FLOW OF INFORMATION WHEN TRANSFERRING A PATIENT BETWEEN HOSPITALS

Issues in Patient Safety and Continuity of Care

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ABSTRACT

Tampereen ammattikorkeakoulu
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JUHOLA, SALLA-MARI & VIERTOLA, SOFIA:
Flow of Information When Transferring a Patient Between Hospitals
Issues in Patient Safety and Continuity of Care

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The flow of information and collaboration between wards and hospitals are essential for safe care giving and care continuity. Studies suggest that poor flow of information is directly connected with patient safety incidents. It has been noted that by enhancing the flow of information, the patient safety can be improved and the costs of patient safety incidents reduced.

The purpose of this thesis was to explore the nurses' experiences about the flow of information between hospitals. The aim was to improve the continuity of care and thus patient safety. Qualitative research method was used in this study. The data were collected by interviewing nurses (N=6) in a specialized care surgical ward. The data of the semi-structured interviews were transcribed and analyzed by searching for similarities and differences between the transcripts.

The findings highly correlate with previous studies. The informants experienced medication safety as the greatest deficiency in the flow of information and the greatest contributor for weakened patient safety. The interviewees felt that more attention should be paid to the transferring patient's documents. The importance of an up-to-date medication list and a nursing summary were highlighted.

The findings can be useful in developing the flow of information connected to patient transfers. The researchers feel that there is a need for mutual reporting practices between wards in order to improve the flow of information.

Key words: flow of information, patient transfer, continuity of care, patient safety

TIIVISTELMÄ

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Sisätautikirurginen hoitotyö

JUHOLA, SALLA-MARI & VIERTOLA, SOFIA:
Tiedonkulku sairaaloiden välisissä potilassiirroissa
potilasturvallisuuden ja hoidon jatkuvuuden kannalta

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Tiedonkulku ja yhteistyö sairaaloiden ja osastojen välillä on edellytys turvalliselle hoidolle sekä hoidon jatkuvuudelle. Tutkimukset osoittavat, että huono tiedonkulku on suoraan yhteydessä potilasvaaratapahtumien esiintymiseen. On todettu, että tiedonkulkua vahvistamalla voidaan parantaa potilasturvallisuutta sekä vähentää potilasvaaratapahtumista aiheutuvia kustannuksia.

Opinnäytetyön tarkoituksena oli tutkia, kuinka hoitajat kokevat tiedonkulun sairaaloiden välillä. Tavoitteena oli parantaa hoidon jatkuvuutta sekä sen kautta myös potilasturvallisuutta. Työ toteutettiin laadullisen tutkimusmenetelmän avulla. Aineisto kerättiin haastattelemalla hoitajia (N=6) erikoissairaanhoidon kirurgisella osastolla. Aineisto litteroitiin ja analysoitiin etsimällä yhdenmukaisuuksia sekä eroavaisuuksia.

Tämän opinnäytetyön tulokset osoittavat korkeaa vastaavuussuhdetta verrattuna aiempiin aiheesta tehtyihin tutkimuksiin. Sisällönanalyysin perusteella lääketurvallisuus koettiin suurimmaksi puutteeksi tiedonkulussa, sekä suurimpana myötävaikuttajana potilasturvallisuuden heikentymiseen. Haastateltavat kokivat, että potilaan mukana saapuviin dokumentteihin olisi syytä panostaa enemmän. Ajantasainen lääkelista sekä hoitotyön yhteenveto koettiin erityisen tärkeänä.

Tulokset voivat olla hyödyllisiä kehitettäessä potilassiirtoihin liittyvää tiedonkulkua. Tutkijat kokevat, että tiedonkulun kehittämiseksi olisi tarvetta osastojen välisille yhtenäisille raportointikäytännöille.

Asiasanat: tiedonkulku, potilassiirto, hoidon jatkuvuus, potilasturvallisuus

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1 INTRODUCTION

The understanding of patient safety is not a new phenomenon. Already in the fourth century BC the famous "father of medicine" Hippocrates stated that a physician should act for the benefit of the patient and avoid deliberately doing any harm (Porter 2006, 57-59). Similar thought of no harm is also embedded in the nursing code of ethics (Numminen 2010, 34). In Finnish legislation, it is set that health care personnel's ethical duties are to promote wellbeing, prevent illness and alleviation of suffering (Laki terveydenhuollon ammattihenkilöistä 1994/559, 15§).

However, the development of the concept of patient safety as an issue is rather new. The ever increasing attention towards patient safety properly began in the 1990´s in the USA, Canada, Australia, New Zealand and UK. In 2008 the European Network for Patient Safety was launched and Finland is one of the important members in the subgroup concentrating on the safety of medical treatments. (Snellman 2009, 30.) The project aims to enhance the quality of care by creating unified patient safety practices between the EU states (European Union Network for Patient Safety 2008). As stated in the Act on the Status and Rights of Patients (Laki potilaan asemasta ja oikeuksista 1992/785, 3§), every patient has the right for high quality health care and nursing services. In 2009 the Patient Safety Strategy was released establishing guidelines for good health care (Sosiaali- ja terveysministeriö 2009, 12).

The topic of this Bachelor's thesis is patient safety associated with the flow of information when a patient is transferred into a different hospital. There has been plenty of discussion about the concept of patient safety. However, qualitative studies that concentrate extensively on the flow of information are still quite rare. This Bachelor's thesis is narrowed to conclude only the aspect of information in factors affecting patient safety and the effect the information has on the continuity of care.

