel it's very rude if I am occupied with a patient and then the ambulance personnel frag you away. Right? It is impolite towards the patient you are treating!"* (ED nurse)
- *" I think that the patient handover is often the most frustrating part of the transport"* (ambulance worker)
- *" You feel that you have to force your way to deliver the information you think is necessary"* (ambulance worker)

Findings – level of experience/ competence

- *" They [the nurses] automatically turn to the ones that are older than me, even if I am ready to give the report. Then they look around or at my colleague" (inexperienced ambulance worker)*
- *" I have my education and in the ambulance they have another. We don't have the same need for information because we have different starting points and different levels of competence, and that's why it is important to have an identical system to relate to. What information do the nurses need and do they have the understanding that they will handover to somebody with a higher competence level?" (ED nurse)*



Findings – usefulness of procedures

- *" Yes, everyone should know the handover protocol. And we have had training course days for using it and we have trained together with the ones working in the Triage. And not long ago, we went through the protocol again" (ambulance worker)*
- *" There is the fact that we have to improvise to be able to keep up with... It's not always easy to follow the protocol if patients keep coming and there are patients falling in between, the sub-acute ones. We have much more to organize here than in the ambulance! They have one situation at a time..." (ED nurse)*

Findings – the surrounding system

- " This Monday I had an experience which could nearly have gone wrong. In the shift handover coming on duty in the Triage, it was a complete chaos. I think it was 19 patients bedside in the Triage. The duty starts with a report from nurse to nurse. In addition several ambulances came in simultaneously. It was an unsystematic situation regarding who was where, and who were able to receive coming patients. Who had responsibility for whom, and who took responsibility?... And then suddenly a patient got stuck in between the folding screens, highly septic with a blood pressure at 70/50. It's not my intention to laugh, but who had the responsibility for what happened?" (ED nurse)*



Assessment of the handover process

- | | |
|-----------------------------------------------------------------------------|--------------------------------------------------------------|
| 1. Structuralization (interaction, communication) | 1. Yes |
| 2. Formal protocol (specific patient cases) | 2. Yes, but for all patient cases in Triage |
| 3. Design and implementation adapted to local conditions | 3. Yes |
| 4. Focus on communication training and management in clinical teams | 4. Yes, but only prior to the implementation of the protocol |
| 5. Focus on active listening | 5. Initially yes, but difficult in practice |
| 6. Common language for all disciplines involved | 6. Initially yes, but difficult in practice |
| 7. Mutual understanding of each others roles and tasks | 7. Initially yes, but difficult in practice |
| 8. Managers to map, improve, ensure quality, plan for monitoring/evaluation | 8. No |

Survival of the handover protocol requires...

1. Renewed focus
2. Training
3. Management attention
4. Revision
5. Evaluation





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Thank you for your attention!

Everyone Makes Mistakes



Yes – Everyone!