Forskning i overgange

IPLS seminar Marts 2018

Doris Østergaard og team

CAMES, CHR

DTU

Patientovergange

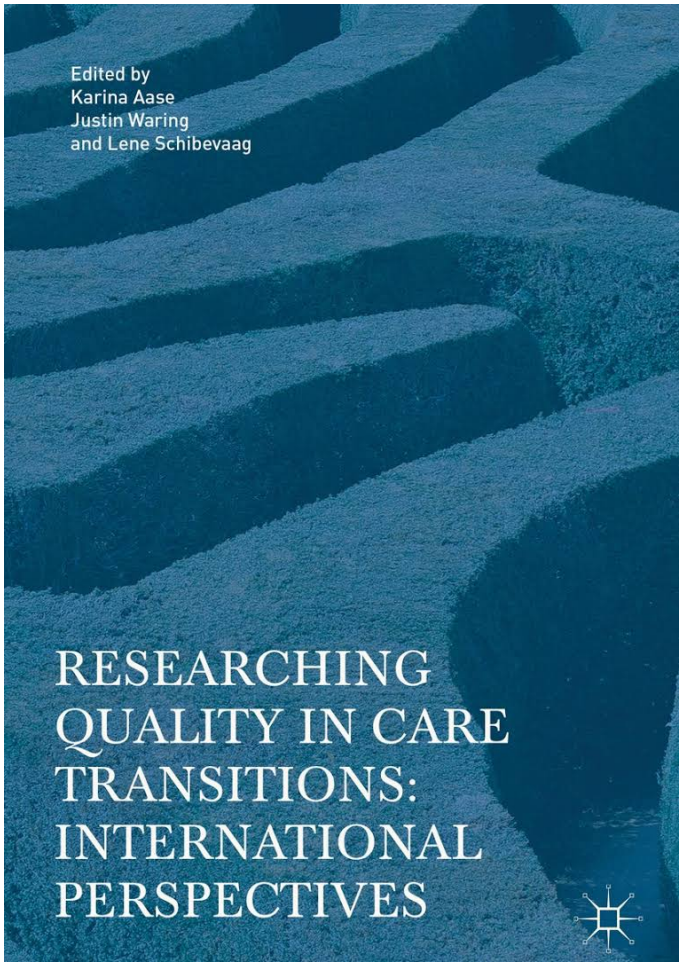
Et eksplorativt studie af faktorer der påvirker sikkerheden af patient-overgange

