



Abb. 1: Schnittstelle Schockraum in der Notaufnahme

Die Patientenübergabe: Element der Notfallversorgung oder schwaches Glied der Rettungskette?

Literatur:

1. Australian Medical Association and Office of Safety and Quality in Healthcare (2012) Clinical Handover Symposium – November 2012: Catchpole K: Human Factors in Clinical Handovers. https://ww2.health.wa.gov.au/Articles/A_E/Clinical-handover
2. Fleischmann T (2016) Schnittstelle Zentrale Notaufnahme. Dtsch Med Wochenschr 141: 19-23
3. Geelhoed G (2012) Handover in Western Australia. <https://ww2.health.wa.gov.au/~media/Files/Corporate/general%20documents>
4. Government of Western Australia, Department of Health (2012) Clinical Handover Policy. https://ww2.health.wa.gov.au/Articles/A_E/Clinical-handover
5. Lazarovici M, Trentzsch H, Prückner S (2016) Human Factors in der Medizin. Notfall Rettmed 17: 234-245
6. Merkel MJ, von Dossow V, Zwißler B (2017) Strukturierte Patientenübergabe in der perioperativen Medizin. Anaesthesist 66: 396-403
7. Porteous J, Stewart-Wynne EG, Conolly M, Cromellin F (2009) iSoBAR – a concept and handover checklist: the National Clinical handover Initiative. Med J Aust 190 (11Suppl): S152
8. Rossi R (2016) Leitfaden für Intrahospitaltransporte zur Vorbereitung und Durchführung von innerklinischen Patiententransfers. Springer Fachmedien, Wiesbaden
9. Schacher S, Glien P, Kogej M, Gräff I (2018) Strukturierte Übergabeprozesse in der Notaufnahme. Notfall Rettungsmed 19: 345-354
10. Schmidt C, Ramsauer B, Witzel K (2008) Risikomanagement zur Fehlervermeidung im Krankenhaus: Standard Operating Procedures aus der Luftfahrt als Vorbild für eine strukturierte Kommunikation im Klinikalltag. Z Orthop 146: 175-178
11. Shah Y, Alinier G, Pilay Y (2016) Clinical handover between paramedics and emergency department staff: SBAR and IMIST-AMBO acronyms. International Paramedic Practice 6 (2): 37-44
12. Sieber R (2009) Strukturierte Patientenübergabe. Star of Life 2: 17-21
13. Stamer AL, Spector MD, Stivastava R et al. (2014) Changes in medical errors after implementation of a handoff program. N Engl J Med 371: 1803-12
14. Sujan M, Spurgeon P, Inada-Kim M et al. (2014) Clinical handover within the emergency care pathway and the potential risks of clinical handover failure (ECHO): primary research. Health Serv Deliv Res DOI 10.3310/hsdr02050
15. The Joint Commission (2007) Improving americas hospitals. The Joint Commission's annual report on quality and safety. https://www.jointcommission.org/assets/1/6/2007_Annual_Report.pdf
16. The Joint Commission (2017) Sentinel Event Alert Inadequate hand-off communication
17. Unger J (2016) SBAR: Strukturierte Patientenübergabe in der Notaufnahme. <https://www.globalems.net/2016/05/10/sbar-strukturierte-patientenuebergabe-in-der-notaufnahme>
18. WHO Collaborating Centre for Patient Safety Solutions (2007) Communication During Patient Hand-Over. <https://www.who.int/patientsafety/solutions/patientsafety/PS-Solution3.pdf>
19. World Health Organization (2014) 10 Facts on patient safety. http://www.who.int/features/factfiles/patient_safety/en/
20. Worten H, van Galen LS, Wagner C (2017) Safe handover. BMJ 359: j4328, doi: 101136/bmj.j4328

Autoren:

Dr. med. Rolando Rossi
Facharzt für Anästhesie
Intensiv- und
Notfallmedizin
Qualitäts-/Risiko-
management
Abteilung Anästhesie
Notarzteinsatz Landkreis
Schwäbisch Hall
Gartenstr. 26
74564 Klinikum
Crailsheim
rolando.rossi@web.de