Studies suggest that problems in the flow of information are key elements in endangering patient safety (Despins 2009, 86; Kripalani et al. 2007, 831; Kuisma 2010, 25; Lattimer 2011, 69; Ruuhilehto et al. 2011, 1036; Reader et al. 2007, 9; Suikkanen 2008, 49; World Health Organization 2007). The discontinuities in care caused by poor communication can lead to patient safety incidents. The quality and safety of care can be en-

hanced by improving the flow of information between personnel and organizations. (Shojania, Duncan, McDonald & Wachter, 2001.)

The authors of this Bachelor's thesis noticed the problems related to patient safety and breakdowns in communication firsthand while working in a surgical ward during the summer of 2011. The actual idea to prepare the thesis came as a request from the head nurse of a surgical ward.

2 PURPOSE AND OBJECTIVE OF BACHELOR'S THESIS

The purpose of this study was to explore the nurses' experiences about the flow of information between hospitals. The complete thesis aimed to improve the continuity of care and to promote patient safety. The objective of the thesis was to provide evidence about existing issues related to the topic. The provided evidence would be beneficial when planning unified methods of information transfer. The ultimate goal was to improve communication between hospitals.

The research tasks were to investigate:

1. how the nurses experience the quality and quantity of received information about patient coming to the ward
2. what kind of problems and issues are related to information transfer
3. whether the nurses have any suggestions for improving communication between wards

3 THEORETICAL APPROACH

The literature for the thesis was searched from Cinahl with Full Text (EBSCOhost). Criteria for the chosen articles included peer reviewed articles in English. Search keywords included: patient safety, patient safety incident, continuity of care, care continuity, transitional care, communication, and documentation. Also Finnish Master´s theses were considered as reliable source of information. More articles were found by studying the reference list of these reliable sources.

3.1 Patient safety

Patient safety is a wide concept that covers the safety aspects of patient care, medications and health care equipment. It includes the principles and actions set to ensure the safety of patients, and is a part of the quality of care. (Stakes & Lääkehoidon kehittämiskeskus Rohto 2006, 6.)

In the Health care Act (30.12.2010/1326, 8§) it is declared that health care functions need to be established on evidence-based and high quality practice of care. In 2006, the Finnish Ministry of Social Affairs and Health (STM) set out to investigate the state of patient safety in Finland and conduct a development plan for future use, resulting in the Finnish Patient Safety Strategy 2009-2013 (Snellman 2009, 33). The objectives of the strategy include the assessment, research, and education of patient safety (STM 2009, 3).

The collaboration between health care professionals is very important in order to improve patient safety. Failure to work together as a team can result in causing harm for the patient. (Despins 2009, 85.)

According to Grant and Larsen (2007), floor nurses are in a center role in the development of patient safety. Their observations reveal the risk factors in the care delivery processes, and they are the ones to assess the results of the changes done on the basis of patient safety incident reports. (Grant & Larsen 2007, 220.)

3.1.1 Patient safety incidents

Patient safety incident is an adverse event or a near miss situation in the delivery of care. The difference between an adverse event and a near miss situation is that an adverse event is a situation that causes harm for the patient, and a near miss situation has the potential to cause harm without actually inflicting it. (Stakes 2006, 6-7.) Patient safety incidents are possible even if the personnel are professionals and the proceedings are regulated. However, the possibility of adverse events is reduced when the organization applies safe and mutually established set of rules and practices. A high quality organization has a clear policy for reporting and handling of patient safety incidents. (STM 2009, 17.)

In 2004, Denmark passed a law (13.7.2010/913) about patient safety that obligates health care personnel to report all patient safety incidents into a national register. In 2005, Finland followed the footsteps of Denmark by beginning to develop a reporting system for patient safety incidents. The aim of project HaiPro was to develop procedures in the working unit by analyzing errors and using them as a learning experience, thus increasing patient safety. (Knuuttila, Ruuhilehto & Wallenius 2007, 11.) Nowadays HaiPro is used by more than 160 different healthcare providers in Finland (HaiPro 2012).

According to international studies, 5-10 % of hospitalized patients are exposed to adverse events. In Finland the estimated amount of serious, life-threatening adverse events are somewhere between 750-1500 per year. (Snellman 2009, 30.) On the basis of these estimations, the costs of adverse events in Finland exceed over 400 million euros annually in ward settings alone. At least half of these expenses would be preventable with proper measures that prevent adverse events and promote patient safety. (Järvelin, Haavisto & Kaila 2010, 1126.) Also Kuisma (2010, 13) agrees that by concentrating on the prevention of patient safety incidents, the total costs of care and the suffering of patients can be decreased.

In 2004 World Health Organization (WHO) launched 'Nine patient safety solutions' that aim to prevent patient safety incidents. One of these safety solutions identified the flow of information when transferring a patient as a problem causing situation (WHO 2007), that can also lead to deficiencies in the continuity of care.

3.2 Continuity of care

Continuity of care can be defined as an experienced continuity, continuity of information, and cross-boundary and team continuity. Experienced continuity refers to patient´s own perception about the fluency of the care process. Continuity of information describes both electronically and orally transferred information. Successful communication between care providers and institutions refers to cross-boundary and team continuity. (Freeman et al. 2000, 6-7.) When the care process of a patient is not carefully planned, there is a risk of gaps in the continuity of care. Gaps might present as lost information during care transition, for example when a transferring a patient between hospitals. (Cook, Render & Woods 2000, 791-792.)

Continuity of care is closely affected by management of the transitional care of a patient. Transitional care can be defined as "a set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location" (Coleman 2003, 549). Transitional care encloses planning and arranging the matters related to transportation (Coleman 2003, 549), and begins with a decision of patient transfer and is completed after the patient is admitted to other location (Coleman & Berenson 2004, 533).

