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Usefulness of a Tailored 'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings

by

Jennifer Jane MacKay

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

CALGARY, ALBERTA

MAY, 2014

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Abstract

Clinical handover is imperative to safety and quality of care. 'Situation-Background-Assessment-Recommendation' (SBAR) communication has been shown to improve the quality of handover. However, usefulness of tailoring the content of an SBAR form for communication between the postpartum acute care and community setting has not been studied. This descriptive mixed methods study evaluates the content validity of a tailored SBAR form and clinicians' perception of the usefulness of the form to transfer psychosocial information between the postpartum acute care and community setting. In Phase One, an expert panel was employed to determine content validity. In Phase Two, focus group questionnaires and interview data were gathered from social workers and nurses. Findings from both Phases informed revisions. The SBAR form had excellent content validity. Focus group findings revealed multiple themes related to attitude about the usefulness of the form. Participants described the form as useful for improving the quality of clinical handover.

Keywords: Clinical handover, SBAR, acute care, community, postpartum, psychosocial.

Acknowledgements

I would like to acknowledge several individuals who provided guidance and support throughout my research. I express sincerest gratitude to my supervisor, Dr. Deborah White, for her encouragement, guidance and support throughout my graduate studies. Dr. White generously gave of her time, shared her expertise, and always helped me find creative solutions to obstacles along the way. I extend appreciation to my supervisory committee, Dr. Jayna M. Holroyd-Leduc, Dr. Shahirose Premji, and Dr. Jackie Sieppert for providing feedback and guidance throughout my thesis work. I would also like to thank Dr. Jenny Godley for being part of my examining committee.

To my husband Ian, who encouraged me to pursue a Master of Nursing degree - thank you for your love, wisdom, and support. To my children, Benjamin, Sarah and Luc - thank you for your patience and understanding as well as giving me the opportunity to learn along with you.

I extend heartfelt gratitude to my parents who always supported my aspirations and believed in me – thank you for the unending prayers. To my sisters and brother for their unwavering support – thank you. I would also like to acknowledge my Mom and sister Julianna for role modeling, mentoring, and coaching me throughout my nursing career. I hope to pass on your wisdom to Sarah as she begins her nursing career.

I would like to thank my friends and colleagues for their continuous support and encouragement throughout my studies. I am especially grateful to the social workers and nurses who contributed to this study.

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Chapter One: Introduction and Framework

Introduction

The contemporary practice of early postpartum discharge (Public Health Agency of Canada, 2000, Chapter 6) has shifted the level of patient acuity and care to the community (Cargill & Martel, 2007). This structural change in care delivery has highlighted the need for effective communication and adequate transfer of information to ensure patients receive well planned, coordinated, and safe care between settings (Accreditation Canada, 2011). This is particularly important for socially at-risk women and their newborns because they are at greater risk for poor health outcomes (Kurtz-Landy, Sword, & Ciliska, 2008; Myors, Schmied, Johnson, & Cleary, 2013). The risk of poor clinical handover between acute care and community settings (Wong, Yee, & Turner, 2008) combined with increased acuity has raised safety concerns for mothers, newborns, and the home visiting public health nurse (PHN).

Background. In Alberta Health Services (AHS) - Calgary Zone, postpartum care is transferred from the hospital to Postpartum Community Services (PPCS). A PHN attempts to contact all families within 24 hours of hospital discharge to offer follow-up care and support. Service delivery occurs through a home visit, clinic visit, or by telephone. PPCS provides service for the first two postpartum months following the birth of the newborn.

Currently clinical handover between postpartum acute care and PPCS occurs through written communication transmitted by facsimile. A provincial Notice of Live Birth form is the primary means of transferring patient information. This form is completed for all births and primarily includes patient demographic and medical data. A Postpartum Referral to Postpartum Community Services (see Appendix A) is completed when there are maternal or newborn concerns that are not addressed on the provincial form. General postpartum topics are included

in this referral form and acute care providers are instructed to document a description of the concern along with action taken. The transferred patient information is used by PHNs to make decisions regarding the location of service delivery; timing of care; as well as anticipating, planning, and coordinating care.

Significance of clinical handover between postpartum settings. PHNs' concern about safety and the importance of transferring quality patient information cannot be underestimated. In 2010, several potential safety incidents presented in Calgary as a result of the poor quality of information transferred between postpartum acute care and PPCS. Inadequate information transfer about psychosocial concerns such as domestic violence, substance abuse, and complex mental health issues resulted in uninformed decisions about care (i.e., timing of care, appropriate referrals). PHNs' safety was potentially compromised when they unknowingly provided care in unsafe environments (i.e., drug house). It is important to note that similar situations continue to occur whereby omitted or insufficient patient information has created personal safety risks and has made decision making about appropriate care difficult.

Opportunity to improve practice. As a result of recent safety incidents, a quality improvement project (Mackay & Stosky, 2011) was undertaken to understand the transfer of information process between a postpartum acute care unit and the community setting. Focus groups and several quality improvement tools and principles (i.e., process maps) were used to gather information from both settings. Five key barriers to transferring patient information to the community setting were identified through this process: (a) limited knowledge of the PHN's role among acute care clinicians (nursing and social work) negatively influenced the adequacy of information transferred, (b) ambiguity about permission to share information and the requirements of the Health Information Act (HIA), (c) the existing clinical handover form

lacked the structure to guide documentation of relevant information, (d) inconsistent social work staffing, and (e) elevated workloads for acute care social workers and nurses. These barriers contributed to time delays (i.e., delays in provision of care), waste (i.e., duplication of service), and gaps (i.e., omitted or insufficient information) that influenced the safety and quality of care provided in the community setting.

Subsequent interviews with a social worker and a nurse within acute care, conducted during graduate course work (MacKay, 2011), confirmed several of the barriers including lack of clarity of the HIA and associated permission to share information and limited knowledge of the professional practice of PHNs receiving the information. Interviewees also suggested that a standardized, structured communication tool might help facilitate information transfer. These findings (Mackay, 2011; Mackay & Stosky, 2011) are consistent with the literature that suggests organizational structures and processes within the healthcare system influence clinical handover (Jeffcott, Evans, Cameron, Chin, & Ibrahim, 2009). Research indicates that elements within the organizational structure such as a lack of strong professional relationships between care settings (Barimani & Hylander, 2008; Homer et al., 2009), diverse practice settings, lack of understanding about the receiver's responsibilities among the senders of patient information (Barimani & Hylander, 2008; Cummings et al., 2010; Homer et al., 2009), and ineffective communication tools (Robison, Pirak, & Morrell, 2000) all influence clinical handover.

The development of this research study was informed by the identified safety issues in community practice and by leaderships' (Postpartum Community Services and postpartum acute care) desire to improve clinical handover and mitigate barriers identified in the initial quality improvement projects. A preliminary literature search of communication tools used to transfer information between the acute and community settings also informed the development of this

study. Extensive clinical handover reviews (Riesenberg, Leitzsch, & Cunningham, 2010; Wong et al., 2008), as well as a review about handover mnemonics (Riesenberg, Leitzsch, & Little, 2009), indicate that structured communication tools such as the *Situation-Background-Assessment-Recommendation* (SBAR tool) that incorporate standard context specific patient information are both a concise means to share information between health care providers and an effective solution to improve clinical handover. SBAR communication has offered a systematic approach to organize patient information that addresses the identified concerns or problems, the background and assessment of the concern, and related recommendations for action. This approach has been used and evaluated in various settings to facilitate communication and promote safe and quality care (Beckett & Kipnis, 2009; Haig, Sutton, & Whittington, 2006; Leonard, Graham, & Bonacum, 2004; Velji et al., 2008; Wentworth et al., 2012).

Structuring and tailoring a communication form using an SBAR format that has information specific to socially at-risk postpartum women may offer an innovative way to improve the quality of clinical handovers between acute care and the community setting. Innovative strategies to improve and maintain the quality of acute care to community clinical handovers is imperative to newborn and PHN safety. The purpose of the study has been twofold: (a) to develop and evaluate the content validity of a tailored written communication form, based on the SBAR tool, to transfer information between postpartum acute care and community settings for socially at-risk women, and (b) to describe clinicians' perception of the usefulness of the form for improving the quality of clinical handover between the acute care and community settings for socially at-risk families.

Research Objectives and Questions

The research objectives and corresponding questions for this study are:

1. To evaluate the content validity of a tailored structured form.

   Primary research question: What is the content validity of the tailored SBAR form?

2. To understand clinicians' perception of the usefulness of the form to transfer maternal psychosocial information between the postpartum acute care and community setting.

   Primary research question: What are acute care social workers' and nurses' as well as PHNs' perceptions of the usefulness of the tailored SBAR form for improving the quality of clinical handover and resultant care from postpartum acute care to the community setting?

   Secondary research question: What are acute care social workers' and nurses' as well as PHNs' perception of the facilitators and barriers to using the tailored SBAR form?

Knowledge Translation Framework

Knowledge translation (KT) is a process that uses a comprehensive approach to facilitate the application of research evidence into healthcare practice (Straus, Tetroe, & Graham, 2009). Engagement in the KT process is important because research findings are not readily transferred into practice (Straus et al., 2009). The Knowledge-to-Action (KTA) framework (Graham et al., 2006) was chosen to guide this study. As Sudsawad (2007) noted, the KTA framework provides a structured and detailed way to understand contextual factors that may facilitate or impede the uptake of knowledge into practice. Key stakeholders were integrally involved in the development of this evidence-informed communication tool.

Knowledge-to-Action framework. The KTA framework is based on common elements found in over 30 planned action theories and encompasses both knowledge creation and action (Straus et al., 2009). The KTA framework (Graham et al., 2006) was specifically chosen because it systematically guides the researcher in both the knowledge refinement and action planning necessary to facilitate knowledge transfer for a practice

change. The following figure pictorially represents the various components of the KTA framework.

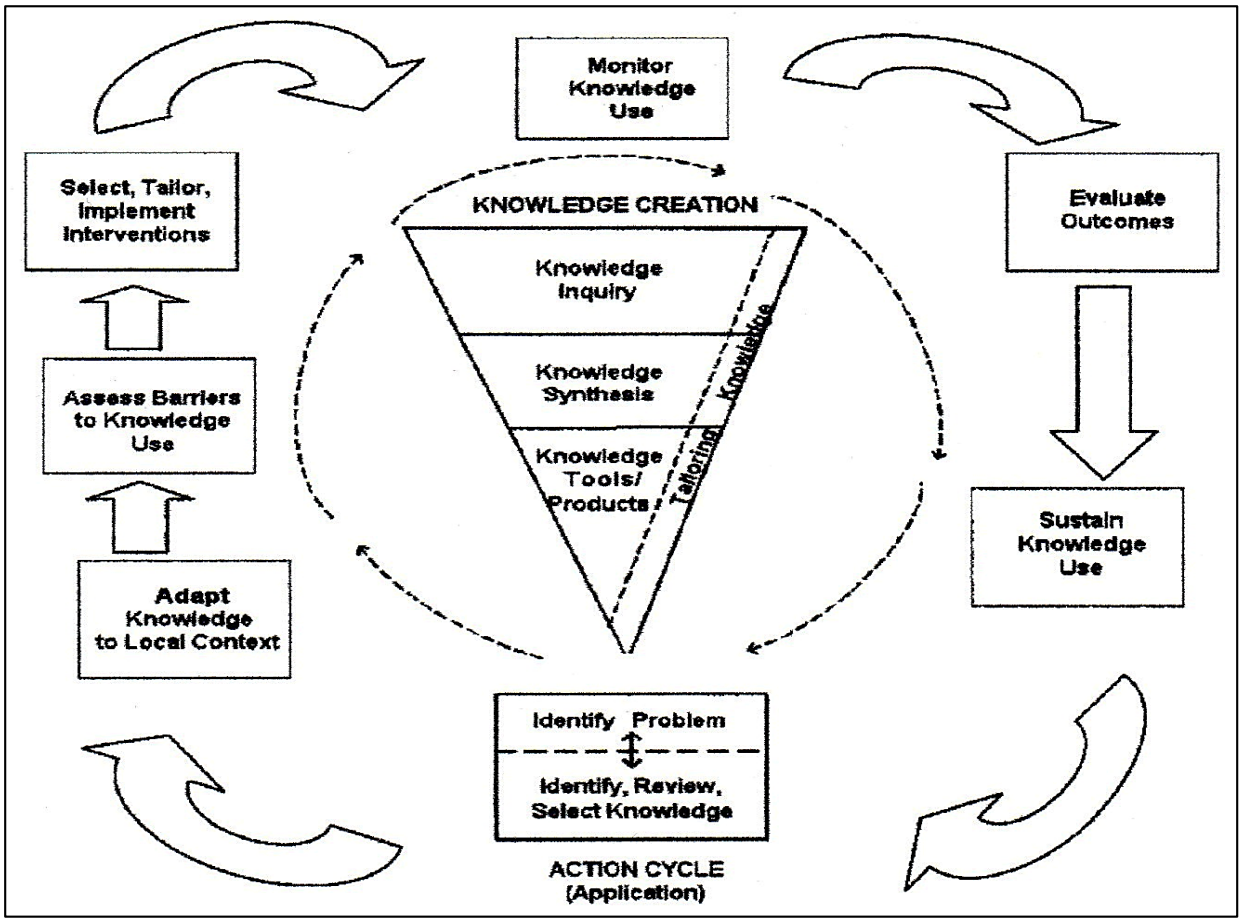

Figure 1. Knowledge to Action (KTA) Framework.[1]

[1] From "Lost in knowledge translation: time for a map?" by I. D. Graham, J. Logan, M.B. Harrison, S.E. Straus, J. Tetroe, W. Caswell, and N. Robinson, 2006, *Journal of Continuing Education in the Health Professions*, *26*(1), p. 19. Copyright 2006 by Wiley Periodicals, Inc. Reprinted with permission (see Appendix B).

A knowledge creation funnel is centered within the action cycle and has been understood to support the scientific underpinning of KTA (Straus et al., 2009). This funnel is comprised of three steps that demonstrate the gradual tailoring of knowledge.

The action cycle uses a planned action approach and interacts with the knowledge funnel (Graham et al., 2006). The cycle involves seven action stages that are common to change: (a) identifying the problem and identifying, reviewing, and selecting knowledge; (b) adapting the knowledge to a local context; (c) assessing the barriers to knowledge use; (d) selecting tailored interventions to be implemented; (e) monitoring knowledge use; (f) evaluating outcomes; and (g) determining strategies for sustaining knowledge use.

The KTA process is iterative, whereby knowledge creation and the action cycle stages inform each other. Throughout the process, knowledge- /end-user participation is important to improve the uptake of knowledge and to create sustainable change (Straus et al., 2009). Involvement of knowledge-/end-users in the process is more likely to produce research findings that are relevant to the knowledge-/end-user. The scientific foundation and participatory approach to KTA are understood to positively affect the use of knowledge in practice (Straus et al., 2009). Engagement of relevant stakeholders is key to implementing and sustaining evidence based practice change (Castiglione & Ritchie, 2012).

The KTA framework was well suited to this study. Stakeholders (i.e., decision makers, leaders, educators, front line clinicians) were engaged throughout the process. A care gap was identified from safety incidents and potential risk events that occurred in 2010 as a result of poor quality clinical handovers of socially at-risk mothers (identify the problem). Knowledge-/end-users (leaders and clinicians from both care settings) recognized the practice issue and were involved in the initial quality improvement project. This project (Mackay & Stosky, 2011) and

related interview data (Mackay, 2011) brought further understanding and helped identify the barriers to transferring information (identify the problem, assess barriers). The preliminary review of the literature provided an overall understanding of clinical handover and assisted in identifying potential solutions (knowledge inquiry; identify, review, select knowledge). Evidence from the literature was synthesized and tailored to clinical handover between the postpartum acute care and community settings for socially at-risk women (knowledge synthesis, tailoring of knowledge). Knowledge about potential barriers for information transfer between postpartum acute care and the community settings was combined with the synthesized literature to develop the tailored written communication form (adapt knowledge to local context, research objective one). Leaders were then briefed regarding this potential solution and research plan. Letters of support from the respective leaders were subsequently provided.

Adopting a change in practice can often be plagued with many challenges. This is especially true for complex change that is multifaceted and involves inter-professionals between care settings (Graham & Logan, 2004). In order to improve knowledge uptake, Légaré (2009) recommends an assessment of possible barriers to the practice change (research objective two) as the third step in the action cycle. Barriers and facilitators related to external factors, as well as end-users' knowledge and attitudes, should be assessed (Légaré, 2009). Knowledge gained from this assessment can be used to further adapt the intervention to the local setting. Wensing, Bosch, and Grol (2009) then recommend that KT interventions be selected and tailored according to the barrier assessment and the evidence regarding the effectiveness of the intervention.

One of the theories that informed the barrier assessment for this study is Rogers' (2003) Diffusion of Innovation theory. This theory provides insight into the change process and

describes factors that may influence the knowledge-/end-user's decision to adopt the change. One of the key factors that influences the uptake of change is the perceived characteristics of the innovation. Rogers (2003) identified that end-users' perception about the compatibility, complexity, advantage, trialability, and observability of the innovation accounts for most (49%-87%) of the variance related to the acceptance of the innovation. This change theory has been particularly relevant to understanding the barriers related to the attributes of the tailored SBAR communication form. Knowledge of factors that may influence acceptance and adherence to using the tailored written form by front line clinicians is important for understanding potential uptake in practice.

To facilitate acceptance, the complexity of the tailored written communication form and compatibility with clinicians' beliefs, experience, and needs within clinical handover required consideration (research objective one and two). Clinicians' willingness to implement the tailored written communication form may also be influenced by their perception of the advantage of the form. Thus, understanding clinician's perception of the usefulness of the tailored written communication form is also important (research objective two).

Similar to the quality improvement Plan-Do-Study-Act cycle (Langley et al., 2009), involving the end-users by trialing the innovation on a smaller scale to identify barriers has been understood to assist with uptake (Rogers, 2003). Therefore, important steps for increasing buy-in from front line clinicians includes their assessment of the barriers to using the tailored written communication form (research objective two) and minimizing the identified barriers (adapt knowledge to local context). These steps are important, as it is conceivable that study participants may assume the early adopter role and facilitate the uptake of the form. Landrum (1998) suggested that reflecting on the innovation's attributes in advance and tailoring the

innovation to the practice context may increase the likelihood that clinicians may change practice and adopt the innovation.

A strength of the KTA framework is that it assists the researcher in considering conceptual barriers and facilitators related to knowledge (i.e., familiarly, forgetting), attitude (i.e., motivation, practicality), and external barriers (i.e., time) (Légaré, 2009). The next step of the cycle is to select appropriate KT interventions that target specific barriers. Targeting barriers is key to facilitating practice change (Bero et al., 1998; Wensing et al., 2009). It is important to note that this last step is not part of this thesis. The following figure positions the planning stages of this current study within the KTA framework.

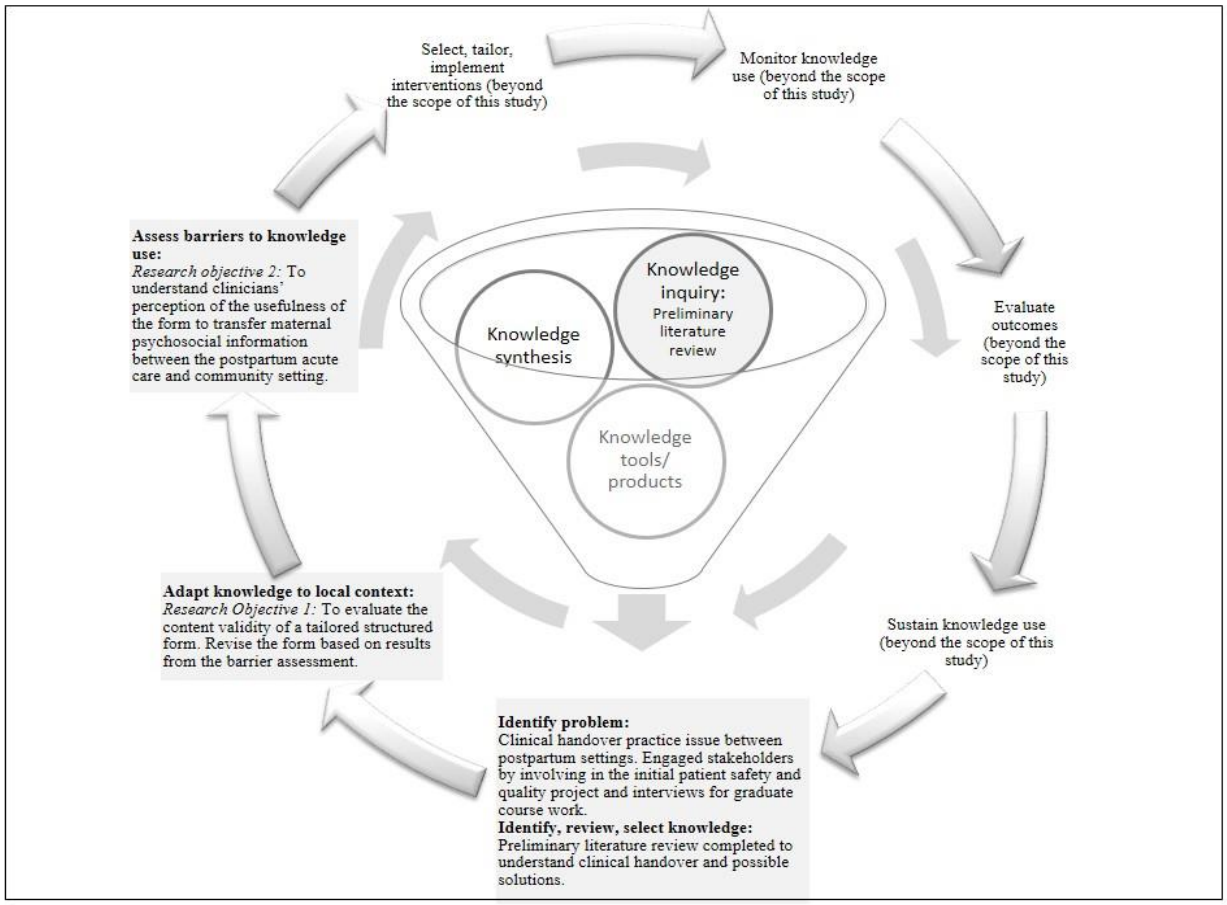

Figure 2. Study planning stages embedded in the KTA Framework.[2]

Summary

This chapter provided the contextual background for the study. The significance of clinical handovers to the provision of safe and high quality care between postpartum settings was

[2] From "Lost in knowledge translation: time for a map?" by I. D. Graham, J. Logan, M.B. Harrison, S.E. Straus, J. Tetroe, W. Caswell, and N. Robinson, 2006, *Journal of Continuing Education in the Health Professions*, *26*(1), p. 19. Copyright 2006 by Wiley Periodicals, Inc. Adapted with permission (see Appendix B).

identified. A synopsis of the KTA framework was provided along with a description of how the framework guided this study. In the following chapter, details about how evidence from the literature, anticipated needs of front line clinicians and feedback from key stakeholders helped to tailor knowledge and inform the research questions.

Chapter Two: Refining and Tailoring Knowledge to the Local Setting

Knowledge creation and refinement is central to tailoring knowledge to the end-users' needs (Graham et al., 2006). At various stages in this study, knowledge was refined and tailored in order to develop and produce a communication form appropriate for clinical handover between the postpartum acute care and community setting. As noted by several authors, a structured communication tool offers a possible solution to clinical handover issues (Australian Commission on Safety and Quality in Health Care [ACSQH], 2010; Joint Commission Center for Transforming Healthcare, 2010; Riesenberg et al., 2009; Riesenberg et al., 2010; Wong et al., 2008).

Situation-Background-Assessment-Recommendation (SBAR) has been the most frequently used tool in healthcare to structure and share relevant and concise information between health care providers (Riesenberg et al., 2009). SBAR has offered a systematic approach to organize patient information to inform the plan of care. Structuring communication in this way has facilitated clear communication and encouraged a common understanding of clinical handover information among health care providers (Dayton & Henriksen, 2007; Haig et al., 2006). SBAR has been successfully implemented in various health care settings such as critical care (Haig et al., 2006; Wentworth et al., 2012), perinatal care (Beckett & Kipnis, 2009; Leonard et al., 2004), and rehabilitation (Velji et al., 2008). Therefore, a structured SBAR form was viewed as a potential solution to address clinical handover issues between the postpartum acute care and community setting. A key step in the development of the SBAR form was synthesis of existing evidence regarding utilization of SBAR to communicate between postpartum acute care and the community settings.

Literature Review of SBAR Communication

An electronic Boolean literature search of Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), and Social Services Abstracts databases was conducted using the key terms: (sbar or "situation background assessment recommendation") AND (situational briefing) AND (handover or documentation or communication or discharge or transfer nurs*) AND (social worker). The literature search was limited to peer reviewed, English language articles. The search method and selection process have been detailed in Appendix C. The search resulted in 104 citations and all abstracts were reviewed. Inclusion criteria comprised conceptual articles, clinical handover implementation guidelines, qualitative and quantitative studies as well as systematic, scoping, and narrative reviews relevant to determining the usefulness of an SBAR form for clinical handover. Duplicated and irrelevant articles as well as commentaries were excluded. Twenty articles were accepted for inclusion in this review. The reference list of the accepted articles and articles that cited the included articles was reviewed and seven articles were added to the total number of accepted articles. Twenty-seven full-text articles were included and the quality appraised using checklists adapted from multiple sources (Critical Appraisal Skills Programme (CASP), 2013a; CASP, 2013b; CASP, 2013c; Loiselle, Profetto-McGrath, Polit, & Beck, 2011; Streubert & Carpenter, 2011). A summary of the literature has been presented in Appendix D.

The Health and Psychosocial Instruments, MEDLINE, CINAHL, Cochrane All Evidence-Based Medicine Reviews databases from 1990-2012 and Google search engine were searched to determine alternative methods to transfer psychosocial patient information between postpartum acute care and community. The search yielded no results that were relevant to the

context of this study. Additionally, AHS's forms data base was searched by Forms Management to determine if other forms have been used to transfer information in this setting. There were no documents produced (J. de Koning, March 21, 2012, personal communication).

Among the 21 included studies, 18 were quantitative and three were qualitative. The earliest literature identified was 1998 and the majority of studies conducted were in the USA and Australia. The literature was categorized into several key areas including: (a) efficacy of SBAR for content, clarity, and communication time; (b) impact of SBAR on patient outcomes; (c) influence of SBAR on a culture of patient safety and teamwork; (d) clinical handover format; and (e) type of patient information. A synthesis of the literature is presented in the next sections followed by a critical appraisal of the evidence that summarizes the strength of evidence to support the use of SBAR communication for transferring patient information between postpartum acute care and the community setting.

