Adult OR to TLC Trauma Transitions Interview Guide

Interviewee code:	
Interviewee service:	
Interviewee role:	
Interviewee gender:	Male Female
Interview date:	
Interview time and duration:	
Interviewers:	

Please note: these questions are open-ended to encourage the respondent to discuss topics related to the study. In such discussions, additional questions and prompts may be used to encourage the respondent to fully explain his or her answer. These questions and prompts include "Can you tell me a bit more?" "I'm not sure I quite understand about [repeat respondent's words]," "You said [repeat respondent's words], could I ask you a bit more about that?" or "Could you explain more about what you meant in saying [repeat respondent's words]."

Participation in this study is voluntary. You may change your mind at any time and discontinue participating in this study. [Hand out another copy of the information sheet to the interviewee, if s/he would like to see one.]

There is minimal risk associated with this interview. Your contact information will be kept by the research team to allow us to contact you again, but it will never be linked to your interview responses. Only researchers associated with this project will have access to the data gathered.

Do you have any questions about the study? Are you willing to proceed with the interview?

Is it OK to audiotape the interview?

Job Title/ Expertise
(ED charge nurse, peds transport team member, PICU nurse manager, etc..)

<u>Transitions of Care</u>
We are very interested in understanding – from your perspective – what is done for a transition of care between departments/units. We would like to understand what does occur in those cases when things go well and we like to better understand what occurs in cases when there is a "breakdown" and you cannot provide your services effectively and efficiently and the patient's care could be compromised.

→OR – TLC (sender)

Next let's talk about when a **level 1** patient is transferred from the **OR to the TLC when you were caring for the patient in the OR**?

1. Could you please ***describe this transition***?
   - What do you do in this transition?
   - When does it start?
   - When does it end?
   - Who participates in the transition?
   - What is the role/task of the family/caregiver in the transition?
   - What information do you provide in the transition?
   - What information do you receive in the transition?
     - Where/from whom do you get the information (EHR, written, verbal communication)?
     - What technologies/tools are used in the transition (EHR, written)?
   - Who do you talk to (communicate with) during the transition?
     - Who do you share information with during the transition? Do you interact with anyone else?
   - Where does the transition occur?
     - Who is with the patient when they leave the OR?
     - Who is with the patient during the transfer?
     - Who is with the patient when they arrive in the TLC?

2. Now lets talk about ***preparing for the transition*** and ***any follow up that occurs after***.
   - What is done to ***prepare for the transition***?
   - What do you do to prepare for the transition?
     - Who do you talk to (communicate with) before the transition?
     - Who do you share information with before the transition? Do you interact with anyone else?
   - What is the ***follow up to the transition***?
   - What do you do as follow up to the transition?
     - Who do you talk to (communicate with) after the transition?
     - Who do you share information with after the transition? Do you interact with anyone else?

3. Give us examples of when the ***transition from OR to TLC went well***; when the transition was good; when the patient's care was not compromised, and the process went well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
   - What worked in this example?
   - Was communication important?
   - What about communication makes the handoff go well?
   - What about the organization of the handoff enhances communication?

4. Give us examples of when the ***transition from OR to TLC went poorly***; when the transition was not good; when the patient's care might have been compromised, and the process did not go well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
   - What did not work in this example?
   - Was communication an issue?
   - What about communication makes the handoff go poorly?
   - What about the organization of the handoff hinders communication?

→OR – TLC, level 2

Now let's talk about when a **level 2** patient is transferred from the **OR to the TLC, when you were caring for the patient in the OR**. Is there anything different?

1. Could you please ***describe this transition***?
   - What do you do in this transition?
   - When does it start?
   - When does it end?
   - Who participates in the transition?
   - What is the role/task of the family/caregiver in the transition?
   - What information do you provide in the transition?
   - What information do you receive in the transition?
     - Where/from whom do you get the information (EHR, written, verbal communication)?
     - What technologies/tools are used in the transition (EHR, written)?
   - Who do you talk to (communicate with) during the transition?
     - Who do you share information with during the transition? Do you interact with anyone else?
   - Where does the transition occur?
     - Who is with the patient when they leave the OR?
     - Who is with the patient during the transfer?
     - Who is with the patient when they arrive in the TLC?

