The Patient and Family Perioperative Experience During Transfer of Care: A Qualitative Inquiry

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ABSTRACT

Patient transfers between the OR and intensive care unit are high-risk events. Previous studies regarding mechanisms to improve these transfers do not account for the perspectives of family members or patients. Using transfer-of-care reports from health care providers, we performed a qualitative study of patient and family member perspectives by transcribing, coding, and analyzing seven interviews using hermeneutic cycling, which revealed three main themes: communication, clinical interaction, and clinician demeanor. Participants reported that anxiety about the plan of care and its outcomes eased when they had more frequent communication with members of the clinical team, observed the team interacting with one another, and felt the clinicians' demeanors were confident. The results of this study showed that families perceived that clinicians who communicated the timing and frequency of protocols and procedures improved patient care. Clinician training on empathy, professionalism, and accessibility may increase patient and family satisfaction and decrease negative interactions between clinicians and patients and their family members. *AORN J* 105 *(February 2017) 193-202. © AORN, Inc, 2017. http://dx.doi.org/10.1016/j.aorn.2016.12.006*

Key words: *patient transfer, transfer of care, hand-over communication, patient-centered care, qualitative research.*

Transfers of care (TOCs) between surgical and intensive care staff members are largely unstructured events that do not always follow a specific order.[1] An efficient TOC of a patient from the OR to the intensive care unit (ICU) is critical to reduce medical error.[1] These TOCs are also known as *hand overs* or *hand offs*. The volume, pace, and unstructured format of the information shared during this time can be associated with miscommunication and increased error rates in health care delivery.[1]

Patient-centered research shows a growing emphasis on providing a TOC report to patients and their family members; however, to date, this focus has been inadequate.[2] Historically, researchers have explored the TOC from the perspectives of the sender (eg, RN circulator, surgeon, anesthesia professional) and the receiver (eg, ICU team members) and have not studied patient and family member perspectives.[3] Care providers may assume that family members will not understand or are not concerned with receiving a TOC report; however, patient-centered research raises doubts about these assumptions.[4] Our qualitative inquiry explored the experiences of patients and their families after TOC from the OR to the ICU. We used a qualitative study methodology to identify important patient and family perspectives regarding the TOC.

http://dx.doi.org/10.1016/j.aorn.2016.12.006

LITERATURE REVIEW

Communication between treatment teams during the caregiver-to-caregiver TOC has been classified as a high-risk event.[5,6] Communication failures related to hospitalized patients are associated with treatment delays, diagnostic delays, failure to follow the plan of care, adverse events, patient dissatisfaction, and increased length of stay.[5,7,8] In 2006, The Joint Commission identified standardized TOC communication as a patient safety goal.[9] In 2008, The Joint Commission identified critical steps, procedures, and processes to decrease defective hand overs by 50%.[10] Additionally, The Joint Commission identified that effective hand overs improve patient, family, and staff member satisfaction.[10] Critically ill patients who are transferred between the OR and the ICU are an especially vulnerable population, and a lack of patient care continuity for this population can result in adverse events.[1] Studies show the Situation, Background, Assessment, Recommendation (SBAR) technique to be an effective method of information transfer. The SBAR technique may help in increasing the strength of communication in health care settings.[3,11]

Crucial to patient error reduction is the consistency, thoroughness, and efficiency of the caregiver-to-caregiver TOC.[6] Zavalkoff et al[8] introduced a TOC tool for use when pediatric patients are transferred from the OR to the pediatric ICU. The tool included four major information sections:

- preoperative status,
- medical intraoperative status,
- surgical intraoperative status, and
- immediate postoperative status.[8]

The study demonstrated that the tool resulted in a more thorough TOC and was associated with a reduction of communication-related high-risk events.[8] Although some data show a reduction in high-risk events post transfer when clinicians use a transfer tool, few research studies have explored the perceived discrepancies when the patient and his or her family are considered.[12]

Models of patient care have been transitioning to a more collaborative approach since the early 2000s.[4] Results from one study show that the use of collaborative decision making (eg, shared decision making between all providers, the patient, and the family members) by staff members in ICUs is correlated with improved patient outcomes and patient satisfaction.[4] One representative description of this paradigm is the collaborative autonomy model for shared decision making, in which patients and family members have increased input in treatment planning and more access to the clinical team.[4]

Research regarding patient and family perspectives of the TOC report provided to them after transfer from the OR to ICU are scarce in the literature. Although these perspectives can be gathered through self-reported questionnaires, there are several other avenues that can add to understanding the perspectives of patients and family members. Qualitative research is one way to better understand the experiences that people are exposed to during a particular process or phenomenon.[13,14] In 2015, McElroy et al[2] published a qualitative study of clinicians' perceptions of patient TOC from the OR to ICU. Their findings demonstrated that communication and teamwork among clinicians is key to a successful TOC.[2] Although this study provides some helpful insights about caregiver-to-caregiver TOCs, a more holistic approach to improving the caregiver-to-patient or -to-family-member TOC process requires a similar qualitative analysis of their perspectives.

Groups that support research (eg, National Institutes of Health, Agency for Healthcare Research and Quality, Patient-Centered Outcomes Research Initiative) are emphasizing the importance of patient experiences in research. Most TOC research has centered on care providers and reducing medical errors through improved protocols, not patient and family experiences.[1,2,15,16] Our study team aimed to better understand the patient and family perspectives about their TOC experience by asking open-ended questions about their experience and their preferences during these transfers, a novel area of investigation that can inform future quantitative research.

METHODS

We used opportunistic sampling in this study. We recruited patients and family members experiencing a perioperative event that would result in a transfer to the ICU who consented to partake in a single, semistructured interview.

Description of Study Design

Our research was approved by the institutional review board at the University of Texas Southwestern Medical Center, Dallas; all interviews took place in the ICU. We collected, transcribed, coded, and analyzed the data using hermeneutic cycling. The purpose of hermeneutic cycling is to add knowledge based on interpretations and understanding of a specific phenomenon or experience. The members of our research team have prior experience in qualitative research, and the primary researcher has a background in psychology and qualitative research methods. This background aided the research team in better understanding the systemic effect of the patient and family member TOC process. The primary researcher used the