Efficacy of SBAR for content, clarity, and time of clinical handover. Several researchers addressed the content and clarity of clinical handover communication among physicians and nurses using SBAR communication. Study designs varied and included: a randomized control study (Cunningham et al., 2012); three uncontrolled pre-test post-test designs (Moseley et al., 2012; Thompson et al., 2011; Woodhall, Vertacnik, & McLaughlin, 2008); one controlled (Marshall, Harrison, & Flanagan, 2009) and one uncontrolled post-test design (Compton et al., 2012); and one action research study (Clark, Squire, Heyne, Mickle, & Petrie, 2009). Findings about the amount of content transferred during clinical handover were incongruent across studies. Cunningham et al. (2012) conducted a randomized control trial (RCT) over two years and showed that there were no item score differences ($p = .051$) between junior doctors that received SBAR education prior to the test scenario (8.5 [IQR 7.0-9.0]) and

those that received the educational intervention after the test scenario (8.0 [IQR 6.5-8.0]). Both Marshall et al. (2009) and Thompson et al. (2011) found a significant increase ($p < .001$, $p = .004$ respectively) in the amount of patient information transferred by medical students when using a modified SBAR tool. Researchers have also found a significant change in the perceived adequacy, $p < .0001$ (Compton et al., 2012), and completeness, $p = .041$ (Moseley et al., 2012), of clinical handover information using SBAR.

Researchers have suggested that SBAR communication may improve the clarity of clinical handover (Cunningham et al., 2012; Marshall et al., 2009; Woodhall et al., 2008) and clinician's communication skill and confidence (Clark et al., 2009; Donahue, Miller, Smith, Dykes, & Fitzpatrick, 2011; Thompson et al., 2011; Woodhall et al., 2008). Cunningham et al. (2012) showed a significant improvement ($p = .003$) to the clarity of telephone referrals when comparing the global rating scores of interns in the SBAR education group (3.0 [IQR 2.0-4.0]) with the control group (2.0 [IQR 1.0-3.0]). Neurology residents were asked to rate satisfaction (scale 1-10) with clinical handover using SBAR (Moseley et al., 2012). There was a significant increase in their satisfaction (6.2 ± 1.6 to 7.4 ± 1.3, $p = .002$).

Findings regarding the amount of time required to communicate using SBAR were mixed. Dingley, Daugherty, Derieg, and Persing (2008) conducted an uncontrolled pre-test post-test study and reported a significant decrease (4.52 minutes to 3.37 minutes, $p = .01$) in the time needed to communicate a patient issue in the Medical Intensive Care Unit; however, there was no significant difference in the Acute Care Unit. Other researchers (Cunningham et al., 2012; Wentworth et al., 2012) reported that SBAR communication did not change the duration of time required for clinical handover.

The impact of SBAR on patient outcomes. Researchers have examined the use of SBAR communication related to medication administration (Field et al., 2011; Haig et al., 2006; Telem, Buch, Ellis, Coakley, & Divino, 2011), quality of care (Andreoli et al., 2010; Freitag & Carroll, 2011; Velji et al., 2008), and patient satisfaction (Freitag & Carroll, 2011; Velji et al., 2008). One study was a RCT (Field et al., 2011), four were either a controlled (Telem et al., 2011; Velji et al., 2008) or uncontrolled (Haig et al., 2006; Freitag & Carroll, 2011) pre-test post-test design, and one employed a mixed methods approach (Andreoli et al., 2010).

Results reported by Haig et al. (2006) demonstrated an increased frequency of medication reconciliation upon admission (72% to 88%) and upon discharge (53% to 89%). Correspondingly, adverse events (89.9 to 39.96 per 1000 patient days) and adverse drug events (29.97 to 17.64 per 1000 patient days) decreased. In the second study, there was a significant decrease (14.5% to 12.2 %, $p = .003$) in order entry errors in the SBAR group; no differences were reported in the control group (12.9% to 13.6%, $p = .47$) (Telem et al., 2011). Field et al. (2011) suggested that a tailored SBAR may improve communication about medication administration and resultant care management. Freitag and Carroll (2011) used a failure mode and effect analysis to understand and develop strategies to improve clinical handover practice. An electronic SBAR was implemented. The quality of care outcomes documented after SBAR implementation included a decrease in falls (5%), use of restraint (31%), and catheter associated urinary tract infections (34%). The researchers also reported an increase in patient overall satisfaction scores (4.4%).

The influence of SBAR on a culture of patient safety and teamwork. Organizational culture and teamwork within a health system has the potential to affect both the quality of clinical handover (Jeffcot et al., 2009) and the associated adverse events (Leonard, 2011). SBAR

has provided a shared mental model for communication (Haig et al., 2006; Leonard et al., 2004) that in turn may influence teamwork and organizational culture. Researchers addressed the effect of SBAR communication on teamwork and on organizational culture of patient safety (Andreoli et al., 2010; Becket & Kipnis, 2009; Donahue et al., 2011; Vardaman et al., 2012; Velji et al., 2008). Three researchers used a mixed methods approach (Andreoli et al., 2010; Becket & Kipnis, 2009; Donahue et al., 2011), one employed a controlled pre-test post-test design (Velji et al., 2008), and one was qualitative (Vardaman et al., 2012). Vardaman et al. (2012), in a qualitative case study, explored three concepts (schema, social capital, and dominant logics) in relation to the influence of SBAR on nurses' daily work experience. Results indicated that SBAR provided a cognitive template for decision making; fostered credibility, trust, and teamwork within an organization; and reinforced a shift to standardized practice. Velji et al. (2008) and Andreoli et al. (2010), in a Hospital Survey for Patient Safety Culture, demonstrated that the study teams on rehabilitation units achieved a significant improvement, $z > 1.96$, in 2 out of the 12 dimensions of safety culture in comparison to the rest of the hospital. The researchers suggested that SBAR improved teamwork and a culture of patient safety.

Clinical handover methods. Clinical handover methods varied across studies and included verbal, written, and an electronic SBAR format. These studies included descriptive retrospective (Anderson & Helms, 1998), uncontrolled pre-test post-test (Freitag & Carroll, 2011; Wentworth et al., 2012), and qualitative designs (Arora, Johnson, Lovinger, Humphrey, & Meltzer, 2005). The findings of two studies showed that use of both a standardized written clinical handover form with verbal communication improved the amount of information transferred when compared to verbal communication alone (Anderson & Helms, 1998; Pothier, Monteiro, Mooktlar, & Shaw, 2005). Pothier et al. (2005) found that written clinical handover

resulted in minimal loss of information ($p < .001$) compared to verbal alone or verbal and note taking. Similarly, study participants in Arora et al.'s (2005) research perceived that standard content within a written format may reduce omission of information.

The efficacy of an electronic SBAR format was addressed in two studies (Freitag & Carroll, 2011; Wentworth et al., 2012). Wentworth et al. (2012) used a participatory approach to develop and implement an electronic SBAR tool for transferring uncomplicated patients between a nursing unit and cardiac laboratories. The electronic SBAR format was reported to be more efficacious than the traditional verbal format. A scoping review (Wong et al., 2008) indicated that electronic tools maybe useful for clinical handover; however, the documentation to support this claim was limited. In comparison to an electronic format, verbal and written clinical handover were more frequently discussed in the literature.

Type of patient information. The Institute for Healthcare Improvement (Rutherford, Nielsen, Taylor, Bradke, & Coleman, 2013) has suggested that failure to address the psychosocial needs of the patient often results in poor transitions from hospital to home. Regardless of the clinical handover format in studies, minimal psychosocial information was included and transferred in comparison to other types of medical information (Anderson & Helms, 1998; Pothier et al., 2005). Only 4 out of the 19 SBAR studies included mental status or psychosocial information as part of the patient's medical information (Andreoli et al., 2010; Moseley et al., 2012; Velji et al., 2008; Woodhall et al., 2008).

Study strengths and limitations. Several quantitative study designs were strengthened through randomization (Cunningham et al., 2012; Field et al., 2011; Marshall et al., 2009; Pothier et al., 2005) and inclusion of comparison groups (Andreoli et al., 2010; Cunningham et al., 2012; Field et al., 2011; Marshall et al., 2009; Telem et al., 2011; Velji et al., 2008).

However, there were various methodological challenges for all studies. These challenges included: weak quantitative designs (i.e., uncontrolled pre-test post-test or post-test only); weak patient safety reporting measures (Andreoli et al., 2010; Velji et al., 2008); limited study information to assess for confounders (Freitag & Carroll, 2011; Haig et al., 2006; Wentworth et al., 2012; Woodhall et al., 2008) or quality of instruments (Compton et al., 2012; Moseley et al., 2012; Telem et al., 2011; Thompson et al., 2011; Woodhall et al., 2008); small sample size (Andreoli et al., 2010; Field et al., 2011; Moseley et al., 2012; Pothier et al., 2005; Thompson et al., 2011; Velji et al., 2008); limited study participation (Thompson et al., 2011); and low post-intervention response rate (Becket & Kipnis, 2009; Moseley et al., 2012) . Other confounding factors such as simultaneous implementation of SBAR communication with multiple teamwork and communication strategies (Dingley et al., 2008; Donahue et al., 2011; Freitag & Carroll, 2011) and patient safety initiatives (Andreoli et al., 2010; Donahue et al., 2011; Velji et al., 2008) limited the ability to determine the efficacy of SBAR alone.

There were three qualitative studies included in this review (Arora, et al., 2005; Clark et al., 2009; Vardaman et al., 2012). Two studies (Arora, et al., 2005; Vardaman et al., 2012) provided detailed study information demonstrating the researchers attempt to ensure credibility (i.e., different investigators independently reviewed interview data), dependability (i.e., constant comparative technique), confirmability (i.e., adequate audit trail), and transferability (i.e., adequate study information to possibly transfer findings to similar contexts) of the findings. The overall quality of the reviewed studies was low due to the weak designs and multiple methodological challenges.

The quality of the included literature reviews also varied. There were two systematic reviews (Riesenberg et al., 2009; Riesenberg et al., 2010), one scoping review (Wong et al.,

2008), and a narrative review (Manser & Foster, 2011). Three authors (Riesenberg et al., 2009; Riesenberg et al., 2010; Wong et al., 2008) reported the literature search and selection methods. Only one author (Riesenberg et al., 2010) described the defined review protocol as well as quality appraisal scoring method and established inter-rater reliability of the quality scores.

Summary, Implications, and Next Steps

A synthesis of the literature revealed that clinical handover information contained minimal psychosocial information which potentially places informational continuity of care for socially complex women and their newborns in jeopardy. While there were methodological issues in the studies reviewed, the findings were suggestive that a tailored written form and SBAR communication improves the content, clarity, and time of clinical handover; patient outcomes; as well as teamwork and patient safety culture.

Critical appraisal of the literature revealed that there was a gap in the existing knowledge not only about communication tools for transferring psychosocial maternal patient information but also about the usefulness of a tailored SBAR form for clinical handover between the postpartum acute care and community settings among professionals. Although the evidence base regarding SBAR communication was limited, an SBAR structured form was seen to be a potential solution to the practice issue. This conclusion along with findings from the initial quality improvement project has led to the development of a structured SBAR communication form. The synthesis of these primary studies also highlighted the need for a more thorough review of the literature on maternal psychosocial aspects to strengthen the SBAR form and the need to validate the form to ensure psychosocial aspects have been appropriately integrated.

A number of authors (Manser & Foster, 2011; Riesenberg et al., 2009; Riesenberg et al., 2010; Wong et al., 2008) have also acknowledged the need for rigorous clinical handover

research and call for further research on the efficacy of SBAR communication. The need for continuity of care for mothers and their newborns, the void of empirical literature about communication tools to transfer information from acute care to community for socially at-risk mothers, the call for further research, and the shift toward a higher level of postpartum care in the community highlighted the importance of examining intra and inter-professional clinical handover between the postpartum acute care and community setting. This study addressed this knowledge gap and therefore has practical implication. Acquired knowledge from the literature posited this study to be relevant and significant given the current clinical issue, the link between clinical handover and patient outcomes, and the evidence that supported a need for a change in practice.

Tailoring an SBAR Form for Clinical Handover

Clinical handovers between the postpartum acute care and community setting occur through written communication making the content critical to achieving effective communication. In an effort to foster this communication and impact care for socially at-risk postpartum women, an SBAR form that included maternal psychosocial risk and protective factors was developed. The SBAR form was evaluated first by determining content validity and then by understanding front line clinicians' perception of the usefulness of the form.

Literature Review of Maternal Psychosocial Risk and Protective Factors

The initial step to ensuring content validity was to complete a thorough literature review to determine relevant items (Lynn, 1986). The literature was searched and current evidence of maternal psychosocial risk and protective factors was selected and synthesized. An electronic literature search of CINAHL, MEDLINE, Social Work Abstracts, Cochrane ALL Evidence-Based Medicine Reviews and Google databases was conducted using the following key terms:

[(postnatal or perinatal or antenatal) AND (psychosocial)] AND ("risk factors") or (protective factors) followed by using a combination of key terms including (maltreatment), (infant maltreatment), ("child abuse"), (predictors of infant maltreatment), (predictors of poor health outcomes), (predictors of vulnerability), (disadvantaged), (predictors of postpartum depression) or (assessment). The literature search was limited to English language articles between 1990 and 2012. The search method and selection process have been detailed in Appendix E. Two hundred and forty seven citations were identified and all abstracts were reviewed. Grey literature was also searched. Systematic reviews, qualitative and quantitative research studies, and government reports that included multiple maternal psychosocial risk or protective factors for poor health outcomes (i.e., postpartum depression (PPD) or infant maltreatment) were included in the review. Duplicated articles and studies that only addressed a specific maternal population such as adolescent mothers were excluded.

Fifteen articles met the inclusion criteria and the full-text of those articles was reviewed and included in the quality appraisal. Mental health issues, social support, domestic violence, socioeconomic status, parenting, maternal unwanted pregnancy, history of child abuse, life stressors, criminal activity, and maternal age were categories that encompassed psychosocial risk factors associated with poor health outcomes. Protective factors that may mitigate the level of risk including social support, parenting, coping, and socioeconomic factors were also highlighted in the literature. A synthesis of knowledge about maternal risk and protective factors is provided in the next section followed by a discussion about the SBAR form design and content.

Maternal psychosocial risk screening tools. Two *screening* tools informed the content of the tailored SBAR study form; the Calgary Postpartum Screening Tool (Hull, 2007) and Antenatal Psychosocial Health Assessment (ALPHA) tool (Reid et al., 1998). Several

researchers also agree that the ALPHA was a useful tool to detect psychosocial concerns (Carroll et al., 2005; Reid et al. 1998; Willinck & Shubert, 2000). These tools were useful in development of the form as the tools collectively have demonstrated reliability and validity. Hull (2007) reported reliability (inter-rater reliability and test–retest reliability [at least .85]), validity (face, content, construct and convergent validity [≥ 0.8]), and sensitivity (92%) for screening at-risk mothers using the Calgary Postpartum Screening Tool. Content validity of the ALPHA tool (Reid et al., 1998) was established through a focus group of experts (Midmer, Carroll, Bryanton, & Stewart, 2002). Different to the purpose of a screening tool, a clinical handover communication tool requires details of the risk factors in order to facilitate continuity of care. Thus, direct use of these tools was not appropriate. Risk factors that were included on the tailored SBAR form and similar to both screening tools were: unwanted pregnancy, recent stressful life event, social isolation, mental health issue, history of prenatal or postpartum depression, substance use, domestic violence, history of involvement with child protection, and limited prenatal care. Additional risk factors identified in the screening tools and included in the tailored SBAR form were: poor relationship with partner and maternal parents and childhood abuse (Reid et al., 1998); coping skills; confidence; cognitive challenges; low education level; financial issues; and food insecurity (Hull, 2007).

Mental health. All reviewed articles (N=15) indicated various mental health concerns such as poor coping skills, substance use, anger management issues, as well as depression in pregnancy and postpartum as factors associated with poor maternal and infant health outcomes (i.e., Shaken Baby Syndrome) (AHS, 2011a; Beck, 2001; Dixon, Browne, & Hamilton-Giachritisis, 2009; Epstein, 2001; Hull, 2007; Midmer et al., 2002; Queensland Government, 2010; Reid et al., 1998; Williams, Tonmyr, Jack, Fallon, & MacMillan, 2011; Willinck &

Cotton, 2004; Willinck & Schubert, 2000; Wilson et al., 1996; Wodonga Regional Health Service, 2008; World Health Organization and International Society for Prevention of Child Neglect and Abuse [WHO], 2006). Researchers have reported that infant maltreatment (Dixon et al., 2009; Epstein, 2001; Williams et al., 2011) and postpartum depression (Beck, 2001) were more likely to occur when a mother or other caregiver has mental health issues. Specifically, multivariate analysis showed that substantiated child maltreatment was significantly associated with substance abuse (OR=1.55, 95% CI [1.01-2.39], $p < .001$) (Williams et al., 2011) and maternal history of depression (OR=2.7, 95% CI [1.1- 6.5], $p < .04$) (Epstein, 2001). Although mental health issues were associated with poor outcomes, one report identified good coping skills as a protective factor (U.S. Department of Health & Human Services, 2011).

Social support. A lack of social support was the second most commonly (N=11) identified risk factor associated with poor health outcomes such as postpartum depression and child maltreatment (AHS, 2011a; Beck, 2001; Dixon et al., 2009; Hull, 2007; Queensland Government, 2010; Reid et al. 1998; WHO, 2006; Williams et al, 2011; Willinck & Cotton, 2004; Willinck & Schubert, 2000; Wodonga Regional Health Service, 2008). Caregivers with few social supports were 1.66 times more likely (OR = 1.66, 95% CI [1.16-2.37], $p < .01$) to maltreat their child (Williams et al., 2011). Social support has also been reported as a protective factor against infant maltreatment and postpartum depression (Dixon et al., 2009; Queensland Government, 2010; WHO, 2006; Wodonga Regional Health Services, 2008; U.S. Department of Health and Human Services, 2011).

Domestic violence. Domestic violence was also associated with poor health outcomes (i.e., infant developmental delay, attachment disorders, physical injury) (AHS, 2011a; Dixon et al., 2009; Epstein, 2001; Hull, 2007; Queensland Government, 2010; Reid et al., 1998; WHO,

2006; Williams et al., 2011; Willinck & Shubert, 2000). For example, the odds of infant maltreatment was approximately 4 times more likely to occur when domestic violence was identified (Epstein, 2001; Williams et al., 2011).

Socioeconomic status. Socioeconomic status including the inability to meet basic needs, food insecurity, and housing instability was linked with poor health outcomes (i.e., infant developmental delay) (AHS, 2011a; Beck, 2001; Dixon et al., 2009; Epstein, 2001; Hull, 2007; Queensland Government, 2010; WHO, 2006; Williams et al., 2011; Willinck & Shubert, 2000). The odds of infant maltreatment was reported to be twice as likely (OR = 2.2, 95% CI [1.2-4.6], $p < .04$) when a mother was socioeconomically disadvantaged (Epstein, 2001). On the other hand, Dixon et al. (2009) identified financial solvency as a protective factor against intergenerational maltreatment because the incidence of financial issues was significantly higher ($p < .008$) in the families that maintain the cycle of child maltreatment in comparison to families that break the cycle.

Unwanted pregnancy. An association has been reported between unwanted pregnancy and infant maltreatment or domestic violence (Carroll et al., 2005; Hull, 2007; Queensland Government, 2010; Reid, 1998, Willinck & Shubert, 2000; WHO, 2006).

Parenting. Various components of parenting such as poor attachment (Dixon et al., 2009; Queensland Government, 2010; WHO, 2006) and lack of knowledge about infant development (Dixon et al., 2009; Queensland Government, 2010; WHO, 2006; Williams et al., 2011; Wilson et al., 1996) have been reported to be associated with poor health outcomes (i.e., failure to thrive). Health issues in the home (WHO, 2006; Williams et al., 2011), maternal cognitive challenges (AHS, 2011a; Epstein, 2001; Hull, 2007; Queensland Government, 2010; Willinck & Shubert, 2000), and a lack of confidence (Beck, 2001; Hull, 2007; Queensland

Government, 2010; Reid, 1998; WHO, 2006) have also been identified as influential factors on parenting. Dixon et al. (2009) reported that parents who do not maltreat their children and have no history of childhood maltreatment had a significantly more positive parenting style overall than the parents who had a history of childhood abuse or maltreated their children. Epstein (2001) reported that the odds of infant maltreatment was 3 to 4 times more likely when a mother was cognitively challenged. At the same time, four authors noted that positive attachment, knowledge of infant development, and parental confidence may buffer against poor health outcomes (Queensland Government, 2010; WHO, 2006; Wodonga Regional Health Services, 2008; U.S. Department of Health and Human Services, 2011).

History of child maltreatment. Two risk factors for child maltreatment also noted in the literature include maternal history of childhood maltreatment and parental history of child maltreatment (Dixon et al., 2009; Hull, 2007; Queensland Government, 2010; Reid, 1998; Williams et al., 2011; Willinck & Shubert, 2000; WHO, 2006). For example, intergenerational maltreatment was shown to have a 6.7% transmission rate (Dixon et al., 2009). Dixon et al. (2009) also suggested that parents who have protective factors were more likely to break the cycle of abuse.

Life stressors. Recent stressful life events have also been identified as a risk factor for poor health outcomes (i.e., physical illness) (Beck, 2001; Hull, 2007; Queensland Government, 2010; Reid, 1998; Willinck & Shubert, 2000; Wilson et al., 1996; Wodonga Regional Health Services, 2008). Wilson et al. (1996) identified a strong correlation (r was unavailable) between

recent life stressor and child abuse while life stress (r =.38-.40) had a moderate effect size for predicting postpartum depression (Beck, 2001).

Criminal activity. Four authors noted an association between known criminal activity and infant abuse and neglect (Epstein, 2001; Queensland Government, 2010; WHO, 2006; Williams et al., 2011). The odds of infant maltreatment was approximately twice as likely when parents had a history of criminal activity (Epstein, 2001; Williams et al., 2011).

Maternal age. Young maternal age was suggested to be a risk factor for a poor health outcome by four authors (Dixon et al., 2009; Queensland Government, 2010; WHO, 2006; Willinck & Schubert, 2000). Bivariate analysis showed a significantly higher, $p < .008$, prevalence of young parents among those that repeated or broke the cycle of child maltreatment (Dixon et al., 2009).

Content and Design of the Tailored SBAR Form

The tailored SBAR form was informed using AHS SBAR and form design template (AHS, 2010b; AHS, 2011c) and constructed following the literature review. The structure of the SBAR form includes four sections; situation, background, assessment, recommendation. The background content of the tailored SBAR form (see Appendix F) was developed by combining key psychosocial risk and protective factors identified in the literature that influenced health outcomes. Both risk and protective factors were incorporated into the background to provide an overall understanding of the mother's psychosocial needs.

Risks such as language barrier (Willinck & Shubert, 2000), lack of prenatal care and education (Hull, 2007; Queensland Government, 2010; Reid, 1998; Willinck & Schubert, 2000), young age (Dixon et al., 2009; Hull, 2007; Queensland Government, 2010; WHO, 2006; Willinck & Schubert, 2000), smoking (Queensland Government, 2010), and medical needs of the

infant (Beck, 2001; Dixon et al., 2009; Queensland Government, 2010; WHO, 2006) were intentionally excluded from the form because this information is transferred to community through the Provincial Notice of Birth form.

The assessment section was developed to include the current concern and the related action taken in the hospital including a possible safety plan. The patient's response was also included in the assessment to provide the PHN with information about whether or not the patient was concerned and whether or not the patient was receptive to support. The recommendation section of the form was developed based on a context specific follow-up plan of care related to the items in the background section.

Document design (i.e., unity, repetition, alignment, flow, emphasis) (AHS, 2011b; Australian National Audit Office, 2006; Sevilla, 2002; Williams, 2008) and usability principles (i.e., easy to learn, easy to remember, efficient to use, liked by the user, designed to minimize error, and accessible) (Bogaard, 2003) were used throughout the design process. Conceptual barriers (i.e., complexity, compatibility) identified in the KTA framework (Légaré, 2009) were also given consideration. As suggested by AHS forms management program, the form title needed to correspond to the subject and the purpose of the form. Acronyms such as SBAR were not recommended in the title or in the content of the form (O. Somefun, March 30, 2012, personal communication). Consequently, the form was titled Maternal Psychosocial Health Information Transfer but has been referred to as the tailored SBAR form for this study.

Consistent with the KTA framework, relevant stakeholders were included in the form development process. During the early developmental stages, the form was vetted by relevant stakeholders (i.e., clinical leads, nurse educators, and unit and program managers). Leaders indicated that the tailored SBAR form would likely be a useful strategy to transfer information.

Some of the leaders offered suggestions for form design such as spacing which were incorporated into form development. Evidence from the literature along with early clinical and leader discussion suggest that a research study to develop a tailored SBAR form was an important step to improving clinical handover between postpartum settings.

Summary

The literature review informed the development of the tailored SBAR form by refining and tailoring knowledge to the anticipated needs of front line clinicians. Appraisal of primary studies led to the reasonable conclusion that appropriate psychosocial risk and protective factors needed to be included in the form and that SBAR communication maybe an effective means to communicate the needs of socially at-risk women. The form was designed and constructed using document design and usability principles in an attempt to meet the needs of front line clinicians by anticipating and minimizing barriers. The methodology for further development of the tailored SBAR form is explicated in the following chapter.

Chapter Three: Research Method

This study employed a descriptive design and pragmatic mixed methods approach. Mixed methods research is an approach that collects and integrates quantitative and qualitative data in either a single study or in a multiphase project (Creswell & Clark, 2011). The strengths and weaknesses of each data collection method are considered so that the methods may complement each other (Rocco, Bliss, Gallagher, & Perez-Prado, 2003; Tashakkori & Teddlie, 2003). As suggested by Straus et al. (2009), incorporation of both methods provides a more in-depth understanding of factors that may influence the uptake of change and may also improve the strength of the evidence.

Pragmatism is a worldview fitting to mixed methods as multiple perspectives are considered and data collection across methodologies is promoted to create a more comprehensive understanding of the research findings (Creswell & Clark, 2011; Tashakkori & Teddlie, 1998, Chapter 1). The researcher took a pragmatic standpoint as this study was informed by a practice issue and the intended outcome was action oriented. Rigorous, useful, and practical approaches were used to develop and evaluate the tailored SBAR form. Consistent with the epistemology of pragmatism (Creswell & Clark, 2011), the research question was considered the most important and data collection methods were chosen to suit the questions. A mixed methods approach was suitable for this study given the researcher's pragmatic standpoint, research questions and guiding framework.

Criteria for a mixed methods design includes the rationale for using mixed methods, collection and analysis of quantitative and qualitative data, order of paradigm implementation, indication of paradigm emphasis, and indication of when integration of data occurs (Creswell, Fetters, & Ivankova, 2004). In order to achieve each of the research objectives and adequately

address the research questions, the study occurred in two phases and included multiple data sources (i.e., questionnaires, individual discussions, and focus group interviews).

The first phase (research objective one) was primarily quantitative and addressed the content validity of the tailored SBAR form. A calculated agreement among a panel of experts was used to determine the content validity of the risk and protective factors included on the SBAR form. A questionnaire was administered to gather both quantitative and qualitative data about the form. Results were used to revise the tailored SBAR form and accompanying guideline which in turn informed the second phase.

