

Communication between teams and the care transfer of critical patients

Comunicação entre equipes e a transferência do cuidado de pacientes críticos

How to cite this article:

Petry L, Diniz MBC. Communication between teams and the care transfer of critical patients. Rev Rene. 2020;21:e43080. DOI: <https://doi.org/10.15253/2175-6783.20202143080>

 Letícia Petry¹

 Marisa Basegio Carretta Diniz¹

¹Hospital de Clínicas de Passo Fundo.
Passo Fundo, RS, Brazil

Corresponding author:

Letícia Petry
Rua Tiradentes, 295, Centro,
CEP: 99010-260. Passo Fundo, RS, Brazil.
E-mail: enfleticiapetry@outlook.com

ABSTRACT

Objective: understanding the process of communication between professionals during intra-hospital care transfers of critical patients. **Methods:** qualitative study, whose data collection was carried out through an interview with nursing technicians, nurses, and physicians who worked in the Medical Emergencies Unit and the Adult Intensive Care Unit, a total of 18 professionals. Data was evaluated according to the Discourse of the Collective Subject. **Results:** the knowledge of professionals with regards to their role was found to have gaps, and verbal communication was superficial as a result of the misuse of the instrument of care transfers in place, which made it difficult to follow the same path of care. **Conclusion:** the transfer of care is carried out between settings. However, the communication process is frail and presents shortcomings resulting from the lack of a proper protocols and the little knowledge about their importance by the professionals.

Descriptors: Critical Care; Patient Safety; Communication; Quality of Health Care.

RESUMO

Objetivo: compreender o processo de comunicação entre os profissionais de saúde durante a transferência do cuidado intra-hospitalar do paciente crítico. **Métodos:** estudo qualitativo, com coleta de dados por meio de entrevista com técnicos de enfermagem, enfermeiros e médicos atuantes na Unidade de Emergências Médicas e Unidade de Terapia Intensiva Adulto, perfazendo 18 profissionais. Os dados foram apreciados segundo o Discurso do Sujeito Coletivo. **Resultados:** evidenciou-se fragilidades no conhecimento dos profissionais quanto aos seus papéis e uma comunicação verbal estabelecida de modo superficial, como repercussão da impropriedade na utilização do instrumento de transferência existente, dificultando a obtenção de uma linha de cuidado contínua. **Conclusão:** a transferência do cuidado é executada entre os cenários, entretanto, o processo de comunicação se estabelece de maneira frágil e apresenta lacunas decorrentes da inexistência de um protocolo e do pouco reconhecimento acerca de sua importância por parte dos profissionais.

Descritores: Cuidados Críticos; Segurança do Paciente; Comunicação; Qualidade da Assistência à Saúde.

Introduction

Patient safety is an increasingly relevant theme in hospital settings. Its objectives and the actions related to it have been widely discussed as goals for health institutions. In the search for improving the healthcare offered in these settings, patient safety is paramount to diminish mistakes, and the six goals recommended by the Joint Commission International (JCI) must be considered⁽¹⁾.

This investigation is directed at the second goal for the safety of patients, and its object is the intra-hospital care transfers. The theme is related to all the stages of care and makes the continuity of care between units easier. Therefore, effective communication is paramount. The sharing of information must take place in a process that is formed by the transfer and acceptance of the responsibility for the aspects involved⁽²⁾.

The processes of communication in a hospital environment are complex and dynamic, characterized by high information flow, professionals from different teams, and a large demand for services. These elements mean that information constantly needs to be updated and exchanged between teams, patients, and patient relatives⁽³⁾. Thus, the human factor also needs to be taken into account, since it is, especially in the form of lack of communication, associated to a higher number of adverse events. Miscommunication between units and teams lead to shortcomings in patient safety, breaking the continuity of care⁽²⁾.

To qualify the communication process, the Joint Commission highlights high-performance transfers. It also connects adverse events to ineffective communication and weak protocols. The transference of responsibility for the care is an essential tool to build safety and implies an effective communication⁽³⁾.

In the assistance to critical patients, due to their high risk of death, a process that is consolidated through effective communication is necessary to attend to the demands of different settings, thus preventing the worsening of clinical situations and/or unfav-

orable outcomes. These patients are more vulnerable due to the severity of their illnesses and their need for specific care. As a result, their safety requires a special attention⁽⁴⁾. The lack of communication, in these settings, contributes to the lack of continuity of care, and can lead to mistakes and adverse events⁽⁵⁾.

