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Patient handover in the emergency department: 'How' is as important as 'what'

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ABSTRACT

Aim: We explored the existing patient handover practices between emergency care practitioners and healthcare professionals in the emergency department.

In the emergency department, patient handover between emergency care practitioner's and healthcare professionals is a complex process involving multiple functions, such as the transfer of information, responsibility and accountability from one person to another.

We used a qualitative study design. Emergency care practitioners and healthcare professionals were identified using purposive and convenience sampling data. Data were collected through unstructured participant observation. We conducted 20 observation sessions, varying between 15 and 20 min. The data were analysed using a creative hermeneutic approach.

The 'how' or manner of patient handover observed between emergency care practitioners and health professionals was perceived as important. A diagnosis of disrespectful behaviour was made which could negatively influence patient handover and ultimately patient outcome. Disrespectful behaviour stemmed from the two signs that supported the diagnosis: task-orientated behaviour and the use of indigenous language.

Involving the emergency care practitioners and healthcare professionals in observing and analysing the existing patient handover practices in the ED raised their awareness of the current workplace culture. Transforming behaviour from disrespectful to respectful should include greeting one another, listening attentively to the patient handover and include emergency care practitioners, patients and their significant other in the handover process that should be conducted in a commonly understood language. Emergency care practitioners and healthcare professionals should recognise that during patient handover 'how' is as important as 'what'.

1. Introduction

Patient handover, a high-risk often overlooked activity, plays an integral part in safe patient care. Patient handover is a complex process involving multiple functions [1]. The most important function is communicating information and transferring responsibility and accountability from one healthcare professional to another [1–3]. Accurately transferring information assures the safe transition of health care from one professional to another [4,5].

Benefits of ideal patient handover, in which all of the patient's health care problems are clearly stated [6] provides direction to healthcare professionals to deliver safe [7], cost-effective quality patient care [8–10] and ultimately optimises patient outcomes [11]. Effective communication of relevant patient information in a structured and standardised format [12,13], includes active listening skills and patient involvement and participation [3,14]. Non-ideal patient handover is characterised by missing, incorrect or irrelevant information [15,16], resulting in disrupted care delivery and compromised patient safety. Non-ideal patient handover has a negative effect on staff because incompleteness or incorrectness of information causes stress, frustration [11] and mismanagement of these patients.

In an emergency department (ED), patient handover occurs multiple times a day [7], including when patients are transferred to the ED by ambulance, from pre-hospital (emergency care practitioners) to in-hospital care (healthcare professionals). Emergency care practitioners have the knowledge and skill to deliver holistic care on a basic, intermediate and advanced level in the pre-hospital environment [17]. Through ideal patient handover the emergency care practitioners transfer the accountability and responsibility of the patient care to the healthcare professionals (nurses and doctors) [18] and ensure continuity of patient care [1]. Patient handover in the ED differs from other environments as it is influenced by a complex, busy and dynamic environment [15] that shapes the existing workplace culture.

Workplace culture or 'the way things are done around here' [19]

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affects the way in which patient handover is done. Emergency care practitioners and healthcare professionals involved in patient handover are responsible for the workplace culture relating to handover practices in the ED through their actions, attitude and behaviour [20]. The workplace culture in the ED may also be affected as the focus is on saving lives as a priority in an environment characterised by multiple interruptions [6] and increased noise levels, which can lead to human errors [3] and subsequently information loss during patient handover [15]. Other possible factors influencing patient handover practices include patient overcrowding, patient acuity levels [6], staff workload, the education levels and prior experience of emergency care practitioners and health care professionals [6], ineffective listening skills [8] and the workplace culture [20].

In an ED in a private hospital with 267 beds in Gauteng, a province in South Africa, healthcare professionals raised concerns about the handover practices. An average of 1070 adults and paediatric patients are admitted to the 19-bedded ED per month of which the emergency care practitioners bring in approximately 20%. There were no clear guidelines or protocols regarding patient handover and it was viewed that patient handover occurred in a haphazard way. If challenges are identified with the way in which patient handover is done, Jensen et al. [8] and Bost et al. [6] suggest that one should 're-look' 'the way things are done around here' (workplace culture). We reached consensus to collaboratively explore the existing patient handover practices between emergency care practitioners and healthcare professionals in the ED in order to raise awareness of the existing workplace culture.