In Phase Two (research objective two), a focus group was used to collect quantitative and qualitative data. As suggested by Krueger and Casey (2009), a focus group was deemed an appropriate method to collect data in order to understand clinicians' perceptions from diverse postpartum settings and to pilot test the tailored form (simulation). During the focus group, a questionnaire and group interview was used to collect similar data about clinicians' perception of the usefulness of the tailored SBAR form. Initially, a questionnaire was used to collect anonymous quantitative data from participants. Then, a group interview was used to augment the questionnaire data and gain a rich description and understanding about the usefulness of the tailored SBAR form (i.e., who, what, when, where, why, and how). The purpose of collecting quantitative and qualitative data during the focus group was to both offset potential bias such as groupthink and gain an in-depth understanding about the usefulness of the form. In the following sections, each study phase is described including the timing of data collection, priority given to the quantitative and qualitative method, and when data was mixed.

Phase One: Determining Content Validity

Content validity of the SBAR form was an important step in determining the degree to which the included risk and protective factors were relevant and complete (Loiselle et al., 2011, p. 264). Content validity is determined in two stages. In the first stage, the content is identified (Lynn, 1986). In the second stage, the content is evaluated and experts are often used to quantitatively evaluate the relevancy and completeness of the developed content (Grant & Davis, 1997; Lynn, 1986). In this study, the content validity protocol began with developing the content and design of the tailored SBAR form through the literature review and application of form design and usability principles. The evaluation stage occurred during Phase One of this study.

Expert panel. Experts were identified by either the program manager for prenatal and postpartum services or the researcher. A minimum of three experts was recommended to determine content validity (Lynn, 1986; Polit, Beck, & Owen, 2007).

Recruitment. As suggested by Grant and Davis (1997), the invitation (see Appendix G) to participate included the reason they were selected, the significance of the clinical issue, and the anticipated use of the tailored SBAR form. The program manager for prenatal and postpartum services provided access to contact information and then invitations to serve as experts were sent by electronic mail. Seven inter-professional experts and opinion leaders (nurses, social workers, and physicians) with knowledge about maternal psychosocial risk and protective factors were invited to participate and six were recruited.

Data collection procedure. The expert participants were asked to review the tailored SBAR form and the Maternal Psychosocial Health Information Transfer Guideline. Next, each completed a questionnaire (see Appendix H) that addressed the clarity, relevancy, and completeness of the maternal psychosocial risk and protective factors on the tailored SBAR

form. The experts rated the items based on a four point likert scale ranging from *not relevant* to *highly relevant* (Polit & Beck, 2006) and provided comments about item clarity and any additional content required. The researcher contacted the experts by telephone to clarify questionnaire responses. Finally, a second questionnaire was administered with at least 14 days between the evaluations (Lynn, 1996). The experts rated the amended items suggested by the expert panel.

Data analysis. The advantages and disadvantages of using either the content validity index (CVI) or modified kappa were considered when selecting a content validity indicator. The advantage of using the CVI is that this indicator provides both item (I-CVI) and scale level measures (S-CVI/Ave); however, it does not adjust for chance agreement (Polit et al., 2007). In contrast, the modified kappa index adjusts for the chance agreement on items rated as relevant. The disadvantage is the kappa does not provide an overall scale measure (Polit et al., 2007).

Polit et al. (2007) compared modified kappa calculations to the I-CVI scores to understand the potential bias related to CVI. Kappa evaluation criteria suggested by Cicchetti and Sparrow (1981) and Fleiss (1981) (as cited in Polit et al., 2007) were used to judge the modified kappa score (> 0.74 = Excellent; 0.60 to 0.74 = good; 0.40 to 0.59 = fair; < 0.40 = poor). The authors (Polit et al., 2007) reported that an excellent modified kappa result ($k > 0.74$) corresponded to an I-CVI score greater than or equal to 0.78 rated by a minimum of three experts. A good or fair modified kappa result (0.60 to 0.74; 0.40 to 0.59 respectively) corresponded to an I-CVI score greater than or equal to 0.67 and less than 0.78. Based on this comparison, Polit et al., (2007) concluded that an item achieving an I-CVI score of at least 0.78 after correcting for chance agreement was considered content valid. The CVI was shown to be a reliable measure of item level content validity while offering additional scale level information.

The CVI was selected as the main content validity indicator for this study because the index was identified as reliable and provided both item and scale level evaluation. Although the use of CVI and the modified kappa index were not required for establishing content validity, both were calculated and compared.

Quantitative data was analysed using SPSS version 19.0.0.1 and Microsoft Excel 2013. Descriptive statistics and the CVI (Polit et al., 2007) were used to analyze and evaluate the data collected from the expert reviewers. The proportion and range of item level content validity was calculated and reported in addition to the average scale level content validity index. The I-CVI was determined by calculating the proportion of experts that scored the item as either *quite* or *highly relevant* (Polit & Beck, 2006). The decision to retain, possibly revise, or delete items was based on Polit et al.'s (2007) recommendations for the evaluation of CVI scores with six experts. Items that achieved an I-CVI score greater than or equal to 0.78 were considered to have excellent content validity and were retained; items that scored between 0.50 and 0.78 were considered for possible revision; and items that received scores less than 0.50 were deleted.

The mean across all I-CVIs was used to determine the average scale level content validity index (S-CVI/Ave) (Polit et al., 2007). A scale level average greater than 0.80 was considered acceptable (Grant & Davis, 1997) and greater than 0.90 excellent (Polit et al., 2007). The following figure illustrates the process for Phase One.

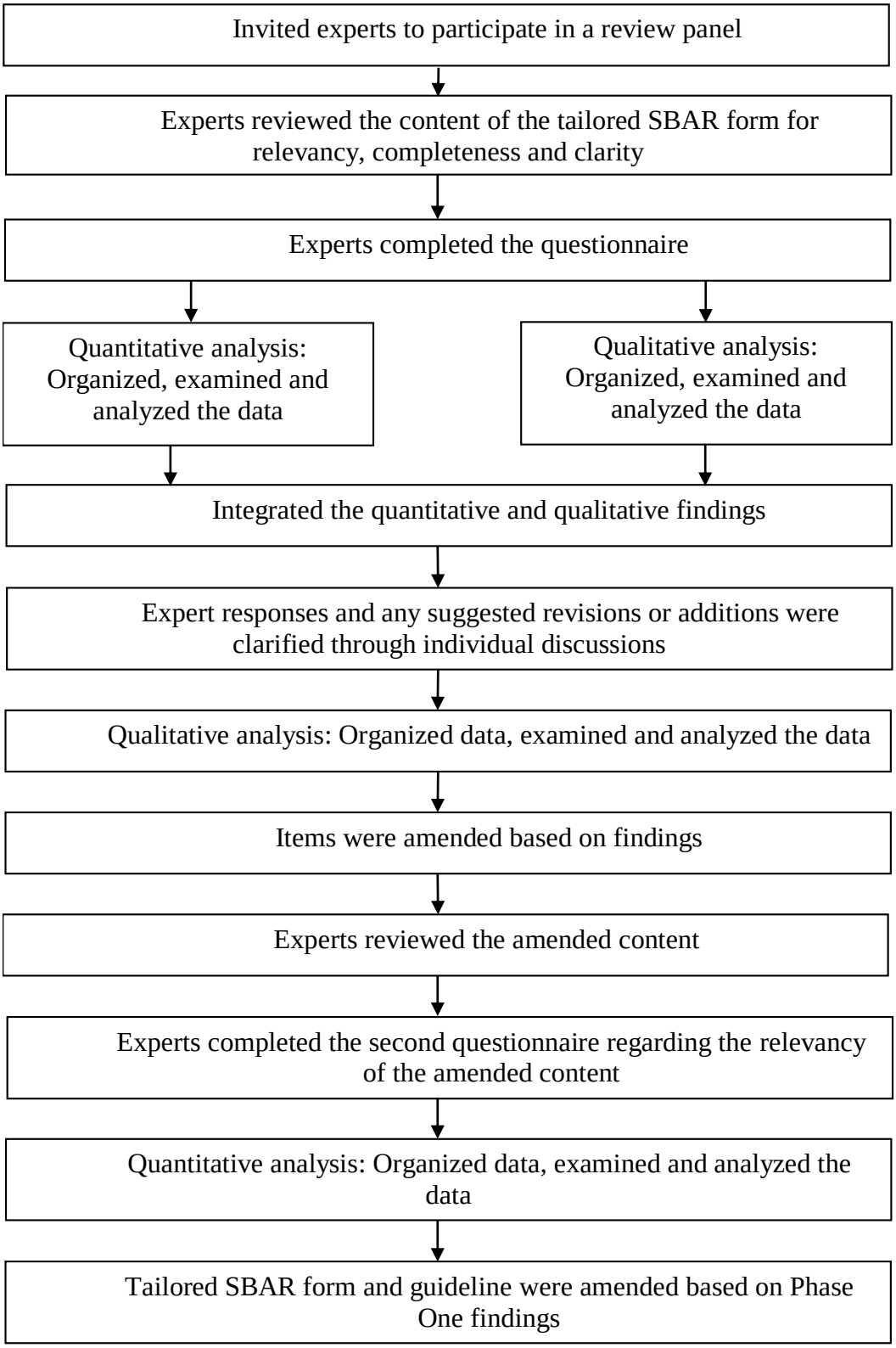

Figure 3. Diagrammatic representation of Phase One.

Phase Two: Understanding the Usefulness of the Tailored SBAR Form

Focus groups provide an opportunity to explore and discuss innovations among end-users (Straus et al., 2009; Streubert & Carpenter, 2011, p.38). Focus groups of postpartum acute care social workers and nurses and separate focus groups of postpartum PHNs were used to elicit information about their perception and experience with the tailored SBAR form.

The researcher facilitated the focus groups and a skilled graduate student assisted the researcher during each focus group. The research assistant completed a training session that included: development of detailed field notes; management of administrative tasks (i.e., room set-up; digital voice recording); and role in debriefing sessions. The field notes and debriefing sessions were guided by note taking templates from a variety of resources (de Negri & Thomas, 2003; Krueger, 2002; Mack, Woodsong, MacQueen, Guest, & Namey, 2005).

Questionnaire and focus group interviews were designed based on recommendations from scholars in questionnaire (survey) and focus group methods (Dillman, Smyth, & Christian, 2009; Krueger & Casey, 2009). Prior to Phase Two, the questionnaire and interview guide were vetted among four non-participating clinicians from the acute care and community settings (3 RNs and 1 social worker) to ensure statements were understandable and clear. Feedback was also received from thesis committee members. Revisions to the questionnaire and interview guide were made according to feedback received. The questionnaires were amended to ensure that the sequence and content of questionnaires for acute care and PHN participants were consistent wherever possible.

Subjects. A convenience purposive sample of all Registered Nurses (RN) (n=65), Licensed Practical Nurses (LPN) (n=26) and regular maternal child social workers (n=10) from a postpartum acute care unit as well as all Postpartum Community Services PHNs in Calgary

(n=145) who are English speaking were invited to participate in the focus group. As suggested by Krueger and Casey (2009, Chapter 2), the acute care and community participants were separated into different focus groups because each type of participant may offer a different view (i.e., sender of information versus the receiver of information). The different focus groups also enabled a comparison between and within the groups. Data saturation was used as a means to determine whether more focus groups were required. Krueger and Casey (2009, Chapter 2) suggest data saturation usually occurs within three to four focus groups and is recognized when no new themes are found.

A focus group is generally comprised of six to ten participants (Streubert & Carpenter, 2011, p.39); although, a minimum of five participants is considered appropriate for academic focus groups (Krueger & Casey, 2009, p.151). Recruitment of at least five participants for each focus group was anticipated.

Recruitment. Postpartum Community Service and postpartum acute care leaders committed and agreed to support the study and provided the researcher with access to the staff. Study invitations (see Appendix I) were sent through AHS electronic mail, recruitment posters, (see Appendix J) and presentations on the respective units. Unit managers and clinical nurse educators also reminded staff of the ongoing recruitment. Participation was voluntary.

Scheduling focus groups. Health care providers that expressed interest in participating were asked to provide dates of availability. The researcher coordinated the focus group dates and times based on submitted availability and preferences. Shift work and participants' personal schedules presented multiple challenges for arranging the focus group dates. The researcher ensured that at least five participants were scheduled in each group and that each profession (social work, RN, LPN) was represented in each postpartum acute care group. The focus groups

were scheduled over a six week period. Acute care focus groups were conducted first and then PHN groups. The groups were scheduled during the afternoon or evening on the following dates: April 12, April 19, April 24, April 28, May 16, and May 22, 2013. An email confirmation of the date, time, and location of the focus group was sent to each participant along with the consent to participate. Participants were asked to review the consent prior to attending the focus group. An email reminder was sent two days prior to each focus group.

Forty-six participants were recruited and scheduled among six different focus groups (postpartum acute care, n=19; postpartum community, n=27). Five out of the 19 acute care participants and four out of the 27 PHNs were not able to attend due to illness, last minute scheduling conflicts, and forgetting. Only one participant did not provide a reason. A total of 37 participants attended the focus groups. The size of each group ranged from three to nine participants. Fourteen participants from postpartum acute care (social workers, n=5; RNs, n=5; LPNs, n=4) took part in three separate focus groups. Three focus groups were conducted in the postpartum community setting and a total of 23 PHNs participated. Following the sixth focus group, the researcher and the assistant agreed that no new themes had emerged and data saturation was reached.

Data collection procedure. As suggested by Asbury (1995), the focus groups occurred at a convenient location that was accessible and comfortable for the participants. Each group took place in a meeting room at the respective worksites. Snacks and beverages were provided for participants in the afternoon groups while supper was provided for participants in the evening groups. The approximate time frame for each focus group was two hours.

Focus group introduction. Voluntary informed consent was obtained. Participants received a stipend of 25 Canadian dollars to support any costs that they incurred. The focus

group session started with an introduction of the researcher and research assistant. An outline of the focus group activities was reviewed. Next, the participants were asked to introduce themselves including their name, occupation, and department.

As suggested by Streubert and Carpenter (2011, p.38), the researcher attempted to minimize potential bias related to groupthink. Ground rules (Mack et al., 2005) were established to lessen the tendency toward groupthink and facilitate the effectiveness of the discussion. These rules were posted in the room and included: equal opportunity to speak and freely participate; equal valued opinion; mutual respect of each other; and silenced cell phones and pagers. Participants were given an opportunity to add to the ground rules; although, no additional rules were suggested.

Maternal psychosocial health information transfer guideline instruction. A brief overview of the study background and instructions to use the tailored SBAR form were provided next. The background to the study (see Appendix K) included a brief description of SBAR communication, the design and development of the tailored SBAR form, and the purpose of the form. Next, the tailored SBAR form and Maternal Psychosocial Health Information Transfer Guideline (see Appendix L) were reviewed and then applied to examples. The participants were given time to gain familiarity with the form and to ask questions for clarification.

During each postpartum acute care focus group, clinicians engaged in a simulated case study. Social workers and nurses were each given a similar scenario (see Appendix M) that reflected their respective scope of practice and then asked to complete the form. In the subsequent postpartum community focus groups, PHN participants were asked to read a tailored SBAR form completed during the acute care focus group. The PHNs were then given the corresponding scenario to read. This offered PHN participants an opportunity to compare their

understanding of the patient situation from information transferred on the form to the scenario. Participants were then asked to complete a questionnaire.

Questionnaire. The questionnaire was used during the focus group as a way to initially gather data anonymously and then the group interview further explored questionnaire topics (Stewart, Shamdasani, & Rook, 2007, p.39). Similar to items in Thompson et al.'s (2011) ISBAR survey, the questionnaire for this study (see Appendix N) was designed to collect data about clinicians' perception of the usefulness of the tailored SBAR form as well as the enablers and barriers to using this form because these elements are important to the uptake and sustainability of change (ACSQHC, 2011a; Straus et al., 2009). The completed questionnaires were collected and stored in a sealed envelope. Subsequently, participants took part in the focus group interview.

Focus group interview. A semi-structured interview guide (see Appendix O) was used to gather in-depth data on clinicians' perception of the usefulness of the tailored SBAR form as well as the enablers and barriers to using this form. The group interview provided an opportunity for participants to elaborate on their questionnaire responses and to share their perceptions about the tailored SBAR form with each other.

Focus group conclusion. As suggested by Krueger and Casey (2009), the researcher summarized and then verified participants' main responses following the group interview. Participants were given an opportunity to add information. The focus group concluded by thanking and informing participants that the data collected will be used to make revisions to the form.

The research assistant took field notes throughout the focus group session to document the seating arrangement and to capture non-verbal communication, key points, notable quotes, and extensiveness of the discussion (Krueger, 2002; Mack et al., 2005). Immediately following each focus group the researcher and assistant debriefed using an adapted guide for focus group note taking (de Negir & Thomas, 2003; Mack et al., 2005). This debrief included: overall impressions, clarifications, main themes, comparisons between groups, facilitators and challenges with conducting the group, and potential management strategies. The focus group interaction and debriefing were digital voice recorded.

Data analysis. Quantitative and qualitative data were initially analyzed separately. Prior to quantitative analysis, data was inspected to ensure the accuracy of data input. Quantitative data was analyzed using SPSS version19.0.0.1. Questionnaire data was either nominal or ordinal. Therefore, the most appropriate statistical analysis method was descriptive statistics and included frequency and percent measures.

Qualitative data was managed both manually and by the QSR NVivo10 qualitative research computer software program as each method offered different advantages. Manual data management offered a broader visualization of the data, whereas the computer software offered easier exploration, access, and location of data.

Digital voice recordings of the focus group interactions were transcribed verbatim by a professional transcriptionist. Initially, the transcripts were read and compared to the digital recording to ensure accuracy and completeness. The researcher reviewed the qualitative data following each focus group. As suggested by Creswell (2007), the researcher became immersed in the data by reviewing and comparing the data several times, reflecting, and then writing notes. A general understanding of concepts was developed by exploring the data following each focus

group. The qualitative data was analyzed using a thematic constant comparative approach (Speziale et al., 2010, p.134). The data was initially categorized according to key concepts and then data that shared similar attributes was further grouped together and coded based on emerging themes (Speziale et al., 2010, p.134). During the ongoing analysis process, data and emerging themes were compared to the identified themes from previous focus groups. Ideas and emerging themes were explored during subsequent focus groups until no new themes emerged.

As suggested by Krueger and Casey (2009, Chapter 6), analysis was based on specific detailed remarks and extensiveness of the discussion rather than frequency because frequency may not accurately represent study findings. Consideration was also given to the context of the focus group interaction rather than individual remarks (Asbury, 1995). A triangulated approach was used to analyze the collective data from the focus groups. Initially, quantitative and qualitative data was analyzed separately and then the findings were integrated and compared. Statistical results were compared to the qualitative themes that either confirmed or negated the quantitative data. This triangulated approach facilitated an in-depth understanding and rich description of participants' perception of the usefulness of the tailored SBAR form. The following diagram has outlined the procedure for Phase Two.

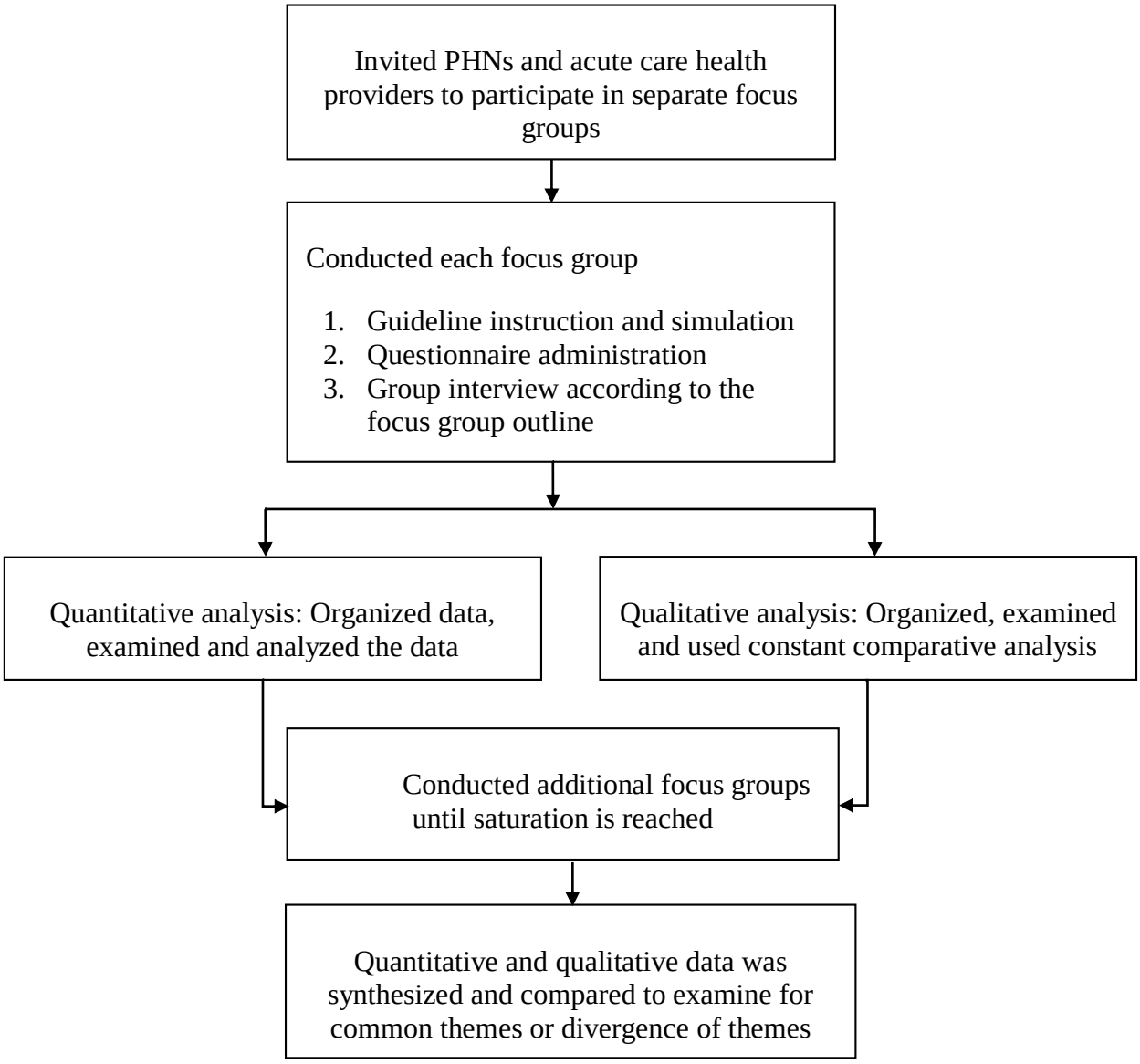

Figure 4. Diagrammatic representation of Phase Two.

Ethical Considerations

Written permission to share the quality improvement project report was obtained from the co-lead of that project. Likewise, signatures of agreement to conduct and permit access for this study within AHS were acquired from the respective departments and unit leaders. This study was approved by the University of Calgary Conjoint Health Research Ethics Board. Ethical

considerations for this study included consent, confidentiality and anonymity, participant stipend, possible conflict of interest, possible risk and benefits to participation, as well as the security and storage of collected data.

Voluntary informed written consent for participation was obtained prior to commencement of the focus group (see Appendix P). The focus group transcripts did not contain participant names. Participants were informed that confidentiality and anonymity was protected where possible; however, it was explained that the ability to guarantee anonymity may not be possible because of the participatory nature of the study (Streubert & Carpenter, 2011).

Postpartum acute care management agreed to relieve relevant social workers and nurses from their regular duties to attend the focus groups when possible. Postpartum Community Service management was asked but unable to provide funding for PHNs to attend the focus group. A stipend was provided to the participants after receiving their voluntary informed consent.

A conflict of interest may have been perceived because the researcher is a current AHS employee in Postpartum Community Service. The researcher's role includes PHN and relief charge nurse. The main role of charge nurse is to act as consultant for clinical issues, organize daily workload, and problem solve. The role is not supervisory and the researcher did not have authority over other PHNs. The perceived conflict of interest was managed by disclosing that the researcher is a PHN and relief charge nurse in Postpartum Community Services.

Possible risks to the participant may have included the participant's time commitment along with stress from an anticipated change in practice such as learning a new process and the possibility of a perceived increased workload. Participants were made aware of possible practice benefits from the study such as improved satisfaction and confidence with transferring and

receiving patient information as well as a perceived improvement to the quality of information transferred. Another ethical consideration was the possibility that participants may view the study to be a type of an employee performance appraisal. This issue was addressed by clearly articulating the research purpose, answering participants concerns and assuring impartiality, confidentiality and anonymity to the extent possible.

Collected data has been stored on password secured computer that has been virus protected. The completed consents, questionnaire data, and digital voice recordings have been stored in a locked filing cabinet in a secured building for the duration of the study. The computer data has been stored on a memory stick in the same way. All collected data will be kept for five years in secured storage. Subsequently, the documents will be secured shredded and the stored electronic data will be erased and the drive will be defragmented. Data may only be accessed by those who have been involved in the research project. Project personnel signed a non-disclosure agreement.

Summary

In this chapter, the rationale for choosing a pragmatic mixed methods approach for this study was both described and explained. Details of data collection and analysis were described for each phase followed by a discussion of ethical considerations relevant to this study. Phase One findings are presented in next chapter followed by Phase Two findings in chapter 5.

Chapter Four: Phase One Content Validity Results

The second step in the KTA cycle is adapting knowledge to the local context (Graham et al., 2006). Lack of appropriate communication tools and limited evidence regarding SBAR communication created a need for an innovation that addressed the knowledge gap. Steps were taken to ensure that the tailored content of the SBAR form was relevant and comprehensive. This approach is seen as important in facilitating the uptake of the form if implemented into practice (Straus et al., 2009). In Phase One of this study, the content validity of the selected risk and protective factors was evaluated and informed further development of the tailored SBAR form. As illustrated in the following figure, Phase One of the study has been situated in the second step of the KTA cycle.

