

Conflicts between health teams in transfer of prehospital care

Conflitos entre as equipes de saúde na transferência do cuidado pré-hospitalar

Conflictos entre equipos de salud en el traslado del cuidado prehospitalario

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ABSTRACT

Objective: to understand, from the health personnel's perspective, the causes of conflicts between health care teams during transfer from pre-hospital care. **Method:** this exploratory, qualitative, descriptive study was conducted at the ambulance service (*Serviço de Atendimento Móvel de Urgência, SAMU*) of Porto Alegre, Rio Grande do Sul, Brazil. Twenty-eight SAMU personnel were interviewed and 135 hours of care service observed. Thematic content analysis was used. **Results:** the causes attributed to conflicts were: (1) hospital overcrowding and poor staff receptivity: SAMU personnel felt blamed for service overcrowding and punished by gurneys being withheld, and (2) the bed regulation center and (in)definition in patient flows: there were gaps in patient routing agreements, it then falling to SAMU personnel to meet the challenge of completing the service. **Conclusions:** excessive demands and poor coordination between services in the health care network cause conflicts between teams in transfer from pre-hospital care.

Descriptors: Transitional Care; Patient Handoff; Continuity of Patient Care; Emergency Medical Services.

RESUMO

Objetivo: compreender as causas dos conflitos entre as equipes de saúde na transferência do cuidado pré-hospitalar sob a perspectiva dos profissionais. **Método:** estudo qualitativo, descritivo e exploratório, realizado no Serviço de Atendimento Móvel de Urgência (SAMU) de Porto Alegre/RS. Foram entrevistados 28 profissionais do SAMU e observados 135 horas de atendimentos. Empregou-se a análise de conteúdo temática. **Resultados:** As causas atribuídas aos conflitos foram: (1) a superlotação dos hospitais e a pouca receptividade da equipe: os profissionais do SAMU se sentem culpabilizados pela superlotação dos serviços e punidos por meio da retenção de macas; e (2) a regulação e as (in)definições de fluxos na rede: há lacunas nas pactuações sobre o destino dos pacientes, recaindo aos profissionais o desafio de dar sequência ao atendimento. **Conclusão:** o excesso de demandas e a baixa articulação dos serviços na rede causam conflitos entre as equipes de saúde na transferência do cuidado pré-hospitalar.

Descritores: Cuidado Transicional; Transferência da Responsabilidade pelo Paciente; Continuidade da Assistência ao Paciente; Serviços Médicos de Emergência.

RESUMEN

Objetivo: comprender, desde la perspectiva del personal de salud, las causas de los conflictos entre los equipos de salud durante el traslado desde el cuidado prehospitalario. **Método:** este estudio exploratorio, cualitativo y descriptivo se realizó en el servicio de ambulancia (*Serviço de Atendimento Móvel de Urgência, SAMU*) de Porto Alegre, Rio Grande do Sul, Brasil. Se entrevistó a 28 miembros del SAMU y se observaron 135 horas de servicio de atención. Se utilizó análisis de contenido temático. **Resultados:** las causas atribuidas a los conflictos fueron: (1) hacinamiento hospitalario y poca receptividad del personal: el personal del SAMU se sintió culpable por el hacinamiento del servicio y castigado con camillas retenidas, y (2) centro de regulación de camas y (in) definición en los flujos de pacientes: Hubo lagunas en los acuerdos de enrutamiento de pacientes, y luego le correspondió al personal de SAMU enfrentar el desafío de completar el servicio. **Conclusion:** las demandas excesivas y la mala coordinación entre los servicios de la red sanitaria provocan conflictos entre los equipos en el traslado desde el cuidado prehospitalario.

Descriptores: Cuidado de Transición; Pase de Guardia; Continuidad de La Atención al Paciente; Servicios Médicos de Urgencia.

INTRODUCTION

The Mobile Emergency Care Service (*Atendimento Móvel de Urgência, SAMU*) represents an indispensable component in the constitution of the Emergency Care Network (*Rede de Atenção às Urgências, RAU*) due to its significant impact on the population's morbidity and mortality, especially due to external and cardiovascular causes. It was instituted with the objective of organizing flows and articulating the other services in the health network, becoming a facilitator for improving access to the emergency services and increasing patients' survival¹. However, to fulfill its purpose of articulation and give continuity to patient care, the interaction of the SAMU with other services and teams is fundamental for transition of care.

