

PATIENT HANDOVER IN THE EMERGENCY DEPARTMENT: ‘HOW’ IS AS IMPORTANT AS ‘WHAT’

Santel de Lange, Ilze van Eeden*, Tanya Heyns

Department of Nursing Science, Faculty of Health Sciences, University of Pretoria, Pretoria, South Africa

* Corresponding author at: University of Pretoria, HW Snyman Building, 31 Bopelo Road, Gezina, 0001 Pretoria, Gauteng, South Africa., E-mail address: ilze.vaneeden@up.ac.za (I. van Eeden)

Highlights

- The findings provided insight into the current patient handover workplace culture between emergency care practitioners and healthcare professionals in the emergency department.
- The findings suggest that practitioners prioritise ‘how’ patient handover is done above ‘what’ information is transferred during patient handover.
- The findings of this study demonstrated that disrespectful behaviour is practiced by both emergency care practitioners and healthcare professionals during patient handover.
- This research provides evidence that task-orientation and use of indigenous languages are signs of disrespectful behaviour during patient handover in the emergency department.

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'.

Keywords:

Disrespectful behaviour, Emergency department, Emergency care practitioners, Patient handover, Workplace culture

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] 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 a 19-bedded ED of a private hospital with 267 beds in Gauteng (a province in South Africa) who mainly serves patients with private health insurance, healthcare professionals identified challenges regarding the way in which they practiced patient handover. Handover practices between emergency care practitioners and healthcare professionals were done haphazardly and there were no guidelines or protocols regarding patient handover practices in the ED. The 19-bedded ED managed an average of 1070 adults and paediatric patients per month of which 20% is brought to the ED by emergency care practitioners. 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). After patient handover practices was identified as a challenge in the ED, consensus was reached 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.

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.

METHODS

A qualitative approach using participant observation was used to explore the existing patient handover practices done daily in the natural setting of the ED [21]. The population included emergency care practitioners and healthcare professionals (medical doctors and nurses) involved in patient handover. The participants were purposively selected to take part in the research due to their experience in the chosen ED and knowledge of patient handover practices. 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.

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. The aim of inviting the participants to be co-observers (emergency care practitioner or healthcare professional) was to raise awareness and enhance buy-in into the research. The co-observers would volunteer to help with observation on their day off and after being orientated to the observation tool would observe patient handover as it took place in the ED together with one researcher. Each observer (researcher and co-observer) would complete their own observation tool. After every observation the researcher and co-observer would compare notes and clarify uncertainties. 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 to 20

minutes 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 [22], the observers wore their uniforms during observation sessions in an effort not to be seen as a threat and to blend in with the environment.

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 [23]. 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.

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 would 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 in Tabel 1. (*f* = occurrence of signs and symptoms / total observation sessions of 20)

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) <i>Task orientated behaviour</i> • (<i>f</i> :3/20)	1. <i>Overlooking greeting</i> (<i>f</i> :6/20) 2. <i>Inattentive listening</i> (<i>f</i> :6/20) 3. <i>Exclusion of emergency care practitioners</i> (<i>f</i> :6/20) 4. <i>Non-involvement of patients and significant other</i> (<i>f</i> :6/20)
	2) <i>Indigenous language</i> • (<i>f</i> :4/20)	•

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.

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 created the impression of disrespect amongst all involved in the patient handover. The 'how' of patient handover '*took a backseat*' to '*non-lifesaving*' tasks. The sign '*task-orientated behaviour*' was based on four symptoms 1) '*a lack of greeting*', 2) '*inattentive listening*', 3) '*exclusion of emergency care practitioners*' and 4) '*non-involvement of the patient and significant other*'.

Task-oriented behaviour resulted in overlooking the importance of greeting as emergency care practitioners '*entered the unit [ED] and passed the front desk (admission clerk) without greeting or reporting [observation tool 1.1]* and took the patient straight through to the management area. Once in the management area, the emergency care practitioners transferred the patient to the ED bed without greeting the healthcare professionals. Likewise, healthcare professionals did not always greet the emergency care practitioners when they entered the ED as the '*nurse arrived and asked why they (emergency care practitioners) want to put the patient in resus (resuscitation room) without*

greeting the paramedics (emergency care practitioners) first [observation tool 17].