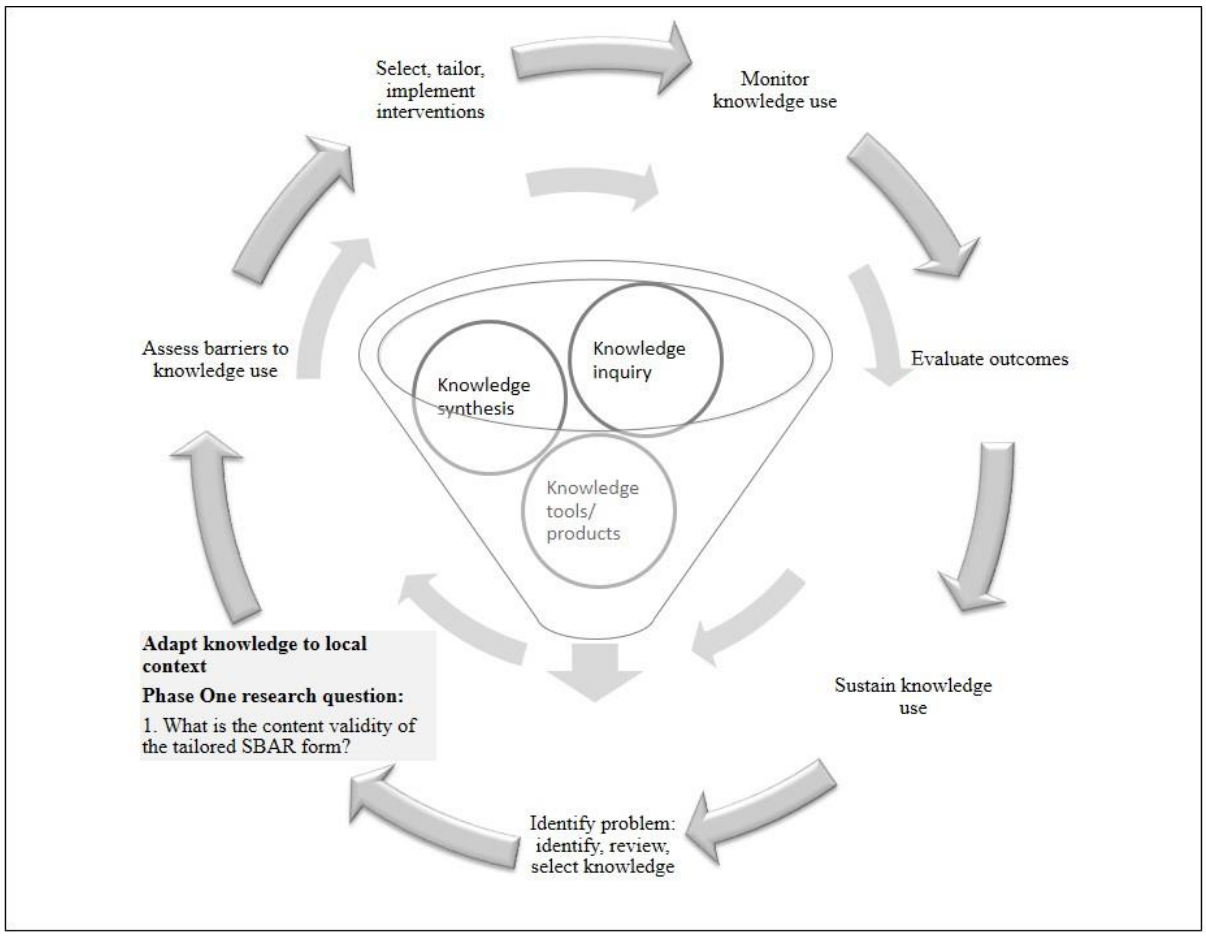

Figure 5. Study Phase One integrated into the KTA framework (see Footnote 2).

Six experts were recruited to evaluate the content validity of maternal psychosocial risk and protective factors included in the tailored SBAR form. The review panel included nurses (n=2), social workers (n=2), and physicians (n=2) (pediatrician and family physician). The content validity was determined through an iterative process that included both an initial and final content validity calculation. In this chapter, results from the iterative content validity process are discussed followed by a description of the resultant amendments and implications for Phase Two.

Initial Content Validity Index Results

The initial I-CVI scores for this study ranged from 0.33 to 1.00. An excellent I-CVI (≥ 0.83) was achieved in 29 of the 36 items (80.5 %) and 14 of those items (38.9%) achieved universal agreement (S-CVI/UA). Seven items (19.4 %) achieved an I-CVI score less than 0.78 (0.33 to 0.67). The initial S-CVI/Ave was 0.85. The initial overall validity of the risk and protective factors was slightly above an acceptable scale average (> 0.80) (Grant & Davis, 1997) and just slightly below the recommended average for excellent scale level content validity (> 0.90) (Polit et al., 2007).

Comparison of the content validity index and modified kappa results. To demonstrate reliability of the quantitative findings for this study, I-CVI results were compared to the modified kappa evaluation (see Table 1 and Table 2). Items in this study that achieved an I-CVI score greater than or equal to 0.83 (at least 5 out of the 6 experts rated as relevant) also achieved an excellent kappa evaluation (> 0.74); I-CVI scores equal to 0.67 (4 out of the 6 experts rated as relevant) achieved a good kappa evaluation (0.60 to 0.74); and I-CVI scores less than or equal to 0.50 (less than 4 out of the 6 experts rated as relevant) were comparable to either a fair (0.40 to 0.59) or poor (< 0.40) kappa evaluation. Interpretation of the compared I-CVI scores to the modified kappa evaluation (adjusted for chance agreement) confirmed that the CVI results for this study are reliable. The initial CVI and modified kappa results have been summarized in the following table.

Table 1

Initial content validity indicator results

Item	Experts						Analysis				
Maternal concern	#1	#2	#3	#4	#5	#6	I-CVI	I-CVI Evaluation [a]	P_c [b]	k^* [c]	k^* Evaluation [d]
Domestic Violence: Past or Current	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Relationship with Partner	4	3	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Known Criminal Activity	3	2	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Incarceration	3	2	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Anger Management Issues	3	4	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Substance/Alcohol Use	4	2	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
Financial	4	3	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Food Security	4	4	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Housing	4	4	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Mental Health Diagnosis	4	3	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Prenatal/Postnatal Depression	4	4	4	3	3	4	1.00	Excellent	0.02	1.00	Excellent
Treatment for Mental Health Diagnosis	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Coping Skills	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Current Stress Level	3	3	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Social Isolation	4	2	4	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Relationship with Maternal Parents	1	2	3	1	3	3	0.50	Delete	0.02	0.49	Fair
Health Issues in Home Impacting Parenting	2	3	4	2	3	3	0.67	Possibly revise	0.02	0.66	Good
Acceptance of Baby	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Attentive to Baby's Needs	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent

Item	Experts						Analysis				
Maternal concern	#1	#2	#3	#4	#5	#6	I-CVI	I-CVI Evaluation [a]	P_c [b]	k^* [c]	k^* Evaluation [d]
Responds Appropriately to Baby	4	3	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Knowledgeable of Baby's Development	2	3	3	2	3	4	0.67	Possibly revise	0.02	0.66	Good
Confident in Baby care	4	4	4	2	3	3	0.83	Excellent	0.02	0.83	Excellent
Years of Education Completed	1	2	3	2	2	3	0.33	Delete	0.02	0.32	Poor
Cognitive Challenges	3	2	4	3	2	4	0.67	Possibly revise	0.02	0.66	Good
CFSA Involvement: Historical	2	2	4	3	4	4	0.67	Possibly revise	0.02	0.66	Good
CFSA Involvement: Open file	4	3	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
CFSA Involvement: Investigation	4	2	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
CFSA Involvement: Reported Concerns during this Hospitalization	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Maternal strength											
Financial ability to meet basic needs	1	3	4	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Community Resources Already in Place	3	3	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Support Network	3	4	4	3	3	4	1.00	Excellent	0.02	1.00	Excellent
Coping Skills	1	3	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Attentive to Baby's Needs	1	4	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent

Item	Experts						Analysis				
Maternal Strength	#1	#2	#3	#4	#5	#6	I-CVI	I-CVI Evaluation [a]	p_c [b]	k* [c]	*k** Evaluation [d]
Responds Appropriately to Baby	1	3	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
Knowledgeable of Baby's Development	1	3	3	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Confident	1	4	4	3	2	3	0.67	Possibly Revise	0.02	0.66	Good
Proportion of relevant items	0.69	0.75	1	0.75	0.92	1					
[e] S-CVI/Ave							0.85				
[f] S-CVI/UA							0.39				

CFSA = Child and Family Service Authority.

Note. Polit et al. (2007) identified the term definitions, formulas and evaluation criteria listed below.

I-CVI = item level content validity index.

[a] Evaluation criteria for I-CVI: ≥ 0.78 = Excellent; < 0.78 and > 0.50 = possibly revise item; ≤ 0.50 = delete item.

[b] Probability of chance agreement (p_c) (component of the modified kappa calculation): $p_c = [N! / A! (N-A)!]*0.5^N$

N = number of experts; A = number of experts in agreement that the item was either quite or highly relevant.

[c] Modified kappa calculation (*k**) (agreement among experts on relevance): $k^* = (\text{I-CVI} - p_c) / (1 - p_c)$.

[d] Evaluation criteria for kappa as suggested by Cicchetti and Sparrow (1981) and Fleiss (1981): > 0.74 = Excellent; 0.60 to 0.74 = good; 0.40 to 0.59 = fair; < 0.40 = poor (as cited in Polit et al., 2007).

[e] S-CVI/Ave = scale level content validity index.

[f] S-CVI/UA = universal agreement.

Expert Clarification and Corresponding Results

Through a discussion with the experts, any reported addition or revision was clarified along with possible revisions for items that scored less than 0.78. Items that scored less than 0.78 were rescored if the respective expert verbally requested a change in their score during the discussion. Items that were added and revised as a result of this feedback were rescored by all experts in a second questionnaire. In the following paragraphs, items that were retained, deleted, or revised are identified. A description of the experts' rating of the item is provided along with the rescored results.

Retention of items and description of ratings by experts. After a discussion with the respective experts, the I-CVI of two items increased (cognitive challenges [0.67 to 0.83], confident [maternal strength] [0.67 to 0.83]) and were therefore retained.

Cognitive challenges. One expert reported that in practice 'cognitive challenges' and 'years of education completed' are both considered risk factors; although, cognitive challenges were considered to present a greater risk than years of education (Expert_5). The expert subsequently increased the rating of both factors to *quite relevant*.

Confident. An expert reported that 'confident', as a protective factor, was erroneously rated low and therefore requested the score be change to *quite relevant* (Expert_5).

One expert (Expert_1) considered the form usability when scoring the protective factors. Several of these factors (financial ability to meet basic needs, coping skills, attentive to baby's needs, responds appropriately to baby, knowledgeable of baby's development, confident) were scored as *not relevant* because these factors were considered a repetition of some of the risk factors. The corresponding risk factors (financial, coping skills, attentive to baby's needs, responds appropriately to baby, knowledgeable of baby's development, confident in baby care),

however, were rated *highly relevant* by the same expert. The expert indicated the protective factors were redundant and did not amend ratings. In contrast to this perspective, another expert suggested emphasizing maternal strengths by moving this section ahead of the maternal concerns section. This expert reported that health care providers tended to focus on problems and were *"less inclined to work from a strength based approach"* (Expert_5). Most of the experts (n=5) rated all of the protective factors as either *quite* or *highly relevant*.

Deletion of items and description of ratings by experts. Three items that were rated either as *not relevant* or *somewhat relevant* were clarified with the experts regarding the need for revision. Following the discussion, all three I-CVI scores (relationship with maternal parents [unchanged, 0.50], health issues in home impacting parenting [unchanged, 0.67], years of education completed [increased from 0.33 to 0.50]) remained less than 0.78. Consistent with the identified criteria for exclusion (I-CVI < 0. 78), the items were deleted from the form.

Relationship with maternal parents. This risk factor referred to childhood maltreatment or family dysfunction. One expert described poor relationship with maternal parents as an *"exception to the rule" (Expert_1)* and not relevant because this item may only be a risk in limited situations.

Health issue in home impacting parenting. This factor was given a somewhat relevant rating because the risk *"doesn't seem to come up with how adequate they care for their child but when it influences their mental health then that can be an issue" (Expert_4).* The expert explained that the risk may be reasonably captured under items such as mental health or coping.

Years of education completed. One expert suggested *"cognitive challenges [are] better than years of education - like [Fetal alcohol spectrum disorder]" (Expert_5)*. The overall scoring for this item remained low.

Revision of items and description of ratings by expert. As a result of feedback from the experts, four items were revised (relationship with partner, mental health diagnosis, knowledgeable of baby's development, CFSA involvement: Historical) and one item (community resources already in place) was slightly modified. The following paragraphs describe the revisions and rescored results.

Relationship with partner. One expert wrote that *"the term relationship with partner is not very clear"* and that *"risk factors of father/social issues with father"* (Expert_5) may provide clarity. Through a discussion with this expert, the item was revised to 'psychosocial risk factors of the partner'.

Mental health diagnosis. The word 'disorder' was recommended to be substituted for 'diagnosis' (Expert_6). A different expert recommended to include personality disorders or traits, as a mental health exemplar, in the Maternal Psychosocial Health Information Transfer Guideline because this disorder has *"a HUGE impact on parent's ability to be attuned to the infant's needs" (Expert_5).* As a result, the item was modified to 'mental health disorder'.

Knowledgeable of baby's development. This item was amended to capture an additional risk factor. The expert wrote that *"a significant risk is mother's perceptions and attitudes related to infant feeding. This is especially significant for the more perfectionist/"rigid" thinkers" (Expert_ 3).* The expert reported that *"any deviation is devastating to the mother"* and *"if didn't go perfect"* the women may report being a *"failure and I'm a bad mother" (Expert_ 3).*

A suggestion was also made to clarify *"how knowledgeable" (Expert_ 3)* by being specific about *"baby development in terms of newborn feeding, crying, sleeping" (Expert_ 3).* The overall risk was summarized as unrealistic expectations of parenting. The expert agreed that 'expectations and perceptions of baby's feeding, crying, and sleeping patterns' accurately captured the *"at risk 'apparent high functioning' woman" (Expert_ 3)* and further clarified the risk factor (knowledgeable of baby's development).

Child and Family Service Authority involvement: Historical. The term 'historical' was clarified by two experts (Expert_1, Expert_2) that rated this risk factor as *somewhat relevant*. Both experts indicated that a previously apprehended child could be *quite relevant* while one expert also acknowledged that a recent history of child protective service involvement was *quite relevant*. One expert explained that *"we look at the person through another lens if identify all history"* and that maybe *"things change and perhaps the person involved is not a concern" (Expert_ 2).* Recent history was reported to include the last two years (Expert_2). The risk factor was amended to recent history instead of all historical involvement.

Community resources already in place. One expert (Expert_6) suggested a slight amendment to this protective factor by including the word 'professionals' along with the professional's contact information. The item was changed to 'community resources and professionals already in place' and was not re-evaluated because the change was small.

Rescored results for revised items. The I-CVI score of 'mental health disorder' remained the same (1.0) while the score of the other three items increased (psychosocial risk factors of partner [0.83 to 1.0], expectations and perceptions of baby's feeding, crying, and sleeping patterns [0.67 to 1.0], and CFSA Involvement: Recent history [0.67 to 1.0]). Each of the four revised items achieved an excellent I-CVI score (≥ 0.83) and was retained. To minimize the

potential for bias, the score of the expert(s) that suggested the specific item revision was eliminated and then the I-CVI score was calculated again. Findings from this second calculation demonstrated the same I-CVI scores as the initial scores that included all experts.

Final Content Validity Index Results

The final content validity was calculated after the respective items were rescored through either verbal feedback or the second questionnaire. The two retained items (cognitive challenges, confident [maternal strength]) (I-CVI ≥ 0.83) and four revised items (psychosocial risk factors of partner, mental health disorder, expectations and perceptions of baby's feeding, crying, and sleeping patterns, CFSA Involvement: Recent history) (I-CVI ≥ 0.83) were included in the final content validity calculation. The three deleted items (I-CVI ≤ 0. 67) (relationship with maternal parents, health issues in home impacting parenting, years of education completed) were excluded from the calculation. A total of 33 of the initial 36 items were evaluated for content validity.

Findings from Phase One demonstrated that all 33 items (100 %) achieved excellent content validity (I-CVI ≥ 0.83). The number of items that achieved universal agreement increased from 14 items (38.9%) to17 items (52.0 %). Risk factors such as mental health disorder; acceptance of baby; attentive to baby's needs; and CFSA Involvement: reported concerns during this hospitalization were rated as *highly relevant* by all experts (n=6).

The final I-CVI scores ranged from 0.83 to 1.00 which is much narrower than the initial I-CVI range of 0.33 to 1.0. The S-CVI/Ave increased from an acceptable score of 0.85 to an excellent score of 0.92. The final S-CVI/Ave reflected an excellent representation of maternal psychosocial risk and protective factors. Results from the final iteration demonstrated excellent item and scale level content validity suggesting that the risk and protective factors on the tailored

SBAR form are content valid. The following table has summarized the final CVI and modified kappa results.

Table 2

Final content validity indicator results

Item	Experts						Analysis				
Maternal concern	#1	#2	#3	#4	#5	#6	I-CVI	I-CVI Evaluation [a]	P_c [b]	k^* [c]	k^* Evaluation [d]
Domestic Violence: Past or Current	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Psychosocial Risk Factors of Partner	4	4	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Known Criminal Activity	3	2	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Incarceration	3	2	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Anger Management Issues	3	4	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Substance/Alcohol Use	4	2	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
Financial	4	3	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Food Security	4	4	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Housing	4	4	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Mental Health Disorder	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Prenatal/Postnatal Depression	4	4	4	3	3	4	1.00	Excellent	0.02	1.00	Excellent
Treatment for Mental Health Diagnosis	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Coping Skills	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Current Stress Level	3	3	4	2	3	4	0.83	Excellent	0.02	0.83	Excellent
Social Isolation	4	2	4	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Acceptance of Baby	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Attentive to Baby’s Needs	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Responds Appropriately to Baby	4	3	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Expectations and Perceptions of Baby's feeding, crying and sleeping patterns	4	3	4	4	3	4	1.00	Excellent	0.02	1.00	Excellent
Confident in Baby care	4	4	4	2	3	3	0.83	Excellent	0.02	0.83	Excellent
Cognitive Challenges	3	2	4	3	3	4	0.83	Excellent	0.02	0.83	Excellent

Item	Experts						Analysis				
Maternal concern	#1	#2	#3	#4	#5	#6	I-CVI	I-CVI Evaluation [a]	P_c [b]	k^* [c]	k^* Evaluation [d]
CFSA Involvement: Recent History	4	3	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
CFSA Involvement: Open file	4	3	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
CFSA Involvement: Investigation	4	2	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
CFSA Involvement: Reported Concerns during this Hospitalization	4	4	4	4	4	4	1.00	Excellent	0.02	1.00	Excellent
Maternal strengths											
Financial ability to meet basic needs	1	3	4	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Community Resources Already in Place	3	3	4	3	4	4	1.00	Excellent	0.02	1.00	Excellent
Support Network	3	4	4	3	3	4	1.00	Excellent	0.02	1.00	Excellent
Coping Skills	1	3	4	4	3	4	0.83	Excellent	0.02	0.83	Excellent
Attentive to Baby's Needs	1	4	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
Responds Appropriately to Baby	1	3	4	4	4	4	0.83	Excellent	0.02	0.83	Excellent
Knowledgeable of Baby's Development	1	3	3	3	3	4	0.83	Excellent	0.02	0.83	Excellent
Confident	1	4	4	3	3	3	0.83	Excellent	0.02	0.83	Excellent
Proportion of Relevant Items	0.82	0.82	1	0.88	1	1					
[e] S-CVI/Ave							0.92				
[f] S-CVI/UA							0.52				

CFSA = Child and Family Service Authority.

Note. Polit et al. (2007) identified the term definitions, formulas and evaluation criteria listed below.

I-CVI = item level content validity index.

[a] Evaluation criteria for I-CVI: ≥ 0.78 = Excellent; < 0.78 and > 0.50 = possibly revise item; ≤ 0.50 = delete item.

[b] Probability of chance agreement (p_c) (component of the modified kappa calculation): $p_c = [N! / A! (N-A)!]*0.5^N$

N = number of experts; A = number of experts in agreement that the item was either quite or highly relevant.

[c] Modified kappa calculation (k^*) (agreement among experts on relevance): $k^* = (\text{I-CVI} - p_c) / (1 - p_c)$.

[d] Evaluation criteria for kappa as suggested by Cicchetti and Sparrow (1981) and Fleiss (1981): > 0.74 = Excellent; 0.60 to 0.74 = good; 0.40 to 0.59 = fair; < 0.40 = poor (as cited in Polit et al., 2007).

[e] S-CVI/Ave = scale level content validity index.

[f] S-CVI/UA= universal agreement.

Corresponding Tailored SBAR Form and Guideline Modifications

The tailored SBAR form and the Maternal Psychosocial Health Information Transfer Guideline were modified based on the final content validity results and the experts' feedback. The tailored SBAR form and guideline were modified to include the revised items and exclude the items that scored below 0.78. 'Knowledge of baby's development' was revised in part for clarity; therefore, the corresponding protective factor (knowledge of baby's development) was amended accordingly. Some of the experts also provided general comments and suggestions regarding the usability of the tailored form.

Description of General Comments and Suggestions by the Experts and Steps Taken

One expert (Expert_1) suggested to combine items that were perceived as similar such as CFSA involvement (open file and investigation) and elements of attachment (attentive and responds to baby) in order to shorten the length of the tailored form. Expert_5 and Expert_6 suggested adding specific exemplars to the guideline. The guideline was amended to include the suggested exemplars (i.e., personality and eating disorders, self-harm, agitation). The suggested amendments are further explored in descriptions of Phase Two of the study.

Feedback was provided on the usefulness of elements within the background (maternal strength) and recommendation sections. Experts expressed differing perspectives about the maternal strengths section. Expert_5 suggested emphasizing the maternal strengths section while Expert_1 questioned the usefulness because of the described similarity between the risk and protective factors. The background section was designed to include both maternal concerns and strengths to facilitate communication about the woman's overall adjustment to life challenges.

The experts' feedback and intent of the design were considered in amendments. A decision was made to revise the prompt for completing the assessment section to reflect both

concerns and strengths and to facilitate a better understanding of the link between the background and assessment sections. The question 'What do you think the concerns are?' was amended to 'What is your assessment of the overall situation? Consider concerns and strengths'.

Feedback was also received regarding the recommendation section. Expert_6 wrote that the recommendation section may potentially create an *"increase strain"* between the acute and community care settings because a recommendation may be perceived as a *"directive"*. The prompt and instructions to complete the recommendation section were also modified to minimize the possibility of this perception. The prompt and corresponding instructions were amended from 'What do you think the community healthcare provider needs to follow-up on?' to 'What do you suggest community healthcare providers may want to follow-up?' End-users' perceptions about the usefulness of the maternal strengths and recommendation sections were explored in Phase Two of the study.

Design components of the tailored SBAR form were also revised to reflect suggestions provided by the experts. One expert suggested that the items could be reordered in *"a sequence that reflects the highest risks"* seen in the community because this may *"help[s] staff who are completing the document to develop the focus on concerns that the community already knows can be a problem" (Expert_6).* The sequence of the items was amended according to the level of the I-CVI scores and the feedback received. As suggested by the experts, additional space was added to the situation section (Expert_4, Expert_5) and assessment section (Expert_6).

Overall, the experts provided positive feedback. One expert wrote *"the form overall is SUPERB" (Expert_3)* and that the form included an *"extensive list of factors" (Expert_4).* Two of the experts (Expert_3, Expert_5) suggested that the tailored form may also be useful to transfer information between other inter-professionals and care settings. Expert_5 commented

that *"this communication tool would work well here as well. I would like to implement it tomorrow if I could"*.

Summary and Implications for Phase Two

Results from Phase One informed development of the tailored SBAR form by establishing content validity through an iterative process. The CVI was compared to the modified kappa evaluations to confirm reliability of this study's findings. Consistent with Polit et al. (2007), the CVI results corresponded to the modified kappa evaluations and at the same time provided both item (I-CVI) and scale level (S-CVI/Ave) evaluations. Both CVI levels provided clarity about the overall content validity and therefore were important reported measures (Polit et al., 2007). Thirty-six items were reduced to 33 of which four items were revised following the initial CVI evaluation and expert clarification. The final CVI results demonstrated both excellent item (I-CVI ≥ 0.83) and scale level (S-CVI/Ave = 0.92) content validity of the revised tailored SBAR form. Universal agreement calculations were reported for transparency reasons; even though, this measure was considered overly conservative and may not truly reflect the overall representativeness of the items (Polit et al., 2007).

Findings from Phase One informed Phase Two of the study which involved further evaluation of the SBAR form. CVI findings along with general comments and suggestions provided by the experts were integrated and used to modify the tailored SBAR form and accompanying guideline. Comments from the experts also generated topics that were further explored in the Phase Two focus groups discussions. These topics included: the usefulness of the recommendation and maternal strengths section; amalgamation of similar risk factors; sequence of risk and protective factors; and the usefulness of multiple exemplars in the guideline. Perceptions of front line clinicians were sought during the focus group interactions to

assess barriers and facilitators and gain understanding about the usefulness of the tailored SBAR form. In the following chapter the focus group results from Phase Two of the study are presented.

Chapter Five: Phase Two Focus Group Results

The third step of the KTA cycle, assessment of barriers to using knowledge, is informed by the Clinical Practice Guidelines Framework for Improvement and Diffusion of Innovation theory (Straus et al., 2009). Several conceptual barriers identified by Légaré (2009) were initially considered when designing the tailored SBAR form and developing the research instruments. The Diffusion of Innovation theory (Rogers, 2003) was particularly applicable as this theory outlines barriers related to the attributes of the innovation (relative advantage, complexity, compatibility, trialability, observability).

In Phase Two, both barriers and facilitators have been further assessed. The results from Phase Two have brought greater understanding to the usefulness of the tailored SBAR form and provided insight into the factors that may influence the uptake of the tailored SBAR form if implemented into practice. Phase Two of this study and its fit in KTA framework are represented in Figure 6.

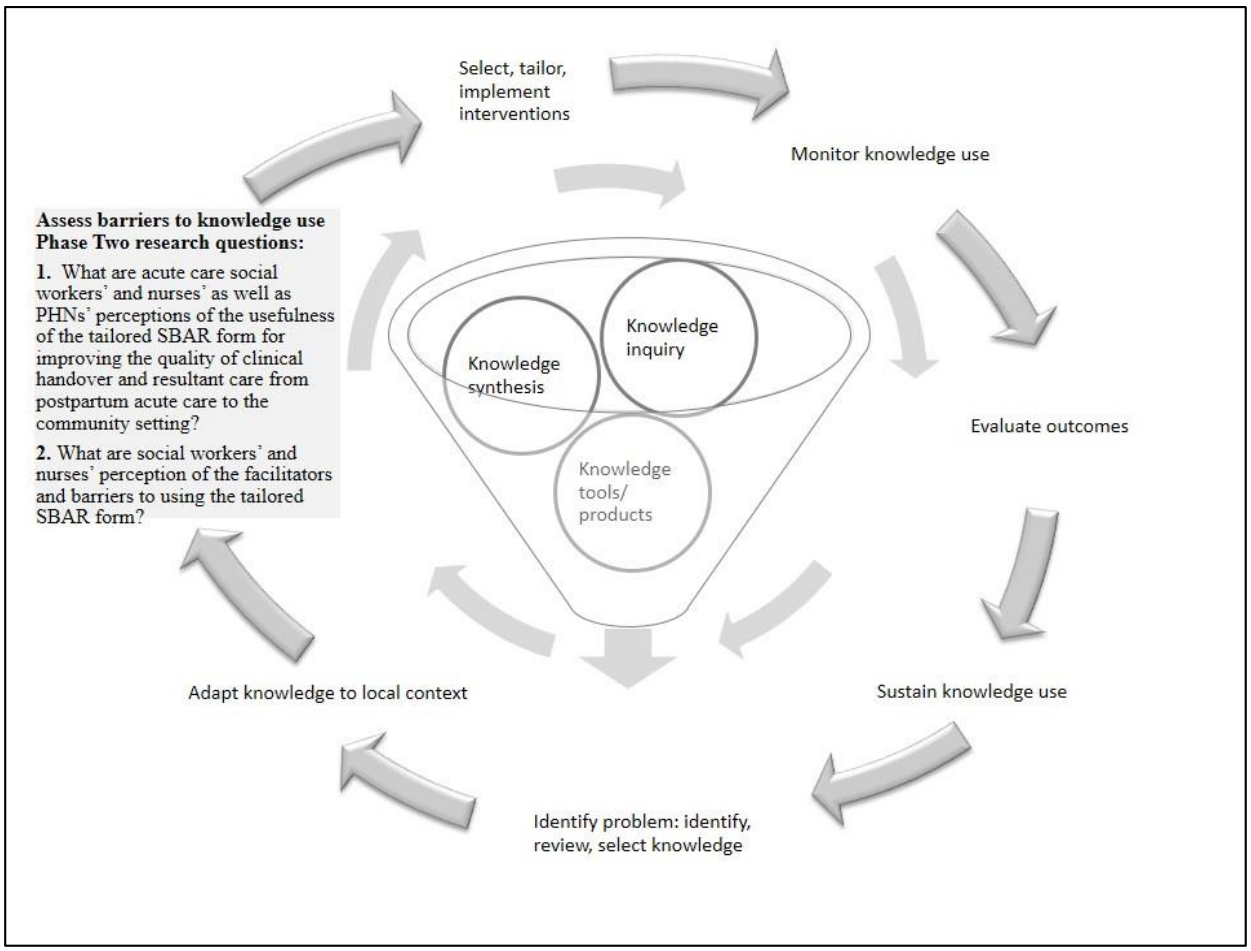

Figure 6. Study Phase Two embedded in the KTA framework (see Footnote 2).

