

Original citation:

Sujan, Mark-Alexander, Chessum, Peter, Rudd, Michelle, Fitton, Laurence, Inada-Kim, Matthew, Cooke, Matthew (Professor of clinical systems design) and Spurgeon, Peter. (2015) Managing competing organizational priorities in clinical handover across organizational boundaries. *Journal of Health Services Research & Policy*, Volume 20 (Supplement 1). pp. 17-25.

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Publisher's statement:

<http://dx.doi.org/10.1177/1355819614560449>

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Managing Competing Organisational Priorities in Clinical Handover Across Organisational Boundaries

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Keywords: Patient Safety; Handover; Emergency Medical Services

Abstract

Objectives: Handover across care boundaries poses additional challenges due to the different professional, organisational and cultural backgrounds of the stakeholders involved. The paper provides a qualitative account of how practitioners in emergency care attempt to align their different individual and organisational priorities and backgrounds when handing over patients across care boundaries (ambulance service to ED, and ED to acute medicine).

Methods: 270 clinical handovers were observed in three emergency care pathways involving five participating NHS organisations (two ambulance services and three hospitals). Half-day processing mapping sessions were conducted for each pathway. Semi-structured interviews were carried out with 39 participants, and analysed using Thematic Analysis.

Results: The management of patient flow and the fulfilment of time-related performance targets can create conflicting priorities during handover for practitioners. Practitioners involved in handover manage such competing organisational priorities through additional coordination effort and dynamic trade-offs. Practitioners perceive greater collaboration across departments and organisations, and mutual awareness of each other's goals and constraints as possible ways towards more sustainable improvement.

Conclusion: Sustainable improvement in handover across boundaries in emergency care might require commitment by leaders from all parts of the local health economy to work as partners and establish a culture of integrated, patient-centred care.

INTRODUCTION

The handover of responsibility for patient care and of information relating to patients from one caregiver to another is an important part of clinical practice to ensure the continuity of care (1).

Failures in handover are a recognised threat to patient safety (2, 3). There is now a wealth of evidence as well as a number of systematic reviews that suggest that inadequate handover practices

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are putting patients at risk (4, 5). Handover failures have been associated with a range of negative outcomes, such as delays in treatment (6), medication errors (7), unnecessary duplication of assessments (8), and poor patient experience (9). A large number of contributory factors have been identified in the literature including unclear structure of the handover conversation (3), frequent distractions (10), inadequate documentation (11) and overreliance on documentation (12), and a lack of training in handover and non-technical skills (13).

Handover in emergency care is a particularly vulnerable activity due to high patient acuity, short patient encounters and situations of uncertainty, as well as overcrowding conditions in the emergency department (ED) (14). The Institute of Medicine identified inadequate handover as one of the leading causes of medical error in the ED (15).

Arguably the most frequently suggested intervention to improve handover is the standardisation of the handover conversation using a range of mnemonics, such as SBAR (Situation, Background, Assessment, Recommendation) or ATMIST (Age, Time, Mechanisms, Injury, Signs, Treatments) (16, 17). Intuitively, this seems a reasonable approach, but there is a lack of evidence in the literature that standardisation of handover provides sustainable improvements in patient outcomes (4). This might be due to the overly narrow focus on handover as simply the transfer of information from a sender to a more or less passive receiver (18). From this perspective, handover failures result from inadequate communication skills or from 'noise' in the environment, such as distractions. Such a narrow focus may be particularly limiting when considering handover across departmental and organisational boundaries. In these situations there are different professional, organisational and cultural backgrounds of the actors involved, which require additional coordination and negotiation (19, 20).

This paper investigates the organisational factors that affect the quality of handover in the emergency care pathway. The paper provides a qualitative account of how practitioners attempt to align their different individual and organisational priorities and backgrounds when handing over patients across care boundaries (ambulance service to ED, and ED to acute medicine). Such an approach embeds handover in the wider network of organisational goals and priorities. This might support organisations in the development of systems-based interventions to improving handover across

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organisational boundaries focusing on collaboration, allocation of responsibility and escalation processes.

METHODS

Setting

Organisations participating in the study were two English National Health Service (NHS) ambulance services and three English NHS hospitals (ED and acute medicine). Each ambulance service provides emergency care in the catchment area of on study hospital and conveys patients there. The third ambulance service felt unable to participate in the study, and as a result no data involving their staff was collected. Organisations were chosen to reflect a range of characteristics in terms of the population they serve and their organisational structure, including a large inner city hospital, a teaching hospital, and a district general hospital in a rural area.