2. Now lets talk about ***preparing for the transition*** and ***any follow up that occurs after***.
   - What is done to ***prepare for the transition***?
   - What do you do to prepare for the transition?
     - Who do you talk to (communicate with) before the transition?
     - Who do you share information with before the transition? Do you interact with anyone else?
   - What is the ***follow up to the transition***?
   - What do you do as follow up to the transition?
     - Who do you talk to (communicate with) after the transition?
     - Who do you share information with after the transition? Do you interact with anyone else?

3. Give us examples of when the ***transition from OR to TLC went well***; when the transition was good; when the patient's care was not compromised, and the process went well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
   - What worked in this example?
   - Was communication important?
   - What about communication makes the handoff go well?
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4. Give us examples of when the ***transition from OR to TLC went poorly***; when the transition was not good; when the patient's care might have been compromised, and the process did not go well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
   - What did not work in this example?
   - Was communication an issue?
   - What about communication makes the handoff go poorly?
   - What about the organization of the handoff hinders communication?

→ OR to TLC, receiving

Next let's talk about when a **level 1** patient is transferred from the **OR to the TLC when you will care for the patient in the TLC**?

1. Could you please ***describe this transition***?
   - What do you do in this transition?
   - When does it start?
   - When does it end?
   - Who participates in the transition?
   - What is the role/task of the family/caregiver in the transition?
   - What information do you provide in the transition?
   - What information do you receive in the transition?
     - Where/from whom do you get the information (EHR, written, verbal communication)?
     - What technologies/tools are used in the transition (EHR, written)?
   - Who do you talk to (communicate with) during the transition?
     - Who do you share information with during the transition? Do you interact with anyone else?
   - Where does the transition occur?
     - Who is with the patient when they leave the OR?
     - Who is with the patient during the transfer?
     - Who is with the patient when they arrive in the TLC?

2. Now lets talk about ***preparing for the transition*** and ***any follow up that occurs after***.
   - What is done to ***prepare for the transition***?
   - What do you do to prepare for the transition?
     - Who do you talk to (communicate with) before the transition?
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   - What is the ***follow up to the transition***?
   - What do you do as follow up to the transition?
     - Who do you talk to (communicate with) after the transition?
     - Who do you share information with after the transition? Do you interact with anyone else?

3. Give us examples of when the ***transition from OR to TLC went well***; when the transition was good; when the patient's care was not compromised, and the process went well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
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   - What did not work in this example?
   - Was communication an issue?
   - What about communication makes the handoff go poorly?
   - What about the organization of the handoff hinders communication?

→OR – TLC, level 2

Now let's talk about when a **level 2** patient is transferred from the **OR to the TLC, when you will care for the patient in the TLC**. Is there anything different?

1. Could you please ***describe this transition***?
   - What do you do in this transition?
   - When does it start?
   - When does it end?
   - Who participates in the transition?
   - What is the role/task of the family/caregiver in the transition?
   - What information do you provide in the transition?
   - What information do you receive in the transition?
     - Where/from whom do you get the information (EHR, written, verbal communication)?
     - What technologies/tools are used in the transition (EHR, written)?
   - Who do you talk to (communicate with) during the transition?
     - Who do you share information with during the transition? Do you interact with anyone else?
   - Where does the transition occur?
     - Who is with the patient when they leave the OR?
     - Who is with the patient during the transfer?
     - Who is with the patient when they arrive in the TLC?