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Transition of care is defined as a set of actions aimed at ensuring coordination and continuity of actions in the transfer of patients between different health services². Thus, transfer of care is a component of the transition and involves an exchange of verbal and documented information, where it is possible to refer a patient from one health professional to another, either during admission, during care, or at hospital discharge³⁻⁴. Considering the potential for harms due to the non-conformities related to transfer of care⁵, protocols and definitions of information flows are indicated⁶.

In addition to the content of the information, the interference of interpersonal relations involved in transfer of care should be highlighted. Sometimes, the occurrence of conflicts between the teams generates tensions among the professionals, wear, and fatigue, impacting on patient safety when transferring care⁷.

In pre-hospital emergency care, transfer of care has been a concern expressed by international accreditation bodies⁸, as well as national initiatives in favor of patient safety⁹. Effective transfers are ways to overcome fragmentation of care, of ensuring continuity of care, and of effective integrated health systems and the reflection of a poorly articulated RAU, with deficiencies in the continuity processes having implications for the effectiveness of safe care continuity¹⁰.

It is also stated in the international literature that the good relationships between the teams function as facilitators of the communication process in responding to emergencies⁷, highlighting the effects that conflicts in interpersonal relationships can have on the care provided, since the impairment in communication during transfer of care can lead to unnecessary delays in diagnosis and treatment, as well as to adverse events that result in deaths or in serious harms to the patients⁴. Thus, understanding the causes of the conflicts between the teams in the transfer of pre-hospital care can support investment in processes related to interactions between the pre- and in-hospital health teams.

Considering the above, this study has the following guiding question: From the perspective of the SAMU professionals, what is(are) the cause(s) of the conflicts between the health teams in the transfer of pre-hospital care? In this sense, this research aimed to understand the causes of the conflicts that occur between the health teams in the transfer of pre-hospital care from the perspective of the professionals.

METHOD

This was a qualitative study of the descriptive-exploratory type, using the techniques of non-participant observation and semi-structured interview.

Observations were made about the services provided, from the call sent by the central regulator to the teams, the information at the place of the occurrence, and the information documented in the medical records, to the interactions of the SAMU with the services that receive the patient. The observations totaled 135 hours, and the situations related to the object of investigation were recorded in the field journal.

The interviews took place in the SAMU bases and were conducted through a semi-structured script applied to 28 SAMU professionals, including 19 nursing technicians, six nurses, and three physicians. The following inclusion criteria were observed: being a health team worker, and working in the sector for more than six months. Workers who were away or on leave during the data collection period were excluded. The participants were selected taking into account the social subjects who had the experiences that the researchers intended to know, and the closure of the interviews and observations followed the criterion of theoretical data saturation.

Data collection was carried out from April to June 2018 and the analysis of the material resulting from the observations and the transcription of the interviews took place together, using the technique of thematic content analysis in the stages of pre-analysis, exploration of the material, and treatment of the results¹¹.

Anonymity was respected, naming the participants with the letters "TE" for nursing technicians ("*Técnicos de Enfermagem*" in Portuguese), "E" for nurses ("*Enfermeiros*" in Portuguese), and "M" for physicians ("*Médicos*" in Portuguese), followed by a number that indicates the order of the interviews. For the observations, the letter "O" was used, followed by a number that indicates the order in which they were observed. The study obeyed the ethical aspects of research with human beings¹² and was approved by the Research Ethics Committees of the Federal University of Rio Grande do Sul (CAEE 82452318.3.0000.5347) and of the Municipal Health Secretariat of Porto Alegre (CAEE 82452318.3.3001.5338).

RESULTS

Most of the participants were female (53.57%) and the age group was between 31 and 60 years old, with a mean age of 41.57. The mean working time in the SAMU was 16.32 years, with the day shift prevailing (64.29%).

Thirteen individuals had post-graduate degrees (46.43%), and 8 (53.57%) were in the urgency and emergency area.