Data Collection

Data were collected during the period September 2011 – November 2012 using observation and informal discussions, focus groups, and semi-structured interviews. Three process-mapping focus groups (21) were held at the start of the data collection period (one at each emergency care pathway involving a purposive sample of 27 members of staff (9, 8 and 5 members of staff for each pathway respectively). Process mapping is an improvement method, and has been used traditionally as part of quality improvement initiatives, such as Lean (22). The aim of process mapping is to provide a graphical representation of the process, which represents a shared understanding of all the stakeholders involved. A total of 270 patient handovers were observed across the three pathways. Observations focused on three different types of inter-organisational and inter-departmental handover identified from the process maps: handover from ambulance service to ED staff in “Resuscitation” (paramedic to senior ED doctor or resuscitation team); handover from ambulance service to ED staff in the “Majors” area (paramedic to senior ED nurse); telephone referrals from ED to acute medicine (different grades of ED doctors to different grades of acute medicine doctors or senior nurse). Members of the project team observed patient handovers during the day and evening

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(8:00 – 22:00) for a period from November 2011 – July 2012, on days when the researchers were on the respective site. Selection and inclusion of handovers were determined by whether staff were willing to be observed, and whether the observation could take place without risk of interference with patient care. Participants had been informed of the study via a participant information leaflet, and had been asked to provide written consent before the start of the data collection period. The researchers kept unstructured field notes. Semi-structured interviews were conducted with a purposive sample of 39 members of staff from the five participating organisations. Table 1 provides an overview of the participants by role. Interviews were conducted during May 2012 – November 2012. The interviews were held in a meeting room on site of the respective organisation. Each interview lasted between 20 and 50 minutes. Interviews were audio recorded and transcribed. During the transcription all identifiers were removed.

Data Analysis

The process maps were used to identify different types of handover across departmental and organisational boundaries for observation, and they provided the research team with an initial understanding of how the different types of handover were embedded in the emergency care pathway. The researchers undertaking the observations kept field notes, which were analysed for patterns, exceptions, and themes during project meetings. These served as input and prompts for the semi-structured interviews. Interview transcripts were read in their entirety, and then analysed using thematic analysis (23). Transcripts were coded using descriptive, open and *in-vivo* codes (24). Codes were clustered to identify main categories during project meetings. Categories were constantly compared with the data and revised until new data added no further conceptual insights. The transcripts were then recoded. The coding was supported by the NVivo 10 software package. Findings were presented to and validated with a broader range of twenty emergency care stakeholders external to the project (from ambulance services and hospitals throughout England) at a workshop held at the College of Emergency Medicine.

Ethics

The study had research ethics approval from South Birmingham Research Ethics Committee (11/WM/0087) as well as institutional approval at all participating organisations. All study participants were staff of the participating organisations. Participants received a participant information leaflet, and provided written consent prior to their involvement.

Table 1: Interview participants by role

Service	Role	Participant ID	Total
Ambulance Service			7
	Paramedic	AS01-AS03	3
	Hospital Ambulance Liaison Officer	AS04	1
	Team Leader (Ambulance Service)	AS05	1
	Area Manager (Ambulance Service)	AS06	1
	Clinical Director (Ambulance Service)	AS07	1
Emergency Department			23
	Staff nurse	ED01-ED04	4
	Senior nurse (coordinator)	ED05-ED07	3
	Nurse Consultant	ED08-ED10	3
	Emergency Practitioner	ED11-ED12	2
	Junior doctor	ED13	1
	Middle grade doctor (registrar)	ED14-ED15	2
	Consultant	ED16-ED20	5
	Clinical lead (consultant)	ED21	1

	General Manager Emergency Care	ED22	1
	Clinical Director Emergency Care	ED23	1
Acute Medicine			8
	Nurse	AM01-AM02	2
	Senior nurse	AM03-AM05	3
	Middle grade (registrar)	AM06-AM08	3
Other	Medical Education (directorate)	OT01	1
Total			39

RESULTS

The analysis identified a number of themes around organisational factors that affect the quality of handover (25). In this paper the focus is on one of the themes that suggests that practitioners involved in handover need to manage competing organisational priorities through additional coordination effort and dynamic trade-offs. Exploring this theme, we set out below perceptions of staff on how (a) the management of patient flow and (b) the fulfilment of time-related performance targets, as examples of key organisational priorities, impact on handover, and the strategies staff adopt to manage such impact. We also describe staff perceptions on (c) the role of collaboration across organisational boundaries to improve the quality of handover.