Due to the fragmentation of the health care system, most patients are being transferred from one unit to another at some point of care. To secure a safe transition, the patient information should transfer as well. (Carayon & Wood 2010, 29.) However, studies have shown that communication between units is often inadequate. According to a study conducted in Pirkanmaa hospital district (Westman 2000, 12) the flow of information between different organizations was not always adequate to secure fluent patient care. Poor flow of information contributes to medical errors and hinders patient safety (Lattimer 2011, 69). Also Manias (2010, 934) stated that there is an increased risk of communication breakdowns and medication errors when the point of care is changed between hospitals. Especially poorly planned patient transfers have the potential to impair continuity of care and negatively affect the patient safety (Jauhiainen 2009, 13; Carayon & Wood 2010, 26).

In a Finnish Master´s thesis study by Jauhiainen (2009), factors improving patient transfer were found to be sufficient and skilled personnel, clear timely information transfer and cooperation between units. Hindering factors were found to be uncoordinated information transfer and different methods of action between units. (Jauhiainen 2009, 38-39.)

3.3 Communication

Communication between health care professionals is an important part of patient safety. Patient safety incidents are often consequences of inadequate flow of information between personnel or organizational levels (Snellman 2009, 36). A study conducted in an intensive care unit setting in the United Kingdom came into conclusion that ineffective communication acts as a contributing factor to adverse events (Reader, Flin & Cuthbertson 2007, 9). Also Kuisma (2010) reported that in specialized care the most common factors contributing to adverse events were deficits in communication and information transfer. The problems in communication were caused by lacking or unclear information and faulty documentation of medications. (Kuisma 2010, 22, 24.) According to Patterson et al. (2004, 749) the most important factor contributing to medication errors in the USA between 1995 and 2003 was inadequate communication. Also in Finland between the years 2007 and 2009, communication and information transfer were the largest contributor (16%) to the occurrence of patient safety incidents reported in HaiPro. Most of the adverse event notifications involved medication errors. (Ruuhilehto et al. 2011, 1038.)

In a study concerning surgical patients by Greenberg et al. (2007, 533) in 60 cases there were 81 miscommunications, of which 43% happened with handoffs and 39% with patient transfers. Also a Finnish Master´s thesis study by Suikkanen (2008) reports that when a process includes multiple operatives and detailed information, poor communication contributes to possible adverse events. Especially patient transfers between units are high-risk situations for medication safety. (Suikkanen 2008, 35.)

The content of transferred information is affected by the experience and documentation skills of the nurse who is handing over the patient (Jauhiainen 2009, 33). According to Leonard, Graham & Bonacum (2004, 85-86) formal training of communication and

teamwork during studies and in the workplace is often insufficient, and patterns of communication between professionals vary according to educational and social background, stress, and fatigue.

Many of the researchers recommend that communication and information transfer between health care settings can be improved by a structured handover report (Greenberg et al. 2007, 533; Kripalani et al. 2007, 834; Jauhiainen 2009, 51) and by becoming acquainted with the other unit's method of actions (Jauhiainen 2009, 50). Good experiences have also arisen from the introduction of check-list outside of operating theatres as a method to increase communication (Aarnio et al. 2009, 516). Such a check-list, named the SBAR-tool (Situation-Background-Assessment-Recommendation) is widely in use in the USA and the UK. The SBAR-tool was originally developed to act as a helping method for communication between nurses and doctors in acute care settings. The helpfulness of the SBAR-tool has also been reported in non-acute care settings and patient transfer situations. (Leonard et al. 2004, 86, 88.)

3.3.1 Documentation

The main principles of nursing are patient centeredness, individuality, continuity of care and safety. These are also the basis for the principles of care documentation. (Ensio & Saranto 2004, 9.)

Information technology used in nursing has generally increased patient safety. However, the safety of the care is still dependent on accurate documentation by physicians and nurses. (Bates & Gawande 2003, 2532.) Even though healthcare information technology was designed to decrease the amount of adverse events, the electronic medical record (EMR) has also been found to add to the risk of causing harm for patients in some situations (Harrington, Kennerly & Johnson 2011, 32). Different health care settings work independently and the electronic medical record systems are not always compatible (Coleman & Berenson 2004, 534). This increases the risk of gaps in the information transfer and affects negatively the continuity of care.

Also interruptions while documenting can negatively affect the quantity and quality of the conveyed information (Moody, Slocumb, Berg & Jackson 2004, 341). The importance of reliable documentation enhances after a change of shift or care setting.

Changes in the responsibility of care can negatively affect patient safety, when a nurse giving the handoff report is not familiar with the transferring patient, and has to rely on the documentation of the previous shift. (Leonard et al. 2004, 88.)

4 METHODOLOGY

4.1 Qualitative research method

Because of the aims of the study – collecting the experiences and observations of the nurses – qualitative method was chosen. Qualitative research focuses on the opinions and thoughts of the interviewees (Holloway & Wheeler 2002, 10). It allows the participants to express insight more thoroughly and emphasizes people's ability to create an experience of their own (Polit & Beck 2008, 17), which plays a massive role in this study.

Qualitative research is described as "context-bound" (Holloway & Wheeler 2022, 11). It is important for the researchers to recognize the context of the research setting in order to understand the phenomenon under study (Holloway & Wheeler 2002, 11). As both of the authors have worked in the research setting, they feel that they understand the context of the research setting very well.