Christian Bernhard
Stv. Leiter
Rettungsdienst
Notfallsanitäter
Bayerisches Rotes Kreuz
Kreisverband Ansbach
Henry-Dunant-Str. 10
91522 Ansbach
bernhard@
kvansbach.brk.de

Weiterführende Literatur:

1. Adams HA, Trentz O (2007) Die Erstversorgung des polytraumatisierten Patienten. *Anästh Intensivmed* 48: 73-96
2. Andersen HB, Siemsen IMD, Petersen LF, Nielsen J, Ostergard D (2015) Development and validation of a taxonomy of adverse handover events in hospital settings. *Cogn Tech Work* 17: 79-87
3. Australian and New Zealand College of Anaesthetists (ANZCA) (2013) Statement on the Handover Responsibilities of the Anaesthetist. <https://anzca.edu.au/documents/ps-53-2013-Statement-on-the-Handover-Responsibility.pdf>
4. Australasian College for Emergency Medicine: Guideline on Clinical Handover in the Emergency Department. http://educationresource.bhs.org.au/library/file/388/G36/Guideline_on_clinical_Handover_in_the_ED.pdf
5. Australian Commission on Safety and Quality in Health Care (2009) ISBAR revisited: Identifying and Solving Barriers to effective clinical handover in inter-hospital transfer. <https://www.safetyandquality.gov.au/publications/isbar-revisited-identifying-and-solving-barriers-to-effective-clinical-handover-in-inter-hospital-transfer>
6. Australian Commission for Safety and Quality in Health Care (ACSQHC) Implementation toolkit for clinical handover improvement (2011). <http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/implementation-toolkit-for-clinical-handover-improvement-and-resource-portal>
7. Australian Commission on Safety and Quality in Health Care: Standard 6 – Clinical Handover. Safety and Quality Improvement Guide. https://www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard6_October_2012_WEB.pdf
8. Brammen D, Bleicher W, Branitzki P, Castellanos P, Messelken M, Pollwein B, Prause A, Röhrig R (2010) Spezielle Empfehlungen und Anforderungen zur Implementierung von DV-Systemen in der Notfallmedizin. *Anästh Intensivmed* 51: 119-26
9. Clinical Quality & Patient Safety Unit, QAS (2012) Clinical practice Procedures: Clinical Handover. https://ambulance.qld.gov.au/docs/clinical/cpp/CPP_clinicalhandover.pdf
10. Coburn M: BDAktuell-DGAIInfo (2016) Qualitätsindikatoren Anästhesiologie 2015. *Anästh Intensivmed* 57: 219-30
11. Colvin MO, Eisen LA, Gong NG (2016) Improving the Patient Handoff Process in the Intensive Care Unit: Keys to Reducing Errors and Improving Outcomes. *Semin Respir Crit Care Med* 37: 96-106
12. De Meester K, Verspuy M, Monsieurs KG, van Bogaert P (2013) SBAR improves nurse-physician communication and reduces unexpected death: a pre- and postintervention study. *Resuscitation* 84: 1192-6
13. Fleming A (2013) Intensivtransport. *Anästh Intensivmed* 54: 59-68
14. Geelhoed G (2013) Handover in Western Australia. https://www2.health.wa.gov.au/Articles/A_E/Clinical-handover
15. Government of Western Australia, Department of Health (2012): Handover. <http://intranet.health.wa.gov.au/orqh/handover>
16. Hannaford N, Mandel C, Crock C et al. (2013) Learning from incident reports in the Australian medical imaging setting: handover and communication errors. *Br J Radiol* 86: 2012; 0336
17. Health Systems Institute: Verifying and Improving the Patient Handoff. <https://www.yumpu.com/en/document/view/33907926/new-physics-in-b-s-sbar-s>