Management of Patient Flow

Participants related handover to capacity and patient flow issues by describing the purpose of handover as supporting the understanding of demand and capacity at a departmental level, as supporting the controlling of the flow of patients, and as enabling them to prioritise their own activities and patients (at an individual level). For example, one participant described the reason for

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having a dedicated senior nurse receiving all ambulance service handovers for patients in the 'majors' area of the ED as the provision of an overview of "*what's coming in*" and the creation of "*awareness of the impacts on the rest of the department over the rest of the shift*" (ED03). Even before ambulances arrive the provision of advance notification through pre-alerts or through the ambulance information system contributes to the anticipation of demand and the preparation for it in the ED in order to maintain patient flow.

Participants described a number of situations where the lack of capacity and inadequate patient flows might create problems for handover. Handover from the ED to hospital specialties (referrals) may be affected when the person receiving the handover cannot be reached, for example surgeons who are in theatre. In such situations handover cannot take place, and the patient needs to remain in the ED or may be admitted without handover. This may lead to situations of unclear allocation of responsibility for patient care or delays in moving the patient onward. A similar problem can occur when handover has taken place, but the patient cannot be moved onward because there are no free beds. Another problem described by participants is the situation where a nurse, who is not familiar with the patient, may need to transfer the patient and then give a handover that is perceived as simply reading off the notes and not providing any added value. This occurs when the nurse who had been responsible for the patient's care is busy with other duties and asks another nurse to take the patient in order to free up the bed and keep patients moving.

The lack of capacity also leads to ambulance queues. This is described as a potentially serious problem. On the one hand, ambulance queues might result in multiple and increasingly filtered handovers as one crew hands over their patient to another crew. This leads to situations where one crew might be handing over several patients with whom they are unfamiliar and where they cannot provide any additional verbal information. On the other hand, as crews are queuing, there might be situations of unclear allocation of responsibility, as the patient is on the premises of the ED, but a formal handover has not yet taken place. Participants from the ambulance services described as the most serious problem resulting from queues the loss of capacity to respond to emergencies in the community as the ambulances are stuck at the ED.

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A participant from an ambulance service describes the trade-off that needs to be made between potentially less than ideal handover and freeing up crews to get back out into the community based on a subjective risk assessment of the patient's condition.

“So we’ll deploy an ambulance liaison officer, particularly if we’ve got multiple patients or multiple vehicles stacking and that is to support the management of those patients. To provide oversight, if necessary, to take over the care of those patients if necessary, because one of the things we practice as an Ambulance Service when we’ve got stacking is to risk-assess those patients and see if we can free up those crews and get the crews to double up and monitor two patients, fully accepting that that’s less than ideal. When we’re in this situation we’re operating in a decompensated circumstance so, in other words, we need to modify. Essentially, we’re effectively managing patients as we would in a major incident where we are sort of streamlining processes, but clearly we’re having to, out of necessity, to address unmet clinical need in the community. So of course, the other side of things that I’m very cognisant of is that the risks of having to accelerate clinical handover or to streamline the handover process and release crews back into the community. The risks of that, in my view, are far less than having a patient with chest pain or a potentially life-threatening issue with no clinician available to support or resuscitate them. So that’s the balance. But if the system is well resourced and well managed the key to this in terms of avoiding these systems, is having upstream management measures in place to prevent the queue occurring in the first place.” (AS07)

The participant describes some of the adaptation processes that staff in the ambulance service utilise in order to manage the tensions arising from inadequate patient flows. These tensions manifest themselves as queues and delays to handover. Ambulance service staff need to make a dynamic trade-off between the risks arising from suboptimal handover (i.e. handing over to another ambulance crew rather than to the ED staff) and the risks arising from unmet clinical need in the community due to being detained at the ED. Staff resolve this trade-off through a subjective assessment of the risk to the patient under their care.

Time-Related Performance Targets

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Emergency Departments and more recently ambulance services have to meet time-related performance targets to ensure that patients are seen in the ED within a reasonable amount of time and that ambulances can get back out onto the road in order to be able to respond to emergencies. Meeting targets acts as powerful motivation. An ED participant with management responsibility described targets as an important quality improvement tool that *"provides significant corporate focus"* (ED22).