The inductive research approach was used in this thesis. Inductive qualitative research is recommended when there is not much previous knowledge about the research topic. In the inductive research the concepts are collected from the experiences of the interviewees. (Elo & Kyngäs 2002, 107.) As this is a qualitative study, the authors applied the methods of perceiving, examining and listening (Holloway & Wheeler 2002, 11). Critical thinking is a part of the research process. It is up to the researcher to recognize the key elements by analyzing and conceptualizing the data. (Banning 2006, 458.)

4.2 Data collection

The authors had a permission to interview a maximum of ten registered nurses. The method of purposive sampling of informants was used so that all of the interviewees had full knowledge about the aspects of the research topic (Tongco 2007, 151). Criteria for the informants were that they are entitled to administer medications via intravenous route, due to the questions about information transfer concerning medical treatment. For purposive sampling the head nurse chose the voluntary participants with varied amount

of working experience. Altogether six (N=6) individual interviews were done, until the same information connected to the topic started repeating in the interviews. This was interpreted as saturation of information and no more interviews were conducted (Hirsjärvi & Hurme 2008, 60).

As all the participants' native language is Finnish, it was natural to conduct the interviews in Finnish. The interviews were recorded, and the length of the interviews varied from 18 to 36 minutes. As instructed by Whiting (2008), semi-structured questions were used to guide the discussion along predetermined topics. In accordance with the inductive study method, the questions were always neutral and open-ended in order to provide the informants a possibility to go deeper into the subject. Further questions were developed during each interview. (Whiting 2008, 36-37.) The topics of semi-structured interview (appendix 2) included general fluency of patient transitions, reporting of a transferring patient, patient´s medications, patient safety, continuity of care, and improvements in transition situations.

4.3 Data analysis

The data were analyzed with qualitative content analysis on the basis of collected data, and similarities, differences, and connections were searched for. As a research method, content analysis provides an opportunity to improve the understanding of the collected data. (Elo & Kyngäs 2007, 108.) While conducting a qualitative study, the researchers tend to analyze the data already in the gathering and transcribing process. This means that the phase of analysis in qualitative research begins relatively early. (Holloway & Wheeler 2002, 235.) There are a few different methods of approach to the qualitative content analysis, but the main steps usually are the same: transcription of the interviews, going through the received material repeatedly, and finally categorizing and coding the received information under headings (Holloway & Wheeler 2002, 235; Elo & Kyngäs 2007, 111).

5 ETHICAL CONSIDERATIONS

For this research the information was gathered during the six interviews. As the informants were chosen by the head nurse of the surgical ward, the researchers did not know the informants´ identity in advance. The interviewees were informed about the purpose and the phases of the research prior to the interviews both orally and by written measures (Hirsjärvi & Hurme 2008, 20). The purpose of a cover letter (appendix 1) was to provide enough information about the study before the informants made the decision to participate. The implementation of the thesis was gone through before each interview with the participant in question. The right to withdraw from the research in any phase was emphasized. (Greaney et al. 2012, 40.) Finally a written permission for the interview was asked from the informants.

Other emphasized matters were confidentiality and anonymity. Protecting the interviewee's privacy was a major ethical consideration during the research process (Greaney et al. 2012, 40). For that reason the quotes of the transcripts were not identified with the number of the informant. Informants' names were not mentioned in any phase of the research.

The study was conducted according to the research policy of a city in Southern Finland. All data were handled confidentially and anonymously and was destroyed properly after analysis.

6 CREDIBILITY

Credibility and trustworthiness of the data were achieved by comparing the gathered data and the similarities of the results from each transcript. The citations from the transcripts were used to strengthen the credibility of the findings. (Thomas & Magilvy 2011, 152-153.) As both of the authors are novice researchers, the trustworthiness of the study was increased by sharing the research process. Having a partner researcher expands the achieved understanding as there are two perspectives to decrease bias. (Thomas & Magilvy 2011, 154.)

In the beginning of the research process, the authors faced a dilemma about the research setting. As both of the authors have been working in the ward chosen for the study, the idea of interviewing colleagues seemed difficult. However, the insider role has its benefits. The researcher is familiar in the research setting and has ready access to informants (Asselin 2003, 99). The inside researchers are also familiar with the organization's structures and method of actions, so they have foreknowledge about possible issues in advance and know when to probe deeper into the subject. The researchers, however, need to be careful not to assume too much and miss opportunities for deeper knowledge. (Coghlan & Casey 2001, 676.) According to Asselin (2003) the researchers can avoid these inside research pitfalls by keeping open mind and pretending not to know anything about the phenomenon under study (Asselin 2003, 100).

7 RESULTS

The interviewees' overall working experience and the experience on the particular ward varied a lot. Interviewees' longest working experience on the particular ward was 22 years, and the shortest was six months. The interviewees reported to admit patients from another hospital several times a week. Most of the patient transfers occurred during evening shift, somewhere between afternoon and midnight.

When asked about the overall experience of the patient transfers, the interviewees reported that there are quite a few problems connected to the flow of information in the patient transfer process. The inadequate flow of information was seen as the major issue, not the transfer situation itself.

> On pieniä hankaluuksia ja on isompia hankaluuksia. Siis periaatteessa yksinkertainen asia, mihin vois olla niinkun hyviä ratkaisuja, niin on tehty kauheen huonosti toimivaksi.
>
> There are minor difficulties and greater difficulties. Basically a simple matter that could be easily solved has been made very poorly functioning.
>
> Ei se tiedonkulku oo sitä mitä pitäis olla.
>
> The flow of information is not what it is supposed to be.