It should be noted that a good interaction between the many hospital sectors, aiming to promote a safe quality assistance to the patient, is essential⁽⁶⁾. In addition, teamwork is seen as a driving force for transformation, and effective communication is its central feature⁽⁷⁾.

This work is based on the assumption that the transfer of care is a strategy to offer safe healthcare, since different professionals and settings make up the path of the patient in the intra-hospital environment. This investigation is focused on the transfer of care and on the process of communication from the Unit of Medical Emergencies to the Adult Intensive Care Unit, and from the latter to the hospitalization units.

Therefore, this study is justified by the need to know the process in order to improve it, increasing its effectiveness. From this perspective, the following guiding question was created for the research: how do the communication process between professionals involved in the intra-hospital transfer of care of patients take place, and how does it interfere in the safety of the patient? To find the answer, this work aimed at understanding the process of communication between professionals during intra-hospital transfers of care of critical patients.

Methods

This is a qualitative study, carried out in a large teaching hospital in the North of the state of Rio Grande do Sul, Brazil. Data was obtained via interviews with nursing technicians, nurses, and physicians who worked in the Medical Emergencies Unit and the Adult Intensive Care Unit, a total of 18 professionals. The number of subjects from each professional category was the same, one representative from each cat-

egory, from each work shift of the units. The workers chosen were those who worked directly in the care of critical patients and in their transfers. The number of subjects was determined by an intentional sample⁽⁸⁾. The research included professionals who worked in the institution for six months or more, a time frame defined to guarantee a more uniform time of experience, thus avoiding the possibility of interviewees that did not know the process being investigated.

Data were collected from April to July 2019, in a single stage, through interviews using an instrument elaborated by the researchers and including seven semi-structured questions. The questions asked the subject to express their understanding of transfers of care between the units mentioned and how they take place, as well as about the professionals involved, their roles, the healthcare offered during the transfers, the transmission of information, and the evaluation of the functioning. The interviews were carried out in a space in the work environment of the participant, during working hours. They were recorded digitally and transcribed in their entirety for later analysis.

To evaluate the data, the Discourse of the Collective Subject (DCS) was used. This method proposes the creation of a collective discourse, written in the first person, which represents the expression of a group of individuals that are similar or complementary⁽⁹⁾. This elaboration is structured by four methodological figures: key expressions, central ideas (CI), anchoring, and, as an outcome, the DCS.

Methodologically, the set of individual discourses referring to each question was analyzed in sequential stages, culminating in the building of the DCS. Excerpts that showed the essence of the contents of each statement were extracted, and key expressions were found. From these excerpts, linguistic expressions that concisely express the theme of the group of key expressions were highlighted, resulting in the central ideas. Then, the DCS for each central idea was elaborated. It should be noted that no pertinent anchoring was found during the analyses.

This research was carried out according to

the ethical precepts required by resolution nº 466, from the National Council of Health in the Ministry of Health. It was approved by the Research Ethics Committee, under protocol nº 3,225,830/2019 and received from the institution that was the setting of the study the Certificate of Submission to Ethical Assessment nº 09259819,6,0000,5342.

Results

Eighteen professionals, divided equally between the units investigated, were part of the research. Ten of them were female, while eight were male. The mean age of participants was 31.94 (± 7.31) years of age. Regarding the mean time of formation of the nurses in years, nursing technicians had been graduated for 6.73 (± 5.97), nurses for 7.61 (± 5.96) and physicians for 12.25 (± 7.50). The mean length of time working in the institution was 2.83 (± 2.11) for nursing technicians, 3.33 (± 1.83) for nurses, and 7.08 (± 5.14) for physicians.

The approach adopted makes it possible to note that the professionals experience care transfers in their daily work in both settings, and that these transfers are a determining factor for the safety of the patient. The DCSs emerged from the results, and the four discourses found are presented below by the CI, followed by the corresponding DCS.