Ph.d.-afhandling
1.2011

DTU Management

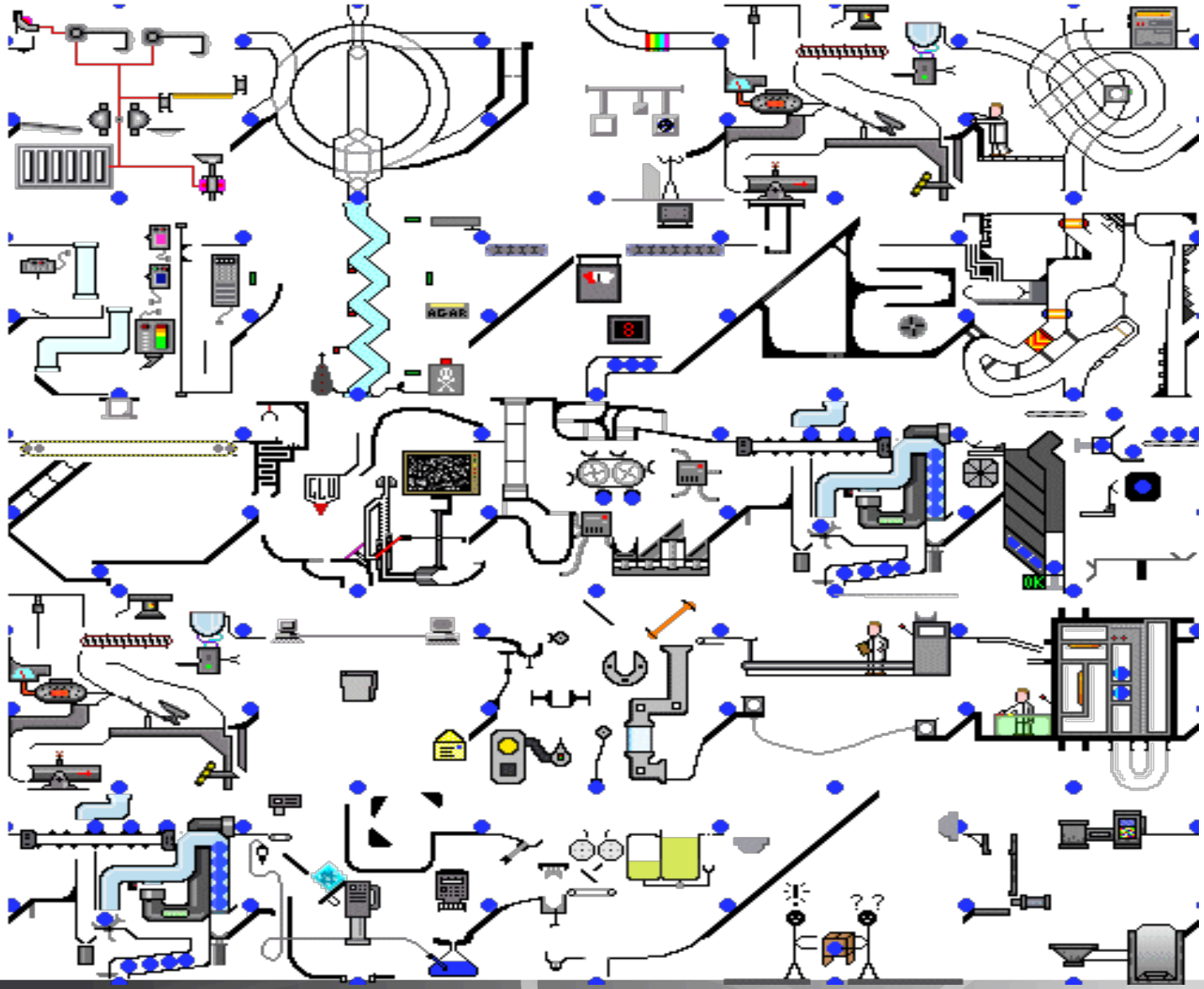
Inger Margrete Dyrholm Siemsen
Marts 2011

DTU Management
Institut for Planlægning, Innovation og Ledelse



Patientovergange

- Situationer, hvor **ansvaret** for en patients diagnose, pleje og behandling, **overgår fra en fagperson til en anden**


AGAR
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OK

Overgange i hospitalet

Overlevering til kollega

- i samme speciale (51% af hændelserne)
- mellem specialer (29% af hændelserne)

Pezzolesi 2010

Typer af svigt i overgange er hyppigt kommunikations-relaterede

Årsagerne bag er hyppigst utilstrækkelig kompetence, infrastruktur, travlhed og afbrydelser samt utilstrækkelige retningslinjer

Siemsen 2011

Operationsstue

Opvågningsafsnit

Sengeafdeling

Ambulatorie/

akutmodtagelse

Jensen 2013, Siemsen 2012, Møller 2015, Munter 2018

Hovedelementer i at etablere og bevare sikre patientovergange

- Overlevering af **information / kommunikation**
  - indholdet, mængden, måden
- Placering og markering af **ansvar**
  - hvem, hvornår
- Erkendelse af vigtigheden af **konteksten** som overgangen finder sted i:
  - Teamet
  - Kulturen, arbejdsmiljøet
  - Organisationsstrukturen
  - Patientkompleksiteten

Siemsen IMD, ph.d. 2011

Journal of Public Health Research 2013; volume 2:e33

Review

Fragmentation of patient safety research: a critical reflection of current human factors approaches to patient handover

Tanja Manser

Department of Psychology, University of Fribourg, Switzerland

Significance for public health

While much of public health research has a preventive focus, health services research is generally concerned with the ways in which care is provided to those requiring treatment. This paper calls for a patient-centred approach to research on patient handover; a significant contributor to adverse events in healthcare. It is argued that this approach has the potential to improve our understanding of handover processes along the continuum of care. Thus, it can provide a scientific foundation for effective improvements in handover that are likely to reduce patient harm and help to maintain patient safety.