7.1 Reporting of a transferring patient

Information about a transferring patient is given both orally and in writing. When a patient is notified to the ward, a nurse from a sending unit usually gives a report on the phone. This practice was generally found quite functional although the content - quality and quantity – varies among the reporting nurses. All of the interviewed nurses wished to receive more information about the medications, the activities of daily living and special requirements of the transferring patient.

When the patient is admitted to the ward, a pile of papers comes along. Some of the interviewees found the excessive amount of material unclear and difficult to read. Generally the incompatibility of electronic medical records was found inconvenient, although a few improvements have happened over the years. For example laboratory values and x-ray pictures taken in the sending unit are now available in the receiving unit as well, which was found to be a great improvement.

> Ja nyt kun on menty tähän tietokonemaailmaan niin nää tiedot on aina vuosi vuodelta puutteellisemmat. Potilas tulee kokoajan niinkun huonommin tiedoin.
>
> Now that we have entered the computerized world, the information is more inadequate year after year. The patients are all the time coming in with less information.
>
> Kaupungin sisällä on kaks eri järjestelmää on tosi huono että pitäis olla ehdottomasti sama tietojärjestelmä niin olis sujuvampaa tää hoito.
>
> There are two different EMR-systems within one city, which is really difficult. There should absolutely be the same EMR so that the care would be more fluent.
>
> - - - kyllä se tietenkin sitä lisäis vielä sitä potilasturvallisuutta kun oltais [sairaalan nimi mainittu] kanssa samassa (potilastietojärjestelmässä).
>
> - - - of course it would increase the patient safety if we used the same (EMR) with [the name of the hospital mentioned].

The interviewees generally felt that the patient's care continues quite quickly after the patient is transferred. However, the transfer was seen as a point of a possible care discontinuity. Some disconnections in the continuity of care happen right after the arrival of the patient. According to the interviews, the amount of time required to admit a patient is lengthy, since many times for example home medications, and how things generally are at home need more or less clarification. Even more time is required if the patients´ transferred information needs checking from the sending unit.

> Kyllä mä uskon että siinä tulee yleensä aina potilaalle itellekin se tunne että uudestaanhan se joutuu ne kaikki asiat kertomaan, kotiasiansa sun muut kun se tänne siirtyy. Paljon paremmin vois olla ja helpommalla vois päästä jos ois oikeesti sillee, että olis selkeet systeemit. Joudutaanhan me kysymään kotiasioista ja todennäköisesti yleensä aina niistä lääkityksistä. Pahimmassa tapauksessa joudutaan kysymään potilaalta iteltään että kuinkahan kauan sulla nyt on menny tää antibiootti, että onko sulla itellä mitään muistikuvaa. Elikä ei jatku katkeamattomana.

> I do believe that usually the patient too feels like s/he has to repeat all the same things, meaning home issues and all that, when s/he is transferred here. It could be a lot better and easier if there really were clear methods. We do have to ask about the patient's coping at home and usually always about the medications. In the worst case scenario we have to ask the patient that how long s/he has had this antibiotic, does s/he have any recollection. So it is not continuing without any interruptions.

The interviewees reported that if the need of more information about the patient arises, it is not always easy to get answers right away. Often the patients are prepared for the transfer in the sending unit during the morning shift, and if patients' matters need resolving after the admittance, there is no longer anyone working in the sending unit who is familiar with the patient's case. In such a situation the nurse in the sending unit has to be able to get the required information from the electronic medical records of that patient. In that case the care documentation should be adequate enough.

> - - - jos se potilas on aamuvuorossa tänne ilmotettu ja lähetetty, ni iltavuorossa siellä ei kukaan enää tiedä siitä potilaasta mitään.

> - - - if the patient transfer has been organized and carried out during the morning shift, then in the evening shift there is no one left who knows anything about the patient.

> - - - jos työvuoro on vaihtunu ja se ei oo ite koskaan sitä potilasta vaikka hoitanu niin sit sä oot ihan vaan sen varassa mitä se lukee jostain kirjauksia. (- - -) kirjaaminen tietenkin pitäis olla sitten niin hyvää että se olis kaiken kattavaa.

> - - - if the shift has changed, and the person has not taken care of that patient, then you just have to rely on what s/he reads from the records. (- - -) of course the documentation should then be good enough to cover every aspect.

7.1.1 Medications

The interviewees saw inadequate information about medications as the greatest contributor to weakened patient safety. The greatest deficiency of all was reported to be obscurities in the transferring patient's medications and their administration. According to the interviews, at times there have been differences between the patient's medications listed in the doctor's medical case summary and the medication list printed out by the nurses, endangering the patient safety.

Often there have also been differences in the patient´s home medications between the two electronic medical record systems. It also emerged that sometimes for one reason or another, the patient's home medications can be forgotten for a certain amount of time, because of the poor flow of information about the patient's medications.

> Onhan siinä paljon muutakin parantamisen varaa, mutta se (lääkitys) on niinku varmasti eniten se, joka sitä potilasturvallisuutta tosiaan vaarantaa.

> There are many other issues to improve, but that (medications) is definitely the one that endangers the patient safety the most.