In this chapter, quantitative and qualitative findings from the focus group interactions are presented. Themes related to the usefulness of the tailored SBAR form are identified. Findings from Phase One are compared to the focus group findings to strengthen understanding. Results from the questionnaire and the focus group discussions were triangulated to gain an enriched understanding of divergence and convergence of themes. Missing questionnaire responses were also noted; however, a pattern was not identified.

Characteristics of the Focus Group Participants

Six focus groups were conducted in which a total of 37 providers from both the acute care (N=14) and community (N=23) postpartum care settings participated. Acute care participants included RNs (n=5), LPNs (n=4), and social workers (n=5), whereas community providers were all PHNs. All focus group participants were female; however, there was diversity within the participants in terms of education and experience. The majority of participants from both care settings held an undergraduate degree (78.4%, n=29). There were also participants who held a diploma (16.2%, n=6) and Master's degree (5.4%, n=2). Different to acute care, all PHNs at a minimum held an undergraduate degree. The majority of acute care RN participants (60 %, n=3) and PHN participants (69.6 %, n=16) had greater than 20 years of experience, whereas all LPN participants had nine years of experience or less. Years of social work experience ranged from one to greater than 20 years of experience. Participants' years of experience have been summarized in the following table.

Table 3

Summary of participants' years of experience

	% (n)				
	Years of experience				
Profession	Greater than 20 years	15-20 years	10-14 years	5-9 years	1-4 years
Acute care participants (N=14)					
Registered Nurse	21.4 (3)	0 (0)	0 (0)	7.1(1)	7.1(1)
License Practical Nurse	0 (0)	0 (0)	0 (0)	21.4 (3)	7.1(1)
Social Work	7.1(1)	7.1(1)	7.1(1)	7.1(1)	7.1(1)
Public Health Nurse (N=23)	69.6 (16)	13.0 (3)	13.0 (3)	4.3 (1)	0 (0)

Description of Findings from the Questionnaire and Focus Group Discussion

Three main themes and several subthemes emerged from participants' descriptions about the usefulness of the tailored SBAR form including: perception of the characteristics of the tailored SBAR form; professional judgement and comfort level regarding sharing information; and motivational factors for using the form. Although the various themes were unique, they were interrelated to one another. The figure below depicts the themes and subthemes related to participants' perception about the usefulness of the form.

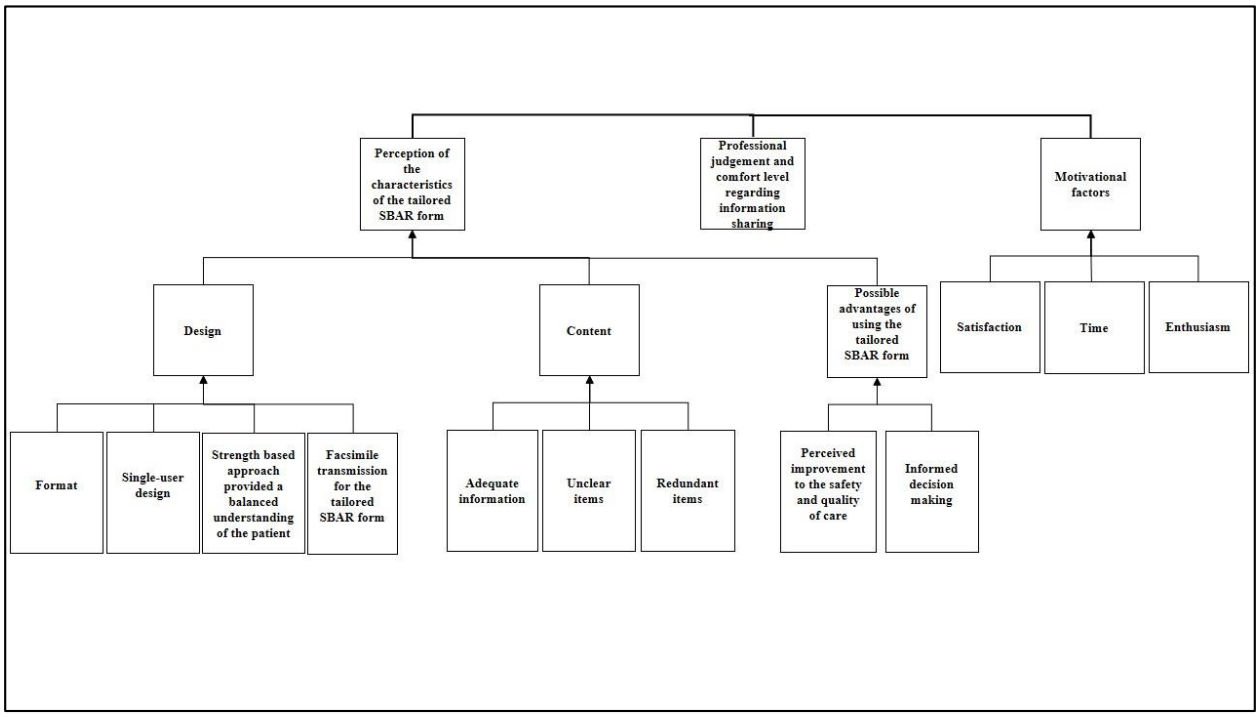

Figure 7. Themes and subthemes related to participants' perception.

Main Theme 1: Perception of the Characteristics of the Tailored SBAR Form

Participants' perception of the characteristics of the tailored SBAR form emerged as a strong theme when describing the usefulness of the SBAR form. Participants' description of the SBAR form was directed at the design, content, and possible advantages of the form.

Subtheme 1: Design. The vast majority of participants described the overall design of the form favorably. The format and strength based approach were features that were viewed as positive. Some participants also disliked certain elements such as the single-user design and facsimile transmission of the SBAR form.

Design subtheme 1: Format. Format was one of four subthemes identified under design. Many participants described the form as easy and efficient to use and indicated that the form facilitated clear and concise communication; although, the amount of space to provide details somewhat constrained communication. Questionnaire responses are detailed in Table 4 and Table 5.

Table 4

Acute care participants' questionnaire responses related to format

	% (n) N=14		
	Yes	No	Missing responses
The form is easy to complete	100.0 (14)	0 (0)	0 (0)
The form is user friendly	100.0 (14)	0 (0)	0 (0)
The reason for completing the form is clear	85.7 (12)	7.1 (1)	7.1 (1)
The instructions on the form clearly guide how to complete the form	78.6 (11)	7.1 (1)	14.3 (2)

Table 5

PHN participants' questionnaire responses related to format

	% (n) N=23		
	Yes	No	Missing responses
The form is easy to read	91.3 (21)	8.7 (2)	0 (0)
The form is user friendly	100.0 (23)	0 (0)	0 (0)

All participants (100%, n=37) identified that the format of the tailored SBAR form was user friendly. Most nursing and social work participants from acute care reported that the reason for completing the form was clear (85.7 %, n=12) and the instructions on the form clearly guided how to complete the form (78.6 %, n=11). All of the acute care participants (100%, n=14) and 91.3% of the PHNs (n=21) agreed that the form was easy to use. Eighty one percent of the study participants from both care settings (n=30) also either *agreed* or *strongly agreed* that the form was not too complicated.

During the focus group discussions, participants elaborated on the use of the form. Participants indicated that the SBAR form was user friendly given its check box format which was *"better than using the blank sheet" (P_12).*

> *I liked it a lot. I think it would be easy to use, to fill out and it's easy to read… I think it's a very good form. (P_31)*

> *I thought it was very easy to use. I liked the checkboxes and then you can elaborate and just give a detail of that, what you checked off… a little blurb to say what's relevant… (P_30)*

Although most liked the check box format, a few had reservations. One participant pointed out that an unmarked check box could mean either not a concern or not assessed and explained that this could lead to miscommunication: *"… Sometimes when they're [check boxes] not checked off you're thinking, it was checked, they already assessed it but it wasn't a concern" (P_27).* A suggested revision was to add an 'unknown' check box to clearly communicate that the item was not assessed.

Only two participants commented that the format was difficult to read:

> *… I find it hard to read [because] it's too much information and too, too many lines and little boxes. So what I like to read, really, and I, and I think it's great, like I like the structure and I like all the content, but I like the paragraphs… so more like a narrative.*

> *It's easier for me to read than a lot of little boxes. But I am notorious about forms. (P_33)*

Focus group participants also suggested the need for more space following the check boxes to document detailed patient information. At the same time there was concern about lengthening the form:

> *There would be need to be just a bit more spaces for actual writing stuff. (P_7)*
>
> *But is this enough of a space just to write briefly that there is something with a partner …? (P_15)*

Several participants identified that the format of the form was conducive to facilitating clear and concise communication between care settings. A large majority of PHN participants (87.0%, n=20) identified that the recommended plan of care was clear. Participants reported that the check boxes facilitated clear communication which would *"at least minimize misunderstandings about things …which helps communication" (P_25).* Other participants suggested that *"it'd be a lot clearer than [the existing form] currently is" (P_8)* and *"[it would] be more specific" (P_7).* An acute care participant pointed out that clear written communication is important because *"you're not having face to face communication with the postpartum nurse" (P_13)* and that *" we all bring our personal bit to communication, right, our personality changes things (P_13).*

In addition to facilitating clear communication, it was evident from the focus group discussions that, overall, participants believed that the tailored SBAR form facilitated concise communication:

> *I like that you check here on this page only the concerns that apply. It just makes it easier, right, we just, we're, that's what we need to know and so it, it's brief and it gives us what the concerns are. I really like that. (P_31)*

> *Yeah, it's pretty good. Something too is, is we're always in such a hurry. It's, it's nice to be able to have this broken down into, little bits, we don't have to try and express the concerns in 5 pages of notes …looking at that blank page going I don't know what to write in there. (P_12)*

> *…It's to the point and I think that's really good. (P_22)*

Design subtheme 2: Single-user design. The tailored SBAR form was designed for either nursing or social work staff to complete. This design was identified as a barrier to information transfer by participants from both care settings. Acute care participants agreed that they *"wouldn't want to introduce another form just for nursing" (P_8)* or *…"social work" (P_7)* and suggested that the form include *"multiple signature boxes" (P_4)* to facilitate a multi-user design.

Acute care participants agreed that nursing and social work have a shared scope of practice and that both professions may contribute to components of a psychosocial assessment for the same mother. Participants suggested that a collaborative approach to completing the form would offer *"…much more insight into what's going on too" (P_7).* Some acute care participants indicated that social work may focus on domains such as the mother's support network while nursing may have more of an opportunity to assess parenting:

> *We know about the mom's coping skills…and her baby interaction. We might learn something about her support network when [social work] talk to the mom. (P_6)*

Others described this shared scope of practice and provided an example where nursing may manage the concern and therefore a social work referral may not be necessary:

> *And they then will fill some things out that we might not. Like if someone is on a current antidepressant and another, the nurse says, you know, have you thought about postpartum? Yes, I didn't have it with my first child, I don't feel I'm at risk. I have a counsellor. They may never refer to us even though it's something… (P_2)*

Many participants indicated that completing the form on an ongoing basis during the hospital stay could improve the accuracy and completeness of the patient information in addition to improving patient and provider satisfaction.

> *Yes, because usually when the mom is discharged or there's a plan for discharge for the day and Social Worker sees them there's also still the discharge nurse that completes everything. So like if there's something that the Social Worker missed like then we could just probably add it up here…and then we could just sign our name. (P_10)*

> *…if it could be… an ongoing process … I mean they're receiving a lot of information and very quickly. I think it'll make patients more receptive to us if we [kind of] do little chunks… (P_13)*

> *…I was just thinking of the number of times when I worked in the hospital where I would be thrown into a situation where I had to discharge a baby and I didn't know them from, I didn't know them at all…how accurate and how quickly would [it] be if I was just thrown in and had to fill it out so I don't know… if there was a….a big history, same thing, here I am with a half an hour… (P_36)*

One participant suggested that it may be useful to have the *"first person who notices something pick[s] it up and start[s] it" (P_33)* because some providers may be more familiar with the mother than others:

> *…one nurse might work with a patient for two days, know her very well, the third nurse comes on, doesn't know anything about this with a morning discharge and she hasn't, doesn't know the patient very well…And sometimes I think people feel, well, like, I don't know this patient that well, I don't really feel like writing this down [because] I, you know I hadn't really validated or checked it further but I often say well, you know, this woman's going home in 24 hours, if you have something that you think is valuable write it down …like everybody has to write their little bit if you hear something that's important. (P_4)*

Design subtheme 3: Strengths based approach provided a balanced understanding of the patient. The design of the tailored SBAR form included a strength based approach to facilitate an overall understanding of the family's needs. Participants across all groups (85.7% of acute care participants, n=12; 91.3% of PHN participants, n=21) either *strongly agreed* or *agreed* that information provided on the form would increase participants' confidence about their

understanding of their client. A preference for the strengths based approach was evident in all focus group interactions. One participant commented that: *"I thought that was good. I liked the way it [the form] was divided into concerns and then strengths" (P_15)*.

Participants elaborated on how the strength based component of the design facilitated an overall understanding of the family's needs and may provide an*"… overall picture, this is what's already happened, this is where I need to go" (P_5)*. Participants also suggested that identifying both risk and protective factors on the form may shift thinking from a more negative to positive understanding of the situation and possibly offer a more balanced view:

> *It also helps us kind of validate the patients in this is your experience, this is what you're already doing, instead of continuing to constantly focus on all of the negative stuff and not saying, hey, you're doing a good job with this. So it [kind of] gives you that, again, that mind switch that we can acknowledge that and that's a good thing. (P_5)*

> *I like the strengths [because] it's so seldom addressed. We only, only see the negative stuff about this family and this mom whereas, you know when you think about it they always have three or four things that are, that's really in their favor. So I think it's good for us to bring that out and think about it. (P_4)*

> *And so you read all the bad things and you go oh, my God, but then you, but if there's something positive it's like oh, okay, gives you a better, a bigger picture… (P_36)*

Several participants described how the strength based approach provided an understanding of patient's level of risk which in turn could inform decision making for planning care:

> *…it's a clue-in to their potential for postpartum depression too. (P_8)*

> *I think both, both pages depending on how many ticks are, are marked off on the concerns but also under the strengths section what resources are already in place, like perhaps they're already quite connected or maybe they're not connected at all. It'll kind of set you up to know. (P_28)*

> *I think you just don't focus so much on all the bad stuff, right. Like, you're more aware of what they've got going on and then you try to build on…their current supports to help them be more successful… (P_7)*

> *It pinpoints where, where the client is at right now…like she has support from her mother that would have been good to know too that she's living and she is taking her medication so she's, that tells you that she's receptive to the information, she's getting counselling, she's dealing with the problem. Like, so this gives you, and she's aware of the resources that are available, it tells me she's on the track to dealing with her problems. (P_17)*

Design subtheme 4: Facsimile transmission for the SBAR form. A fully integrated electronic health record does not currently exist within Alberta Health Services. Therefore, facsimile transmission would be used to transfer patient information on the SBAR form and appropriate measures would be in place to ensure security of the information being transferred. A few participants from both settings felt that a hand written fax method of communication could be a potential barrier to information transfer due to confidentiality issues and the potential need to repeatedly fax the form. Participants explained:

> *And I wouldn't have a problem like, if Public Health called me then I could tell them like, that's not the issue, it's just I would be worried that, you know. And too if this got faxed accidentally or something, you know, you just wouldn't want that information out there either about a safety plan. (P_7)*

> *So sometimes…it is a problem when we're faxing and refaxing that every time we refax it, it can become a problem to be able to see it. (P_21)*

One PHN participant noted that in practice acute care providers seem more comfortable with sharing certain information, such as assessment, verbally rather than through documentation *"... they'll tell you stuff they won't write down but it's really what they think" (P_27).*

Acute care participants from two different groups suggested a possible revision to include *"safety plan: yes or no. Maybe it could be a check box" (P_8)*. A check box was perceived to potentially trigger PHNs to complete a further assessment:

> *...if it was checked off Safety Plan in Place…and it's checked off I think it would prompt the Public Health Nurse to…make sure that she knows…what the safety plan is. (P_14)*

A few participants also suggested that an electronic health record could be a beneficial method of transferring information. As one participant stated: *"That's why electronic records would be so handy [because] then they could just log in and see my notes and then that'd be it, right" (P_7).*

Overall, participants liked the design of the tailored SBAR form; however, a few barriers to using the form were also identified during the focus group interactions. Suggested design revisions are identified in Table 6.

Table 6

Suggested design revisions described by participants

Theme	Suggested revision
Format	A few suggested to add 'unknown' box to communicate that the item was not assessed Several suggested to add space if possible: particularly to 'situation' section and 'psychosocial risk factors of partner'
Single-user design	Several suggested to add multiple signature boxes and then alter guideline procedure to reflect collaborative design
Facsimile transmission for the tailored SBAR form	Several suggested an electronic health record Some suggested to add a 'yes' and 'no' check box to 'Safety plan in place'

Subtheme 2: Content. The second subtheme of perceptions of the characteristics of the tailored SBAR form was content. Three subthemes emerged from content including adequate information, unclear items, and redundant items. Questionnaire results regarding the content of the tailored SBAR form have been summarized in Table 7 and Table 8.

Table 7

Acute care participants' questionnaire responses related to content

	% (n) N=14		
	Yes	No	Missing response
The design of the form is useful to guide what information Postpartum Community Services needs to provide care	100.0 (14)	0 (0)	0 (0)
The form guides me to clearly identify which patient situations require the form to be completed	100.0 (14)	0 (0)	0 (0)
The form provides consistent information for each patient	92.9 (13)	7.1 (1)	0 (0)
The form requires me to provide too much psychosocial information	14.3 (2)	71.4 (10)	14.3 (2)
The form requires me to provide sufficient psychosocial information	92.9 (13)	0 (0)	7.1 (1)
The form requires me to provide too little psychosocial information	0 (0)	100.0 (14)	0 (0)
Important psychosocial patient information is omitted on the form	0 (0)	100.0 (14)	0 (0)
The recommended plan of care is sufficiently documented on the form	85.7(12)	7.1 (1)	7.1 (1)

Table 8

PHN participants' questionnaire responses related to content

	% (n) N=23		
	Yes	No	Missing response
The design of the form is useful to direct what information I may expect to receive from acute care participants	87.0 (20)	4.3 (1)	8.7 (2)
The form provides consistent information for each patient	95.7 (22)	0 (0)	4.3 (1)
There is too much psychosocial information on the form	0 (0)	100.0 (23)	0 (0)
There is too little psychosocial information on the form	17.4 (4)	82.6 (19)	0 (0)
Important psychosocial information is omitted on the form	17.4 (4)	82.6 (19)	0 (0)
The recommended plan of care is clear	87.0 (20)	13.0 (3)	0 (0)

Participants identified that the tailored content was useful to guide both communication and assessment. All acute care participants (100 %; n=14) reported that the form clearly guided what information to transfer to the community setting and for which patient scenario. Similarly, 87% (n=20) of PHN participants indicated that form was useful to guide what information PHNs could expect to receive. During the focus group discussions, participants further described how the tailored content of the form provided a visual prompt which could guide information transfer between the settings. This was seen to be important due to the busy work environment:

> *I think it [the form] really structures exactly what you need to focus on… And so it would help in that sense…of this is the relevant information instead of going through the whole history, it just, it sets it out for you, this is what I need to tell them. (P_5)*

> *…specifically for Acute Care, given that they're also busy… I think it also serves as a learning tool for them to see what information is valuable and what we're actually looking for. So if maybe there was a gap in that in terms of what we are looking for under the patient history, this, this set up and the way that it's laid out gives them an idea of possibly what maybe they, has been missing in terms of the transfer of information. (P_24)*

> *I think it's [going to] focus the acute care setting on the information and details that we need to do our job well and I don't think that they know that and I don't expect that they would. We don't always know what other services do and so this actually focuses what our needs are from them in terms of communication… they don't really know what you need to know but this kind of demonstrates to them… they want to know this information for continuity of care so great… This is a great way to glean the information from their notes that we need to know. We might not get it all but we're getting way more than we would otherwise… (P_29)*

In addition to guiding communication, participants described the content of the form as being useful for guiding assessments and facilitating recall. Many participants believed that the tailored SBAR form could create a balanced awareness between the psychosocial and physical needs of mothers and improve the adequacy of information transfer:

> *I think it would be on our mind a lot of more instead of, like I said, we're in such a rush, we get the, the bleed feed, bleed feed, we just get that. You know, unless there are other, you know, like the big issues, the standout flags, right, but this I think would, would*

> *definitely make us more aware, just having that. You know. And as far as the time involved, like, I don't think it would be feasible to do on every single patient. But if we did have concerns… (P_13)*

> *Useful in the sense that we're able to transfer a lot more information and it gives us that opportunity to really start thinking about the psychosocial cause as an RN on the floor, it's really easy to get caught up in all your tasks and let that kind of fall to the wayside until you see a flag in the chart or something really obvious stands out. So I like that, that having that there just gets you [kind of] thinking about needing to assess those things a little bit more. (P_5)*

> *It's kind of like a good little kick [to] your brain; give[s] you more of a point form, [kind of], okay, you need to look at these points… instead of just going, okay now brain, like, you've just seen like, 18 different people, now what do you remember about this one person. (P_12)*

> *And I just think it cues you too, like, once you get familiar with the form it would cue you, you know, a newer nurse or one that wasn't as experienced as to what to watch for or questions to ask, history to ask. (P_35)*

Participants also indicated that information transferred on the tailored SBAR form could help guide and tailor PHNs' assessment:

> *I think your assessment will be more tailored instead of maybe asking them, tell me about your financial situation, are there any concerns there might be, I understand that there are concerns, how can we best support you. Like you, you already, you know that's a concern and so you already know what is in place, tell me about you know your use of the Food Bank, have you found that helpful, what else can we build on that as opposed to do you have any food concerns, you already know… (P_24)*

> *…I think the part that talks about, you know the, what's required in the community…the issues that have, that have been identified by the parents as well because we're wanting to go from, from what their perspective is, what are they needing. And this is giving you a good idea of what they're identifying…their needs as being. (P_26)*

Participants from both acute care and the community settings suggested the form provided a consistent way to transfer psychosocial information between the settings so *"...that we're all doing the same thing" (P_12)*. The majority of acute care (92.9 %, n=13) and PHN participants (95.7 %, n=22) also reported that the form provided consistent information for each

patient. Participants further described how the form could facilitate consistent information transfer:

> *…more consistent than right now, we get the, the Social Worker, some, some of it all but not all, so just the consistency of the forms filled out for the socially at risk population. (P_23)*

> *It's great because it's, it would make everybody do the same, ask the same questions consistently to clients, which I don't feel is currently being done…in acute care. (P_15)*

> *Forces people to think of the different topics that [PHNs] would want to know about. (P_29)*

Participants also talked about possibly altering the sequencing of items in the background section to improve the flow of the form. Based on the results from Phase One, the sequence of risk and protective factors in the background section was modified from the original design. Likewise, there were a few participants in this Phase that suggested additional minor sequencing changes:

> *The other at the bottom of the first page, if that could be just moved up and put before the Child and Family Service involvement. Just because if there is something else that comes…up the other looks like it's part of, the way I see. (P_24)*

> *… I still think if I was a person filling this out I might be ticking Anger Management and Incarceration and thinking of the father, even though it says Maternal Concern. I might not have gotten that if I was initially starting to use this form. (P_17)*

> *Maybe just put this partner piece in a different spot, just to separate it out a little bit more. (P_15)*

Content subtheme 1: Adequate information. Overall, participants from all focus groups indicated that the tailored SBAR form adequately covered required psychosocial information. Participants from both care settings described the content of the tailored SBAR form as comprehensive. One participant remarked: *"I think it's nice… comprehensive, I think you got it all" (P_29*). The majority of nursing and social work participants from acute care (92.9 %,

n=13) reported that there was sufficient psychosocial information on the form. None of the acute care participants and only a few PHN participants (17.4%, n=4) identified that there was too little psychosocial information on the form. A few acute care participants (14.3%, n=2) identified that the form required too much patient information; whereas, none of the PHN participants reported that there was too much information. Several participants further described the adequacy of information:

> *I think it's great in terms of all the important topics are being addressed. (P_7)*

> *It certainly gives us more information. Way more than we would get now in a lot [of] instances. So it's great that way. (P_25)*

> *…going, from this side as a Public Health nurse, I go, my goodness, this is all the stuff that we have been asking for, for a long, long time… (P_22)*

Although the content was described as adequate overall, there was no consensus. On the questionnaire, only four PHN participants (17.4%) and none of the acute care participants indicated that important psychosocial information was omitted. During the focus group discussions, participants identified scenarios that may not be captured by the SBAR form (i.e., adoption and apprehension, family dynamics, prenatal acute care social work referrals).