Abstract

The integration of human factors science in research and interventions aimed at increased patient safety has led to considerable improvements. However, some challenges to patient safety persist and may require human factors experts to critically reflect upon their predominant approaches to research and improvement. This paper is a call to start a discussion of these issues in the area of patient handover. Briefly reviewing recent handover research shows that while these studies have provided valuable insights into the communication practices for a range of handover situations, the predominant research strategy of studying isolated handover episodes replicates the very problem of fragmentation of care that the studies aim to overcome. Thus, there seems to be a need for a patient-centred approach to handover research that aims to investigate the interdependencies of handover episodes during a series of transitions occurring along the care path. Such an approach may contribute to novel insights and help to increase the effectiveness and sustainability of interventions to improve handover.

entists). Stepping back, these misconceptions may also signal some of the specific challenges that will have to be addressed in taking human factors expertise forward in healthcare and they may provide learning opportunities for human factors experts. In his editorial to the article by Russ and colleagues,[1] Catchpole puts his finger on a sore spot for many human factors experts by stating:[2] *If we wish healthcare to be fundamentally changed by HF (human factors), we must also expect HF to be changed by healthcare. Collaboration between clinicians and HF professionals, with each shaping the views of the other, will develop and extend the use of HF for the unique demands of healthcare*. Following up on this thought of how key characteristics of healthcare might inspire change in human factors science this paper discusses the challenges of overcoming fragmentation of care. Research and intervention efforts aiming to understand and mitigate the effects of fragmentation of care on patient safety frequently focus on patient handover. Using examples of recent handover research we argue that the predominant research strategy is to focus on isolated handover episodes. This approach may actually hinder the development of an integrative framework that is urgently needed to effectively manage the risks associated with today's fragmentation of care. This paper does, however, not put forward such an integrated research framework. Instead it is a call to start a discussion of current areas of healthcare human factors that might benefit from a critical reflection of the predominant approach to research and improvement. Because the examples used to illustrate the need for such a discussion are drawn from handover research, the discussion will only cover selected aspects of fragmentation and additional or different challenges may be present in other areas of healthcare human factors. Nevertheless, we believe that this paper may inspire critical reflections of the blind spots inherent in certain research approaches used when addressing patient safety problems. In the future, these reflections might make a unique contribution to moving the field forward.

Perspektivering

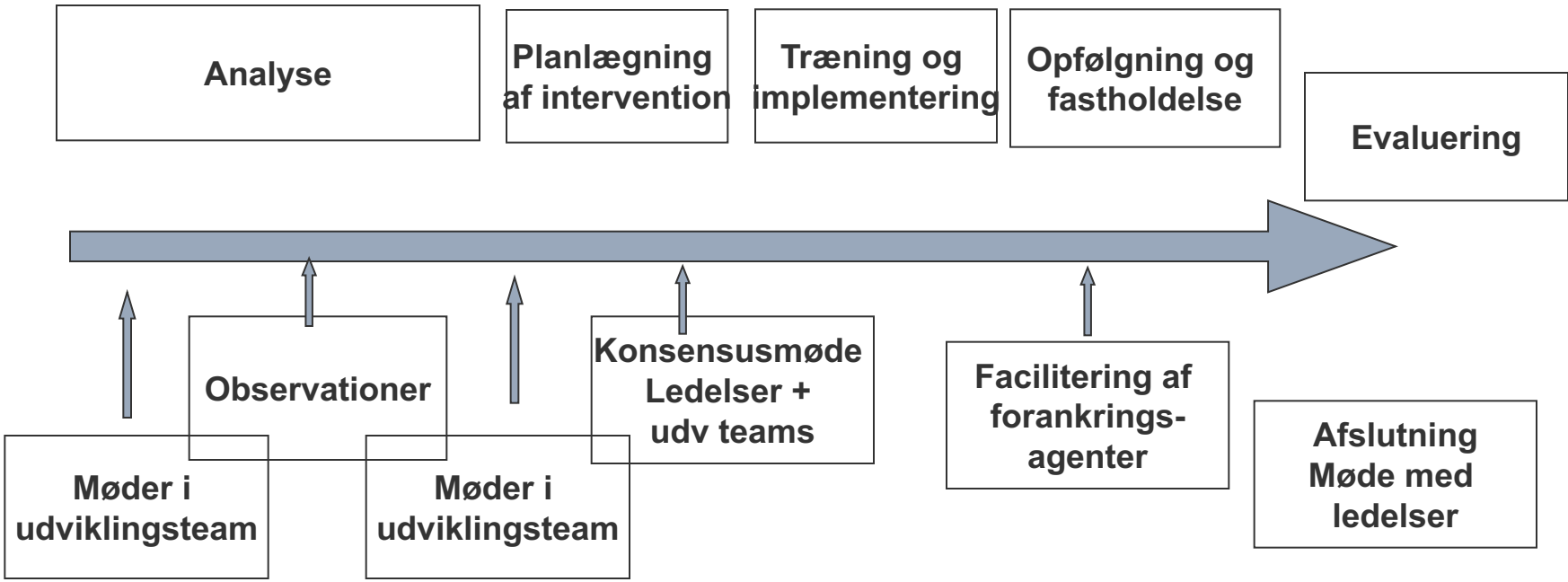
- Interventioner til forbedring af overgange bør tænke organisationen og medarbejderne ind i løsningerne
- Forstå hvordan arbejdet reelt gøres
- Handlingsanvisende forskning / aktionsforskning som supplement til den biomedicinske forskning