> - - - se on uskomatonta, että esimerkiksi [sairaalan nimi mainittu] on tapana tauottaa kaikki kotilääkkeet, ja sitten kukaan ei niitä enää laita menemään sinne listalle. Että se saattaa siis tulla ihan puutteellisten tietojen

> kanssa, tai että se ei oo saanu jotain omia verenpaine-, tai jotain mieliala/psyykelääkkeitä tyyliin moneen päivään.
>
> - - - it is unbelievable that for example [name of the hospital mentioned] tend to stop temporarily all the home medications, and then nobody starts them on the list again. So the patient might come in with totally inadequate information, or has not received his/her own blood pressure- or some psychiatric medications in several days.
>
> Jos on muistamaton ihminen ja se tulee sieltä puutteellisen lääkelistan kanssa ja meillä on taas koneella ihan eri lääkkeet ni se on aika vaarallistakin.
>
> It could be quite dangerous if a memory impaired person is admitted with an inadequate medication list, and that medication list totally differs from our own.

The interviewees felt that there were sometimes obscurities in the time of administration of medications. It is not usually mentioned in the nursing summary, what medications the patient has last taken in the sending unit before the transfer. The importance of this was highlighted in the interviews, especially if the patient has a long list of medications. Also issues with time of administration of intravenous medications like antibiotics were mentioned. There have also been cases that the receiving unit had no information about the transferring patient's intravenous medications, threatening the patient safety.

> Potilas oli ilmoitettu puhelimitse, niin oli ilmoitettu että oli menossa tämmöiset antibiootit IV:sti. Kun potilas tuli, niin sillä ei ollut mitään antibiooteista mainintaa ja kun soitettiin niin ilmeni, että siellä onkin ollut antibiootit menossa. Ne oli vaan unohtunu kaikilta listoilta ja lääkelistat oli tulostamatta. Ja sitten että kun löydettiin potilaalta huumelaastari iholta, ja sitä ei ollut missään ylhäällä. Että kyllä ne puutteet voi olla aika isoja.
>
> Information about a transferring patient was reported to the ward via telephone, and it was informed that the patient had antibiotics going via intravenous route. When the patient arrived, there was no mention about the

> antibiotics and when we called the ward, it emerged that there were antibiotics ongoing. They just were forgotten from all the lists and the medication lists were not printed out. And then when we found a transdermal patch containing opioid analgetic, and it was not mentioned anywhere. So the deficiencies can really be quite great.

The interviewees reported that information about the effectiveness of the patient's medications is rarely addressed. Only exceptions were reported to be antibiotic treatments and their effectiveness, which were found to be well covered in the doctor's medical summary. Information about the effectiveness of pain medications in some cases would be useful to avoid unnecessary medication alterations. Generally information about pain management was experienced to be often disregarded. This was found to be an issue especially with cancer patients.

> - - - niin aika harvoin puhutaan ylipäätään kivun hoidosta, tosi harvoin, ellei se oo jotenkin aivan akuutisti ongelmallinen tilanne.

> - - - the pain management is rarely addressed, very rarely, unless it is somehow pressingly problematic situation.

7.1.2 Activities of daily living

When a patient is transferred between hospitals, the interviewees reported to receive a doctor's medical case summary describing what and when has been done medically and how the patient's recovery has started. In addition, a printed medication list is attached. A separate nursing summary about the patient is rarely done by the sending unit. Instead, printed pages of nurses' daily documentations are attached. The interviewees experienced that these texts do not very well describe either the patient's condition or the needs of the patient. The interviewees felt that a separate nursing summary would be very beneficial for the receiving unit.

> Kyllä mä koen sen aika tärkeäksi, että lääkäri tekee oman lopputekstinsä, mutta siitä hoitajan tekstistä mä näen kaikista parhaiten minkä kuntoinen se potilas on.

> I do find it quite important that a doctor writes the medical case summary, but from the nursing summary I can easily see in what kind of condition the patient is.

A good nursing report was said to include all aspects of daily living and individual needs of the patient. The interviewees wished to receive information about the patient's overall condition, ambulation and possible assistive devices, eating and special diets, ability to manage personal hygiene, bowel and bladder functions, and the locations and secretions of catheters, cannulas, drains and wounds. It emerged in the interviews that sometimes given information does not correspondent to the real situation of the patient and the overall condition of the patient is sometimes quite a surprise.

> Tämmöisillä tiedoilla me odotetaan sitä potilasta, se voi olla joskus yllätys suuntaan tai toiseen kun se potilas tulee että minkä kuntoisena hän tuleekin.

> With this kind of information we wait for the patient to arrive, it can sometimes be quite a surprise one way or another in what kind of condition the patient then arrives.

One topic that rose from the discussion was information about patients' psychological status. The interviewees felt that the psychological wellbeing of a transferring patient is rarely addressed in the transfer report, although often the information would be very useful. Usually it is mentioned, if the patient has Alzheimer's disease or is otherwise demented, but other psychological issues are often left unnoticed. It was mentioned that sometimes the transferred patients have not been aware of the severity of the disease, or in the worst cases they had not been told about the diagnosis at all. Improvements in this area were needed, because the patients definitely have the right to know what is the current situation and diagnosis.

> Ei oo ihan yks, eikä kaks eikä kolme kertaa ku on tullu jatkohoitoon jollain syöpädiagnoosilla vaikka ihminen, joka on ollu papereiden mukaan diagnoosi tiedossa jo vaikka viikon tai kaks, niin potilas ei oo ite tietonen siitä.

> It has not happened just once, or twice or even three times when a patient has come to the ward for follow-up care with cancer diagnosis, which according to documents has been known for a week or two, and the patient is not aware of the diagnosis.

Another issue that the interviewees felt needed more attention was the patient's need of isolation. The interviewees reported that there have been cases, where a patient with contagious disease or nosocomial infection has been sent to the ward without information about the need of isolation. Information about the need of isolation would of course be quite vital for the staff to be able to prevent the spreading of infections, and the interviewed nurses experienced these situations to be quite problematic, since in a full ward it is hard to organize a room without any other patients.

