A tailored intervention to improving the quality of intrahospital nursing handover

Jochen Bergs a,⇑, Frank Lambrechts b, Ines Mulleneers c, Kim Lenaerts c, Caroline Hauquier c, Geert Proesmans d, Sarah Creemers b, Dominique Vandijck a,e

a Faculty of Medicine and Life Sciences, Hasselt University, Belgium
b Faculty of Business Economics, Hasselt University, Belgium
c Faculty of Healthcare, PXL University College, Belgium
d Emergency Department, General Hospital Vesalius Tongeren, Belgium
e Faculty of Medicine and Life Sciences, Ghent University, Belgium

ABSTRACT

Introduction: Nursing handover is a process central to the delivery of high-quality and safe care. We aimed to improve the quality of nursing handover from the emergency department to ward and intensive care unit (ICU).

Methods: A quasi-experimental non-equivalent control group pre-test — post-test design was applied. Handover quality was measured using the Handover Evaluation Scale (HES). A tailored intervention, inspired by appreciative inquiry, was designed to improve the implementation of an existing handover form and procedure.

Results: In total 130 nurses participated, 66 before and 64 after the intervention. Initial structure of the HES showed no good fit to our data; the questions were reshaped into 3 dimensions: Quality of information, Interaction and support, and Relevance of information. Following the intervention, mean changes in HES factor scores ranged from +3.99 to +15.9. No significant difference in factor scoring by ward and ICU nurses was found. Emergency department nurses, however, perceived Interaction and support to be improved following the intervention.

Conclusion: The intervention did not result in an improved perception of handover quality by ward and ICU nurses. There was improvement in the perception of Interaction and support among emergency department nurses. The intervention positively effected teamwork and mutual understanding concerning nursing handover practice amongst emergency nurses. In order to improve intrahospital nursing handover, hospital-wide interventions are suggested. These interventions should be aimed at creating a generative story, improving mutual understanding, and establishing a supportive attitude regarding standardised procedures to reduce human error.

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1. Introduction

Innovations in medicine, healthcare technology, and the pharmaceutical industry have led to new treatment options — even for previously incurable diseases. The implementation of these innovations resulted in decreased mortality rates for acute health problems (e.g., acute myocardial infarction or stroke) and improved life expectancy for patients with chronic diseases (e.g., diabetes mellitus or chronic obstructive pulmonary disease). As people tend to live longer with one or more chronic conditions their care needs have become significantly more complex. In addition, the setting in which healthcare is provided progressively outstepped the architectural borders of the doctor’s cabinet, the hospital ward, and even the hospital itself. Healthcare has become a complex process; characterized as a multi-aspect care process involving numerous sub-processes delivered by several healthcare providers often at various locations — both in and outside of the hospital. Hence, coordination and adequate communication between healthcare providers are essential to ensure the quality and safety of patient care.

A process central to the delivery of high-quality and safe care is handover. Clinical handover is defined as “the transfer of professional responsibility and liability for some or all aspects of care for a patient or patient groups, to another person or a professional

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The aim of this study was to improve the quality of nursing handover, we hypothesised that the intervention would improve the quality of nursing handover.

2. Methods

A quasi-experimental non-equivalent control groups pre-test/post-test design was used. We compared the quality of intrahospital nursing handover — for patients transferred from the emergency department to the ward or ICU — before and after an intervention designed to improve the implementation of an existing practice standard (i.e., a structured handover form and procedure).

2.1. Setting

This study was conducted at a general hospital in Belgium's Flemish region with 326 beds divided over 14 wards (including an ambulatory surgical daycentre). The hospital employs over 100 physicians and 800 employees. In 2015 the emergency department had an annual census of 16,837 patient visits of which 32.7% was admitted in the hospital. The emergency department consists of 10 rooms, 4 nonroom bed-spaces, and 4 observation unit treatment spaces [12]. The hospital participates in various regional and national quality and safety programs. Currently, the hospital is actively engaged in an accreditation process (NIAZ). Prior to this project several other initiatives to improve the quality of nursing handover have been carried out. To meet the accreditation standards, a standardised handover system was implemented. Building on the various recommendations, a digital handover form has been developed — summarising important information from the electronic patient file (e.g., personal data, allergies, completed and pending investigations, etc.).

2.2. Rationale and theoretical underpinning

As the current literature cannot confirm that any method reliably brings improvement in the quality of nursing handover [9], we designed an intervention tailored to the needs of the participating emergency department. As previously mentioned, various efforts have already been initiated in order to improve the quality of patient handover. Much attention has been paid to the development of a structured handover form — in accordance with accreditation standards — and accompanying handover procedure. Hence, the main problem was not the lack of a system or structure to facilitate the handover process, but is rather to be found in the implementation of these practices. Therefore, the intervention was designed to improve the implementation of the handover form and procedure amongst emergency nurses.

From the broader field of implementation science we learn that, before a new practice will be used properly, change is needed at two levels: (1) the perception of the sharp end user about the new practice (i.e., problem recognition and practice is accepted as a valid solution) and (2) the workflow of the sharp end users (i.e., the new way of working fits with the existing routines) [13]. We used Normalization Process Theory (NPT) to facilitate the implementation process. It provides a set of sociological tools to understand and explain the social processes through which new or modified practices of thinking, enacting, and organizing work are operationalized in healthcare and other institutional settings. The theory is described in detail elsewhere [14–17]. In this study, we focused on the mechanism of Reflective Monitoring, more specifically on the component Communal appraisal.
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