Frontline staff also felt quite strongly about time-related performance targets, but cautioned against too many pressures. In combination with increasing patient numbers and more junior staff responsible for their care this poses additional significant challenges. Organisations respond to the pressure created by the targets by changes to their systems and processes, including for example the handover from the ambulance services to the ED. Some participants expressed significant negative attitudes towards the resulting system of handing over patients to the ED (*"I hate it!"*). For example, the target introduced for ambulance services was described by one participant as leading to a handover process *"designed entirely around the target"* (ED06), which may threaten the quality of care and which people feel is inappropriate. This can lead to situations that create patient safety risks, such as when a patient is simply left in the ED and the nurse is unaware.

A participant from the ED describes the tensions in perception between clinical and management staff, and between the ambulance service and the ED. They describe a situation from their clinical experience where the focus on targets led to a hazardous situation for the patient.

"That [ambulance handover time target] is a problem. We know it's a problem. They [Ambulance Service] just say 'It's your problem, why are you keeping our paramedics too long'. It's not us, it's them pressing their button and getting out there. So there are issues around timing, and there are organisational pressures, which I don't think you should put too much pressure on, because actually they ensure quality. But the Ambulance Service is great. They do a superb service but they have managers who are pressing their guys to be back out on the road, back out on the road, back out on the road. Too much pressure inevitably will cause quality of care to drop. I've seen a patient two or three months ago who was just left on the spinal board in a cubicle. [...] The patient was left on the

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spinal board [pre-hospital device used for moving patients with possibility of spinal injury] but none of us knew about it except the handover people. That's because the paramedics had been told to get out and leave the boards here. In the past, we would always have a policy where they were always logged off by the paramedics. So organisational pressures to achieve organisational targets, like paramedics attending to patients within 8 minutes or whatever, are pressures, which can impact on the quality of handover and have done. And will continue to do. We guard against that. The paramedics guard against that. But you may have some people sitting in offices upstairs here or sitting in offices in [Ambulance Service] who don't appreciate our efforts." (ED21)

The quotation above provides an example of how the introduction of time-related performance targets can contribute to the creation of new risks to patient safety resulting from inadequate handover practices. Such targets could be regarded as instances of static trade-offs, i.e. the target requires handover to have taken place within a certain time frame in order to free up ambulance crews irrespective of the specific situation.

On the other hand, participants described many examples of how they used their professional judgement in order to balance the tension of having to meet the target and delivering high-quality care to the patient they are responsible for through dynamic trade-offs based on a consideration of the requirements of the current situation. This can lead to the adoption of informal working practices and a discrepancy between work-as-imagined (i.e. prescribed by policy) and work-as-is.

A participant from an ambulance service described how they perceive the time frame set by the target as the point by which they have to be back out on the road. They will use this time available according to their own judgement in order to ensure good care. The participant is referring to the situation where handover has taken place to the senior nurse, but they are concerned that there is additional patient-related information (often concerning the patient's social or psychological needs), which they want to hand over to a nurse directly involved in the patient's care. This practice is officially discouraged by the organisation as it is regarded as a redundant handover, but clinical frontline staff welcome the opportunity for a verbal handover.

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"We've got fifteen minutes from when we arrive to when we should hand over. [...] And then fifteen minutes from when we've handed over to when we've finished our paperwork and we've come clear. [...] So we've only got a 30-minute window here. [...] So I look at it as, OK as long as I press that button I will wait around and talk to the nurse, as long as I've cleared in 30 minutes, how I spend my time here is up to me." (AS03)

Similar attitudes were expressed towards the ED breach target. This may lead to what are perceived inappropriate referrals in order to meet the target, and it may threaten trust among colleagues from different departments. Lack of trust might result in the transfer of responsibility for patient care being refused. Participants from the ED attributed this to "boxing" or "gatekeeping" behaviour of specialist wards and their concern for their own work. On the other hand, participants from acute medicine described the conversation around patient referral as an opportunity to discuss and to ensure that the patient goes to the right place.

A participant from the ED describes the difficulties they experience when referring patients that may not fit a particular speciality unambiguously. From their perspective, specialists are controlling their workload and the patient flows by accepting only patients that fit very specific criteria, and they are refusing referrals for patients that do not fit these criteria by suggesting that they are motivated by the breach target. This ultimately leads to delays in care and overcrowding in the ED.

