NON-TECHNICAL SKILLS

Patient handover from operating theatres

Professor Tanja Manser (tanja.manser@unifr.ch)

Psychology Department, University of Fribourg, Switzerland.

Marie Curie Fellowship, University of Aberdeen, School of Psychology, 2009 – 2010.

The definition of patient handover is 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients to another person or professional group on a temporary or permanent basis'. Recent research suggests that patient handover is a critical aspect of care and yet a lack of training and formal requirements for patient handover can impede good practice. Consequently the main aim of this research project was to identify handover strategies that help clinicians to assure continuity of care and maintain safety of surgical patients during care transitions between anaesthesia and the recovery room or the intensive care unit (ICU).

Handover practices assuring patient safety at care transitions

A field study of patient handover using ethnographic observations and semi-structured interviews (with 30 healthcare providers) was conducted in one Scottish hospital to extract aspects of current handover practice which help to create and maintain safety for patients being transferred from anaesthesia to recovery room / ICU. Interview topics included the participants clinical expertise, task structure, leadership and factors influencing the quality and safety of patient handover.

That was followed by the adaptation of an existing measure for assessing the quality and safety of patient handover from anaesthesia to recovery room / ICU. The measure integrates aspects of "technical" (i.e. information accuracy and completeness) and "non-technical" performance (i.e. cognitive and social skills involving decision making and team work).

A final field study was then conducted in one Scottish hospital using structured observations to investigate the effectiveness of different handover practices in relation to the safety of patient transfers (determined using the above measure); observation of 50 patient handovers from theatre to recovery room, 25 theatre to cardiac ITU handovers and 42 patient handovers from recovery room to ward. Analysis incorporated an assessment of trainee versus consultant handover and overall handover quality.

Related Publications

Manser, T. & Foster, S. (2011). Effective handover communication: an overview of research and improvement methods. *Best Practice and Research Clinical Anaesthesiology, 22,* 181 – 191.

http://www.sciencedirect.com/science/article/pii/S1521689611000255

Manser, T., Foster, S., Gisin, S., Jaeckel, D., & Ummenhofer, W. (2010). Assessing the quality of patient handoffs at care transitions. *BMJ Quality and Safety in Healthcare, 19,* 1-5.

http://qualitysafety.bmj.com/content/19/6/1.55.short