Australian Critical Care xxx (2017) xxx–xxx

Contents lists available at ScienceDirect

Australian Critical Care

journal homepage: www.elsevier.com/locate/aucc

Research paper

Developing a minimum dataset for nursing team leader handover in the intensive care unit: A focus group study

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ARTICLE INFORMATION

Article history:
Received 21 August 2016
Received in revised form
21 December 2016
Accepted 19 January 2017

Keywords:
Clinical handover
Intensive care unit
Minimum dataset
Intensive care

ABSTRACT

Background: Despite increasing demand for structured processes to guide clinical handover, nursing handover tools are limited in the intensive care unit.
Objectives: The study aim was to identify key items to include in a minimum dataset for intensive care nursing team leader shift-to-shift handover.
Methods: This focus group study was conducted in a 21-bed medical/surgical intensive care unit in Australia. Senior registered nurses involved in team leader handovers were recruited. Focus groups were conducted using a nominal group technique to generate and prioritise minimum dataset items. Nurses were presented with content from previous team leader handovers and asked to select which content items to include in a minimum dataset. Participant responses were summarised as frequencies and percentages.
Results: Seventeen senior nurses participated in three focus groups. Participants agreed that ISBAR (Identify-Situation-Background-Assessment-Recommendations) was a useful tool to guide clinical handover. Items recommended to be included in the minimum dataset (≥65% agreement) included *Identify* (name, age, days in intensive care), *Situation* (diagnosis, surgical procedure), *Background* (significant event(s), management of significant event(s)) and *Recommendations* (patient plan for next shift, tasks to follow up for next shift). Overall, 30 of the 67 (45%) items in the *Assessment* category were considered important to include in the minimum dataset and focused on relevant observations and treatment within each body system. Other non-ISBAR items considered important to include related to the ICU (admissions to ICU, staffing/skill mix, theatre cases) and patients (infectious status, site of infection, end of life plan). Items were further categorised into those to include in all handovers and those to discuss only when relevant to the patient.
Conclusions: The findings suggest a minimum dataset for intensive care nursing team leader shift-to-shift handover should contain items within ISBAR along with unit and patient specific information to maintain continuity of care and patient safety across shift changes.
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1. Introduction

Adverse patient incidents associated with miscommunication during clinical handover remains a recurring problem nationally and globally in healthcare.[1–4] Breakdown in communication accounted for 20% of all reported sentinel events in Queensland

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http://dx.doi.org/10.1016/j.aucc.2017.01.005
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Please cite this article in press as: Spooner AJ, et al. Developing a minimum dataset for nursing team leader handover in the intensive care unit: A focus group study. *Aust Crit Care* (2017), http://dx.doi.org/10.1016/j.aucc.2017.01.005

(Australia) public hospitals between 2005 and 2006[4] and the Joint Commission recently reported that poor communication is the leading cause of all sentinel events and that more than one third of all patient handoffs are defective.[5] Gaps in communication have been linked to delays in diagnosis, patients receiving the wrong treatment, breakdown in continuity of care and life threatening adverse events leading to longer hospital stays and increased healthcare expenditure.[6] In Australia, clinical handover is listed as a priority area for patient safety improvement, and has led to the roll out of the National Safety Quality Health Service Standard (NSQHSS) 6—Clinical handover.[7] To fulfill accreditation standards healthcare organisations are required to have structured handover processes in place, including a minimum dataset (MDS) to handover patient information. Growing awareness of this patient safety issue has led to the development of a wide range of handover resources with an increasing evidence base in this important area.[8,9]

The introduction of standardised handover processes ensures all participants know the process and content required to present complex patient information.[9] Part of the standardised process includes the incorporation of structured handover tools that enable clinicians to deliver handover in a structured format. Commonly used handover tools include SBAR (Situation-Background-Assessment-Recommendation), I-PASS (Illness severity-Patient summary-Action list-Situation awareness-Synthesis by receiver) and SHARED (Situation-History-Assessment-Risk-Expectation-Documentation). While the use of structured handover tools has been linked to improved continuity of care and patient outcomes,[6,10,11] not all handover tools can be successfully used across all clinical settings. This may be due to the tools containing too much or not enough information, or content that is not applicable to the clinical context. Health care facilities vary widely and have differing functions and size in relation to service delivery, location and workforce.[7] One solution is to utilise flexible standardisation which involves either adapting an established framework or developing a minimum dataset (MDS) that contains content pertinent to the clinical context.[6,10,12,13] Recent studies indicate that standardised handover processes encourage more effective handover[10,12,14] and positive patient outcomes.[11] In particular, there are reports of improved handovers, with fewer technical errors,[15] enhanced clinical performance and clinicians reporting greater knowledge of patients[14,16]; higher satisfaction amongst patients[14,16]; improved patient safety and reduced costs to the healthcare system.[6,11]