"The classic thing is medicine has become so boxed and every specialty in the hospital has made their box as small as possible and they put up as big a wall as they can around it, so we've got our upper GI [gastrointestinal] surgeons, we've got lower GI surgeons, we've got little finger, toenail surgeons almost. It's just ridiculous. We, as the attending clinicians, have to make a decision about who is most appropriate. And if we're wrong, which we will be, they then send on to the next team that they think. But it's classically patients who fall in between. So that GI bleed. Is it lower GI or upper GI? So should a surgeon take that or is it Medicine? So you can end up with patients waiting in the ED, and that's what's classically has happened across EDs, across the country. For hours and hours and hours, no one makes a decision. So we have to make a decision which way they should go. It's still a problem but we try and force the issue by doing these techniques. The patient is coming in, I say they are

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coming in under you, that's been agreed by the Chief Operating Officer of the Trust, and you need to come and see them now. Occasionally they fight back. Occasionally I have very difficult conversations with consultant colleagues. And they say 'Oh, this is all about 4 hours [breach target]' and I say, 'Yes, it is about 4 hours.' But that's really about quality of care of patients." (ED18)

Collaboration Across Care Boundaries

Participants suggested that handover across care boundaries can only be improved by better collaboration of the different individuals and organisations involved. However, participants expressed at times very strong views about the perceived lack of concern or unwillingness to collaborate by parties in other departments or other organisations. As described above, ED staff expressed their frustrations with specialists from other disciplines whom they perceive to be only *"interested in their own work"*. Similarly, participants described their dissatisfaction with General Practitioners' (GP) attitudes and the provision of out-of-hours service. This may lead to predictable peaks in demands in the ED, for example on a Monday when patients who had been feeling sick over the weekend are sent in large numbers to the ED. These in turn cause ambulance delays and flow problems. Participants described that the solution to such problems will probably not be found in increasing the numbers of staff or improved local handover practices. The problem would need to be addressed at a system level, by engaging with GPs, where the problem is created.

Closely related to this is the set-up of the health system and the drivers that are in place. One participant from the ED suggests that the drivers would need to be reconsidered and realigned in order to create appropriate incentives for engagement and collaboration at the system level. At present, hospitals and their EDs are penalised financially, for example, for failures to meet the corresponding time-related performance targets. The participant suggests that this creates incentives for practices and behaviours aimed at meeting those targets, without due concern for the impact these might have on the quality of handover.

"The key thing that needs to change though in the NHS is the drivers. The drivers are all in the wrong place. The money has to follow the patient. It doesn't at the moment. The money is given to the self-

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interest groups who use it in their own way, to the GPs at the moment and to the hospital doctors to an extent. It is going back to basic simple things. You know, we're not going to improve the quality of care until we sort out what's driving things. I have problems with handovers because things that my consultant colleagues are judged on are nothing to do with the quality of patients that arrive in the department. [...] You've actually got to change the drivers in the system. So while the drivers are set up as they were, these issues, these pressure points, are going to get worse. And they're going to get worse at the final deliveries of care." (ED21)

Participants also described their own attempts at finding solutions to these problems. A participant from the ambulance service describes engagement with people at all levels as a key ingredient in fostering greater collaboration, and in developing whole system solutions. The participant refers to the previously described problems of ambulance crews queuing at the ED, which creates risks for both the patient they are looking after as well as patients in the community requiring emergency services.

"In fact I've just come from a meeting with one of our hospitals in the region where we've been exploring the issues of ambulance delays and one of the issues that I'm certainly now very comfortable with is that I think all Acute Hospitals are on the same page as us as an Ambulance Service. [...] The challenge is managing surges in demand and trying to secure the cultural awareness that this is an issue and that we all do have a responsibility to ensure that our crews get back out into the community quickly. [...] This is why I have felt it's been critically important to engage at the highest level within the organisation so we've had engagement at Chief Executive and Medical Director level. [...] The reason that that is critical is that, in order to maintain flow in these circumstances, you actually need the whole system supporting so it requires good operational management but also actually requires clinical buy-in from the in-patient team." (AS07)

Joint working was proposed as an additional way of strengthening collaboration and creating a shared awareness of risks to patient safety. This could include joint, part-time appointments between the ambulance service and the ED, or ambulance service staff being integrated within the ED. This would create staff with experience of working both in pre-hospital as well as hospital-based care.

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Participants described the need to tackle the problem where it arises, before it actually becomes a problem (*"if there's a queue, the system has failed"*). This requires communication and collaboration between all stakeholders involved in order to develop a system that is able to maintain flow. For example, one way of reducing ambulance queues at the ED and the resulting problems for handover and quality of care is to reduce the number of necessary conveyances to hospital. Participants from the ambulance service described protocols they had established with GPs for patients with a degree of uncertainty about their past medical history. The protocol ensures there can be a discussion with the patient's GP, who may choose to take on responsibility for that patient or advise that they be escalated, admitted or they may choose to arrange an alternative care pathway. Similar arrangements have been proposed by participants from the ED in order to ensure senior clinical input prior to referral of a patient by their GP. One participant nicely summarised that what was needed was *"a systems approach – how do we provide emergency care services for people who live in this area"* (AS06).