Hollnagel 2011, Koch and Kralik 2006, Rudolph 2007

Generisk koncept (”pakken”)

- Analyse, intervention og evaluering i samarbejde med brugeren
  - Organisatorisk forankring med langvarigt engagement af ledelse og ansatte – udviklingsteam/forankringsagenter
    - Skabe ejerskab
  - Strukturering af overgangen - tilpasset lokale forhold
  - Undervisning og træning af personale på tværs af afdelinger
  - CAMES faciliterende rolle i alle faser
  - Evaluering af proces, koncept og interventions fastholdelse

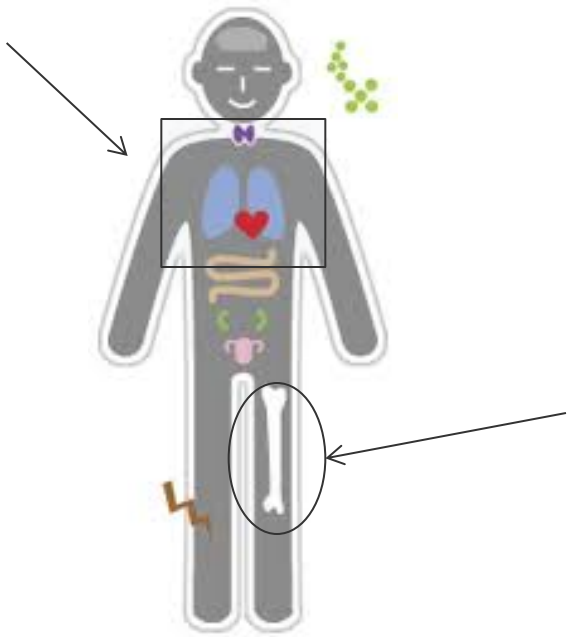
Proces oversigt



Overgang fra opvågningsafsnit til ortopæd kirurgisk afd.

Udfordringerne

- Administrative
- Organisatoriske
- Kommunikative - mundtlige/ skriftlige
  - ”Lang tid at komme igennem til den rette”
  - ”Gennemsivning af forbinding”
  - Uenighed om prioritering, længde, modtager
- Kulturelle



