Factors that impact on the safety of patient handovers: An interview study - DTU Orbit
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Aims: Improvement of clinical handover is fundamental to meet the challenges of patient safety. The primary aim of this
interview study is to explore healthcare professionals' attitudes and experiences with critical episodes in patient handover
in order to elucidate factors that impact on handover from ambulance to hospitals and within and between hospitals. The
secondary aim is to identify possible solutions to optimise handovers, defined as "situations where the professional
responsibility for some or all aspects of a patient's diagnosis, treatment or care is transferred to another person on a
temporary or permanent basis". Methods: We conducted 47 semi-structured single-person interviews in a large university
hospital in the Capital Region in Denmark in 2008 and 2009 to obtain a comprehensive picture of clinicians’ perceptions of
self-experienced critical episodes in handovers. We included different types of handover processes that take place within
several specialties. A total of 23 nurses, three nurse assistants, 13 physicians, five paramedics, two orderlies, and one
radiographer from different departments and units were interviewed. Results: We found eight central factors to have an
impact on patient safety in handover situations: communication, information, organisation, infrastructure, professionalism,
responsibility, team awareness, and culture. Conclusions: The eight factors identified indicate that handovers are complex
situations. The organisation did not see patient handover as a critical safety point of hospitalisation, revealing that the
safety culture in regard to handover was immature. Work was done in silos and many of the handover barriers were seen
to be related to the fact that only few had a full picture of a patient’s complete pathway.

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