CI 1: Weaknesses of the routine of care transfer with regards to the role of the multidisciplinary team

DCS 1 is about the routine and organization of transfers of care, revealing some healthcare actions that take place before the transfer. As shown below, some weaknesses were expressed. DCS 1: *Nurses, physicians, and nursing technicians are involved in the transfer of care. I notice that the process starts with a telephone call between the nurses in the different units, the quick transmission of information about the clinical state of the patient, and the infusion of drugs. For the transfer to take place, the patient must be hemodynamically stable. Before I*

leave the unit, I organize the patient and the devices being used, check the duration of the continuous infusion drugs, review the prescription, the documents and what still needs to be done, as not to compromise the safety of the patient, and give information to the professional that will assume the care. However, it is not always that all professionals get involved in the care before it is transferred. Sometimes I only see the nurse and the nursing technician doing it.

CI 1: Verbal communication as an instrument in the transfer of care

The DCS 2 shows that verbal communication is used to transmit information between the professionals involved. However, some shortcomings can be identified as resulting from the lack of standardization. DCS 2: *As the patient arrives, I transmit the information to my colleague verbally, this happens with each professional category. However, I do not always see all professionals transmitting information, sometimes the physician is the only one to do so. I see that communication is very important, all information must be transmitted so another professional can assume care. However, the professional who is responsible for the transfer is the one who decides which information to share, since there is no protocol to follow. Generally, the physician transmits the history and clinical condition, what was done and what the therapeutic plan is, the nurse transmits the procedures carried out, what medications are being administered and what is missing, and the nursing technicians mostly communicate direct care issues. Nonetheless, this is not a rule. There is lack of knowledge about patient information, and it rarely is a collective conversation. Sometimes the technicians do not communicate anything, and the physicians only talk to each other.*

CI 3: Inadequate use of the written instrument for the transfer of care

The DCS 3 clarifies how the instrument destined for the transfer of care is used, pointing out at the important shortcomings of the process. DCS 3: *There is an instrument for the transfer of the patient, which I fill in with the most important information, such as clinical history, actions carried out, therapies and antibiotic therapies being used, what still needs to be done, and vital signs before leaving to the other unit. Still, I see*

different professionals filling the instrument in, there is no standardization as to who is responsible for doing it. I also notice that, sometimes, the instrument does not come with the patient, or is incomplete.

CI 4: Shortcomings in the communication process that hinder the guarantee of patient safety

DCS 4 refers to an evaluation of the process of transference of the patient and the aspects that diminish the safety of care and are related to effective communication. DCS 4: *I believe there are important shortcomings in communication. In most cases, information is lost, the team who brings the patient does not know or have the proper training to transmit certain information, the information is not enough, making the moment confusing, and the information communicated depends a lot on the professionals who are transferring the care. In addition, I notice a lack of interest in the transferring of care. Oftentimes they do not receive me well and do not pay the attention that the situation requires.*

Discussion

This study had limitations, stemming from the fact it was executed in only two settings within a single hospital. The transfer of care of the critical patient is, in most cases, started by the transport of the patient from the place where the health problem took place. Therefore, looking beyond the doors of the institution would allow for a broader perspective on the importance of this transfer, as it would involve many different professionals and settings, while maintaining as an objective the building of a continuous line of care. Also, associating the method used here with the observation of the process and a document analysis allowed for broader findings.

The results in the discourses showed that the processes of communication and transfer of care have weaknesses in their execution and depend on the perspective of each professional, since there is no standardization for their execution. The weaknesses were associated to the lack of a pre-established routine that was not entirely known by the professionals in the DCS 1.

From this perspective, it can be noticed that communication between teams is permeated with difficulties. The lack of standardization and familiarization of the professionals with the routine makes these difficulties even bigger, and reduces the potential of tools to improve behavior⁽¹⁰⁾. Therefore, confronted with the lack of a protocol, which was mentioned in the discourses, one must agree to the prediction according to which there is a higher risk of adverse events in the transfer of unstable patients, and that it is necessary to create strategies to make it so professionals will not make mistakes, strategies such as the implantation of protocols⁽²⁾.

Corroborating the need for a protocol that can direct professionals with regards to their role during the transfer of care, the impact on patient safety stands out as an outcome of the implementation of strategies in a broad sense, and their use in a systematized way by the teams, considering well-defined assistance protocols⁽¹¹⁾.