2. Ethical considerations

The research ethics committees of the Faculty of Health Sciences, University of Pretoria (Reference number 249/2015), the hospital group and ambulance services involved approved the study protocol prior to data collection. Informed consent was obtained for the observers as well as those being observed (emergency care practitioners and healthcare professionals) before observation was commenced.

3. Methods

A qualitative approach using participant observation was used to explore the existing patient handover practices in the ED. The population included emergency care practitioners and healthcare professionals (medical doctors and nurses) involved in patient handover who were identified using purposive and convenience sampling. The researchers invited all the emergency care practitioners who transported patients to the ED as well as the healthcare professionals who worked in the ED to attend information sessions about the study. During these sessions the emergency care practitioners and healthcare professionals were given an opportunity to ask questions and once informed consent was signed, the observation dates and times were negotiated.

3.1. Data collection and participants

Patient handover between all emergency care practitioners and healthcare professionals who signed informed consent was observed. Patient handover practices of patients brought in by emergency care practitioners and triaged as priority one patients were excluded. Priority one patients are critically ill or injured patients who require patient handover practices that tend to be more complex, and therefore may differ from non-critical patients.

The researchers conducted two pilot observation sessions to ensure the appropriateness of the observation tool, which were not included during the data analysis. Thereafter, the researchers invited the emergency care practitioners as well as the healthcare professionals to participate as co-observers. A total of 20 unstructured participant observation sessions were conducted. Data saturation was reached after 17 observation sessions and confirmed with an additional three sessions. The observation sessions occurred during different times on day and night shifts and different days of the week (including weekends), lasting between 15 and 20 min per session. Observation was done unobtrusively and did not interfere with the patient handover practices or patient care. Being aware of the Hawthorne effect and the possible impact on behaviour during patient handover practices [21], the observers wore their uniforms during observation sessions in an effort not to be seen as a threat and blend in with the environment.

3.2. Data analysis

The researchers formally invited all the emergency care practitioners and healthcare professionals to a pre-arranged data analysis session held at a neutral venue outside the ED (board room of hospital). The data were collaboratively analysed using a creative hermeneutic data analysis approach as described by Boomer and McCormack [22]. Eight participants participated and were divided into two groups consisting of one emergency care practitioner and three nurses. Each participant read the observational data and created their own visual image that captured the essence of their general impressions, thoughts and feelings. Participants were paired in the small group and asked to share the story of their image with a co-participant, who wrote down the story verbatim. The groups were then asked to develop as many themes as possible using the creative images and verbatim stories as centrepieces. Each theme was written on a paper strip and then stuck onto the creative images. The participants shared their identified themes and reached consensus on a central theme.

4. Findings

The participants acknowledged that pockets of excellence were observed regarding 'what' information was transferred during patient handover, for example the structured way in which patient data were presented. However, the 'how' patient handover was done, which could also be referred to as the existing workplace culture, was a concern. The participants reached consensus that the central theme '*disrespectful behaviour*' that emerged will be referred to as the 'diagnoses'. The participants decided to refer to the categories as 'signs' and subcategories as 'symptoms'. The frequency (f) of the signs and symptoms observed related to disrespectful behaviour is indicated. View Table 1 *(f = occurrence of sign or symptom out of total observations being 20)*.

The signs and symptoms of the diagnosed workplace culture 'disrespectful behaviour' relating to existing patient handover in the ED are discussed.

4.1. Sign 1: Task-orientated behaviour

During patient handovers, participants recognised that the emergency care practitioners and healthcare professionals focused on non-lifesaving tasks such as transferring the patient from the ambulance stretcher to the ED bed rather than on patient handover. As the patients are non-critical performing these tasks should not be a priority and

Table 1
Summary of diagnosis and frequency *(f)* of signs and symptoms relating to patient handover.

Diagnosis *(Theme)*	Signs *(Categories)*	Symptoms *(Sub-categories)*
Disrespectful behaviour	1) Task orientated behaviour *(f:3/20)*	1. Overlooking greeting *(f:6/20)* 2. Inattentive listening *(f:6/20)* 3. Exclusion of emergency care practitioners *(f:6/20)* 4. Non-involvement of patients and significant other *(f:6/20)*
	2) Indigenous language *(f:4/20)*	