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Achieving safe patient transition: recognizing the complexity

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What is patient transition?

- Situations, where the responsbility for the patients diagnoses, care and treatment, fully or partially shift hands on a temporary or permanent basis (from one healtcare worker to another)

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Research Project: Safe Patient Transition

- Result presented here
  - Part of a larger project using various data sources to investigate and analyze types and causes of unsafe patient transition to develop interventional programs
- Conducted by
  - Danish Institute for Medical Simulation (DIMS), Herlev Hospital, The Capital Region of Denmark
  - Danish Technical University (DTU), Department of Management Engineering, Safety, Reliability and Human Factors
- Funded by Trygfonden Denmark

Project group

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Why focus on patient transition?

- Patient transition is:
  - A patient safety challenge
  - Happens very frequently
  - Involves many different healtcare workers (cultures)
  - Involves many different forms of communications
  - Calls for high coordination

Aim of interviews

- To explore healthcare professionals' own attitudes and experiences of the phenomenon patient transition

Method – data collection

- 47 semi-structured single-person interviews
- Healthcare professionals close to the patients
- At one large university hospital in Denmark
- Eight different departments
- Critical Incident Technique

Method – analysis

- Interviews were partly transcribed
- Qualitative method of systematic text condensation (Malderud, Giorgi)
  - Four main steps
    1. Seeking a general sense of the whole
    2. Organizing the material into “meaning units” (“themes”)
    3. Abstracting the insights of each meaning unit
    4. Synthesizing all meaning units into the essential meaning of the phenomenon “patient transition”

Results: general themes

- Results are not given in this web based presentation, because of publishing issues….
- The authors can be contacted for more information

What can be concluded?

- The themes found using systematic text condensation illustrate both the complexity of transition and the areas which can be addressed to make safer patient transition
- Safety threats posed by transitions go beyond the actual process of patient transition
- Transferred into “systems thinking” all areas of the organization therefore need to be addressed, when designing interventional programs to optimize safe patient transition.
- Patient transition is a complex process with no single solution

Further reflections….

- Why is there a lack of structural or systematic guidelines/procedures for transition in the departments and between departments?

- Why is there lack of reflection on
  - when a transition occurs?
  - what a transition is?
  - who is responsible when in the process?
  - when responsibility is given and taken?

- How do we make sure that responsibility is clear in transition?

Critical questions

- What is the solution to overcome the complexity in transition?
- What does qualitative research bring to patient safety?
  - what about evidence??