18. Jantzen T, Dreyer A, Fischer M, Messelken M, Müller M, Seewald S, Wnent J, Gräsner JT (2001) Das innerklinische Notfallprotokoll. *Anästh Intensivmed* 52: S723-6
19. Ka-ye, HJ (2016) Improving clinical handover: Development of a web-based intensive care unit consultation system with structured reply generation. *BMJ Qual Imp Reports* 2016; doi: 10.1136/bmjquality.u210292.w4180
20. Machaczek K, Whietfield M, Kilner K, Allmark P (2013) Doctors and Nurses Perceptions of Barriers to Conducting Handover in Hospitals in the Czech Republic. *Am J Nurs Res* 1: 1-9
21. Messelken M, Schlechtriemen T, Arntz HR et al. (2011) Der Mini-male Notfalldatensatz MIND3. www.divi.de/images/dokumente/Empfehlungen/MIND/mind3/Artikel_DIVI_03_2011.pdf
22. Pezzolesi C, Manser T, Schifano F, Kostrzewski A, Pickles J, Harriet N, Warren I, Dhillon S (2013) Human factors in clinical handover: development and testing of a "handover performance tool" for doctors shift handovers. *Intern J Health Care* 25 (1): 58-65
23. Pezzolesi C, Schifano F, Pickles J, Dhillon S (2010): Clinical handover incident reporting in one UK general Hospital. *Int J Qual Health Care* 22: 396-401
23. Redley B, Bucknall TK, Evans S, Botti M (2016) Inter-professional clinical handover in post-anaesthetic care units: tools to improve quality and safety. *Int J Qual Health Care* 2016; doi: <http://dx.doi.org/10.1093/intqhc/mzw073>
24. Schröder H, Gilles L, Stieger L, Beckers S, Sopka S (2017) Patientensicherheit und Patientenübergaben in der studentischen Ausbildung der Anästhesie, Intensiv- und Notfallmedizin in Aachen. *Anästh Intensivmed* 58: S52
25. Segall N, Bonifacio AS, Schroeder RA, Barbeito A, Rogers D, Thornlow DK, Emery J, Kellum S, Wright MC, Mark JB, Durham VA (2012) Can we make postoperative patient handovers safer? A systematic review of the literature. *Anesth Analg* 115: 102-5
26. Seifert PC (2012) Implementing AORN Recommended Practices for Transfer of Patient Care Information. *AORN Journal* 96: 475-93. <http://dx.doi.org/10.1016/j.aorn.2012.08.011>
27. Toccafondi G, Albolino S, Tartaglia R (2012) The collaborative communication model for patient handover at the interface between high-acuity and low-acuity care. *BMJ Qual Saf* 21: i58-i66. Doi: 10.1136/bmjqs-2012-00178
28. Von Dossow V, Zwißler B (2016) DGAI Info: Strukturierte Patientenübergabe in der perioperativen Phase – Das SBAR-Konzept. *Anästh Intensivmed* 57: 88-90
29. Von Eggins S, Slade D, Geddes F (2016) Effective Communication in Clinical Handover. Walter de Gruyter Berlin Boston Peking
30. Van Rensen EL, Groen ES, Numan SC, Smit HJ, Cremer OL, Tales K, Kalkman CJ (2012) Multitasking during patient handover in the recovery room. *Anesth Analg* 115: 1183-7
31. Walton H, Munro W (2015) Improving the quality of handover by addressing handover culture and introducing a new, multi-disciplinary, team-based handover meeting. *BMJ Qual Improv Report*. doi:10.1136/bmjquality.u206069.w2989
32. World Health Organization (2014) 10 Facts on patient safety. http://www.who.int/features/factfiles/patient_safety/en/
33. WHO (2012) Surgical Safety Checklist: https://www.who.int/patientsafety/safesurgery/ss_checklist/en/
34. Wissenschaftlicher Arbeitskreis Notfallmedizin der DGAI (2003) Rettungsdienst in Deutschland; Bestandsaufnahme und Perspektiven. *Anästh Intensivmed* 2003; 44: 354-69