A few acute care participants discussed the possibility that scenarios related to adoption and apprehension of the newborn may not be captured by the form:

> *I would like adoption by itself [because] you know that I'm partial to…that type of work and it, and it does have its own particular issues. (P_11)*

Conversely, PHN participants believed that items related to adoption and apprehension were adequately captured on the standard provincial form that is transferred to community providers for all births and therefore, one provider remarked: *"I don't feel like that's a huge thing" (P_37).*

When describing the adequacy of information, participants explained that items on the form were sufficiently flexible to capture diverse scenarios (i.e., current stress level, coping skills, mental health, parenting, substance use, cognitive challenges, risk factors of partner, and the assessment). Participants provided multiple exemplars to describe possible scenarios that could be captured by existing items on the form. Many participants believed that current stress level was *"a really good marker" (P_25)* to capture multiple scenarios:

> *My person wrote single parent under Current Stress Level. (P_33)*

> *If it, if it was truly a concern for her, I mean you could tick off the Current Stress Level, right because if she came in with a birth plan and ended up with a C-Section under general, I mean obviously she's [going to] be stressed about that so I mean that's, you could just tick that off and elaborate on the assessment. (P_15)*

A few participants perceived the need to add 'family dynamics' as an item, whereas other believed that this item was already be captured by the form. Some participants preferred that situations related to unhealthy relationships among family members be captured by *"…a check box with family dynamics" (P_9).*

> *One of the things that I'd like to see in that area is 'others in the home' because you may have… a grandmother who's abusive to the new mom, or whatever, you know, somebody else that's living with them that's causing financial stress… (P_22)*

> *…the in-laws don't talk to her but they live with her. (P_7)*

Poor parenting of other children in the home was also perceived as an important family dynamic because this could be an indicator relevant to *"…having a new baby in the home and their ability to adjust to it. It's also a heads up for the transition that's coming for that child (P_11).* Although 'family dynamics' was perceived as important, participants reported that items such as 'coping skills', 'current stress level', or 'other' could adequately capture the impact of poor family dynamics. One provider remarked: *"I don't think you need another box" (P_27).*

Parenting and attachment were domains that also captured various scenarios. One participant questioned whether the form could capture scenarios regarding mothers whom as children required child protective services:

> *…what about our little gals that are raised in foster homes themselves, you know and they…that's just a piece of their problem but it, it's hard to capture. They didn't, never had consistent parenting models themselves. (P_8)*

Whereas others believed that if there were concerns related to lack of role modeling, the parenting and attachments domains could capture this scenario: *"Well there's that whole attachment piece right…" (P_7).*

Unplanned pregnancy, safety concerns as well as childhood trauma and sexual abuse were identified scenarios that could also be captured by various domains.

> *Would that not be captured in the second page under you know, coping skills and acceptance of the baby, attentive, like how they're actually coping with being a new mom rather than putting that as another separate. I think we have to be really careful here that we don't start adding a whole bunch of extra boxes and make it, you know, too cumbersome for the staff that are doing it. So I think keeping it simple… (P_22)*

> *I remember one of the, one of the families we had, it mentioned on there that the, that the partner was very abusive toward the staff so that would be…you know, a perfect place to put that in.(P_26)*

> *I've been following her for a while… it even affected her relationship with baby's dad and they ended up separating so it was all, that childhood was such a huge factor [because] it did influence parenting and relationship and mental health. (P_23)*

Participants described the situation, background, assessment, and recommendation sections of the form as largely conducive to transferring adequate information. Approximately 86 % of the acute care participants (n=12) indicated that the recommended plan of care was sufficiently documented on the form.

PHN participants indicated that the main concern described in the situation section was useful because this section provided cues to transfer more detailed information, especially in situations when social work had not assessed the mother:

> *I think it's helpful the 'Social Work Referral Declined'. I mean, some, in our little box on our thing it just says whether they had it or not, even if they do a lot of times, that's not marked off… But here, if, this is good, I like this, that if they declined it, or other… (P_25)*

> *…the nurse might actually think, oh, maybe I should actually check off these things… and transfer that information to us, whereas in the past they might have just said, you know, did not see Social Worker, but they didn't necessarily explain why they didn't. (P_18)*

There was disagreement about whether or not to add an item in the situation section that specifically identified scenarios where a referral to the acute care social worker was completed prenatally. One acute care participant believed that providers may not be prompted to include prenatal acute care social work referrals because the main concern:

> *…could be different than what was the initial referral because if we have, say we go see a patient because we have three alerts, which can be common, you can have an alert from Best Beginnings, you can have an alert here from triage and you have an alert from ER over at whatever, but that's not the concern… So that can give you a little bit of better sense about why we're going into someone's room. (P_1)*

Conversely, others suggested that the form would capture this type of scenario.

One participant was also concerned about how to communicate that CFSA completed the assessment and direction was given to the acute care social worker by CFSA not to complete the assessment:

> *…our feedback is how can we capture in this [what] the direction from Children's Services has been, they will do the assessments, that it shows why there's the gap because I think if you look to us and say well, this is a serious referral but you don't have a lot of information… (P_2)*

Others suggested that this scenario *"could be in the assessment piece I guess or action taken" (P_1).*

A simulation exercise was part of the focus group interaction. PHN participants' experience with using the tailored SBAR form during the simulation highlighted that the adequacy of information transferred was also dependent on *"who fills out the form... the legibility and their attention to detail" (P_29).*

> *The person that filled mine out did a fairly good job. (P_18)*

> *Mine just said that it, they were referred to Community Resources. I would like to know which resources they were referred to. (P_15)*

Additionally, participants from both settings described how a lack of awareness of the family's home situation could inadvertently influence the adequacy of information transferred:

> *There's always [going to] be missing information [because] you have no idea what their home situation is [going to] be…and people act differently when they're in the hospital than what they're [going to] be like in their own home environment. (P_12)*

> *They're not seeing her in her own environment and what's going on in her own house, and maybe there was something happening at home that, you know, she was able to forget about it in hospital because she wasn't there and she goes back home and it, you know, hits her right in the face and she's like, oh but this is really stressing me out. So it, it, the environment is very different. (P_26)*

> *…if it becomes that we use this form that we as Public Health Nurse realize that this isn't everything about the client, right because I think we get a form and we start to think oh, okay well they've done it, right, that we're, you know, that this is just a start and that the nurse in the hospital might not have known, or the patient didn't say, yes, my husband's part of a gang right. Like they didn't divulge that information, right, so, [because] it's, really in the end, comes down to what the client is [going to] offer up and lots of times they don't necessarily offer that. (P_18)*

Several participants recognized that the content of the form needed to be balanced between capturing sufficient information and being user friendly. PHN participants identified that information transfer through the form was *"very much needed, on our part" (P_27)* but also recognized it was *"more work for them" (P_32).* For that reason, a few participants perceived the potential need to shorten the length of the form to increase acute care providers' satisfaction:

> *What we would like is it to be buy-in for, for Acute Care so I'm sure there's some negotiation that needs to be done to have kind of a buy-in on their part and that's where I think we could negotiate. I mean, we'd love to have both the pages completely filled but it needs to be tweak to allow for better compliance. I'm all game for it. (P_21)*

> *…if you want people to fill out the form you want it as concise as possible and just the stuff that we agree is super helpful should be on it and anything we're like, well, don't put it on…to increase compliance filling it out. (P_29)*

Content subtheme 2: Unclear items. When further describing the content of the tailored SBAR form, participants spoke about items which were unclear in the situation and background sections (parenting, CFSA involvement) of the tailored SBAR form. A few participants suggested that the scenario could be communicated more clearly in the situation section if the reason the mother was discharged before the social work assessment was documented:

> *So the discharge before the Social Work assessment is helpful I think if you have why, because the why that was missing for me would have actually been a strength, like it, you know what I mean, like, for her, that she went because she had a pediatrician appointment and she prioritized that and that was really important, whereas if I just looked at this ticked off I'd think oh… was she avoiding the Social Worker or did they just discharge her because the hospital needed beds or whatever… somehow the why could be captured there because I did make a value judgment based on that she went before the Social Work assessment… in my own head... As a negative. (P_29)*

The background section of the tailored SBAR form included parenting items in both the maternal concerns and strengths categories. Participants indicated that similar phrasing of the parenting items in the concerns and strengths categories leads to confusion and hence documentation errors:

> *… what am I working on? Is it the strengths, the concerns, and I'm finding myself checking off boxes that should have been checked of the other one and I'm going back and crossing [them] out. (P_4)*

> *…people would make an error there; it [the structuring of the parenting items in the maternal concerns and strengths section of the form] is very conflicting. (P_36)*

> *They put, you know under Acceptance of Baby, Attentive to Baby's needs as a concern on this side, they ticked all of those but then as Maternal Strengths, they ticked them all again…so it's like they don't understand, maybe…(P_25)*

This lack of clarity regarding the parenting items could lead to miscommunication between the care settings. Many participants suggested that parenting items in the 'maternal concerns' section should be negatively worded in order to match the connotation of the corresponding section. One provider remarked *"I think just the negative in front of the concerns would, would help" (P_5).*

In addition to rephrasing the parenting items, some participants suggested combining some items. An expert from Phase One also indicated items should be combined. There were conflicting opinions about combining the parenting items. Although some participants perceived that there was value in combining items, others reported that the items should be kept separate:

> *And even under that area for the baby, it's all good but I'm not sure that we need five check boxes. I mean, it's all valuable information … (P_21)*

> *One of things too was just as far as this block here, with the Acceptance of Baby, Attentive to Baby Needs, Responds Appropriately…I think some of that can be combined. (P_13)*

> *Attentiveness to the baby's needs and responds appropriately, I think those could go together…keep Acceptance separate though because sometimes we have babies that have things that are wrong with them and… it's not like they're not taking care of the baby, but they're not bonding with their baby because they just feel like something is wrong with it. (P_12)*

A few participants disagreed with combining parenting item because the separate parenting items were perceived as an educational tool which could be helpful for inexperienced providers:

> *… I think maybe for the hospital staff too depending on their experience as a health care worker there. Like, if they, if they don't know what Attachment means then for them to just be able to tick it off I think it breaks it down a little bit because attachment can be pretty general, like you can love your baby but do you know how to change their diaper and respond to their needs.. I like that it's a lot space. (P_24)*

CFSA was another item that was unclear. There was extensive discussion in all focus groups about the lack of clarity about CFSA terminology (i.e., name of the agency and level of involvement). When participants talked about child protection issues, the term 'child welfare' was more commonly referred to than CFSA and many participants used the terms interchangeably. Likewise, participants indicated that 'child welfare' is commonly used in practice:

> *It's more cumbersome though so we tend to stick with the, the two words instead of the whole. It is because you get new residents and nursing students and everyone knows Child Welfare. (P_1)*

Participants believed that some providers are more familiar with the term 'child welfare'. As one participant stated: *"I just think our staff will look at that and say, Family Service Authority, who's that?" (P_4).* Some participants suggested that families are also uncertain about the various social work roles and tend to associate social work with child protection agencies. Use of consistent terminology was suggested as a way to differentiate the various social work roles:

> *So it does confuse families. Like when we go in sometimes they think we're the Child Welfare worker or they'll say we're Social Services, we get that term a lot from families and… they get us confused with like, financial programs as well. It's just a really tricky, it's tricky wording. (P_2)*

> *We should eventually get to use this term… (P_1)*

The various levels of CFSA involvement were also unclear among many of the acute care nursing participants. The following quotes illustrate this ambiguity:

> *I don't really what the difference between the open file and the investigation would be…And how long is the file open for, like is it open until… (P_6)*

> *Well investigation, open file to me, to me that's both the same thing. (P_4)*

> *And the Child and Family Services Authority Involvement, I think you could put reported concerns during this hospitalization and then the Social Worker's name because I don't*

> *think nurses are [going to] be able to delineate between investigation, open file, recent history. They're just [going to] use their text. (P_2)*

Different to nursing, all social work participants indicated that they understood the various levels of CFSA involvement. One participant remarked: *"Like we know, we understand exactly" (P_1).* Most PHN participants were also familiar with the various levels of involvement:

> *Well investigating, they're just gathering information. They haven't decided if they're [going to] open a file. (P_20)*

> *And open file, they have identified current concern, a safety concern and so they're working with that family to get supports in place to prevent any harm. (P_15)*

> *...I think until recently I might not know the, the difference of that. I think we're getting more, yeah, like we're just more in tune with system and realize if it's investigation… they're just gathering information, it's not assigned to anybody at this point in time, right. So I think we [kind of] know that … (P_37)*

Many PHN participants described how clear communication about the level of CFSA involvement was useful for planning care. One participant remarked: *"…I really like this open file recent history…That's so helpful [because] it's often it just says Child Welfare involved and you don't know is that now, past, or what" (P_31)*. PHN participants indicated that the level of risk and subsequent plan of care could be different in the investigative versus open file phase.

> *It could be worse in an investigation than an open…they haven't decided or they haven't gathered information so really, realistically it could be an investigation more serious than open. (P_23)*

> *I just think if I knew it was just investigation I'm [going to] go full bore on resources anyways [because] I don't know if they're [going to] do anything, right, so I'd still be doing like, 'Healthy Families', 'Healthy Babies' and whatever stuff, whereas open I kind of maybe correctly assume that their looking after that. (P_33)*

Others spoke about how knowing the level of CFSA involvement had implications for practice such as openly discussing CFSA's involvement with the family:

> *Well the only thing might be is if an investigation, when you're speaking to the client, if it's an investigation they may not know it's an investigation. But if it's an open file you know the woman would know it was open. (P_21)*

> *I think the concern for me is if it's an investigation what I've learned is I won't bring up Child and Family Services involvement because the client may not be aware yet of the involvement in the investigation phase [because] I've had that unfortunate experience…of talking about it with the client and she was like, oh, I have Child Welfare. So, whereas an open file she will know she has Child Welfare. (P_29)*

> *…if it's an open file then she's probably working on things, and you can help her work on those things that, that are, have been identified… (P_30)*

Another participant described how communication with CFSA may differ depending on the stage of CFSA's involvement:

> *… your intention is to help them with their process and help the client, right… so an open file I would call them prior to the visit and see if I could discuss it with them and an investigation I would not. I would call them after and share what I felt was relevant… so I would operate differently. (P_29)*

'Recent history' was also an ambiguous item for many participants from both care settings despite being defined by the researcher:

> *I think maybe you could just put history and then specify like when, when the history was because even recent history…It's vague. I don't know if that means in 5 years or 10 years or two. (P_3)*

> *They put open file and recent history so I was actually wondering what Recent History meant, do you mean past history now closed [because] that might be more accurate. (P_33)*

In contrast to experts' descriptions in Phase One, numerous participants perceived that any history with CFSA was relevant to practice. The subsequent quotes have exemplified participants' preference to include all history:

> *Any previous involvement…with Child Welfare, whether it was a month ago or ten years ago, to me that's Child Welfare… That just comes from an ex Child Welfare worker. (P_7)*

> *…what if she had, like 5 kids apprehended. And the, you know it was 3 years ago, I'd still want to know that. (P_33)*

> *I would like to know historical, period …Sometimes too, we notice on the Notice of Birth there's children missing…and so that can actually tell us, you know, if it's historical maybe they'll think to say, you know, two children apprehended and whatever, and then we can go oh, okay, that's where those two children are because…we go to the home and where's the other 4, 3, 2, whatever, kids and so that could be really beneficial as well. (P_29)*

Participants suggested that scenarios where the mother was once a child in care was important for monitoring parenting skills because *"it's a huge risk factor for parenting"* (P_37). This historical involvement was seen to be relevant.

Following the simulation exercise, a few participants identified that CFSA involvement was not accurately documented on some of the completed tailored SBAR forms. As a result, participants from one focus group expressed concern that ambiguity regarding the terms 'open file' and 'investigation' could lead to miscommunication and negatively influence care. One participant remarked that *"…we'd have to be sure that the person filling out the form really knew the difference…" (P_33).* PHN participants indicated the potential need to clarify the level of involvement with the CFSA social worker identified on the tailored SBAR form prior to providing care. Participants suggested possible revisions such as *"…maybe a past history or a current involvement" (P_3)* to improve clarity. As suggested by participants, a check box for 'current' and 'historical' involvement followed by space to provide details was seen to be user friendly and thereby could minimize the risk of miscommunication.

Content subtheme 3: Redundant items. Participants also described redundant items in the assessment and recommendation sections on the tailored SBAR form. The assessment section consisted of three components: the actual assessment; action taken in hospital; and patient's response. Following the mock scenarios, there was considerable agreement across the

focus groups that the actual assessment repeated information found in the situation and background sections:

> *…I'm just looking at the two and I wrote almost the same thing for situation and assessment. (P_1)*

> *Well the Assessment is kind of already in this checklist and…and it leaves space where you can put little notes. And on the Assessment it, it, a lot of it was, you know, repeating what was in there. There was some elaboration… (P_13)*

> *I almost think it's a little bit of a duplicate from, kind of the situation again we got the assessment, like their synopsis is pretty much identical, at least on the one they filled out with mine they just wrote the same thing for situation as well as the assessment so I don't know if that's almost duplicate charting. (P_23)*

The assessment section was difficult to complete for some because participants were uncertain as to what additional patient information was required and where to document.

> *Yeah, it, that was the hardest part of the form to fill out…because I was trying to figure out what I needed to…fill it in. (P_14)*

> *I didn't fill out the assessment because… I couldn't differentiate that from the situation. I didn't know what to put in there because I thought the information was already there. (P_3)*

Participants held differing views in regards to the value of the actual assessment. Some participants perceived that the assessment added value while others did not.

> *It really sums it up right there that, what the priorities could be. …that's very useful. (P_36)*

> *I think the advantage to the assessment is it gives you that opportunity to really focus on the strengths [because] the situation, typically you're just [going to] put down what you need… (P_5)*

> *But I'm thinking too, in terms of the assessment, the overall situation, that could be a spot where perhaps you've witnessed something and you've seen something, it's a little different that gives you an opportunity to say you know, this is what was witnessed, this is what was seen and, because that will, that will change your perception a little bit as well, in just giving the other piece. (P_26)*

> *Maybe a little bit more detail but not a lot. (P_23)*

... if didn't have it I don't think it would really matter. (P_29)

Overall there was consensus about the need to delete the actual assessment component from this section because of the perceived redundancy, preference for additional space, and time constraints experienced in practice:

I was thinking that if it's redundant that I would just, I would take it out. (P_37)

Unless you said, you just ask for additional comments you didn't have and then leave the Action area to be a greater area to write in. (P_21)

Maybe make the situation spot a little bit bigger…if you take away from this assessment part. (P_30)

... I feel like I'm just reiterating the tick boxes and I'd rather not have to do that… just again, because of time. (P_7)

Although participants found the actual assessment redundant, many reported that 'action taken in hospital' and 'patient's response' in the assessment section were useful:

I like the responses, the patients' responses. (P_35)

I did like the Action Taken though. (P_31)

The recommendation section was also identified by some as redundant which is similar to a response from an expert in Phase One of this study. A few participants from one group indicated that the recommendation section may not be needed for planning follow-up care because the plan could be deduced from the other sections on the form. The same participants suggested deleting the section in order to shorten the length of the tailored SBAR form:

…if you can somehow simplify this form, and I'm looking at this last part where it talks about recommendation, so to apply, support continuity of care, does that really need to be reiterated here when it's already on the front part? I think you can just leave that out and let us as nurses, from the information we get, make our decision as to where we're going with that follow-up. (P_22)

> *I don't know if that is, to me, is useful as just getting the other information [because] I'm [going to] do my own plan and, based on what this information they've given me, plus what I did assess, right… I'm just thinking I probably wouldn't need that just based on this. I could figure that out myself based on, I don't know, because even though you know, mental health may have been addressed, they're on Effexor and whatever, I'm still [going to] follow it up. If they didn't tick it off I still would follow it up. So I mean, they can tell me what to do but I'd probably would do my own thing, right, or suggest things that they want us to do. I'd probably do that and more. (P_27)*

Conversely, participants from the same focus group indicated that the recommendation section could be useful to support learning for less experienced participants and to support patient centered care:

> *... this tool would also be quite helpful for like colleagues or staff that are new to Public Health though too just to help them solidify their care plan, like…they've gone through orientation and I think it's also just through experience that you learn what you need to do. But I think this just solidifies, okay, so this is what the hospital staff have identified, then I know that I need to follow-up with that so I think for new staff that would be awesome. (P_24)*

Revisions suggested by the participants regarding the tailored SBAR form content are outlined in Table 9.

Table 9

Suggested content revisions described by participants

Theme	Suggested revision
	Several suggested minor sequencing changes: move 'other' to area prior to 'CFSA involvement'; change order of maternal risk factors to highlight the difference between 'psychosocial risk factors of partner' and maternal risk factors
Adequate information	A few suggested to add 'family dynamics' A few suggested to add a check box for adoption and apprehension scenarios A few suggested to add 'Prenatal social work referrals'
Unclear items	A few suggested to add 'reason' after 'Discharged before social work referral' Many suggested to rephrase parenting items in the concerns section and combine 'attentive to baby's needs' and 'responds appropriately to baby' Several suggested to combine CFSA 'investigation' and 'open file' to state 'current' involvement Many suggested to change 'recent' history to 'historical' involvement
Redundant items	Several suggested to delete the actual assessment component of the 'assessment section' A few suggested to delete the recommendation section

Subtheme 3: Possible advantages of using the tailored SBAR form. The third key theme that emerged from the perceived characteristics of the tailored SBAR form was the possible advantages of the form. Participants in both settings consistently identified that the SBAR form may enhance the safety and quality of care and inform decision making.

Possible advantages of using the tailored SBAR form subtheme 1: Perceived improvement to the safety and quality of care. Participants reported that psychosocial information transferred through the tailored SBAR form would improve the *"quality of care for sure" (P_5)* and be *"…way more beneficial" (P_11*). The vast majority of all participants

(94.6%, n=35) either *strongly agreed* or *agreed* that the tailored SBAR form would improve the quality and safety of patient care. None of the participants disagreed. A comparison between PHN and acute care participants' responses are presented in Figure 8.

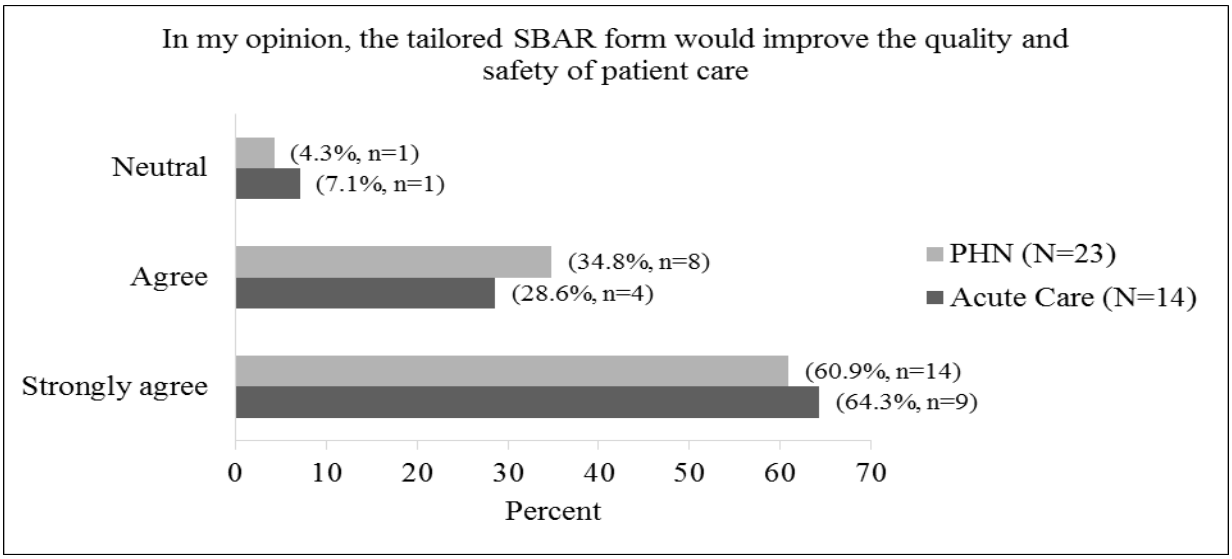

Figure 8. Possible advantage of the tailored SBAR form: Perceived improvement to the safety and quality of care.

During the focus group discussions, participants elaborated on how and why the tailored SBAR form could improve care. Participants explained that PHNs could *"…give better care because you've got definitely more information" (P_21*). Others suggested that greater awareness about the mother's psychosocial needs could facilitate better care because *"… if you have something that stands out then you…can kind of spend a little bit more…time with that patient" (P_12)*. Another participant remarked that the information provided on the form *"…helps us assess risk to the baby better" (P_20).* Participants also explained how the form could positively influence the effectiveness of communication, collaboration, and continuity of care and thereby result in improved and more client centered care.

The tailored SBAR form was reported to facilitate effective communication and collaboration within and between settings. When similar questionnaire responses were compared, at least 85.7% (n=12) of acute care and 95.6% (n=22) of PHN participants agreed that the tailored SBAR form would overall improve the quality of information transferred. Of particular interest, 91.9 % (n=34) of all participants either *strongly agreed* or *agreed* that the tailored SBAR form was also a useful way to transfer information between care settings. There were no participants that disagreed. A comparison of participants' perceptions about the usefulness of the tailored SBAR form is presented in Figure 9.

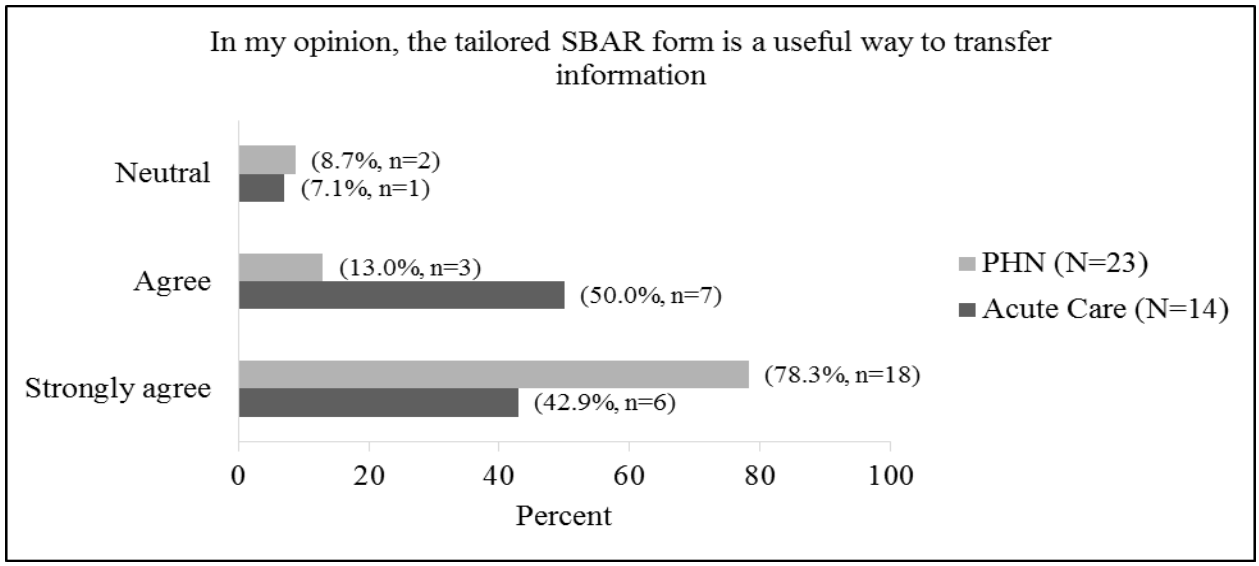

Figure 9. Possible advantage of the tailored SBAR form: Useful way to transfer information.