> - - - kyllähän pääsääntöisesti tietenkin kaikki sanoo sen, mutta joskus on sitten niitä yllätyksiä että siinä vaiheessa kun potilas tulee osastolle niin ambulanssikuskit sanoo että hän on sitten MRSA positiivinen, mitä ei tietenkään ikinä sais käydä niin. En halua uskoa että kukaan sitä niinkun salais tahalleen, tai ainakaan toivottavasti.

> - - - of course mainly everybody tells about it, but sometimes there have been surprises that when the patient is coming to the ward the ambulance personnel inform that the patient is MRSA positive, which of course should never happen. I don't want to believe that anyone would intentionally hide such a thing, hopefully not.

7.2 Improving the flow of information

The interviewees shared similar ideas about factors that would improve the flow of information. An adequate nursing summary and a list of up to date medication were found to be the most important factors improving the flow of information and the continuity of care. The interviewees suggested that when reporting of a transferring patient, it would be beneficial to consider the most important matters to know about the particular patient.

> Ajattelis että siinä vaiheessa kun heiltä lähtee potilas niin he ajattelis et mitä he itse haluu tietää potilaasta, kun potilas tulee heille hoitoon.

> You would think that when a patient is being checked out from the ward, they would think what they themselves would wish to know about an incoming patient.

The interviewees reported that a mutual reporting practice has not been agreed between the hospitals, and that the existent practice has formed by itself over time. Mutual reporting practices were seen as a matter of improving patient safety, and the interviewees thought positively about the possibility of that kind of practice. Suggestions of a form about the activities of daily living, which would be attached to the patient's papers when the patient is transferred to another ward, and a check-list about all the papers that should be coming with the patient to the receiving ward were brought up during these interviews.

> Kyllä se varmaan olis hyvä ja parantais potilasturvallisuutta. Voitais päättää että minkälaista tietoa puolin ja toisin siitä potilaasta haluttais hoitajana tietää.

> I think it would be beneficial and it would improve the patient safety. We could mutually decide what kind of information we as nurses would like to know about the patient.

> Mun mielestä se olis aika toimivaa niinku että olis yhteinen käytäntö, joku tietty kaavake tai joku mikä siitä potilaasta täytettäis. Luulis ettei tällaset asiat vois olla niin ydinfysiikkaa, mutta ilmeisesti ne on.

> I think that it would be quite functional to have mutual practices, a form or something that would be filled. You would think that these kind of matters would not be like nuclear science, but apparently they are.

> Tietysti jos olis jotkut sellaiset tsekkauslistat, että mitkä kaikki paperit pitää olla kunnossa ennenkun se potilas lähtee eteenpäin. Vähän samaan tapaan kun voi olla leikkaussaliin menevästä potilaasta.
>
> Of course if there were some kind of check-lists about all the papers that should be handled before the patient is transferred. The same way that there are check-lists about a patient going to surgery.

Improving the communication between the hospitals was also seen as a supporting method to improve the flow of information. Becoming familiar with the other ward's method of action was seen to be the best way to improve the communication. Some of the interviewees felt that the nurses in the sending hospital are not properly familiar with the unit's nature of operation. Because of that there have been some misunderstandings about the reason, and duration of the course of treatment from the patient's side. Feelings of underestimation were also felt, since the patients were assumed to receive this kind of false information from the sending unit.

> Mun mielestä sillä vois parantaa sairaaloiden välistä kommunikointia, että sairaalassa oikeesti tiedettäis että mitä se toinen sairaala tekee. Ettei ne niinkun lähetä [sairaalan nimi mainittu] meille sillee, että sä pääset sinne kuntoutumaan ainakin kolmeksi viikoksi.
>
> I think that communication between hospitals could be improved by really knowing the method of actions of the other hospital. So that they do not send patients from [name of the hospital is mentioned] to our ward in a false belief that they can stay for at least three weeks in rehabilitation.
>
> On tullu semmosiakin potilaita ketkä luulee, että täällä voi olla kolme kuukautta kuntoutumassa. Tää on kuitenkin leikkausosasto ja tää on hetkellisesti jatkohoitopaikka, mut ei postia voida kääntää tänne…
>
> There have been patients coming in, who think that they can stay here in rehabilitation for three months. This is, however, a surgical ward and this can temporarily be the place for follow-up care, but you cannot redirect your mail here…

When asked about the feeling of collegiality between the most common sending units and the receiving unit, the interviewees' opinions differed from one another. The interviewees did feel that the units share a similar goal and patients, but not all of them were feeling the collegiality as strongly as the others. Still, even without the strong feeling of collegial relations, the interviewees reported that it is not difficult to call, and ask for more information from the sending ward.

> Kyllä tavallaan, samanlaisten asioiden kanssa siellä painitaan kun me täällä. Ei oo mitään estettä soittaa ja kysyä lisätietoja.

> In a way yes, they handle the same kind of matters as we do here. There is no problem to call and ask for more information.

8 DISCUSSION AND CONCLUSION

This Bachelor's thesis aimed at exploring experiences of the nurses in a surgical ward about patient transfers and the flow of information. Every interview was conducted according to the planned timetable, which allowed the researchers to have plenty of time to reflect and discuss about each interview afterwards. The experiences of the interviewed nurses were highly consistent with each other, so the researchers felt that the findings were reliable.