2. Now lets talk about ***preparing for the transition*** and ***any follow up that occurs after***.
   - What is done to ***prepare for the transition***?
   - What do you do to prepare for the transition?
     - Who do you talk to (communicate with) before the transition?
     - Who do you share information with before the transition? Do you interact with anyone else?
   - What is the ***follow up to the transition***?
   - What do you do as follow up to the transition?
     - Who do you talk to (communicate with) after the transition?
     - Who do you share information with after the transition? Do you interact with anyone else?

3. Give us examples of when the ***transition from OR to TLC went well***; when the transition was good; when the patient's care was not compromised, and the process went well from your viewpoint. Tell us about an example. We're interested in understanding what went well in terms of **the care transition.**
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   - Was communication important?
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→ OR to TLC, receiving

Comparison

Now, lets compare and contrast the transition when you care for the patient in the OR and in the TLC.

- What is similar?
- Are there differences as well?
- Would you ever care for the patient in both the OR and the TLC?
  - How does this impact the care transition?
- Do you think one works better than the other?
  - If so, why?

Solutions

- Can you describe solutions to improve these transitions?
  - Can you specifically describe ways of using health information technology to improve the transition?
  - Are there ways that information could be organized to improve transitions (SBAR)?

Wrap up questions

- Who else should we interview in your service/unit (e.g., other nurses)?
- Do you have any questions for us?
- Is there anything else you would like to add?

Survey and background Information:

References for reviewers:

Care transition, transition of care and handoff have been used in the literature, seemingly interchangeably. We are using the term transition of care (or transition) in this project.

Definitions:

Solet et al. (2005, p. 1094): "Handoffs involve the transfer of rights, duties, and obligations from one person or team to another…Effective information transfer requires a solid foundation in communication skills"

Arora and Johnson (2006): "The handoff can be thought of as a communication of information (content) that can take place through different modalities, which can include a written or verbal component." (p. 647). However, "[t]he handoff is more than just transfer of information—it is also a transfer of professional responsibility. It is crucial that the handoff indicate a clear transfer of professional responsibility. When the transfer of professional responsibility occurs at the time or close to the time of the transfer of information, this process is transparent and easily understood" (p. 654)

Cohen and Hilligoss (2010): "the exchange between health professionals of information about a patient accompanying either a transfer of control over, or of responsibility for, the patient." (p. 494)

Physician in the OR

Physician in TLC

Survey

Please indicate your agreement of disagreement with the following statements about adult care transitions.

		Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1.	Hospital units do not coordinate well with each other.	☐1	☐2	☐3	☐4	☐5
2.	Things "fall between the cracks" when transferring patients from one unit to another.	☐1	☐2	☐3	☐4	☐5
3.	There is good cooperation among hospital units that need to work together.	☐1	☐2	☐3	☐4	☐5
4.	Important patient care information is often lost when transitioning patients between units.	☐1	☐2	☐3	☐4	☐5
5.	It is often unpleasant to work with staff from other hospital units.	☐1	☐2	☐3	☐4	☐5
6.	Problems often occur in the exchange of information across hospital units.	☐1	☐2	☐3	☐4	☐5
7.	Hospital units work well together to provide the best care for patients	☐1	☐2	☐3	☐4	☐5
8.	Transitions between units are problematic for patients in this hospital.	☐1	☐2	☐3	☐4	☐5

See reverse side for pediatric trauma interview race/ethnicity questions.

Pediatric Trauma Interview Guide
Race/ethnicity questions

We are required by our funding agency to keep track of the race and ethnicity of research participants. Please respond to the questions below or tell us if you would prefer not to answer.

1. Do you consider yourself to be Hispanic, Latino or of Spanish origin?
   - ☐ Yes
   - ☐ No

2. Please choose one or more races that you consider yourself to be.

   CHOOSE ONE OR MORE

   - ☐ White
   - ☐ Black or African-American
   - ☐ Asian
   - ☐ American Indian or Alaska Native
   - ☐ Native Hawaiian or Other Pacific Islander

Thank you for your participation.