The second symptom '*inattentive listening*' was identified due to the observation where '*nurses started management*' [observation tool 1.1] and were '*talking to the patient and each other during patient handover and did not listen [observation tool 15]*' to the emergency care practitioner handing over. Consequently, the healthcare professionals '*asked questions on information already provided [observation tool 13]*' and the emergency care practitioners had to repeat the information. Prioritizing tasks lead to inattentive listening and was identified as a symptom of '*disrespectful behaviour*'.

The third symptom was '*exclusion of the emergency care practitioners*'. Emergency care practitioners were excluded as '*nurses started closing curtains to do ECG (electrocardiograph) while paramedic (emergency care practitioners) was still handing over. Curtains placed all paramedics (emergency care practitioners) outside and handover stopped*' [observation tool 1.1]. The behaviour created a barrier between the emergency care practitioners, healthcare professionals and patients. This behaviour of healthcare professionals were perceived to be disrespectful when '*curtains (were) drawn around the patient and they (emergency care practitioners) were standing on the outside*' [observation tool 6].

The fourth symptom was *'non-involvement of patients and their significant other'*. *'Patient(s) not involved, no questions or input asked during handover'* [observation tool 14] regardless of the fact that the patients who was handed over were all awake and orientated. Patients and their significant others were observed to be willing and sometimes desperate to participate as the *'patient kept on adding information during the handover, interrupting it'* [observation tool 5]. The *'family came in for second time interrupting the handover and tried to provide information but the RN (nurse) asked family to please leave the room'* [observation tool 3] and thus regarded their attempts as unimportant and a distraction to patient management. This behaviour of the healthcare professionals left the patient and their significant other voiceless and excluded them from the handover.

Sign 2: Indigenous languages

The second sign of disrespectful behaviour was the occasional use of *'indigenous language'* during patient handover. Although this sign was not based on any symptoms, the participants identified it as important and serious sign of disrespect as it also influences the *'how'* of patient handover. It was observed (four out of 20 times) that emergency care practitioners and healthcare professionals had the tendency to use their *'mother tongue'* during patient handover, especially if two or more involved in the handover was from the same indigenous background. Participants acknowledged that they were aware that communication during patient handover should be done in English, but during the observation sessions it became clear that both emergency care

practitioners and healthcare professionals *'used another language than English to do the handover which wasn't understandable to everyone present [observation tool 5]*. The observation notes made the participants aware of the fact that indigenous languages were used during patient handover in the ED despite not all involved being from the same indigenous background. In all four of the observed instances where English were not used either one of the emergency care practitioners, healthcare professionals or patients were from a different background. Not being able to understand handover was identified not only as unacceptable practice, but also as disrespectful behaviour.

DISCUSSION

The pre-hospital and ED (in-hospital) environments are considered to be medical-technical environments [24], where the emphasis is placed on technology, clinical skills and life-saving patient management. During patient handover in the ED, the pre-hospital and in-hospital environments intersect. During patient handover emergency care practitioners transfer information relating to pre-hospital management [24] to healthcare professionals, whilst healthcare professionals are focussed on initiating life-saving management as needed by the patient arriving in the ED. During the observation sessions, 'how' the patient handover was done was negatively perceived and diagnosed by the participants as 'disrespectful behaviour'. The disrespectful behaviour was so embedded in the day to day patient handover workplace culture, that it seemed 'normal', which is congruent with the findings of Leape et al [26]. Disrespectful behaviour however could erode communication, professional relationships and

collaboration and impact negatively on patient outcomes [27]. In our study, being too task-oriented and using indigenous languages in the workplace were identified as '*signs*' of disrespectful behaviour.

Working in a medical-technical environment, both emergency care practitioners and healthcare professionals were very task-orientated, which was perceived as disrespectful behaviour that negatively influenced patient handover. Healthcare professionals in the ED are usually more concerned about assessment and commencement of patient management than about the details of patient handover [10, 28], especially in emergency situations [8]. This task-orientated behaviour, originating from emergency situations, has become the norm even when the patient is not critically ill or injured and no emergency exist [12, 25, 29].

