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Optimising the emergency to ward handover process: A mixed methods study

Shannon Bakon [a,*], Tracey Millichamp [b]

[a] Queensland University of Technology Caboolture Campus, Cnr Manley and Tallon Street, Queensland Health Caboolture Hospital, McKean Street, Caboolture, Queensland 4510, Australia
[b] Queensland Health, Caboolture Hospital, McKean Street, Caboolture, Queensland 4510, Australia

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ABSTRACT

Background: The effective handover of patient health data from the emergency department to other hospital units is integral for the continuity of patient care. Yet no handover process has been identified as superior to others within this context.
Methods: This study within a regional Australian hospital employed mixed methods approach including focus groups and key stakeholder consultation to develop a handover form appropriate for patient transfer from the emergency department to a variety of clinical areas. Paper-based surveys and audits were then employed to evaluate the implementation and understand staff perceptions of the form.
Results: The implementation of a patient handover form within the emergency setting was well received. Participants indicated that the form is clear, well designed and easy to navigate. It provided prompts to standardise their clinical handover and increased their accountability and responsibility within this process.
Conclusions: To deliver an optimal nursing handover from the emergency department to various wards handovers should be structured and provide standardised content. The positive reception and use of this form provides evidence that a structured handover process can ensure standardisation of emergency department to ward nursing handovers.
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Introduction

The handover process is a complex interaction between healthcare professionals that directly influences patient care and subsequent health outcome [1]. Handover has been defined by the Australian Commission on Safety and Quality in Health Care (ACSQHC) [2], as the transfer of responsibility and accountability for a patients care from one person to another. Handover has also been described as a formal method of sharing information [1]. The effectiveness of this process is indisputably integral for the continuity of patient care and in ensuring patient safety [3]. Yet despite its importance, handover is widely recognised as an opportunity for error [4]. Rushed, inadequate and incomplete handovers may lead to adverse health events including medication errors, inappropriate treatments regimes, or delays in initiating treatment [4].

Handovers specifically within emergency departments (ED) have been described as complex with an increased risk of error due to the emergent nature of the care provided and the department environment [5]. Emergency patients may require a higher acuity of care, with treatment requiring precise timing, rapid decision making and multiple health professionals [6]. Furthermore, ED nurses experience a rapid patient turnover, increased patient numbers, inconsistency and unpredictability with their patient load. This may decrease the nurses' opportunities to complete documentation due to the developing nature of the care they provide [4,5]. These environmental and patient factors result in a heightened risk of the nurse receiving or giving an inadequate handover [6].

Many models, tools and strategies have been developed to optimise the handover process within the ED [3]. These strategies such as distributing transfer information and updating computerised patient tracking systems assist to increase handover efficacy and consistency [3]. Yet, these strategies are inconsistently applied and therefore in regards to optimising and standardising the handover process have met with limited success [3]. This lack of success may be because there remains a lack of consensus regarding the most appropriate model to employ, the method through which to ensure

* Corresponding author.
E-mail addresses: shannon.bakon@qut.edu.au (S. Bakon), Tracey.Millichamp@health.qld.gov.au (T. Millichamp).

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standardisation and consistency and an underlying attitude that one model cannot be generically applied to all clinical areas [1]. Indeed, research suggests that it may not be necessary to introduce a standardised handover as different wards and specialties have different needs [1]. However, whilst the common purpose may remain the same, this variation in the models employed between individual units and has resulted in a lack of internal consistency within the implementation, adherence and execution of the handover process [1].

Within the ED of a regional hospital it was identified that the handover 'tick and flick' checklist which was used as a prompt for verbal emergency department handovers to the wards was inadequate. This checklist was not consistently used by the ED nurses and methods of completing the checklist were inconsistent and highly variable. Furthermore the checklist was not retained by the wards as evidence of the communication exchange. Considering these concerns it was identified that there was a high potential for error and adverse patient outcomes. Therefore, a collaborative project was initiated to develop a form to assist ED nurses to provide a consistent structured handover. The aim of this form was to provide guidance on the information that was relevant to include and communicate in a verbal handover and to standardise the handover process.

Material and methods

The broad aim of this study was to improve the handover consistency, by developing and evaluating a structured handover form for use in handover from the ED to the ward.

Form development

The development of an ED handover form required a five step mixed methods approach. The aim of the five step approach was to increase communication, and collaboration between the ED and the hospital wards and the consumers of the healthcare service.

Step one

Hospital employees collaborated on with local university researchers to gain multiple different versions of patient transfer and handover forms. These forms were sourced from other hospitals and universities globally. Literature was sourced from various papers detailing important aspects that nurses feel should be included within a standardised handover such as vital signs, and treatment that is has yet to be commenced.

Step two

Utilising this literature an initial handover form was drafted by university researchers. This form was provided to a focus group comprised of a convenience sample of senior nursing staffs including the nurse unit manager, clinical nurse consultants and clinical nurses within the emergency department. These individuals reviewed the document and suggested initial changes. These changes centered upon the readability, perceived ease of use, and their perception of what data was important to incorporate. Material that was considered to be extraneous was removed and a second version incorporating their recommendations was drafted. Verbal validation of the included changes was received from the step two participants.

Step three

Once validation of the included changes had been received the second version of the handover form was provided to a convenience sample of emergency department nursing staff for further feedback utilising anonymous paper based surveys. Once feedback was provided further amendments were incorporated to create Version three of the form.

Step four

Version 3 of the handover form was then provided to a convenience sample of senior nursing staff located on the hospital wards and units. This step was to address differences in the perception of important information between emergency and ward nursing staff. Whilst emergency nurses may perceive patients vital signs to be the most important information to communicate, ward staff may be more concerned with other patient factors such as the patients decision to not be resuscitated and therefore the ward staffs ability to accommodate the patients' health care wishes. Suggestions from the ward staff were then incorporated into the form to create Version four.

Step five

Version 4 of the handover form was provided to a focus group comprised of individuals from the patient and consumer feedback group located within the hospital. This step focussed on engaging the community as consumers of the healthcare services provided. Final recommendations and suggestions were incorporated where appropriate to create Version 5 of the handover form.

Form implementation

Regular short education sessions were held for a period of four weeks to familiarise nursing staff with the new form (Fig. 1), promote its use and to educate nursing staff on how to appropriately complete the form. Nursing staff were also sent emails with this information. After four weeks of education Version five of the handover form was then implemented within the ED.

Handover process

ED nurses were required to complete sections on the form with bolded grey sections emphasizing areas that were mandatory. The form was then faxed to the ward receiving the patient. This was followed by a telephone call with a verbal handover confirming and/or elaborating on the completed elements. This telephone call allowed the receiving nurse the opportunity to ask questions and gain further clarity.

Form evaluation process

Four weeks after implementation an anonymous paper-based survey incorporating both quantitative and qualitative elements that evaluated the use of the form was circulated to a convenience sample of both the emergency and ward nursing staff. This data was collected over a four week period by providing evaluation forms within the staffroom and a feedback box in which staff could anonymously leave their feedback to be collected. The use of the form by emergency nurses was also audited. The quantitative data components were entered into Statistical Package for Social Sciences (SPSS) Statistics version 22 to ascertain descriptive statistics, frequencies and percentages.

Research ethics statement

This paper reports the findings of a research study that adhered to the National Statement on the Conduct of Human Research by the Australian National Health and Medical Research Council, and was part of a service improvement initiative by Queensland Health. Ethical Approval number HREC/17/QPCH/261

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