In the DCS 1, participants talked about the care carried out before the transfer, such as transmitting information through telephone, reviewing the actions of care already implemented in the patient, and the organization of devices and documents, which were associated to the guarantee of patient safety. In fact, the care mentioned in the study is prescribed for transfers, especially considering the needs of the patients, since the success of the process results from planning and from organizing the actions of the entire multidisciplinary team⁽¹²⁾. Despite the mentions to the actions of care that precede the transference, it was found that this practice is not carried out by all professionals involved. Therefore, there is a margin of error for adverse events to take place, meaning that this process needs to be improved.

The analysis of the second discourse indicates that participants recognize that it is important for the patient to be hemodynamically stable before being transferred to another setting. This is based on the assertion that, to guarantee the patients' safety, it is important, before the transfer, to clinically assess the

patient and guarantee a minimum level of stabilization⁽¹¹⁾.

With regards to the DCS 2, it was found that professionals recognized how important it is to communicate all information related to the patient during the transfer to another professional. Therefore, establishing continued care requires not only the transfer of information, but also the transfer of responsibilities from the professionals transferring the patient to the ones receiving them⁽¹⁰⁾.

Related to this is the second discourse, which states that the transference of care in the settings investigated is primarily developed using the resource of verbal communication, which was the most used. Considering this, it is necessary to point out the difficulties in the communication between professionals, which interfere in carrying out teamwork in the continuity of care⁽¹¹⁾. In addition, when the transfer of clinical patients was analyzed, it was found to be linked to the occurrence of adverse events and physiological alterations, as well as failure in equipment and, especially, to the lack of knowledge of professionals and the shortcomings in the communication between the team transferring the patient and the one receiving the patient⁽¹²⁾.

Communication failure was also mentioned by the subjects. It is related to the fragmentation in the transmission of information among professional categories, to professionals who do not participate in the transferring of information, and to the fact that the data transmitted depend on the professional transferring the patient, due to the lack of a proper protocol. Nonetheless, the participants know that sharing information between the teams is an important factor to guarantee continued assistance. To do so, data about the patient are recommended to be shared in their entirety, in a clear and objective manner, making it possible to monitor, evaluate, and plan the care of the patient⁽¹³⁾.

Considering the shortcomings in the transmission of information mentioned above, communication was emphasized as a mechanism to integrate the mul-

tidisciplinary team and avoid distortions and failures in attention, since it is the tool through which information is evenly distributed between those responsible for the care⁽¹⁴⁾. Therefore, it is important to recognize the relevance of spoken communication strategies, but these become more effective when there is a written record to make them safer. The association of the two aims to guarantee that necessary information on patients is not lost during transfers of care⁽¹⁵⁾.

In DCS 3, it was found that the institution uses an instrument destined to the transfer of the patient, which comprises relevant information for continuing the care. However, it was found that there were shortcomings in the use of said instrument, due to the fact that here were no standards regarding which professional should be responsible for filling it in. Also, sometimes the instrument was not used or presented incomplete information.

A mapping of transfer documents corroborates these findings as it shows variability and inconsistency. The documents were mentioned by the team that receives them as incomplete and low-quality. Among the causes for this problem, the shift changes of professionals is a factor that influence in the lack of knowledge of information about the patient⁽¹⁶⁾.

Despite the difficulties involving the implementation of an instrument for this objective, the notes on the transfer of patients between sectors are used as strategies for effective communication⁽¹¹⁾. Therefore, the actions that are the best fit to the local context should be used to actually make the transference of all necessary information possible, enabling the continuity of a quality and safe care⁽³⁾.

Therefore, the use of the instrument must be understood by the team as a tool to make the communication process among teams easier, to offer quick access to information and give support to spoken communication, enabling the therapeutic plan to be continued through different settings. Educational actions regarding this process are necessary for it to be adequately used⁽¹⁵⁾.

Another extract of DCS 3 showed that, as routine, vital signs are verified and noted as an additional measure of safety before transfers. According to literature, vital signs are important information to effectively transfer care and justify clinical actions, since the absence of this type of information is seen as a risk factor for adverse events during hospitalization⁽¹⁷⁾.

The DCS 4 stated that there are shortcomings in the communication process that can undermine the quality of transfers of care and may end up compromising the safety of the process. Inconsistencies in the process were associated to the fact that the professionals involved in the transfer lacked information about the patients. Other studies found similar results. Knowing that the very professionals who are transferring the patient from one setting to another do not know their clinical characteristics and the type of care they need⁽¹⁵⁾ shows how susceptible to failures this process is.