The first '*symptom*' of being too task-orientated in this study was that emergency care practitioners and healthcare professionals overlooked the importance of greeting each other. Not greeting each other was perceived as disrespectful behaviour and resulted in healthcare professionals being unaware of new patients entering the ED, which in turn delayed patient handover [30]. Greetings between emergency care practitioners and healthcare professionals during patient handover may foster feelings of being valued and respected, enhance teamwork and consequently patient outcomes. Being too task-orientated led to inattentive listening during patient handover, the second symptom of disrespectful behaviour.

Healthcare professionals that were attentive to patients and assessments of patients, rather than the emergency care practitioners, did not listen to the information given by the emergency care practitioners during patient handover. This is problematic to the handover process, especially if the patient is not critical [12, 25, 29]. Inattentive listening leads to a loss of patient information and resulted in emergency care practitioners needing to repeat themselves [6]. Many emergency care practitioners have expressed that healthcare professionals who listen during patient handover are showing respect for them as persons and recognizes their contribution to patient management [31]. Emergency care practitioners further perceived the act of drawing the curtains around the patient's bed before the patient handover was completed as disrespectful behaviour. Drawing the curtains left the emergency care practitioners standing on the outside of the curtain, creating a barrier that prevented the transfer of information between the emergency care practitioners and healthcare professionals in the ED.

According to Sadri et al [32] the ideal patient handover in the ED involves healthcare professionals, emergency care practitioners, the patient and the patient's significant other. Putting the patient (and his significant other) at the centre of handover and involving them during the process can lead to the realisation of patient-centred handover practices. Involving patients and their significant other in the handover process leads to a decrease in adverse events, improves communication and enhances the continuity of patient care [14, 33, 34]. Involvement of the patients and significant others provides an opportunity to

rectify unclear information and allows them to contribute additional information [33, 35]. Despite the benefits, patients and their significant others were not involved during patient handover in this ED, which correlates with the findings of studies conducted by Klim, et al [36] and Tidwell et al [35]. The non-involvement of alert patients and their significant others in the patient handover practices can be construed as disrespectful [35].

Effective, explicable communication forms the corner stone of quality patient care and improves patient outcomes [37]. Using a commonly understood language during the patient handover is important [12], but the use of languages that are not understood by all involved in the patient handover practice forms a barrier to the transfer of information [38]. The use of language that are not understood by all involved in patient handover not only result in loss of information, but affect patient outcomes [6, 12, 25, 39]. The statement was resonated by Manser and Foster [40] who identified that poor communication during patient handover leads to poor patient care and negative outcomes. Using a language (English) understood by all was suggested by the participants to bridge this challenge.

LIMITATIONS

Despite being invited, the medical doctors did not participate in the observation sessions or the data analysis session and therefore their voices were silent. The patients and their significant others were also not involved in the data collection or analysis. As only one private ED of a private hospital in Gauteng was the

focus of this study it cannot be overall representative of patient handover practices in all ED's of Gauteng.

RECOMMENDATION

Future research on patient handover practices should focus on ways to involve the patient, family and the medical doctors in order for all voices involved in this practiced to be heard. It is also recommended that both private and provincial hospital ED's be included in future research to be representative of the pluralistic healthcare system in South Africa. Strategies to improve handover practices between emergency care practitioners and healthcare professionals in the ED could in future be developed.

CONCLUSION

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 workplace culture. The 'what' of patient handover was not regarded as a concern, however the 'how' was identified as a challenge and diagnosed as 'disrespectful behaviour'. The task orientated behaviour and use of indigenous languages during patient handover practices affected the workplace culture negatively.

Both emergency care practitioners and healthcare professionals recognised that the workplace culture should change to address the challenges identified on 'how' patient handover is done in the ED. Emergency care practitioners and

healthcare professionals should behave in a respectful way by greeting one another, listening attentively to and including emergency care practitioners as well as involving and giving the patient and significant other a voice during handover. Patient handover should be done in a language understood by all involved to prevent the loss of information that could affect patient outcomes.

Based on the findings the emergency care practitioners and healthcare professionals should collaboratively plan and implement strategies to address the current workplace culture. Practitioners should continuously evaluate and improve patient handover workplace culture in the ED. Emergency care practitioners and healthcare professionals should recognise that during patient handover 'how' is as important as 'what'.

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