Despite the availability of a variety of structured handover tools, transferability to the intensive care unit (ICU) can be challenging. The ICU is an event-driven, time-pressured environment prone to continuous distractions. Patients are critically ill and require timely care at a moment's notice.[17] The complex and multidisciplinary nature of the ICU renders it susceptible to healthcare errors. Handovers occur frequently in the ICU (e.g., change of shift, meal breaks, admissions, transfers) amongst members of a multidisciplinary team (nurses, doctors and allied health staff). Despite a growing body of research focusing on handovers in adult and pediatric ICUs, relating to admissions to the ICU from the emergency department[18] or operating theatre,[15,19–21] nursing bedside shift-to-shift handover[22] and transfers from ICU to the ward,[12,23] little is known about ICU nursing team leader shift-to-shift handover. Unlike bedside nurses that care for one or two patients per shift and discuss detailed patient information at handover, nursing team leaders oversee care provided by bedside nurses, are responsible for the coordination and management of multiple critically ill patients in the ICU and require a succinct overview of patient information. Informative handovers are critical for maintaining patient continuity, safety and a high standard of care, however no structured process for nursing team leader shift-to-shift handover currently exists. Evidence based handover strategies are urgently required to improve communication transfer during handover to avoid unnecessary patient harm. Therefore, the aim of this study was to identify the key items to include in a MDS for nursing team leader shift-to-shift handover in the ICU.

2. Methods

This focus group study was conducted over two days during February 2014 in a 21-bed (government funded) adult medical/surgical ICU, specialising in cardiothoracic surgery at a tertiary referral hospital, in Queensland, Australia. Ethical approval was obtained by the institutional and (HREC/10/QPCH/5) and university (NRS/09/13) Human Research Ethics Committee.

2.1. Setting

There were 180 registered nurses employed in the ICU including 63 senior registered nurses working in team leader roles. The ICU consists of three areas (ICU 1—cardiac surgical, ICU 2/3—general); each area containing up to nine beds coordinated by one team leader. Handovers occur at the nurses' station with a maximum of nine patients discussed by each team leader. The ISBAR (Identify-Situation-Background-Assessment-Recommendation) schema was the hospital's approved handover tool to conduct clinical handover at the study site. The ISBAR schema is widely used in healthcare settings[24,25] and has undergone extensive testing.[24,26] Despite having an approved handover tool at the study site, no standardised or evidence based handover tools were being used. Prior to commencing this study, team leaders could choose up to five different templates that were either developed by individual staff members or printed from an electronic computer system. Team leaders in the two general ICUs predominantly used a template containing the body systems (e.g., central nervous system, respiratory system, cardiovascular system etc.), the registrars weekly patient summary or a printed template from the hospital computer system (WardView provides a brief summary of the patient's demographics and medical status). Team leaders in the cardiac surgical ICU often used a paper template with a cardiac surgical focus (e.g., surgery type, surgeon, cardiac drainage etc) and/or a template containing the patient's medical history and clinical events. Although the templates are vastly different they all contained patient identifiers (name, bed number).

2.2. Participants

Senior ICU registered nurses (grades 5, 6 and 7 registered nurses) involved in team leader handover were purposively sampled. Grade 5 nurses have successfully completed the ICU transition program and team leader educational package, grade 6 nurses have completed the ICU transition program, Graduate Certificate in Intensive Care and team leader educational package, while grade 7 nurses have postgraduate qualifications and coordinate the clinical and managerial operation of the unit. All team leaders worked across the three ICU areas. Participant information sheets and consent forms were sent via internal mail to all nursing staff who met the inclusion criteria (Senior ICU registered nurses involved in team leader handover). Potential participants were told about the study at staff meetings and written consent was obtained prior to study commencement. Consent was also confirmed verbally at the time of data collection.

2.3. Data collection

Registered nurses involved in team leader handover were invited to attend focus groups. Focus groups occurred over two

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