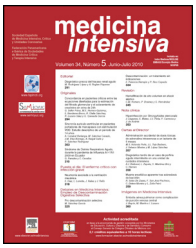
Med Intensiva. 2018;42(3):168–179

medicina intensiva

www.elsevier.es/medintensiva



SPECIAL ARTICLE

Handover in Intensive Care☆

G. Sirgo Rodríguez[a], M. Chico Fernández[b], F. Gordo Vidal[c], M. García Arias[c], M.S. Holanda Peña[d], B. Azcarate Ayerdi[e], E. Bisbal Andrés[f], A. Ferrándiz Sellés[f], P.J. Lorente García[f], M. García García[g], P. Merino de Cos[h], J.M. Allegue Gallego[i], A. García de Lorenzo y Mateos[j], J. Trenado Álvarez[k], P. Rebollo Gómez[l], M.C. Martín Delgado[l,*], Planning, Organization and Management Group of the Sociedad Española de Medicina Intensiva Crítica y Unidades Coronarias (SEMICYUC)

[a] *Servicio de Medicina Intensiva, Hospital Universitario Joan XXIII, Instituto de Investigación Sanitaria Pere Virgili, Tarragona, Spain*
[b] *UCI de Trauma y Emergencias (UCITE), Servicio de Medicina Intensiva, Hospital Universitario 12 de Octubre, Madrid, Spain*
[c] *Servicio de Medicina Intensiva, Hospital Universitario del Henares, Madrid, Spain*
[d] *Servicio de Medicina Intensiva, Hospital Universitario Marqués de Valdecilla, Santander, Spain*
[e] *Servicio de Medicina Intensiva, Hospital Universitario Donostia, San Sebastián, Spain*
[f] *Servicio de Medicina Intensiva, Hospital Universitario General de Castellón, Castellón, Spain*
[g] *Servicio de Medicina Intensiva, Hospital Universitario Río Hortega, Valladolid, Spain*
[h] *Servicio de Medicina Intensiva, Hospital Can Misses, Ibiza, Spain*
[i] *Servicio de Medicina Intensiva, Hospital Universitario Santa Lucía, Cartagena, Spain*
[j] *Servicio de Medicina Intensiva, Hospital Universitario La Paz-Carlos III/IdiPAZ, Madrid, Spain*
[k] *Servicio de Medicina Intensiva, Hospital de Terrassa, Terrassa, Spain*
[l] *Servicio de Medicina Intensiva, Hospital Universitario de Torrejón, Madrid, Spain*

Received 22 September 2017; accepted 1 December 2017
Available online 16 March 2018

KEYWORDS
Handover;
Clinical safety;
Process;
Communication;
Intensive care

Abstract Handover is a frequent and complex task that also implies the transfer of the responsibility of the care. The deficiencies in this process are associated with important gaps in clinical safety and also in patient and professional dissatisfaction, as well as increasing health cost. Efforts to standardize this process have increased in recent years, appearing numerous mnemonic tools. Despite this, local are heterogeneous and the level of training in this area is low.

☆ Please cite this article as: Sirgo Rodríguez G, Chico Fernández M, Gordo Vidal F, García Arias M, Holanda Peña MS, Azcarate Ayerdi B, et al. Traspaso de información en Medicina Intensiva. Med Intensiva. 2018;42:168–179.

* Corresponding author.
E-mail address: mcmartindelgado@gmail.com (M.C. Martín Delgado).

The purpose of this review is to highlight the importance of IT while providing a methodological structure that favors effective IT in ICU, reducing the risk associated with this process. Specifically, this document refers to the handover that is established during shift changes or nursing shifts, during the transfer of patients to other diagnostic and therapeutic areas, and to discharge from the ICU. Emergency situations and the potential participation of patients and relatives are also considered. Formulas for measuring quality are finally proposed and potential improvements are mentioned especially in the field of training.

PALABRAS CLAVE
Traspaso de información;
Seguridad clínica;
Proceso;
Comunicación;
Medicina intensiva

Traspaso de información en Medicina Intensiva

Resumen El traspaso de información (TI) es una tarea frecuente y compleja que lleva implícito el traspaso de la responsabilidad del cuidado del paciente. Las deficiencias en este proceso se asocian a importantes brechas en la seguridad clínica e insatisfacción de pacientes y profesionales. Los esfuerzos por estandarizar el TI se han incrementado en los últimos años, dando pie a la aparición de herramientas mnemotécnicas. Globalmente las prácticas locales del TI son heterogéneas y el nivel de formación, bajo.

El objetivo de esta revisión es enfatizar la importancia del TI y proporcionar una estructura metodológica que favorezca el TI efectivo en las UCI, reduciendo el riesgo asociado a este proceso. Específicamente, se hace referencia al TI durante los cambios de guardia y los turnos de enfermería, durante el traslado de los pacientes a otras áreas diagnósticas y terapéuticas y en el momento del alta de UCI. También se contemplan las situaciones de urgencia y se señala la potencial participación de pacientes y familiares. Por último, se proponen fórmulas para la medición de la calidad y se mencionan posibles mejoras en este proceso, especialmente en el ámbito de la formación.

Introduction: the impact of information handover upon patient safety

In current medical practice, which is fundamented upon teamwork and where no single professional is able to supervise the care of a patient for 24 h, 365 days a year, information handover (IH) is a frequent and unavoidable process.

In our setting, IH is essentially a matter of habits and routines, and only in exceptional cases is it mediated by some type of specific training.[1,2] Perhaps for this reason communication errors are an important source of incidents and adverse events. In the SYREC study, contributing factors related to communication were found to be present in 5.76% of the incidents and in more than one-half of the sentinel events.[3] In this respect, deficient IH has been associated to treatment errors, prolonged patient stay and increased healthcare costs.[4]

The Joint Commission has recommended the development of structured communication procedures among professionals.[5] In parallel, other countries have launched similar initiatives.[6–8] In our setting, the Patient Safety Strategy of the Spanish National Health System 2015–2020[9] has underscored the need to promote communication among professionals in order to ensure that the information handed over is precise, adequate and addressed to the correct person, and advocates the implementation of structured communication techniques.

The aim of the present review is to illustrate the importance of IH and at the same time afford a methodological structure favoring effective IH in the Intensive Care Unit (ICU), and reducing the risks associated to this process. Specifically, this document refers to IH established during changes in medical shifts or nursing shifts; during the transfer of patients to other diagnostic and therapeutic areas; and at discharge from the ICU. Emergency situations and the potential participation of patients and relatives are also considered. Lastly, formulas for measuring quality are proposed, and potential improvements are mentioned particularly in relation to training.

Information handover: terms and definitions

Information handover: this refers to communication among healthcare professionals, in which the clinical information of a patient is transmitted, and the responsibility of care is transferred either temporarily (change in shift) or permanently (change in Unit or healthcare level; see the subsection ''Care transition'').[10]

Intra-disciplinary information handover: this occurs between healthcare professionals that have the same academic training (physician–physician in the change in shift,