The discourse also mentioned aspects such as the lack of credibility of the professionals, the lack of attention during information exchange, and the fact that said information goes through the subjective analysis of what the professional sees as important. That said, communication noise is a factor that negatively affects care, i.e., interferences in the moment of information exchange, and information which is not transmitted completely or is incorrectly understood, are all related to compromised patient safety⁽⁵⁾.

Therefore, the context found reiterates the repercussions in the lack of a systematized protocol for the establishment of a line of care that can effectively be a basis for continued attention in the setting top which the patient is being transferred. The effecting of a safer assistance involves implementing actions such as the attention to specific protocols and the use of safety barriers that are functionally adopted to be effective in their execution, preventing risk situations and adverse events⁽¹¹⁾.

Also, the complexity in the execution of care transfers stands out, especially as it depends on an

effective communication, and this is a barrier that can lead to adverse events⁽¹⁸⁾. Therefore, offering continuous investments to improve the communication process with regards to care transfers make it possible to put the multidisciplinary team in line, thus guaranteeing an efficient and safe assistance⁽¹⁸⁾.

Considering the weaknesses in the process mentioned in the discourses, the standardization of the processes is aimed at avoiding the gaps in knowledge that result from personal decisions from the professionals with regards to what information should be shared⁽¹⁹⁾. Therefore, actions to guarantee that the care will continue adequately after a transfer favor the safety of the individual, improving the quality of care and reducing costs, while showing themselves to be efficient strategies to diminish adverse events in assistance⁽²⁰⁾.

Conclusion

The transfer of care takes place between different settings. However, the communication process has weaknesses and presents shortcomings resulting from the lack of a proper protocol and the little knowledge about its importance by the professionals. The transfer of care is an important strategy that must be improved. To do so, spoken communication must be directed by an instrument that can guide the professionals in the transfer process, to guarantee the transmission of all information that is necessary for the continuity of care. As a result, it is important to invest in the quality of the information shared, since, from the perspective of planning individualized attention, the effectiveness of care depends on it.

Acknowledgments

To the Ministry of Health, for the concession of a scholarship to Letícia Petry through the Multidisciplinary Residency in Health, under the protocol nº 2572/2017, registered in the Sistema da Comissão Nacional de Residência Multiprofissional (SisCNRMS).

Collaborations

Petry L and Diniz MBC contributed for the conception and for the project, data analysis and interpretation, article writing, in the relevant critical review of the intellectual content and the final approval of the version to be published.

References

1. Silva ACA, Silva JF, Santos LRO, Avelino FVSD, Santos AMR, Pereira AFM. Patient safety in the hospital context: an integrative literature review. *Cogitare Enferm.* 2016; 21(n.esp):1-9. doi: <http://dx.doi.org/10.1590/S0080-62342013000100010>
2. Ministério da Saúde (BR). Agência Nacional de Vigilância Sanitária. Assistência segura: uma reflexão teórica aplicada à prática Agência Nacional de Vigilância Sanitária [Internet]. 2017 [citado 2020 jan. 13]. Disponível em: https://proqualis.net/sites/proqualis.net/files/1%20Assist%C3%Aancia%20Segura_%20Uma%20reflex%C3%A3o%20te%C3%B3rica%20aplicada%20%C3%A0%20pr%C3%A1tica.pdf
3. Silva MF, Anders JC, Rocha PK, Silva MOV, Souza S, Carneiro ES. Transfer between hospital units: implications of communication on pediatric patient safety. *Rev Enferm UFPE on line [Internet]*. 2017 [cited Feb 11, 2020]; 11(10):3813-20. Available from: <https://pdfs.semanticscholar.org/46b6/cfee5b77a10768d4b69bd52b8b7c903cb7a4.pdf>
4. Santos GRS, Campos JF, Silva RC. Handoff communication in intensive care: links with patient safety. *Esc Anna Nery.* 2018; 22(2):e20170268. doi: <http://dx.doi.org/10.1590/2177-9465-ean-2017-0268>
5. Santos GRS, Barros FM, Broca PV, Silva RC. Communication noise during the nursing team handover in the intensive care unit. *Texto Contexto Enferm.* 2019; 28:e20180014. doi: <http://dx.doi.org/10.1590/1980-265X-TCE-2018-0014>
6. Minuzzi AP, Salum NC, Locks MOH, Amante LN, Matos E. Contributions of healthcare staff to promote patient safety in intensive care. *Esc Anna Nery.* 2016; 20(1):121-9. doi: <http://dx.doi.org/10.5935/1414-8145.20160017>

