Queensland University of Technology
Brisbane Australia

This is the author's version of a work that was submitted/accepted for publication in the following source:

Calleja, Pauline, Aitken, Leanne M., & Cooke, Marie L. (2010) Barriers to information transfer for multi-trauma patients upon discharge from the Emergency Department in a tertiary level hospital. In *Queensland Statewide Trauma Symposium 2010*, 4-5th November 2010, Royal Brisbane & Women's Hospital, Brisbane, Queensland. (Unpublished)

This file was downloaded from: http://eprints.qut.edu.au/46830/

**© Copyright 2010 the authors.**

**Notice**: *Changes introduced as a result of publishing processes such as copy-editing and formatting may not be reflected in this document. For a definitive version of this work, please refer to the published source:*

# BARRIERS TO INFORMATION TRANSFER FOR MULTI-TRAUMA PATIENTS UPON DISCHARGE FROM THE EMERGENCY DEPARTMENT

Pauline Calleja, Leanne M Aitken and Marie Cooke

# Overview

- Background
- Purpose
- Method
- Results
- Conclusions and further directions

# Background

- Communication is integral to trauma care
- Communication can be impacted on by:
  - context,
  - number of people involved
  - urgency of the communication topic
- Limited research re adequacy of structures and processes of communication
- Anecdotal evidence of poor information transfer
- Missing or fragmented patient care information appears to be a significant challenge

# Purpose

- Report on barriers to meaningful information transfer for multi-trauma patients upon discharge from the Emergency Department to:
  - Intensive Care Unit
  - High Dependency Unit
  - Perioperative Services
- Barriers will be described as discovered in an ongoing study at one tertiary level hospital in Queensland.

# Method

**Phase 1 – Context appraisal**
- Literature review
- Focus groups
- Patient chart audit
- National and international practices
- Staff survey

**Phase 2 – Strategy development**
- Strategy development working group

**Phase 3 – Strategy implementation**
- Implement strategy devised in Phase 1's working group with use of practice development framework

**Phase 4 – Strategy evaluation**
- Focus groups
- Staff survey
- Patient chart audit

# Results

- Literature review - 45 research papers, 4 literature reviews and 1 policy statement
- Focus Groups - 6 groups
- Chart Audit –93 charts
- Staff survey – 58 over 5 staff groups
- International and national chart review – 4 International, 1 Australian

# Results

- Quality of information transfer was variable
- Barriers related to:
  - Nursing handover
  - Documented information
  - Time inefficiency
  - Patient complexity
  - Time of transfer

# Staff expectations

- Differences in nursing staff expectations of:
  - What should be handed over
  - What information should be documented
- This led to variation in these aspects of information transfer
- No agreed minimum dataset of patient information to handover

# Handover

- Handover issues were mostly about inconsistency of performance
- Staff agreed that they did not know what expectations of the different wards were
- Issues with receiving staff engaging in the handover
- Handover impacted upon by seeing to patient needs during handover.
- 81% patients had injuries that were likely to affect physical transfer

# Documentation

- Missing, illegible or difficult to find information in medical and nursing notes
- Low compliance with some forms for documentation
- Patients transferred from other hospitals are more complex for information transfer
- Often wards received conflicting information about patients before they arrived from the ED

# Documentation

- 62% of patients were transferred out of the ED between 1731-0759 hrs.
- 35% of patients transferred on weekend
- Time inefficiency of accessing charts due to jumbled order
- Chart audit time: 8mins to 54mins.

# Time inefficiency

- Time inefficiency for receiving staff
- Barriers were also discussed as patients who went to ICU or HDU via operating theatres:
  - In these situations gaps in handed over information were large in particular about the patient's history, treatment in the ED and pre-operative stability

# Relationship of factors affecting information transfer for multi-trauma patients to themes

| | Trauma Teams | Communication | Documentation | Handover |
|---|---|---|---|---|
| Ethical elements | | | | X |
| Legal elements | | | X | |
| Team factors | X | X | | |
| Patient factors | X | X | | X |
| Environment factors | X | X | | X |
| Process factors | | X | X | X |
| Individual performance elements | X | X | X | X |
| Resource factors | X | X | X | X |
| Organisational factors | X | X | X | X |

# Future directions

- Strategy development group have:
  - Agreed on a minimum dataset for handover of these complex and time acute patients
  - Used this to form a structure for handover
  - Also will trial sequencing of handover for patients who are stable enough: handover then transfer
  - Recommended that some forms be revised for ease of use, relevance and to reflect the minimum dataset agreed on between wards
  - Until forms can be revised run education/awareness raising in the units about the intervention and findings

# Intervention

- **Nursing handover structure**- **IM SO BARF trial** for nursing handover
- **Information dissemination** for awareness-raising.
- **Trial sequence of handing over** first then transferring patient wherever possible.
- **Nursing handover processes**: Engage accountability of minimum information recorded and handed over with both ED and receiving ward staff, negotiating this with the receiving ward staff.

## IM SO BARF HANDOVER STRUCTURE

**Are you handing over or receiving this trauma patient? This is what should be included...**

**I- Identification of patient**

**M- Mechanism of Injury**

**S- Situation** (for T/F to theatre?) **& stability/status**

**O- Observations** (trends, impact in response to treatment)

**B- Background & History** (+ management to date)

**A- Assessment & Actions** (plan of care, tasks to complete, abnormal or pending results)

**R- Responsibility & Risk Management** (acceptance of change of care responsibility, read back/clarification of critical information, communication line if deteriorates/teams to contact)

**F- Family & Social** (Family present? Contacted? Any social or other information that may impact, do we know what family has been told about situation?)

Handover structure - IM SO BARF - Adapted from Australian Commission on Safety & Quality in Health Care. (2010). **The OSSIE guide to clinical handover improvement.** Sydney: ACSQHC.