Nødvendigt at <u>forventningsafstemme</u> og forstå samarbejdspartnere

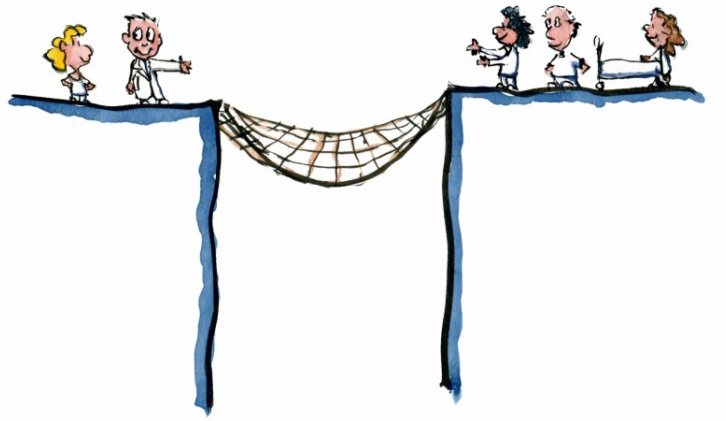
Intervention og evaluering

- Udvikling af struktureret overgangspapir (SOP)
- Kursus for forankringsagenter
  - Teamtræning
  - Anerkendende kommunikation
  - Træning i brug af struktureret overlevering
  - Oplæring i at være forankrings agenter
- Evaluering
  - Nemt at bruge, anvendes i 50-100% af overgange
  - Tidsbesparende (30 sek. - 2 minutter)
  - Personalet mere trygge, husker mere, bedre relation, ejerskab til projekt

Overgang fra fødegang til OP

- I 2011 blev 34.4% af grad 2 akutte kejsersnit påbegyndt indenfor 30 min. (Nationale standard er 95%)