During the focus group discussion, participants further described just how the form could facilitate information transfer and effective communication. Many participants viewed information transfer through the tailored SBAR form as an improvement and *"a solution to getting better information transferred" (P_28)* and suggested that *"there would be some effective communication" (P_15).* One participant emphasized the importance of communication among

providers especially because mothers experience care from multiple providers across the continuum of care:

> *…our whole perinatal service, not just us, but from beginning to end is pretty good assembly line care. It's not really like, integrated perinatal care, care for the childbearing year, right. So people are with, you know, different prenatal instructors, different prenatal medical givers. Different people in the hospital they met and then they come and see us, then they go see someone else. Like, it's quite crazy actually, so the communication is so important…. Or like, just not, yeah, they don't have to say it all over every, every time. (P_33)*

Participants also spoke about the way in which the tailored SBAR form could impact various components of collaborative care including: teamwork, shared scope of practice, and continuity of care. PHN participants pointed out the need for providers to understand the importance of information transfer between settings:

> *I think sometimes the nurses in acute care don't really understand how important the information that they have is to share with us. I don't think they realize how much they do and whatever they can transfer to us just helps us. (P_26)*

The tailored content of the SBAR form was designed to guide the transfer of relevant psychosocial information for providing care in the community. A participant suggested that a sense of teamwork across the continuum could be created by knowing what information is relevant to care in community and remarked: *"…Then they'll see how we work together" (P_21).*

Participants described the shared scope of practice between nursing and social work in relation to using the tailored SBAR form. All acute care participants agreed (100 %, n =14) that their scope of practice included transferring psychosocial information to community providers. Acute care participants also described how social work and nursing roles overlap and how role function within their scope of practice are shared in regards to the psychosocial needs of the family:

> *I'm not into nursing. Like that's not my scope so, but also though the difference though with nursing is they do so much social work, right, like that's a big piece, they do that 'social worky' work. (P_7)*

Participants spoke about how the tailored SBAR form could be useful for transferring psychosocial information related to the overlapping roles such as when *"… it wasn't like, a big flag, just like a minor flag, like something to just watch but doesn't warrant a Social Worker consult, I think this would be fantastic and it would cover a lot" (P_13).* Participants described various scenarios and pointed out that nursing rather than social work is often the profession to identify issues related to the interaction between the mother and the newborn. One participant described such a scenario where *"you know every once in a while you'll get a mom that won't even look at her baby" (P_8).* Similarly, another commented that:

> *…I don't usually get a lot of referrals based on the baby section…it's usually everything else first and then they'll be like, yeah, well you know, we've been [kind of] watching her and she's you know, really flat affect but …I don't even think I've ever had a referral based on the baby box that's on here. (P_7)*

Although nursing and social work knowledge and resultant care may overlap, a few participants from both settings articulated the differences and described social work's scope as more in-depth:

> *… Social Workers sometimes ask different questions so there is that little bit of difference between our disciplines…like in the interview we, we tend to ask different questions. (P_9)*

Another participant suggested that social work would likely be completing the tailored SBAR form for more complex scenarios such as when CFSA is involved with the family because:

> *…they would be involved at that point anyway, but I mean we, a lot of the time we don't hear what the follow-up or any of that's [going to] be. Its baby is either apprehended or not. You know, as far as nursing's concerned. (P_13)*

Participants described how effective communication through the tailored SBAR form and shared scope of practice could facilitate collaborative care between the settings and in turn improve the care delivered. Collaborative efforts along the continuum were perceived as a facilitator for the early identification of psychosocial needs and as a result, *"the Public Health Nurse could put in referrals to postpartum support groups and things like that…" (P_13*) and expedite care. Others pointed out that early identification could expedite consultations and referrals with community social workers. In turn *"more guidance" (P_19)* could be provided to the PHN regarding the plan of care which could ultimately improve the quality of care provided:

> *… if it's a Social Worker filling it out they often will look at things a little bit differently than, than we as nurses will look at it. You know, for example…they'll say look it, well this is the situation, they'll, what else am I looking, okay you need to ask this, you need to find out this and she'll pull things out where I go oh, I didn't even think of that because she's looking at it from a different focus. So that gives [social workers] that opportunity to put that in there. It's something that we may not have thought about. (P_26)*

> *…you could be talking to your Social Worker about how you could better assess the situation right… before you go on the visit, it's helpful. (P_20)*

In addition to collaborating with the acute care or community social worker, PHN participants indicated that information transferred on the form related to CFSA (i.e., level of involvement, contact information, and plan of care) was also important to coordinating care with CFSA social workers in the community:

> *You could even do a joint visit with the Social Worker if you knew… and if you know the Social Worker's schedule it could even be arranged sooner than down the road, right. (P_18)*

> *It's nice too sometimes, [because] if we know they're going out, like the next day, you know, and we're [going to] be contacting them I think it's nice to know so that we're not necessarily there when they show up, you know. (P_35)*

> *And I even like that they have like the plan visit from the Child and Family Services… and get a heads up, that's something really important that we, kind of get surprised by that… And with having their information, their contact information anyways prior, that*

> *also helps [because] often we'll call them before we go out anyways and if we know that there's a worker involved just to get…what was going on. (P_23)*

Although CFSA's plan of care was important to know, acute care participants identified that this plan is often unknown because the plan may not be finalized prior to discharge or because of lack of communication between CFSA and acute care social workers. Participants reported that information tends to be gathered by CFSA providers rather than shared which therefore inhibits acute care providers from sharing CFSA's plan regardless of the communication tool used. Participants emphasized that acute care providers sometimes receive *"little information [from CFSA] although it's you know, a serious issue" (P_2)* and further described this gap in communication:

> *There's always a bit of a gap with Children's Services because in this case we wouldn't normally see this woman before Children's Services did. Yeah, we're not to taint the interview. So we often have a patient that we have a Social Work referral to that we've done a lot of work with but we never meet them from the time that they, they come here to the time that they leave. We don't have direct face to face with them, it's only nursing because Children's Services wants us to wait until they do the investigation and then they direct us… after the investigation about what they're [going to] do. (P_2)*

> *Just in terms of Child Welfare, when we call it in they take the information from us, they don't give us back. So we wouldn't know if there's a follow-up. (P_11)*

Another participant provided an exemplar of the lack of communication between the agencies:

> *So I, I have a…Domestic Violence. So I've already done my assessment and it's in SCM, so my conclusion is Social Worker first called to Child and Family Services and spoke with so and so…case worker reported all that and faxed it…done… they will respond as appropriate. (P_9)*

Despite limited communication between the agencies, participants reported that CFSA would communicate if there was a safety issue regarding discharging the newborn home or if further follow-up was needed in the community:

> *If babe's being discharged to mom that's all the information we would probably get except for there's [going to] be community follow-up but we don't know what that is in*

> *terms of Child Welfare…but they, they've deemed it safe for babe to go home… Otherwise they'll apprehend the baby. We'd know that Child Welfare's involved at some level … (P_9)*

> *…by the time of discharge then we need to know whether the Child Welfare worker is going to allow the baby to go home or not… the Social Worker that came out will stay in touch with Social Work. (P_11)*

> *Sometimes we don't have contact with them any further because …they tell us patient can be discharged but they don't tell us exactly every single detail what they are [going to] be doing… They will just maybe let us know patient will be discharged, we will be doing further investigation in the community… (P_1)*

Several participants from both care settings suggested adding an 'unknown' checkbox to communicate scenarios when CFSA's plan of care was unknown.

Similar to experts' opinion if Phase One, participants also perceived that the tailored SBAR form may facilitate communication at other points in care along the continuum:

> *So it doesn't really only help them. Like, we could see this already because sometimes even our report board doesn't have room for us to, you know, elaborate on all that stuff, so if this is already filled out then we could also, like the Discharge Nurse would be helped out looking at this too. (P_10)*

> *If we just had that in the front of the chart somewhere and we checked it all off and just left it for each other we don't have to hunt for each other either. (P_14)*

> *… a much better form to send to Well Child as well instead of the nurse to nurse referral.…Because sometimes I think maybe I'm sending them kind of a poor little pitiful paragraph and they're ranting about me not sharing the good information…And they probably would absolutely love this. (P_29)*

> *From my experience with working in Well Child …you don't have the time to read through that big, thick chart … this would probably make for Well Child nurses a lot more concise…So if they are running short and late and they don't have the time to read through all those notes… they could look through and go oh my, look what we're dealing with here or oh, look it, this is, doesn't look so good but she's doing well here. (P_35)*

Furthermore, the information transferred through the form *"… would facilitate continuity of care" (P_8)* and *"good patient care" (P_4).* Specifically, providers would *"know what's been done and what, what's left to be addressed…" (P_8)* as well as provide a foundation for

providers in the community to address families' unmet needs so that *"… you're not starting completely uninformed" (P_21)* and *"you're not going in cold…" (P_19).* Participants explained:

> *It will be actually true continuity of care versus I'm starting from the very beginning again knowing nothing, whereas I could have, you know, I could have started halfway through and then I build on it a little bit more and then Well Child builds on it a little bit more, which is so beneficial to the client, rather than just kind of doing the same thing over and over. (P_29)*
>
> *I agree too. It starts, it really is the start of the assessment and then we just continue…I think it would be complimentary to the client, they would see we're working together right, because you, you would be able to say I hear you have lack of money and not able to pay for food… (P_21)*
>
> *…it gives us a good starting point and it highlights different concerns for her. (P_30)*

The vast majority of participants (91.9 %, n=34) either *strongly agreed* or *agreed* that the tailored SBAR form would improve patient transitions along the continuum of care. Figure 10 illustrates the comparison of acute care and PHN participants' view about patient transitions between care settings.

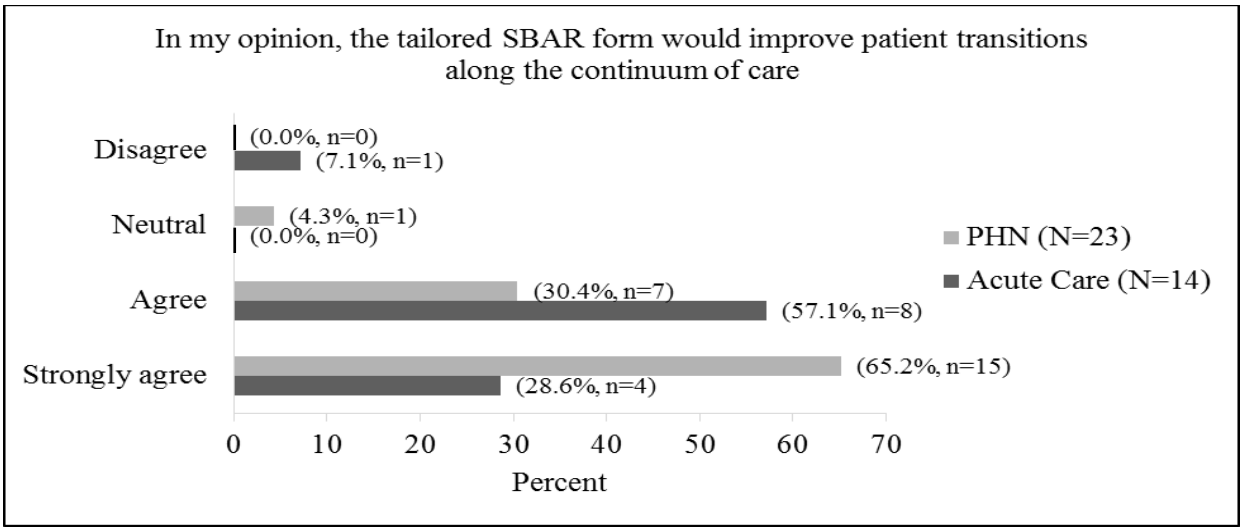

Figure 10. Possible advantage of the tailored SBAR form: Improved patient transitions.

Participants further described the benefit of using the tailored SBAR form to help communicate the identified need for follow-up in the community and thereby contribute to the quality of care. The brief postpartum hospital stay was reported to shift the priority given to the psychosocial needs of families from the hospital to the community. One participant remarked that: *"... Public Health would be able to, you know, weight in on follow-up but wouldn't necessarily be high priority for us" (P_2)* while another perceived the tailored SBAR form as *"...a huge step towards strengthening [PHNs] ability to continue to assess the patient in the appropriate areas" (P_5).* Similarly, another participant stated that *"... a form like this would be valuable" (P_4)* to practice and perhaps this is because the same participant described that *"some of our families here are, for anything, getting more and more complicated, so much stuff going" (P_4).*

Acute care participants expressed concerns for patient safety and talked about how the tailored SBAR form could support care across the continuum and improve the quality and safety of care provided:

> *Less chance that somebody will totally fall through the system, you know…when they're moving through the system so fast with so many different caregivers they're out the door and if there was a big issue nobody picked it up because there's so many people involved. (P_4)*

> *I mean, when we're seeing them like 24, like for me it's, it's not so much the very blatant like you know, Child Welfare's involved, there's domestic violence, very cut and dry, for me my concern is the ones that's, are slipping through the cracks because we're only with them for 24 hours, barely. (P_13)*

> *We're highlighting everything their needs, their wants, their current issues and I think that we can help them in the community, we can't do everything here. I think its ultimately optimum care for the patient. (P_9)*

PHN participants also spoke about the importance of continued assessment and monitoring of psychosocial health in the community *"because things can change" (P_20)* when families transition home:

> *...the thing I like about this is it's really [going to] help you guys, right? Like, I send people home and I kind of wonder and I hope that they don't slip through the cracks but there's nothing I can do about it, but when I'm here, because again that they just need watching or the need some time to kind of see how it plays out deal, and this gives you guys more information to go in so you have an idea of what my concerns are when you see them which is, you know, instead of, oh, just another one with history of depression, one little thing on the [Provincial Notice of Birth]. (P_13)*

> *And I like the, the section on the baby's needs, responding to the baby and when we come into the home and we're only there an hour, not that they're in the hospital that long but you never know what little glimmers they see when they're in and out of the room and that with that contact, with the baby. So I just think when those things are marked as a concern we can be observing and attentive to that. (P_25)*

> *And sometimes it's, they are exhausted in those 24 hours and we don't see a good side of them because they had 2 hours of sleep the entire time they're here…Because with a follow-up in their own situation at home you're [going to] see okay, you know what, their family was there with them at home and they did have 4 more hours of sleep and they're completely fine. (P_12)*

Informational continuity of care through the tailored SBAR form was perceived to potentially reduce duplication of components of care and reduce the need for mothers to retell their story:

> *I hear from patients all the time. I've heard this three or four times from four different people, whereas this, if it's already on here then you know it's already been addressed and you don't have to frustrate that patient by every person coming in, like a blank slate starting all over again. So it may actually, for the patients, improve their confidence in us as for care. (P_5)*

> *... would also be a message of caring [because] you've taken the time to find out information about them and not having to repeat it over and over again. (P_22)*

> *...I could write all the resources I had given to mom. So then Public Health isn't just ...regiving her stuff that I've already done for her. Like I could say gave resources for, you know, Connect, Neighbour Link, shelters, so then they knew that piece is taken care*

of and if they think of anything extra on top of what I must have missed or whatever, then, then they could do that. (P_7)

Informational continuity was further described as promoting transparent communication with families because PHNs would already be aware of the overall situation and the plan of care.

…opens the door of the conversation… it just opens the door for continuing care…rather than us come in cold. (P_16)

…you can use this to start up a conversation, so for example, you know, information from the hospital says you have a history of depression, can you tell me more about that versus do you have any mental health concerns and they can just tell you no. (P_15)

Possible advantages of using the tailored SBAR form subtheme 2: Informed decision making. At least 82 % of PHN participants identified that the tailored SBAR form could facilitate decision making regarding planning and timing of care as well as care setting. A summary of PHNs questionnaire responses about decision making are presented in the following table.

Table 10

PHN participants' questionnaire responses related to decision making

	% (n) N=23		
	Yes	No	Missing responses
There is sufficient psychosocial information on the form to make decisions about determining appropriate care setting such as a home visit or clinic visit	82.6 (19)	17.4 (4)	0 (0)
There is sufficient psychosocial information on the form to make decisions about determining timing of care such as contacting the family the next day or potentially deferring contact	91.3 (21)	8.7 (2)	0 (0)
There is sufficient psychosocial information on the form to make decisions about determining what follow-up care and support maybe required	91.3 (21)	8.7 (2)	0 (0)

Participants indicated the tailored SBAR form could *"make it a little easier for [PHNs] to plan…" (P_5)* and make decisions about what care, the timing of that care as well as foster PHN safety in the delivery of that care.

Information received on the tailored SBAR form could help PHNs anticipate the family's needs and be *"just more prepared, right" (P_22).* Most PHN participants (91.3 %, n=21) identified that there is sufficient information on the form to make decisions about what follow-up care and support could be required:

> *You can anticipate what kind of resources you might need for them so you can take out a layette… you have a little bit more understanding what they have. Sometimes we get some [Notice of Births] that you have no idea that there's financial issues and you get out there and you don't have that layette or provisions or anything to give them. (P_23)*

> *…sometimes you're going out and you're, and you're going out blind and you're sort of guessing well, this could be an issue, this could be an issue so let's just load up the chart with, you know, 50 forms and everything and then you go out there and you realize oh no, this really not needed, or you go out there and because it looks good and then you go, oh man, like I've got another hour and half to deal with resources. (P_26)*

PHN participants described how the tailored SBAR form could inform decision making about prioritization and the timing of care. At least 91% (n=21) of PHN participants reported that there was sufficient psychosocial information on the form to make decisions about determining timing of care such as contacting the family the next day or potentially deferring contact. PHN participants elaborated about how early identification of the concerns could facilitate prioritization and timing of care and potentially expedite care in the community:

> *…it would help me prioritize my visits as well because if …I see that she's confident, she's, all those nice little, attentive to baby's needs, responding appropriately, that might not be, be my very first home visit, if I have a couple of socially complex ones in a particular day …I can say no, I don't have to run out there, oh my goodness, I can say, wow, this is looking pretty good so I think I can go for the 2:00 o'clock, or… (P_29)*

> *…quicker care. I mean, we're [going to] zero in more quickly what the concerns are and get some resources in place to deal with those needs more quickly. (P_17)*

> *And I think specifically, like, especially the, the ones where mom's discharged before, before baby …sometimes we just defer, but if you have more specific information you might be following up with either, sooner or, or more consistently throughout…the time prior to baby's discharge with more information. (P_24)*

Participants also indicated that PHN safety could be fostered by having safety concerns communicated on the tailored SBAR form:

> *I definitely think it would help with PHN safety, for sure, with the initial contact. I think more information the better for us going in, yeah. How many times do we go and we find out oh there's all this history or stuff and we've gone into their home and, I mean, luckily most of the time nothing happens but still. (P_20)*

> *And more safe… [because] how many times have you just done a drive by…and dropped in and, oh my God, the situation that you find. (P_17)*

Approximately 82.6 % (n=19) of PHN participants reported that there was sufficient psychosocial information on the form to make decisions about determining the safety need for the family to be seen in the clinic rather than in the home. Participants further explained how information transferred on the form could also prompt PHNs to complete a more detailed assessment to determine environmental safety for the home visiting PHN:

> *… so it [kind of] gives you the heads up that that person maybe has to come into clinic the first time so we can do our own assessment…and then deem whether or not they'd be safe for a home visit. (P_15)*

> *Or you could do a more thorough assessment on the phone right when you, [because] if you've, if it's already been flagged coming from the hospital, when you're doing that initial telephone call you would do, instead of just the quick one you could go into more detail on that. (P_18)*

> *…You just have more information to know where you're [going to] see them, what your plan will be. (P_27)*

Criminal activity was described as an important item for determining PHNs safety *"so they [the nurses] know what they're walking into" (P_13)* and *"especially if they've been*

involved with the gang or drug culture" (P_11). A participant described a scenario whereby critical information about safety concerns could be transferred through the form:

> *... I've got this partner downstairs. I wouldn't want the Community Nurse going into an environment like that. So I think there is a place for it, whether that's it, but I would definitely want to relay that information. (P_9)*

Even though there was strong agreement that the form could facilitate decision making about the care setting, the usefulness of the form was perceived to be dependent on how adequate it was completed by the sender. One participant indicated that the form would be useful for making decisions *"as long as the people are writing that information…but if they aren't…then we can't make a decision" (P_15)* and *"it would be difficult to make a decision to home visit based on this form" (P_15)* particularly for scenarios that involved domestic violence and substance use because *"those are things that we need to nail down" (P_15).*

Information about the 'patient's response' (i.e., concerned about issues; receptive to support) in the assessment section of the form was particularly useful for planning client centered care:

> *Gives you an idea if, if the client sees it as a problem, right? (P_15)*

> *…if it's just there day to day and they're not really concerned that they have no food in the house, us providing them a whole bunch of information and resources, they're not [going to]take it anyways, right, like…so we know how much they're wanting (P_18)*

> *Determine what sort of resources might still be needed but also you can tap into …her strengths that she's already got, right, and, and just kind of build from there. (P_32)*

Main Theme 2: Professional Judgement and Comfort Level Regarding Information Sharing

The second main theme was professional judgement and comfort level regarding information sharing. Participants' perception about the tailored SBAR form was influenced by

their professional judgement and comfort level with sharing psychosocial patient information with providers at the next point of care. Judgement and comfort level were both considered a facilitator and barrier to transferring information on the tailored SBAR form.

Participants were cognizant about protecting sensitive client information and explained how professional judgement guides sharing relevant information:

> *… there are certain things that I don't chart about…there's been times where we don't chart or don't pass that information on because, lots of reasons, I guess, but one being if mom feels that it's not an issue I don't want to make it an issue for her…It follows them, right, it's like that, you know, getting diagnosed with a learning disability as a kid that it follows you all through your school, right. So it's, it's kind of a fine line about… what, sometimes we chart and what we don't chart… It's more about what is relevant to mom's current care and current situation and the potential of stuff too, I guess. (P_7)*

Acute care participants described and judged various scenarios as not relevant to care and were therefore uncomfortable sharing that information:

> *Yeah, even struggle with, yeah, if they had really historical things like domestic violence but it was 5, 10 years ago, how is that really relevant right now to put it on this form for, for domestic violence past. What, what is the relevance if, if that person's [not] at all involved… (P_1)*

> *Yeah, like some women have brought up the fact that they've been assaulted while they're having their baby because it brings up, like, issues for them but it's historical, they've addressed it, it doesn't become like a focus or anything that we would be referred to, like, it's just a sensitive time for, for women and if the nurses feel like it's something that has already been addressed and is historical it doesn't go down. And same with like, alcohol abuse, like sometimes we'll say to women, do you have any history of alcohol use? Oh, well when I was a teenager and… and their 35, we wouldn't even write that down in the chart because it's not fair… (P_2)*

Some participants remarked that the tailored content of the SBAR form could facilitate awareness of what information is required to provide care in the community which in turn could facilitate acute care providers' comfort level with sharing sensitive information:

> *And perhaps they'll feel safer sharing the information when they have it designated what they can be sharing… Because that seems to be a huge barrier is they don't feel safe*

> *telling us this information. They think that they're doing something [Freedom of Information and Protection of Privacy] related or, so this might help them. (P_29)*

> *…that this really fits within [Freedom of Information and Protection of Privacy], that we're only sharing what is really relevant here… I like how this lines it out and you're only putting in that information that's really important… (P_5)*

Most social worker participants commented that they would share information *"if it was relevant" (P_1)* but cautioned against sharing *"private information" (P_2)* not relevant to the current situation. In order to address this noted concern about sharing relevant information, participants suggested adding an 'unknown' checkbox beside each item to indicate if the item was assessed.

The sender's knowledge about the role of the receiver of information may also influence judgement and comfort level about sharing information. One participant described uncertainty about PHN's role and the need to share psychosocial information with the PHN:

> *…so what, what does community, postpartum nursing do about, about, what does that mean, like they would follow-up with domestic violence, mental health, parenting, do you mean the social work? … what skill set they would have, do they have training in, in counselling or in kind of, because some of these things they are pretty big things to deal with, mental health… and…domestic violence. (P_1)*

The same participant perceived that information regarding historical involvement with CFSA may only be relevant to acute care providers and not for community providers:

> *I mean, it's relevant maybe, maybe for, for us to know, like in, in terms of just having that information and seeing, assessing her if everything, if has changed since then. But I don't know how relevant it would be for Community Health. (P_1)*

In contrast to social work participants, many of the nursing participants perceived that the information on the form was relevant to care. All PHN participants (100 %, n=23) reported that the items on the form were relevant to providing care in the community and as one participant commented:

> *… It's all relevant, it's all really important information that we receive. …I also think it gives them a really good guideline as to why and what we're looking for. So, so I think it's education too. It'll be helpful. (P_22)*

A few acute care participants were concerned that the form could be used for an unintended purpose and this concern influenced participants' comfort level with using the tailored SBAR form. Participants talked about the potential for the form to be used inappropriately as a validated assessment tool rather than a communication tool. These same participants were concerned that client information could be sought when that information may not necessarily be relevant to the family's current situation:

> *We wouldn't necessarily go into those issues that like are open wounds…we don't hit all these domains if they're not necessarily indicated because there's, you know, we only have two days to, to work with people. (P_2)*

Main Theme 3: Motivational Factors

Motivational factors was the third main theme. Factors specifically identified were satisfaction, time, and enthusiasm.

Subtheme 1: Satisfaction. Satisfaction was identified as a motivator to use the form in practice. One participant spoke of job satisfaction and commented that *"…it'll be like anything. There will be some people that think it's great and there'll some people that say no thank you, you know, but I don't know what would make people want to do it, other than you know, perhaps maybe feeling like you're doing a better job of what you're doing" (P_6).* Acute care participants explained that they would be more satisfied with transferring information to the community setting if the form would facilitate effective communication and therefore *"decrease the calls and the pages from Public Health [Nurses]" (P_7)* attempting to retrieve the missing information. One participant reported that the form was *"…real practical; we won't get so many phone calls from Public Health… asking us what's going on, and usually the chart's gone and if*

you weren't here yesterday you don't know and you… you feel pretty helpless like… sorry" (P_8) and that *"…it's way easier to do it in the moment than go back 3 days later and try to…figure out what happened" (P_8).* Another acute care participant reported dissatisfaction with the telephone calls from PHNs and described this scenario as *"stressful, [because] usually we're always in the middle of something. Too, we're not supposed to be faxing the progress notes. You know, and, and it's kind of hard because I understand they need that information but we're not allowed to……" (P_13).*

In addition to job satisfaction, a few participants also talked about personal satisfaction in knowing that the family would receive specific follow-up at the next point of care and commented that *"if I [had] a patient when I worked at the hospital who I'm really worried about, like I would like to know that it's [going to] be followed-up on" (P_33).*

Subtheme 2: Time. Time was described as either a positive or negative motivational factor. The majority of participants overall reported that the time to complete (78.6% of acute care participants, n=11) and read (100% of PHN participants, n=23) the tailored SBAR form was acceptable and that time efficiencies were a positive motivator. Participants from both care settings described various time efficiencies that could be incurred by using the tailored SBAR form. Participants explained that the tailored SBAR form could reduce the need for PHNs to contact acute care providers to retrieve missing information which could result in *"time saved"* (P_5). For instance:

> *There's been recent situations where Public, the Public Health Nurse has called our unit to see the Social Worker's notes. So this would save them from going through health records and read what the Social Worker has said, or what the primary nurse has done for this patient. (P_10)*

> *It's more time consuming on the out, you know……once we get used to it'll save backtracking. (P_8)*

> *…I think we got into the swing of it and using the form, like it wouldn't take us long to just quickly tick stuff off it… think in the long term it would save time I guess, too. (P_7)*

> *In a sense, as a nurse we already do it, just in a less efficient manner. (P_5)*

PHN participants also believed that the tailored SBAR form could create time efficiencies by minimizing the need to retrieve missing information. Participants recognized the time saved by *"not having to call the hospital for notes" (P_23)* and therefore the PHNs could *"… hit the ground running" (P_30)*.

