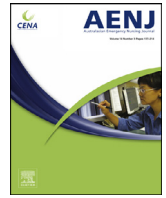




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Research paper

Interprofessional communication supporting clinical handover in emergency departments: An observation study

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ABSTRACT

Background: Poor interprofessional communication poses a risk to patient safety at change-of-shift in emergency departments (EDs). The purpose of this study was to identify and describe patterns and processes of interprofessional communication impacting quality of ED change-of-shift handovers.

Methods: Observation of 66 change-of-shift handovers at two acute hospital EDs in Victoria, Australia. Focus groups with 34 nurse participants complemented the observations. Qualitative data analysis involved content and thematic methods.

Results: Four structural components of ED handover processes emerged represented by (ABCD): (1) Antecedents; (2) Behaviours and interactions; (3) Content; and (4) Delegation of ongoing care. Infrequent and *ad hoc* interprofessional communication and discipline-specific handover content and processes emerged as specific risks to patient safety at change-of-shift handovers. Three themes related to risky and effective practices to support interprofessional communications across the four stages of ED handovers emerged: 1) standard processes and practices, 2) teamwork and interactions and 3) communication activities and practices.

Conclusions: Unreliable interprofessional communication can impact the quality of change-of-shift handovers in EDs and poses risk to patient safety. Structured reflective analysis of existing practices can identify opportunities for standardisation, enhanced team practices and effective communication across four stages of the handover process to support clinicians to enhance local handover practices. Future research should test and refine models to support analysis of practice, and identify and test strategies to enhance ED interprofessional communication to support clinical handovers.

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Introduction

Emergency departments (EDs) are complex, high-risk clinical environments where interprofessional teams of doctors, nurses and allied health staff care for a wide range of patients in settings of uncertainty, where time and resource constraints can impact communication effectiveness. Continuity of ED care requires frequent clinical handovers to transfer responsibility for ongoing patient care between clinicians. Clinical handover involves the transfer of professional responsibility and/or accountability for patient care to another person(s) or professional(s) [1]. Change-of-shift handovers, when the clinician previously caring for the patient leaves

the clinical area, can be a source of communication failure if handover communication is incomplete, inaccurate or misunderstood. Communication errors during clinical handover are a significant contributor to preventable patient harm [2,3].

Effective interprofessional communication is important for comprehensive clinical handovers in the ED where clinicians from multiple disciplines often work independently but have complementary roles in delivering care to a single patient [4]. Differences in clinician perspectives and expectations, professional sensitivities, the context of care delivery, relationships between clinicians, and the types of care institutions can adversely influence the quality of interprofessional communication [5–7].

The importance of clinical handover communication for patient safety in EDs is well recognised and researched [8–10]. Previous research has examined discipline-specific content and communication patterns in EDs [11]: for example, between medical staff [12,13]; between nursing staff [14]; and at interfaces with other

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care settings such as inpatient units [15], intensive care [16] and ambulance paramedics [17,18]. These studies highlight each situation and clinician network has unique communication patterns likely to hinder effective interprofessional communication within the ED. Research on communication that occurs between health professionals is limited [19]. Current ED handover research literature has major gaps related to the impact of interprofessional communication on the quality of clinical handover at the change-of-shift, and the implications for the quality and safety of ongoing patient care.

Another gap in existing ED handover research relates to its predominant focus on contributors to error or harm [20], often omitting examination of practices that are effective, build resilience and mitigate risks [21,22]. Research describing behaviours and processes that contribute to patient safety and quality outcomes for patients and clinicians in the ED is sparse. Learning from what works well rather than correcting errors is a fundamental principle of building resilience in healthcare [22]. 'Positive deviance' research assumes the most useful knowledge about 'what works' is available within existing practices and is demonstrated by individuals who consistently display exceptional performance [23,24]; hence, it is particularly useful for quality improvement research in healthcare [25–27]. In this study, a novel approach to describe 'positive communication behaviours' as well as identify sources of risk was adopted to examine practices of interprofessional communication to support change-of-shift handovers in the ED. The purpose was to generate propositions about practices and strategies expected to support good performance [23] to enhance the quality of communication and patient safety. The aim of this naturalistic, multi-site observation study was to describe patterns and processes of interprofessional communication that impacted transfer of responsibility for patient care between clinicians during change-of-shift handovers in two hospital EDs. Objectives were to (1) identify risks to communication effectiveness and (2) describe practices used to enhance the quality and safety of interprofessional communications to support change-of-shift handovers in the ED.

Methods

A naturalistic, ethnographic design triangulated two data sources in analyses; detailed observation field notes of clinical handover for 315 patient transfers and transcripts of focus group interviews with 34 nurse participants.

Setting and participants

Two acute metropolitan hospitals, one public and one private, in Victoria, Australia were selected to capture similar size, workload, patient profile and variability in handover practices and interprofessional relationships. Both EDs managed between 70 and 90 patient presentations per day and between 9 and 11 nurses were rostered to morning and afternoon shifts. Medical rosters and shift times varied between the sites. Doctors and nurses working regularly in the EDs were informed about the study and given the opportunity to 'opt out' of observations prior to the start of their shift; none declined to participate. All staff received an open invitation to join the focus groups; however only nurses accepted the invitation to participate. Written consent was obtained from focus group participants. Human Research Ethics Committees at the two hospitals and affiliated university approved the study (Ref. 2009-170, EC00217, 09164B).

Data collection

Observation focused on interprofessional communication processes surrounding change-of-shift handovers as clinicians leaving

Table 1
Data collection items and interview questions.

Observer 1 (Trained ED clinician)	Observer 2 (non-clinician)
Handover start and end time	Detailed description of behaviours and interactions Audio-tape content
Patient characteristics Significant event Elements of ISBAR Simultaneous activities Documentation check Staff involved, number and role Interruptions Interventions/tasks performed Patient Outcomes Detailed description of handover steps and processes	
Focus group questions	
<ul style="list-style-type: none"> Briefly describe what you know and understand about effective communication in clinical handovers in the ED. What has been your best experience of clinical handover communication in the ED? What has been your worst experience of clinical handover communication in the ED? What satisfies you when receiving or giving a clinical handover? What irritates you when receiving or giving a clinical handover? What suggestions would you make to improve clinical handover and patient safety outcomes? 	

the clinical area transferred responsibility for patients' ongoing care to oncoming clinicians. Data were collected once on each weekday (5 days) at each site over four continuous weeks, on weekdays only (Monday–Friday), at times that maximised the opportunity to observe change-of-shift for both doctors and nurses (morning, afternoon, evening). Interactions between clinicians immediately before, during and immediately after the change-of-shift handovers were observed. Two trained clinicians collected observation data simultaneously using semi-structured tools and detailed field notes (Table 1). Observer one at each site was a local ED clinician trained to observe the tasks and verbal content. Observer two (same at both sites), was unfamiliar with the EDs and trained to observe interpersonal behaviours and interactions. All observers were trained by the researcher (BR); inter-observer agreement between each observer and the researcher (BR) was >90% before data collection commenced. At the conclusion of weekly data collection, the observers and researcher (BR) debriefed about complementary and divergent understandings of the study data to contest any assumptions and enhance field notes taken. At the conclusion of the observation period, four focus group interviews (two at each site) involving 34 participants (site 1 n = 26; Site 2 n = 8) were conducted using a semi-structured interview guide (Table 1), audio-taped and transcribed verbatim for analysis.

Data analysis

Characteristics of the handovers and participants were summarised using descriptive statistics. Transcribed observation field

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