- Workshops, data opsamling/analyse
- Ændringer i arbejdsprocesser, kognitive hjælpemidler mv.
- Før-efter interventions studie af 100 grad 2 kejsersnit
- Træning af personale (239 deltagere) (95%).
    - Andelen af grad 2 kejsersnit var højere efter team træning 87.5% sammenlignet med 74% før træning

Fuhrmann et al Acta Anaesthesiol Scand 2015



Implementation of an electronic checklist in the patient handover from the ward to the operating room

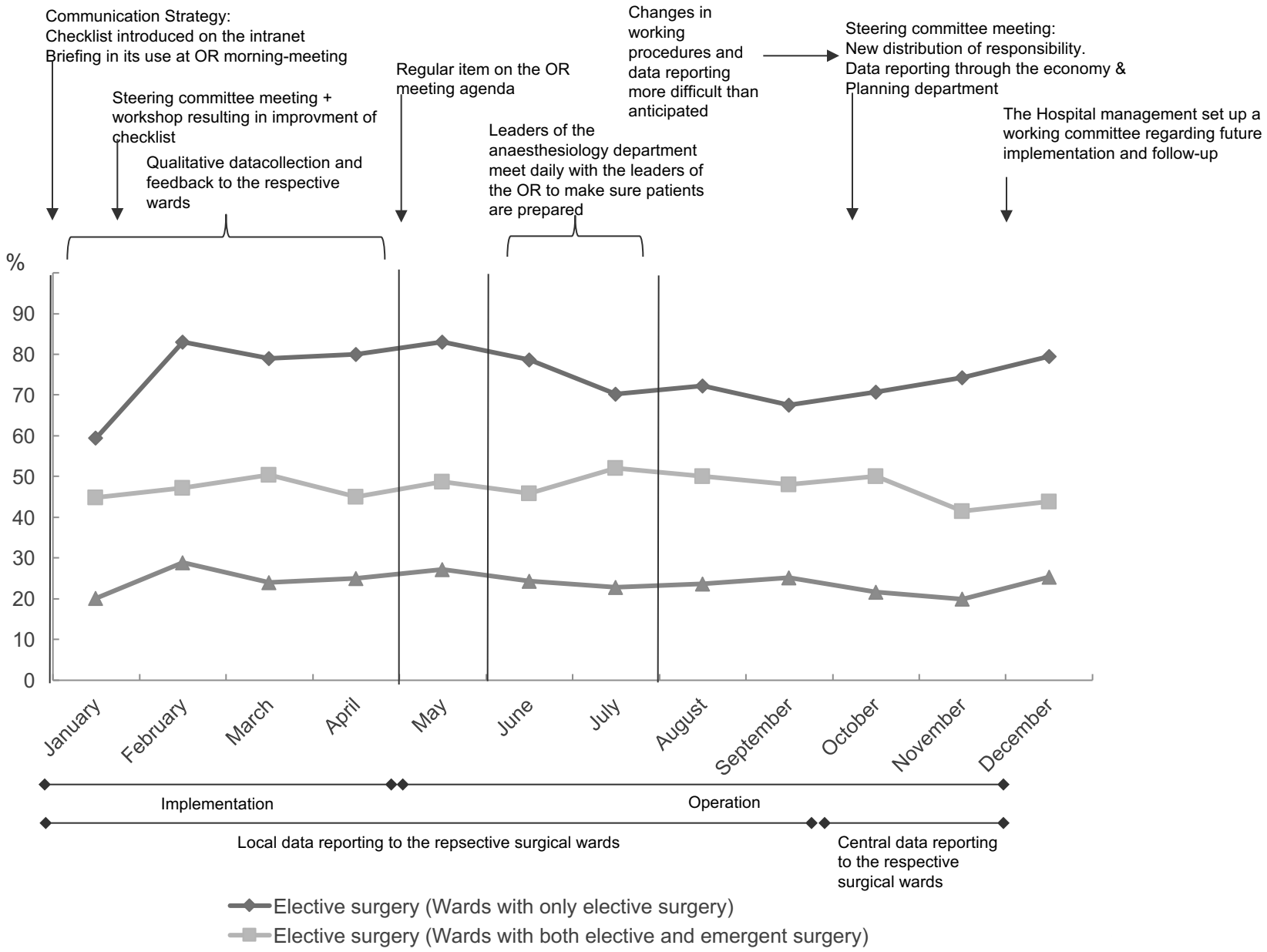
K. Münter[1], T.P. Møller[2], D. Østergaard[2], L. Fuhrmann[1]
[1]Dept. of Anaesthesiology and [2]Danish Institute of Medical Simulation, Herlev Hospital, Copenhagen, Denmark.