From the speeches of the participants and from the non-participant observations, two categories were composed that allowed understanding the conflicts in the transfer of care between the teams of pre-hospital and hospital care, namely: (1) hospital overcrowding and low staff receptivity; (2) network flow regulation and (in)definitions.

Hospital overcrowding and low staff receptivity

In the opinion of the professionals, the interaction between the teams involved in the transfer of pre-hospital care has been compromised by the impasses resulting from the overcrowding of the services. The following passages clarify that:

[...] we have a bad receptivity in almost all the places, I think that due to the demand, the services are overloaded, so the SAMU arrives, you're no longer well seen there, it seems that you're bringing service to the places, when you also went to meet a demand, trying to give continuity to that service. [...] It happens that they don't even let the ambulance door open to get the patient down, but I say that there's no other place, it'll have to be right here, it has to be hard, then that generates friction, a game of pushing (TE-17).

[...] with the overcrowding of the emergencies we're not well received, it is as if the SAMU invented patients, took patients out of its pocket (ME-01).

It is possible to identify interactions that are potentially capable of compromising transfer of care, which are manifested through conflicts that generate indispositions between the teams:

[...] I think it's very annoying when you arrive at a service and you're with your patient up front and they say: oh again, another one?! Why did you bring this one now?! Didn't you say you weren't coming anymore?! They're not even looking at the patient, if he's dyspneic, cyanotic, they want to look at you and say: another one?! (TE-05).

[...] people get really excited, they get rougher with the teams because they think we're taking patients on our own (TE-07).

[...] the way they receive us, with jokes, questions, trying to deny what you're going through (TE-17).

[...] we are badly received [...] they pass by you and pretend they don't even see you, as if you didn't exist, I was already half an hour waiting for someone to answer me (TE-14).

[...] The nursing technician speaks [during the ambulance's journey] that he has great difficulty with the entrance doors, because "they put their foot down" to accept a patient (O-1).

According to the study participants, the retention of the SAMU transportation stretchers has been a strategy used by the in-hospital professionals to contain transfers and even to "punish" the SAMU:

[...] they hold our stretcher unnecessarily [...] to punish (TE-08).

[...] there are days that it's really war, there are many places that have professionals that interpret it this way: I'll hold your stretcher, because if I do that you won't bring another patient to me (TE-11).

[...] they retain our stretchers, and that affects the next appointment, sometimes I stay four, five hours with a stretcher retained (TE-13).

It thus appears that, in addition to being the cause of the conflicts, the overcrowding of the services can be used as a justification to stop the work of the SAMU, causing a sense of injustice by the control exercised.

Network flow regulation and (in)definitions

The regulation of the cases served by the SAMU and of its referrals faces numerous challenges related to communication about the services and the previous agreement on the destination of the patients transported by the SAMU to the hospitals, which sometimes generate impasses between the teams in the transfer of care. The following statements exemplify this finding:

[...] it also happens that the regulation doesn't pass on the real situation of the patient and when we arrive with him they see a very different problem and generally more serious than the regulation passed on to the hospital. This generates a lot of friction. Due to lack of reliable information (TE-01).

[...] the nurse didn't want to accept the patient [...] she says to take him to hospital B. The technician says that the regulation sent it to hospital A. The nurse says that the regulation was aware of the restriction (O-2).

[...] you have so many challenges, the first is that they accept the patient, which is often regulated by the doctor for that location and they get there and bar the patient, they don't accept (TE-13).

[...] This would be much easier if the regulating doctors made contact with our destination, to facilitate communication and the welcoming of the team and especially of our patient (TE-15).

In addition to this, flows are defined to maneuver the directions, in order to seek solutions for the referral of the patients, but which are not exempt from disagreements between the teams:

[...] The SAMU enters through the yellow room, justifying that the patient had loss of consciousness. The medical intern questions the classification made by the SAMU. The technician tells me that this is a problem, because it's the SAMU that "triages" the room in which the patient will enter in hospital A and they always disagree [...] the nurse says that the regulation was aware of the restriction of hospital A. The SAMU technician calls regulation and they say it is to try to keep the patient in hospital A (O-2).

