Title of the project
Achieving safe patient transition: recognizing the complexity

Keywords
Research in patient transition, qualitative research method, interviews, systematic text condensation method, healthcare professionals' own attitudes and experiences of the phenomenon of unsafe/safe patient transition.

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Research organization
The research project has been conducted by the [1)] Danish Institute for Medical Simulation (DIMS), Herlev Hospital, The Capital Region of Denmark in collaboration with the [2)] Danish Technical University (DTU), Department of Management Engineering, Safety, Reliability and Human Factors. It is funded by Trygfonden in Denmark.

Purpose
The goal of this research project is to investigate healthcare professionals' experiences with adverse events to elucidate the themes that impact on safe patient transition. The research is part of a larger project using various data sources to investigate and analyze barriers against and opportunities for achieving safe patient transition to further interventional programs

Research method
In 2008 and 2009, 47 interviews were conducted in a large university hospital in the Capital region in Denmark with various healthcare professionals directly involved with patients from eight different departments: the emergency department, two medical and two surgery departments, an intensive care unit, a radiology unit and the porter unit.

Each interview was conducted by two interviewers where at least one with a background in healthcare. The interviews were conducted as semi-structured single-person interviews, lasting about an hour. Interviewees were recruited on a voluntary basis and had received a one-page introduction to the purpose of the project in advance, emphasizing that the goal of the interview was to obtain a comprehensive picture of the interviewee's subjective perceptions of critical episodes in patient transitions. The Critical Incident Technique was used to make the healthcare professionals focus on specific incidents in which they had been involved. They were asked to talk about what happened, how they reacted, what the consequences were for the patient, themselves, others or the organization, if any learning or changes were implemented because of the incident, and lastly if they had reported the incidents. In particular, interviewees were asked to recall and recount the factors that were involved in causing and possibly exacerbating the incidents.

The interviews were transcribed and analyzed using the qualitative method of systematic text condensation (Malderud) inspired by the psychological phenomenological method (Giorgi). The aim is to explore healthcare professionals' own attitudes and experiences of the phenomenon of primary unsafe patient transition and secondary - safe transitions. Four main steps were followed: 1) Seeking a general sense of the whole; 2) Organizing the material into "meaning units" also called

"themes"; 3) Abstracting the insights of each meaning unit; 4) Synthesizing all meaning units into the essential meaning of the phenomenon "patient transition".

It should be noted that the method and the results primary focus is on "barriers, breaches and problems" as we have not as systematically asked about "efficient work-arounds" that staff engage in to assure safe patient care. The results are therefore the product of the method and should not give a misconstrued impression that unsafe patient transition is more normal than safe transition.

Results (results unpublished – will be presented at the poster-session)
A total of 33 themes of specific interest to transition were found through the interview analysis. Further results are left out because of publishing issues.

Conclusions
The themes found using the systematic text condensation method illustrate both the complexity of transition and an aggregate of the areas which can be worked on in order to make patient transition safer. Further conclusions are left out because of publishing issues.

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