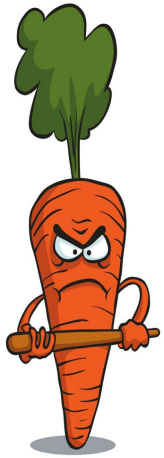
Møller TP, DMJ 2015, Münter K, J Pat Safety 2017

Projekt faser

- Behovsanalyse – dataopsamling på OP
- Etablering af styregruppe (incl. hospitalsledelse)
- Workshops med afdelinger
- Udvikling af checkliste ”bording kort”
- Elektronisk data
- Tilbagemelding til afd.

- Fra projekt til drift!

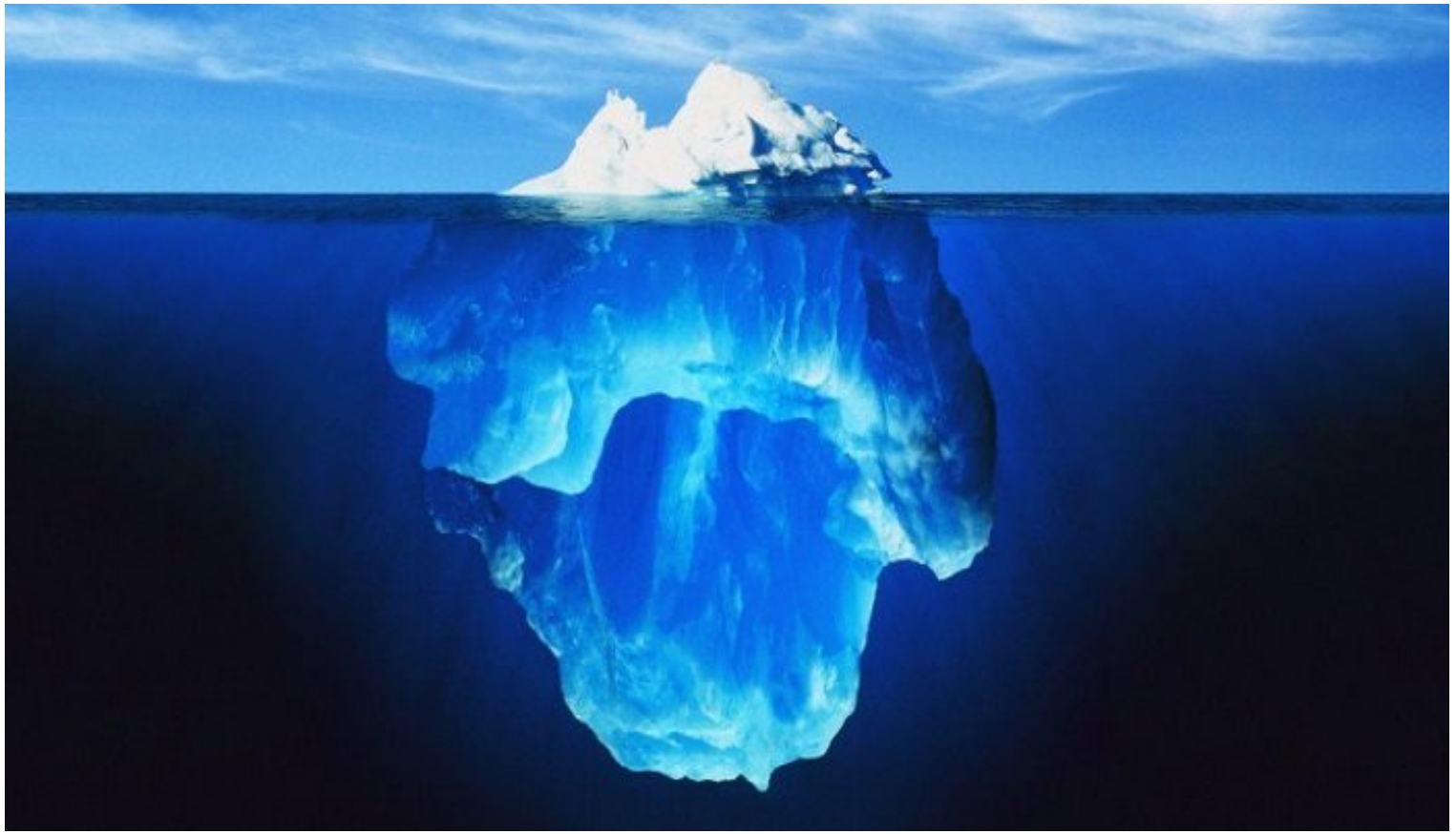

Communication Strategy:
Checklist introduced on the intranet
Briefing in its use at OR morning-meeting
Steering committee meeting + workshop resulting in improvment of checklist
Qualitative datacollection and feedback to the respective wards
Regular item on the OR meeting agenda
Leaders of the anaesthesiology department meet daily with the leaders of the OR to make sure patients are prepared
Changes in working procedures and data reporting more difficult than anticipated
Steering committee meeting:
New distribution of responsibility.
Data reporting through the economy & Planning department
The Hospital management set up a working committee regarding future implementation and follow-up
%
90
80
70
60
50
40
30
20
10
0
January
February
March
April
May
June
July
August
September
October
November
December
Implementation
Operation
Local data reporting to the repsective surgical wards
Central data reporting to the respective surgical wards
Elective surgery (Wards with only elective surgery)
Elective surgery (Wards with both elective and emergent surgery)



Implementation – a challenge

- Between 30-50% of major change initiatives achieve the intended outcome
- (Balagan 2004, Dent 2001, Kotter 1995)