[...] The answer of the place where he goes sometimes takes time. If he's not a serious patient, we even take and regulate (TE-04).

The barriers related to the regulation of the cases reveal the lack of coordination between the services in the network, which also occurs with other operational flows, causing situations in which the professional ties are affected and overlap with the organization of the services:

[...] sometimes he's a zero-vacancy patient, he goes like "down the throat" so sometimes you don't already know how he'll be received (E-02).

[...] I made the police report against the doctor. The SAMU protocol: patient convulses, has to get on a stretcher and to stay on a stretcher. This one had already convulsed three times, had not taken the medication, he would convulse again. Are you going to put this patient in a chair, leave him there in the front? He's going to fall and besides the convulsion he's going to have a trauma, and who's going to take responsibility for that? [...] I don't follow absurd orders, that's when it got me all messed up. (TE-10).

DISCUSSION

Transfer of care is a key element for continuity of care; however, there are high rates of degradation of important clinical information that ends up not being shared. Therefore, a number of studies signal that effective communication depends on the objectivity in the transmission of information and on systematization of the records¹³⁻¹⁴ and that it is necessary to invest in improvement plans for the communication processes¹⁵.

The complexity of transfers is related to elements of communication, information, organization, infrastructure, professionalism, responsibility, team awareness, and culture. In addition to these, the lack of adequate reception and lack of time corroborate this^{5,16}. Scarce verbal and written communication during transfers is described as one of the main components that hinder the achievement of an effective and quality transfer¹⁷.

The structural problems of the health care network, mainly related to the overcrowding of the hospitals and to the lack of physical structure, equipment, professionals, and availability of beds, contribute to the occurrence of conflicts in the transfer of patients between the services. This complaint is daily in the urgency and emergency services¹⁸. These weakened working relationships create tension in the teams, generating countless negotiations and definitions of territorial limits, which end up promoting the lack of an adequate and effective service, and disagreement among the professionals can compromise continuity of care¹⁹.

The paramedics report that several professionals ask for the patient's information, but do not pass it on to each other. In addition, the nurses in the emergency department performed patient screening on the stretchers of the pre-hospital service and were sometimes interrupted by other professionals, increasing the waiting time for the paramedics to transfer the patient, as well as occupying a stretcher needed for other services. One of the main causes of this delay is attributed to the overcrowding of the emergency departments, causing fatigue and work overload for both professionals^{7,20,21}.

The working conditions of the professionals in mobile emergency services indicate that the challenges have increased along with the increase in the population demand. These professionals are overloaded and, in this context, precarious relationships are established due to the intensification of work²². Therefore, the results of the present study showed that the interaction between the SAMU and the other components of the RAU does not always favor a safe line of care, as the relationship established with the hospital teams is described in a conflicting way.

The interactions between the pre- and intra-hospital teams, which are so fundamental for continuity of care, are permeated by the occupation of the services and by the availability of beds. The network supply has proven to be incompatible with the current demand; and large hospitals, which are references for the SAMU, are often overcrowded. Given this, the prerogative of the zero vacancy stands out, which prevents the referral hospital from refusing care alleging lack of available beds. Even though this flow is regulated, this practice performed by the SAMU generates some

resistance in the professionals of the hospital setting, which can be observed in small attitudes, such as blaming the SAMU for increasing the workload, resulting in conflicting relationships^{18,23}.

The fragmentation of the health services, as well as the inadequate functioning of the flows and referrals, has corroborated for the maximization of the conflicts between the teams of pre-hospital and in-hospital care. According to an Australian study, there are reports that the emergency department professionals often stick to other tasks and do not receive patients brought by ambulances, often 'look the other way' and leave the paramedics and stretchers occupied for longer with those patients⁷.

These results are in line with the results of this research and of another Brazilian study that revealed that the SAMU professionals report resistance in opening doors, retention of rigid stretchers so that the pre-hospital service does not transport any more patients, as well as that, in more impacting situations, these professionals pronounce aggressive words and curses²⁴.