There were also many similarities found between the experiences of the nurses and the already made studies. In accordance with Westman's study (2000, 12) the interviewees found quite a few challenges and obscurities in the flow of information related to patient transfers. As in the studies conducted by Reader et al. (2007, 4) and Suikkanen (2008, 12), the interviewees saw the matters of medication safety to be the greatest contributor to weakened patient safety. Likewise as in the study by Patterson et al. (2004, 749), the reason behind the impaired medication safety was often experienced to be poor flow of information.

In the beginning both of the researchers had a hunch what to expect, due to the experiences from working in the research setting during the summertime. Still some of the results were found quite shocking. The researchers agreed that there are a lot of ethical issues that the nurses have to consider while giving a handover report of a transferring patient. Nurses sharing knowledge, such as diagnosis or prognosis, the patient is not yet even aware is one such matter.

Even though the findings correlated with previous studies, and the authors of this thesis are satisfied with the received information and results, further research is needed in order to establish standard practices of patient transfers. The researchers found only a few Finnish Master's degree level studies about the topic. There is also little research done about the transfer situations of elderly patients with decreased cognitive function.

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APPENDICES

Appendix 1. Cover letter

Hyvä sairaanhoitaja !

Pyydämme Teitä osallistumaan opinnäytetyöhömme, jonka tarkoituksena on selvittää hoitajien kokemuksia sairaaloiden välisestä tiedonsiirron sujuvuudesta. Valmiin opinnäytetyön tavoite on parantaa potilasturvallisuutta ja hoidon jatkuvuutta potilaiden siirtymisessä kahden sairaalan välillä.

Osallistumisenne tähän opinnäytetyöhön on täysin vapaaehtoista. Voitte kieltäytyä osallistumasta tai keskeyttää osallistumisenne syytä ilmoittamatta milloin tahansa. Opinnäytetyölle on myönnetty lupa kaupungilta, joka toimii opinnäytetyön yhteistyötahona.

Opinnäytetyö toteutetaan haastattelemalla yhteensä maksimissaan kymmentä sairaanhoitajaa, joilla on lupa toteuttaa suonensisäistä lääkehoitoa. Kohdeosaston osastonhoitaja valitsee haastateltavat. Jokaista haastattelua varten on varattu n. 1,5 tuntia. Haastattelut toteutetaan sairaalan tiloissa ja ne tullaan nauhoittamaan laadullista sisällön analyysia varten. Haastattelut toteutetaan 01.03.-15.05.2012 välisenä aikana.

Opinnäytetyön valmistuttua aineisto hävitetään asianmukaisesti. Aineisto on ainoastaan opinnäytetyön tekijöiden käytössä. Aineisto säilytetään salasanalta suojattuina tiedostoina, kirjallinen aineisto lukitussa tilassa.

Teiltä pyydetään kirjallinen suostumus opinnäytetyöhön osallistumisesta. Opinnäytetyön tulokset käsitellään luottamuksellisesti ja nimettöminä. Yksittäistä vastaajaa ei pysty opinnäytetyön raportista tunnistamaan. Valmis opinnäytetyö on luettavissa elektronisessa Theseus - tietokannassa. Mikäli Teillä on kysyttävää tai haluatte lisätietoja opinnäytetyöstämme, vastaamme mielellämme.

Opinnäytetyön tekijät

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SUOSTUMUS

Flow of information when transferring a patient between hospitals

Olen saanut sekä kirjallista että suullista tietoa opinnäytetyöstä, jonka tarkoituksena on selvittää hoitajien kokemuksia sairaaloiden välisestä tiedonsiirron sujuvuudesta. Lisäksi olen saanut mahdollisuuden esittää opinnäytetyöstä tekijöille kysymyksiä.

Ymmärrän, että osallistuminen on vapaaehtoista ja että minulla on oikeus kieltäytyä siitä milloin tahansa syytä ilmoittamatta. Ymmärrän myös, että tiedot käsitellään luottamuksellisesti.

Paikka ja aika

_____ _____._____._____

Suostun osallistumaan opinnäytetyöhön:

_____

Haastateltavan allekirjoitus

_____

Nimenselvennys

Suostumuksen vastaanottaja:

_____

Opinnäytetyön tekijän allekirjoitus

_____

Nimenselvennys

Appendix 2. Frame of the semi-structured interview

- Taustatiedot
    - Kauanko olet työskennellyt sairaanhoitajana kyseisellä osastolla?
    - Kuinka usein vastaanotat toisesta sairaalasta siirtyvää potilasta?
    - Millaisia kokemuksia sinulla on potilassiirroista?
- Potilastietojen vastaanottaminen
    - Miten siirtyvästä potilaasta tiedotetaan (suullisesti, kirjallisesti)?
    - Mitä potilaasta yleensä raportoidaan? Ovatko tiedot usein riittäviä?
    - Lääkitystiedot, ovatko selkeät ja riittävät?
    - Minkälainen on hyvä siirtoraportti?
- Hoidon jatkuvuus
    - Miten potilaan hoito jatkuu jatkohoidossa?
    - Onko usein tiedonkatkoksia, ongelmia?
    - Hoitajan raportti hoidon jatkuvuuden kannalta?
- Potilasturvallisuus
    - Oletko havainnut potilasturvallisuutta vaarantavia tekijöitä potilassiirroissa? Minkälaisia?
    - Eri potilastietojärjestelmien rooli potilasturvallisuudessa? Parantaako vai vaikeuttaako? Millä tavalla?
- Tiedonkulun kehittäminen ja kommunikaation tukeminen
    - Kuinka tiedonkulkua voitaisiin parantaa? Entä sairaaloiden välistä kommunikaatiota?
    - Onko yhteisistä raportointikäytännöistä sovittu? Olisiko tarvetta?