DISCUSSION

The results provide a qualitative account of how organisational priorities, such as the management of patient flows and time-related performance targets, can impact the quality of handover in emergency care. For example, the evidence suggests that inadequate patient flows might cause delays in handover as ambulances are queuing; the ambulance handover-time target might lead to the omission of communication of important information, typically pertaining to the social and psychological needs of the patient; and the ED breach target and a lack capacity might lead to situations where allocation of responsibility for patient care is unclear.

In any complex, dynamic and interactive process involving multiple actors representing different roles, perspectives, motivations and organisations it is almost inevitable that practitioners experience competing organisational demands and priorities in their everyday clinical practice, such as handover. Managing such competing organisational priorities requires additional coordination effort and trade-offs, which form part of practitioners' everyday work, and which they do not distinguish as such from the technical work that they undertake (26, 27). The results presented in the paper provided several

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examples of situations in which practitioners undertake such trade-offs when handing over patients, for example: when ambulances are queuing crews might trade-off the risk of not meeting clinical need in the community with the risk of having a poor quality handover from a crew who are not familiar with the patient; when paramedics feel there is important information that should be communicated to the cubicle nurse they might trade-off the risk to the community of delaying their departure with the risk to their present patient of missing important information; when ED clinicians are referring a patient that could be seen by different specialities they might trade-off the risk resulting from delays in treatment and overcrowding situations in the ED with the risk of sending the patient to the wrong speciality and undermining trust among those colleagues by forcing an admission using certain keywords.

Hollnagel argues that safety should not simply be regarded as the absence of adverse outcomes, but rather as a capability – the ability to anticipate and adapt to changes and disturbances in a dynamic environment (28). From this perspective, trade-offs are both inevitable and useful, because they form part of the strategies that practitioners employ to adapt to the needs of the current situation. Such dynamic trade-offs (29) also present risks of their own as they are based on the subjective assessment of the particular characteristics of a specific situation.

This perspective might provide additional insights into how current improvement efforts have been framed, and what kind of future recommendations might be appropriate. Many efforts at improving handover have regarded the problems with handover as a matter of inadequate communication skills or problems in the immediate work environment, such as distractions (16, 17). Education in handover and standardisation are useful, but the results of this study suggest that there are additional organisational factors, such as the management of patient flows and the influence of targets, which might create the conditions for what practitioners then experience as problems with handover. While organisational factors such as competing priorities are experienced and managed at the individual level, solutions should also be targeted at the organisational and system levels.

More generally, Waring provides a socio-cultural critique of traditional improvement approaches suggesting that wider aspects of cultures and identities, the organisational system and the political

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context should be considered (30). One might argue that this will be particularly important when considering improvement to handover processes that cross departmental and organisational boundaries, where there is an increased coordination cost between individuals from different backgrounds and organisations (31). The results of the study suggest that practitioners perceive greater collaboration across departments and organisations, and mutual awareness of each other's goals and constraints as possible ways towards more sustainable improvement. While the problems with handover appear locally in everyday clinical practice, significant improvements might occur only when leaders from all parts of the local health economy commit to work as partners and establish a culture of integrated, patient-centred care. Commissioning groups and boards (responsible for commissioning or buying health and care services) have a role to play, for example by monitoring that organisations, which regularly transfer patients across the interfaces of care, have systems in place that ensure ongoing joint consultation and improvement efforts focusing on handover and transitions of care. Organisations and regulators might consider determining and implementing quality indicators to monitor the effectiveness of inter-organisational collaboration. Such quality indicators could include patient-focused outcome measures that reflect the whole pathway, as well as specific measures of process across boundaries.

CONCLUSION

The problems with handover, which practitioners experience in their everyday clinical practice, are frequently linked to organisational factors such as the management of patient flows and time-related performance targets. Practitioners manage competing organisational priorities through additional coordination effort and dynamic trade-offs. Sustainable improvement in handover across boundaries in emergency care might require commitment by leaders from all parts of the local health economy to work as partners and establish a culture of integrated, patient-centred care.

DECLARATION OF CONFLICTING INTERESTS

The authors declare that there is no conflict of interest.

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