7. Nogueira JWS, Rodrigues MCS. Effective communication in teamwork in health: a challenge for patient safety. *Cogitare Enferm.* 2015; 20(3):636-40. doi: <http://dx.doi.org/10.5380/ce.v20i3.40016>
8. Polit DF, Beck CT. *Fundamentos da pesquisa em enfermagem.* Porto Alegre: Artmed; 2011.
9. Lefèvre F, Lefèvre AM. *Pesquisa de representação social: um enfoque quali-quantitativo: a metodologia do discurso do sujeito coletivo.* Brasília: Liber Livro; 2012.
10. Alves M, Melo CL. Handoff of care in the perspective of the nursing professionals of an emergency unit. *Rev Min Enferm.* 2019; 23:e-1194. doi: <http://www.dx.doi.org/10.5935/1415-2762.20190042>
11. Olino L, Gonçalves AC, Strada JKR, Vieira LB, Machado MLP, Molina KL, et al. Effective communication for patient safety: transfer note and Modified Early Warning Score *Rev Gaúcha Enferm.* 2019; 40(esp):e20180341. doi: <https://doi.org/10.1590/1983-1447.2019.20180341>
12. Pires AF, Santos BN, Santos PN, Brasil VR, Luna AA. Transporte seguro de pacientes críticos. *Rev Rede Cuid Saúde [Internet].* 2015 [citado 2020 Jan 13,]; 9(2):1-4. Disponível em: <http://publicacoes.unigranrio.edu.br/index.php/rcs/article/view/2531/1313>
13. Bueno BRM, Moraes SS, Suzuki K, Gonçalves FAF, Barreto RASS, Gebrim CFL. Characterization of handover from the surgical center to the intensive care unit. *Cogitare Enferm.* 2015; 20(3):511-7. doi: <http://dx.doi.org/10.5380/ce.v20i3.40274>
14. Araújo Neto JD, Silva ISP, Zanin LE, Andrade AP, Moraes KM. Healthcare professionals of an Intensive Care Unit: perception of restrictive factors of the multiprofessional work. *Rev Bras Promoc Saúde.* 2016; 29(1):43-50. doi: <http://dx.doi.org/10.5020/18061230.2016.p43>
15. Hemesath MP, Kovalski AV, Echer IC, Lucena AF, Rosa NG. Effective communication on temporary transfers of inpatient care. *Rev Gaúcha Enferm.* 2019; 40(esp):e20180325. doi: <https://doi.org/10.1590/1983-1447.2019.20180325>
16. Roberts JC, Johnston-Walker L, Parker K, Townend K, Bickley J. Improving communication of patient issues on transfer out of intensive care. *BMJ Open Quality.* 2018; 7:e000385. doi: <https://doi.org/10.1136/bmjopen-2018-000385>
17. Cross R, Considine J, Currey J. Nursing handover of vital signs at the transition of care from the emergency department to the inpatient ward: an integrative review. *J Clin Nurs.* 2018; 1-12. doi: <https://doi.org/10.1111/jocn.14679>
18. Moraes KB, Riboldi CO, Silva KS, Maschio J, Stefani LPC, Tavares JP, et al. Transfer of the care of patients with low risk of mortality in postoperative: experience report. *Rev Gaúcha Enferm.* 2019; 40(esp):e20180398. doi: <https://doi.org/10.1590/1983-1447.2019.20180398>
19. Penna MM, Melleiro MM. Eventos adversos decorrentes de falhas de comunicação: reflexões sobre um modelo para transição do cuidado. *Rev Enferm UFSM.* 2018; 8(3):616-625. doi: <http://dx.doi.org/10.5902/2179769225432>
20. Mendes FRP, Gemitto MLGP, Caldeira EC, Serra IC, Casas-Novas MV. Continuity of care from the perspective of users. *Ciênc Saúde Coletiva.* 2017; 22(3):841-53. doi: <https://doi.org/10.1590/1413-81232017223.26292015>



This is an Open Access article distributed under the terms of the Creative Commons