Relationships based on mistrust and misunderstanding during transfer of care²⁰ compromise the continuity of safe care. The dissatisfaction of the nurses in a Dutch study was due to the waiting time and to the lack of medical professionals during transfer of care²⁵. In addition, a study carried out with pre-hospital professionals in Scotland mentions that interruptions, variability, lack of coordination, and a structured process portray barriers that prevent the transfer from being carried out effectively¹⁷.

The professional's behavior during the transfer implies the quality of inter-professional communication. Multitasking or non-urgent tasks contributed to distractions and interruptions during the transfer^{26,27}. Interruptions are seen by the professionals as instances of disrespect, as well as the difficulty in transferring the responsibility for the patient between the professionals was a factor that contributed to the failure in communication²⁶. It is highlighted that good inter-professional relationships are indispensable for effective communication during transfers of care.

In addition to the irrelevant demand that compromises the organization of the SAMU flows, the weakness of the regulation is also attributed to the scarce training of the regulatory physician²³, with regulation of care being one of the causes involved in the conflicts between the teams in the transfer of pre-hospital care. In this respect, it is clear that, although the regulatory aspect is well described in the ordinances, divergent conceptions of urgency can occur between physician and patient. One of the main difficulties is the lack of training of the regulatory physicians and the other is the training focused on the technical aspects of care, insufficient to regulate under a broad understanding of urgency, punctual training, lack of a permanent education policy, and low adherence to this practice, as well as the high turnover of these professionals^{1,23}.

Still on regulation, a study showed unsatisfactory performance, mainly related to the updated information and autonomy indicators. Communication with the hospital services has not been sufficiently effective, so the impossibility of receiving new patients due to overcrowding, to lack of professionals or to lack of equipment has not been information availed to the regulators¹⁸.

The most effective regulation action allows the emergency department to organize itself internally, regarding the physical space and the distribution of team tasks. The federal rules state that the health network must avail for the regulation of the SAMU the status of the availability of the service to receive patients, as well as the availability of equipment. However, these agreements between the managers do not apply in the practice, as access to the beds often depends on personal relationships on the part of the physicians, and some do not feel obliged to comply with referral agreements on the network and, thus, inter-professionals conflicts occur due to the fact that the professionals do not always feel committed to comply with the agreements established between the managers²³.

These situations established during the transfer of care directly interfere in providing adequate and qualified care to the patients, since they cause conflicts that are harmful to communication. The international literature also points out that the professionals working in ambulances feel dissatisfied with the waiting time, while the satisfaction of the professionals in the emergency departments is affected by the use of transfer instruments and by the integrity of the transferred information²⁵. The relationships among the health professionals involved in the transfer of care can be weakened by the gap between planning and work organization, requiring investments in terms of conflict management and advances in communication among the professionals²⁸.

Limitation of the study

Regarding the limitation of the study, the perspective given to the professionals in the pre-hospital setting stands out. However, such limitations do not invalidate the results of the research, but indicate the need for further studies on the subject.

FINAL CONSIDERATIONS

The overcrowding of the health services, especially the emergency units, was seen as responsible for setting up conflicting interpersonal relationships between the teams during the transfer of care from pre- and intra-hospital care, since it generates overload in the professionals and causes 'buck passing' between services to see who is responsible for the patient. Under these circumstances, the SAMU professionals feel guilty through resistance behaviors in receiving the patients, as well as punished through the retention of ambulance stretchers in intra-hospital services.

Furthermore, the weakness of regulation and the (in)definition of flows in the network also configure factors that cause conflicts between the teams, since there are gaps in the agreements on the patients' destinations, leaving the professionals with the challenge of continuing the care provided.

In view of these findings, it was concluded that the excessive demands and the low articulation of the services in the network cause conflicts between the health teams in the transfer of pre-hospital care, since the conflicts experienced during the transfer directly affect patient safety for focusing on interpersonal relationships and, therefore, on the communication processes among the professionals of the teams involved. In view of the causes identified, investments are suggested in agreeing on the processes and flows of the network and systematizing communications between the teams involved in the transfer of pre-hospital care with a view to improving the quality of the team meetings, which are so indispensable for the continuity of care and for the safety of the patients.

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