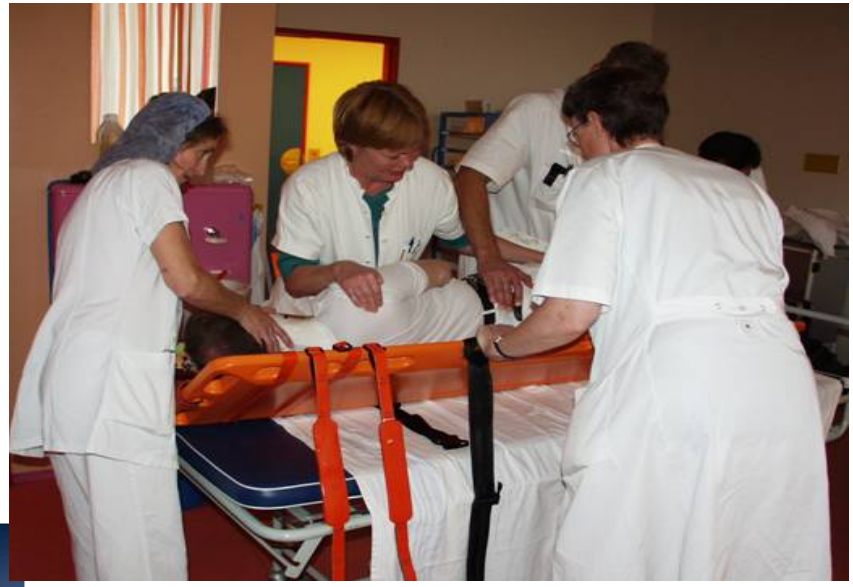
At ændre en kultur – hvor svært kan det være?

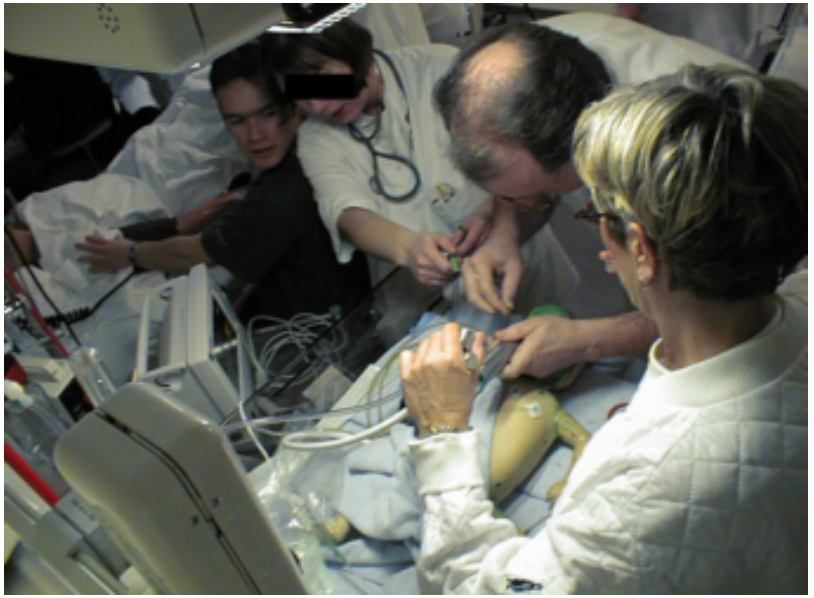


Kontinuerlig professionel udvikling

- ”Vi er motiverede for at lære, men ikke altid vidende om, hvad vi ikke gør godt”

- Livslang læring – og aflæring!
- Refleksion
- Inter-professionel læring
- *Feedback*





- Asking the right question at the right time
- Forming the question in an understandable manner
- Listen to the answers and ask more questions
- Train, train and train again

Patienters oplevelser i Overgange mellem Primær og Sekundær sektor

Fremtidens sundhedsvæsen – nye udfordringer?

Helhedstænkning i et samlet sundhedsvæsen

Digitalisering, kognitiv databehandling og kunstig intelligens

Aktive patienter - selvdiagnosticering

Nye akuthospitaler

Hjemmebehandling og individuel medicin

Fra volumen til outcomes

Klinisk performance – højere kvalitet i processer og aktiviteter

Populationsbaseret tilgang til forebyggelse og sundhed

Flere kronikere og multisyge

Aldrende befolkning

Forsknings- og udviklingsaktiviteter

Personale

- Forstå udfordringerne og årsagerne (Human factors perspektiv)
- Ejerskab til løsninger
- Motivation for at gøre det sikrere og bedre for patienterne

Patienter og pårørende

- Involvering af patienter og pårørende i forskning i overgange

”De er de eneste, der tager hele rejsen”

"*I cannot do it on my own – will you help me?*" (Gernes P)