> *I think one of the positive things though is ...we're not [having] to re-go back… and have to re-request information, the Social Work notes from the hospital. So rather than having to wait and put off your visit and put off your decision making you've got the information there and…it gives you a much better picture much, much quicker. So that's a really nice piece. (P_26)*

> *It would, it would save nursing time because …if Social Work consult is ticked off on the NOB but you don't have notes, clerical's [got to] a call, nursing's [got to] call, you know, try and communicate with the Social Worker regarding the concerns in the hospital…so it would help to save nursing time just by having this form there and faxed with the [Notice of Birth]. (P_15)*

> *Well you don't have to phone for the…Unit Clerk and the Social Worker, find the Social Worker and ask them to send the Social Worker report and half the time the Social Worker report doesn't come back before you go out to do the visit. (P_17)*

Other participants suggested that time could be saved as a result of having patient information readily available to organize care:

> *We don't always have time to do an assessment because I'm, when I'm triaging in the morning and doing 6 charts in the morning I mean, this is a great summary, yes, they have to come into clinic. Like I, you have…to decide that within seconds. (P_15)*

> *Oh, because a lot of times, by the time we get the [Notice of Birth] let's say we may not be able to request the information from records in evening, we have to wait 'til the next day. So then we have to determine are we doing a home visit, are we doing a clinic visit, how is this [going to] affect us and, and it affects your workload as well, right? If you've got, you know, 27 things filled out and you're like, wow, this is [going to] be fairly heavy and fairly comprehensive, that depends on how you're [going to] set your workload up. (P_26)*

Others commented on efficiencies related to referring families to community resources.

> *And it could save you some nursing time …because if we don't get consent for everything then we have to have a second contact …it will help with maybe getting consents where needed. (P_17)*

> *You know the areas that are concerned for this client so you can grab the resources quicker before you even get out there. So if there's time during the initial you can give them those resources versus having to phone and follow-up. (P_15)*

> *It could take it down from three visits to two visits …three contacts to two contacts so …it, it could decrease the workload potentially because that is exactly right. I mean, if you know that ahead rather than oh, I'll contact you tomorrow to provide the resources, or you come to us tomorrow, or I'll phone you tomorrow, if you can compress it possibly that could be a workload saving. ..makes things more efficient. (P_28)*

On the other hand, time constraints, largely due to workload, were described as a strong deterrent for using the tailored SBAR form. Most of the focus groups (5 out of 6) perceived that heavy workloads and resultant time constraints were major barriers to using the tailored SBAR form because *"people are so swamped as it is" (P_4)*. Several participants indicated a willingness to use the tailored SBAR form, yet suggested that time constraints were inhibitive:

> *I can definitely see myself do it if I have time for it. I honestly can't see myself do this for every patients, patient that I see when I'm extremely busy [because] …some days are just crazy …because this is on top of all of our charting and we write novels sometimes in our charting so. (P_1)*

> *But in terms of time for us this is very time consuming… it's one thing to tick it off but then to have to write everything, like I find it quite time consuming and… Time wise I don't know how detailed we would get some days… That's my only concern is I think it would be very time consuming. (P_7)*

Despite participants' perception that the actual amount of time to use the tailored SBAR form was acceptable, time constraints due to workload were perceived as a strong barrier to using the form in practice.

Subtheme 3: Enthusiasm. Participants described their enthusiasm for using the tailored SBAR form. This enthusiasm was further exemplified by quantitative data when participants were asked to report about willingness to use the form and sustainability if implemented in practice. Participants' perceptions about sustainability and willingness to use the form are reported in the following table.

Table 11

Acute care participants' response related to willingness to use the form and sustainability

	% (n) N=14					
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Missing responses
I would be willing to use the tailored SBAR form to transfer information to community care providers	42.9 (6)	42.9 (6)	14.3 (2)	0 (0)	0 (0)	0 (0)
In my opinion, use of the tailored SBAR form would be sustainable on our unit	50.0 (7)	21.4 (3)	21.4 (3)	7.1 (1)	0 (0)	0 (0)

Most acute care participants (85.6 %, n=12) were willing to use the form and then expanded on why they may be willing to use the form and described a desire to improve care:

> *We don't need more paperwork unless it's going to benefit the patient… I like to see my patients' needs met…I want the transfer of care to be as seamless as possible. (P_3)*

> *Our time waxes and wanes you know. Ultimately it's about the best practice and, and patient care. (P_9)*

Several other quotes exemplified enthusiasm regarding the use of the tailored SBAR form:

> *I think this is just a fantastic idea and thank you for putting all this work in… I hope it helps… (P_13)*

> *This is awesome. (P_29)*

It's like 200 times better than what we have now. (P_31)

Participants were also asked about sustainability and what may encourage other members of the team to use the tailored SBAR form in practice. Approximately 71% (n=10) of acute care participants either *strongly agreed* or *agreed* that using the form would be sustainable. A few participants offered strategies that may persuade others to use the form and in turn influence sustainability. Strategies described included increasing awareness of the importance of information transfer to community providers and familiarity with the form:

> *From a nurse's point of view I think it's only [going to] get busier and busier in the future so it has to be presented in a way that it's not yet another form that we're doing… (P_4)*

> *Once we get used to using this form it would be so much better……for communication. (P_10)*

Based on results from Phase One, the guidelines to using the form were amended to include additional exemplars. Education and exemplars in the guideline may be a useful strategy for gaining familiarity with the tailored SBAR form:

> *As long as the nurses knew, like maybe in the, you know, your information on how to fill out the form… (P_18)*

Summary

Three levels of interconnected themes related to participants' perception about the usefulness of the tailored SBAR form were revealed. Three main themes emerged including: (a) perceptions of the characteristics of the tailored SBAR form, (b) professional judgement and comfort level regarding information sharing, and (c) motivational factors.

Themes that emerged from perception of the characteristics of the tailored SBAR form included the design, content, and possible advantages of using the tailored SBAR form. Elements of the design (format, single-user design, strength based approach, facsimile

transmission) were described as both facilitators and barriers. Overall, the format was perceived as a strong facilitator. The layout of the form was described as easy and efficient to use, although space constrained. Participants also perceived that the tailored SBAR form facilitated clear and concise communication. The strength based design was perceived to provide a balanced understanding of the situation and a facilitator for providing care. Design elements perceived as barriers included the single-user design and facsimile transmission of the form.

The tailored content of the form was perceived to structure and guide communication as well as assessment. The content was described in terms of adequate information, unclear items, and redundant items. Overall, participants perceived that the form captured adequate information and was flexible. There was disagreement about items identified as possibly missing (family dynamics, adoption and apprehension scenarios, prenatal social work referral) or redundant (actual assessment, recommendation section). A few items were also described as being unclear (discharge prior to social work assessment, parenting and CFSA items). The tailored content was perceived as adequate and a strong facilitator for determining what information to transfer. At the same time, items that were possibly missing, redundant, or unclear were perceived as barriers to using the tailored SBAR form.

The possible advantages of using the form were a perceived improvement to the safety and quality of care and informed decision making. Participants described a perceived improvement to the safety and quality of care in relation to the influence of the form on effective communication, inter-professional collaboration, and continuity of care. Informed decision making was the second perceived advantage and was described in terms of determining care setting and fostering PHN safety, prioritization and timing of care, as well as anticipating and planning care.

Professional judgement and comfort level regarding information sharing was a main theme and was perceived as both a facilitator and barrier to using the tailored SBAR form. Participants were keenly aware about protecting the confidentiality of patient information and how this awareness guides the sharing of relevant information. Participants described how professional judgement could influence what information was documented on the form. Judgement could also be influenced by knowledge of the receiver's role.

Motivational factors were viewed as both facilitators and barriers. These factors included satisfaction, time, and enthusiasm. Satisfaction was described in relation to a perceived improvement to job and personal satisfaction. Time was described as both a positive and negative motivator. Time constraints were identified as a strong deterrent; however, time efficiencies were described as a facilitator. Enthusiasm emerged through exemplars along with an overall reported willingness to use sustain the form if implemented into practice. Findings from Phase Two provided insight into the usefulness of the tailored SBAR form along with the barriers and facilitators to using the form. In the following chapter study findings are positioned within the literature, next steps are identified, study implications, and limitations are discussed.

Chapter Six: Discussion, Next Steps, and Implications

A descriptive mixed methods approach has offered a practical and thorough way to develop and evaluate the tailored SBAR form. There were two synergistic phases to this study. The objective of the first phase was to develop and evaluate the content validity of a tailored SBAR form. The objective of the second phase was to describe providers' perception of the usefulness of the form as a means to transfer maternal psychosocial information between the acute care and community setting.

In this chapter the results from Phase One and Phase Two are discussed within the existing body of evidence related to content validity, maternal psychosocial risk and protective factors, and SBAR communication. The discussion is also positioned within components of the KTA framework. Implications for practice, health care infrastructure, and future research are presented. The chapter concludes with a discussion of study strengths and limitations.

Discussion of Phase One Findings

The second step in the KTA cycle involves tailoring knowledge to the needs of the local context and knowledge-/end-user (Graham et al., 2006). This step was largely accomplished by engaging a local panel of six experts in an iterative process and in turn establishing excellent content validity of risk and protective factors to be included in the tailored SBAR form.

Following the established content validity protocol (Grant & Davis, 1997; Lynn, 1996; Polit & Beck, 2006; Polit et al., 2007), four items were revised to improve clarity (relationship with partner, mental health diagnosis, knowledgeable of baby's development, CFSA: Historical) and three items were deleted (relationship with maternal parents, health issues in home impacting parenting, years of education completed).

Although items were deleted, the experts' feedback indicated that these items were captured by other factors already identified on the form. 'Relationship with maternal parents' was one of the deleted items on the form. This item referred to childhood maltreatment or family dysfunction. Important issues related to relationship with maternal parents were identified by experts as potentially being captured under the mental health category. This finding is consistent with the "Adverse Childhood Experiences" study (Felitti et al., 1998) that showed a significant dose response relationship ($p < .001$) between the number of adverse childhood experiences (childhood abuse and neglect, household dysfunction) and mental health issues (i.e., depression, suicide, alcoholism, drug use).

'Health issues in home impacting parenting' was the second deleted item as experts felt this item was captured by mental health or coping skills. Literature supports this premise that poor physical health may negatively influence mental health (Canadian Mental Health Association Ontario, 2008) and lead to poor health outcomes (Beck, 2001; Dixon, et al., 2009; Hull, 2009; Midmer et al., 2002; Queensland Government, 2010; Reid et al., 1998; WHO, 2006; Williams et al, 2011; Willinck & Cotton, 2004; Willinck & Schubert, 2000; Wilson et al., 1996; Wodonga Regional Health Service, 2008).

The third deleted item was 'years of education completed'. This deleted item was felt to be related to 'cognitive challenges', which was identified as a better marker for poor health outcomes by one expert. Additional feedback provided by the expert review regarding design elements was considered and then prompts and instructions to complete the form were amended accordingly.

Discussion of Phase Two Findings

In Phase Two of this study, focus groups were conducted with nurses (acute care and community) as well as social workers (acute care). During the focus group discussion, barriers and facilitators to using the form for transferring information between the postpartum acute care and community settings were explored. This phase of the study is congruent with the third step in the KTA action cycle, assessment of barriers.

The Institute for Healthcare Improvement (Bradke & Nielsen, 2013; Rutherford et al., 2013) highlights the need for team collaboration across the continuum to co-design and enhance care transitions. As such, focus groups involving front line clinicians from both care settings was a useful way to receive feedback from both the senders and receivers of information. The use of mock scenarios was a practical and extremely valuable way to deepen understanding about the potential barriers to utilization of the form that may not have been otherwise revealed by the questionnaire or group interviews.

Recruitment and retention of focus group participants was challenging. Most participants were recruited following unit presentations. Nine providers that originally indicated a willingness to participate did not participate due to unexpected circumstances such as illness, scheduling conflicts, and forgetting. Although the overall number of respondents (19.6 %, 9 out of 46) that did not show up was less than ideal, Stewart et al. (2007, p. 58) suggests that this response (≤ 2 participants in each group failed to attend) is to be expected. Opportunities to participate in the focus groups were limited to the dates and times convenient for the majority of participants. This limitation may have influenced the participation rate.

There was a range of clinical years of experience amongst participants consistent with the range seen within the practice settings (R. O'Connor, September 20, 2013, personal

communication; K. York, October 11, 2013, personal communication). All participants were female, which was not surprising given that over 93 % of RNs and LPNs in Alberta are female (College and Association of Registered Nurses of Alberta [CARNA], 2012; College of Licensed Practical Nurses of Alberta [CLPNA], 2012). The range of participants' level of education (diploma to master's degree) was consistent with the reports published by the respective professional regulatory bodies and entry to practice requirements (Alberta College of Social Workers [ACSW], n.d.; CARNA, 2012; CLPNA, 2012). All PHNs had at least an undergraduate degree, an employment qualification at the time of the study.

Discussion of the key focus group themes. Perception is inherently linked to attitude, which is a known predictor of behavior (Hutchinson & Estabrooks, 2009). All identified themes in this study were conceptually linked to participants' attitude about the usefulness of the tailored SBAR form. Three main themes related to participants' attitude included: perception of the characteristics of the tailored SBAR form; professional judgement and comfort level regarding information sharing; and motivational factors. Participants' perception about the tailored SBAR form may influence how readily the form may be adopted if implemented into practice (Rogers, 2003).

Barriers and facilitators captured under each theme were consistent with those identified in the KTA framework and include the innovation, care provider (i.e., knowledge, attitude, behavior), and external factors (i.e., local setting, organization) (Castiglione & Ritchie, 2012; Légaré, 2009). The form revisions addressed the perceived barriers where possible as this is important to facilitating the uptake of the tailored SBAR form within practice (Castiglione & Ritchie, 2012).

Main theme 1: Perception of the characteristics of the tailored SBAR form. Perceived characteristics of the form were described as both barriers and facilitators to transferring psychosocial patient information between the postpartum acute care and community settings. These characteristics included the design, tailored content, and possible advantages of the tailored SBAR form. Participants' perception of the characteristics of the tailored form were believed to influence the acceptance and adherence to using the form if implemented in practice (Rogers, 2003). For example, providers may use the form more readily if the tool is perceived as uncomplicated, beneficial, and compatible than if the form is complicated, detrimental, and incompatible. Therefore, participants' perceptions were given careful consideration when revising the form.

The initial design of the tailored SBAR form was informed by document design (AHS, 2011b; Australian National Audit Office, 2006; Sevilla, 2002; Williams, 2008) and usability principles (Bogaard, 2003). Four subthemes emerged from descriptions of the design including format, strength based approach, single-user design, and facsimile transmission.

Overall, participants perceived the format to be a stronger facilitator than barrier. The form was easy and efficient to use and facilitated clear and concise communication. Other authors have also identified that the SBAR approach provides structured communication (Dayton & Henriksen, 2007; Haig et al., 2006; Leonard et al., 2004) in a manner that facilitates clear (Cunningham et al., 2012; Marshall et al., 2009; Woodhall et al., 2008) and concise communication (Riesenberg et al., 2009; Woodhall et al., 2008).

Participants' perception about the format corresponded to barriers and facilitators addressed in the KTA framework related to the innovation and the individual care provider

including: practicality, simplicity, and anticipated positive outcomes as a result of using the form (Légaré, 2009). Overall, the format was perceived as practical and uncomplicated.

A few specific practical revisions to the format were suggested by participants to minimize practicality barriers and increase overall usefulness of the form. Most of the suggested revisions (i.e., add space where possible; slightly change sequencing) were used to complete the final design of the form where possible (see Appendix Q).

A second design subtheme was the strength based approach of the form. There was resounding participant support for inclusion of the strength based approach; an approach that was seen to provide a balanced understanding of the patient. This holistic approach facilitates communication about how the patient is managing with life challenges and provides a platform for providers to build upon the patient's strengths, promote resiliency (i.e., through community support), and improve positive outcomes (Gottlieb, 2013). As anticipated, a strength based approach shifted participant thinking from a negative to a more positive view of the patient's situation. This shift was perceived as valuable for creating a balanced understanding of the patient's needs and could positively impact care. Innovations that are believed to positively influence the outcome of the patient and clinical process are perceived favorably and more likely to be adopted by the front line clinician (Rogers, 2003). Positive outcome is one of the most frequently noted facilitators for the uptake of change (Gravel, Légaré, & Graham, 2006) and therefore the strength based approach of the SBAR form is considered an important facilitator.

The last two design subthemes were the single-user nature of the form and the need to fax the form. Participants reported that a single-user design could inhibit information transfer because the content may be inadequate if both nursing and social work did not have an opportunity to communicate on the same form. Légaré (2009) suggests that when a negative

outcome of the innovation is anticipated, end-users attitude towards utilization of that innovation is also influenced. In this study, these specific design features of the SBAR form were seen as a disadvantage. To address this concern, multiple signature boxes were added to the final tailored SBAR form (see Appendix Q) and the SBAR form guideline was altered accordingly (see Appendix R).

Participants also described confidentiality concerns about providing safety plan information through facsimile transmission. Participants suggested converting the tailored SBAR form to an electronic form. Prior research (ACSQHC, 2011b) indicates that an electronic discharge summary offers a secure way of transferring information to the community in addition to other potential benefits (i.e., timeliness, legibility, consistent information, accessibility, and contributing to the electronic health record). At the same time, an electronic medical record is not without its problems (i.e., time intensive, difficulty locating information in the system, transcription error, adherence to use, unconfirmed acceptance of responsibility for care) (ACSQHC, 2011b) and the initial implementation cost deserves consideration (Canada Health Infoway, 2013; Holroyd-Leduc, Lorenzetti, Straus, Sykes, & Quan, 2011). A call for further research about the usefulness of electronic tools and record systems has been made (ACSQHC, 2011b; American College of Obstetricians & Gynecologists, 2010; Wong et al., 2008). For the purpose of this study and as suggested by participants, the final form was revised to alleviate participants concern about the confidential nature of a safety plan. The area of the form titled 'action taken in hospital' area was modified to include 'safety plan in place' and 'yes' and 'no' check boxes rather than including the details of the safety plan. The overall positive findings about the design of form suggests that attention to design concepts (AHS, 2011b; Australian National Audit Office, 2006; Sevilla, 2002; Williams, 2008), usability principles (Bogaard,

2003) as well as theoretical barriers and facilitators (Légaré, 2009) was important to developing a useful form.

Authors of the "OSSIE Guide for Clinical Handover Improvement" (ACSQHC, 2010) suggested that the content of clinical handover needs to be adapted to the needs of the specific care settings. Content development of the tailored SBAR was an ongoing process that began during the initial development and continued during both phases of this study.

When asked about the content, both health care providers who are the sender and the receiver of the form added valuable perspectives on the content required for effective communication. Findings from this study suggested that the tailored content cued participants as to what information to transfer and therefore guided communication and assessment. This visual cue on the form was seen to facilitate recall of information and contribute to consistent information transfer and better outcomes. Three content subthemes included: adequate information, unclear items, and redundant items. There was not consensus about the adequacy, clarity, or redundancy of items.

Overall, participants reported that the SBAR form captured adequate information indicating the content was relevant and comprehensive yet flexible enough to capture various scenarios related to clinical handover for socially at-risk women. Although the development and evaluation of a form is time intensive, the positive finding in this study reflect the benefit of iteratively developing and adapting the content of the form to the postpartum setting prior to implementation and further front line clinician evaluation.

Because the SBAR form was tailored to the postpartum setting and the form content was overall perceived as adequate and comprehensive, this innovation was perceived as applicable and beneficial to practice and the patient (Légaré, 2009). Flexibility of the items to capture

various situations was also viewed favorably by participants as this was important to help clinicians communicate endless scenarios and yet still be user friendly. However, there was disagreement among participants regarding three items that were identified as potentially missing (family dynamics, adoption and apprehension scenarios, and prenatal social work referrals). Some participants preferred that the items be added, whereas others perceived that the existing items were flexible enough to capture these missing items. A possible explanation for this disagreement is the need for a balance between providing sufficient information, limiting the length of the form, and being user friendly.

Although the identified items may be captured by existing items on the form, omission of these items may inhibit recall when transferring related information. In Gravel et al.'s (2006) review of barriers and facilitators to implementing shared decision making, impracticality of shared decision making was cited more frequently as a barrier than forgetting. Adding unnecessary items could create impractical barriers (length of form) and decrease adherence to using the form. Therefore, a decision was made against adding the identified missing items to the final tailored SBAR form since all of the items were captured elsewhere on the form (i.e., coping skills, current stress level, action taken in hospital and other) or by other discharge documents which could facilitate recall when completing those respective documents.

Unclear items was the second subtheme of content. The CFSA and parenting items in the background section and an item (discharged before social work referral) in the situation section of the SBAR form were identified as being unclear and believed to potentially lead to miscommunication. Items related to levels of CFSA involvement (open file, investigation, and recent history) were unfamiliar to many participants and thus differentiating between the levels of involvement was seen to be difficult. This finding was important because miscommunication

about the level of CFSA involvement could significantly impact care in the community. For example, in the investigative stage there would be a greater need for the PHN to initiate referrals to community resources than if CFSA was already involved and resources were in place. While CFSA terminology was unfamiliar to nursing participants in acute care, the terminology was familiar to social work participants. This discrepancy may partially be explained by the differences between nursing and social work scope of practice, knowledge, and familiarity with the child protection agency.

Parenting items were phrased similarly in both the concern and strength sections. Consequently, participants confused parenting items in the concern section with parenting items in the strength section. Participants also indicated that lack of communication about why the patient was discharged prior to social work assessment created uncertainty and could lead to misinterpretation about the patient scenario. Ambiguity about these items may negatively influence clinician's use of the tailored SBAR form in practice. Unfamiliarity with an innovation and perception of a poor outcome as a result of the innovation can impact the adoption of that innovation (Cabana et al., 1999; Gravel et al., 2006; Légaré et al., 2006).

Suggested revisions to improve clarity were considered and the tailored SBAR form was modified accordingly. To simplify communication and minimize error, the items 'investigation' and 'open file' were changed to read 'current' involvement. Front line participants, in contrast to the expert review panel, suggested changing 'recent history' with CFSA back to 'historical' involvement because the time frame of 'recent history' was unclear. Given the feedback from front line participants and the expert review, the final tailored SBAR form was revised to include 'historical' involvement. Professional judgment could then determine whether or not the historical involvement was relevant.

Minor revisions were made to items in the parenting category and situation section. As suggested, parenting items were rephrased differently to differentiate between a maternal concern and strength. Similar parenting items (attentive to baby's needs, responds appropriately to baby) related to attachment behavior were combined into one item (inattentive and inappropriate response to baby's needs) because separate items were perceived as unnecessary. In the situation section, the word 'reason' was added after 'discharged before the social work referral' to provide greater detail and a broader understanding of the patient scenario.

Although there was a lack of consensus, the required assessment summary statement in addition to completion of the recommendation section was perceived as redundant. The perceived redundancy of these items was unexpected. Some acute care participants perceived that assessment components were already communicated and therefore an assessment summary statement was unnecessary. Participants perceived that providers could make inferences regarding the assessment summary and recommended plan of care from the detailed patient information provided elsewhere on the tailored SBAR form (i.e., situation, background, and assessment sections [action taken in hospital, patient response]). Once again, when aspects of an innovation are perceived to have a negative outcome for either the patient or the provider, the end-user's attitude about the utilization of the innovation is impacted (Cabana et al., 1999; Langley et al., 2009; Rogers, 2003). However, assessment and plan of care are required components of documentation standards (ACSW, 2013; CARNA, 2013) and considered critical elements of SBAR communication and other related clinical handover tools (ACSQHC, 2011a). Thus, a decision was made against deleting the assessment and recommendation sections.

This study revealed two key advantages of using the tailored SBAR form: perceived improvement to the safety and quality of care and informed decision making. Study participants

suggested that effective communication through the tailored SBAR form could improve the safety and quality of care for at-risk mothers and newborns. The SBAR form was perceived to be a useful way to communicate quality information between care settings along the continuum. The tailored SBAR form was also seen to facilitate inter-professional collaboration by collectively contributing to the coordination of care between care settings. When discussing care coordination, participants identified an existing communication gap between CFSA and acute care providers regarding CFSA's plan of care in the community. This communication gap was perceived to limit the accuracy of information transferred on the form. As Oandasan et al. (2006) suggested, effective communication is essential for inter-professional collaboration and patient centered care.

Poor communication between child protection agencies and other health care providers had also been noted in previous research (Green, Rockhill, & Burrus, 2008). A minor revision was made to accommodate the unanticipated communication gap between acute care providers and CFSA. The final tailored SBAR form included an 'unknown' checkbox in relation to 'Planned CFSA follow-up' in order to accurately communicate CFSA's plan of care.

Overall, the SBAR form in this study was seen to act as a structure to facilitate communication. Perceptions of the participants in this study are consistent with SBAR research documenting improved communication (Clark, et al., 2009; Compton et al., 2012; Marshall et al., 2009; Moseley et al., 2012; Thompson et al., 2011;Woodhall et al., 2008) and improved patient outcomes (Field et al., 2011; Freitag & Carroll, 2011; Haig et al., 2006; Telem et al., 2011; Velji et al., 2008).

Informed decision making was perceived to be the second advantage of the tailored SBAR form. Effective communication between the acute care and community setting is

important for making informed decisions about care in the community. Study participants indicated that the tool informed decision making about environmental safety for the home visiting PHN; timing and prioritization of care; along with anticipating and planning care. This finding was consistent with Vardaman et al.'s (2012) study regarding the effect of SBAR on nurses' daily work experience. Participants in their study indicated that SBAR communication facilitated decision making by creating a mental template to organize and process information.

The initial quality improvement project (Mackay & Stosky, 2011) identified that poor information transfer had a negative impact on decision making specifically about timing of care, newborn safety, workload organization, and PHN safety. Therefore, the findings in this study are important as the tailored SBAR form could be viewed as a solution to the existing clinical handover issues. Recognized benefits of an innovation by the knowledge-/ end-user such as positive patient or practice outcomes are important to accepting and sustaining change (Castiglione & Ritchie, 2012). Conceivably, the perceived advantages of the SBAR form may facilitate uptake if implemented into practice.

Main theme 2: Professional judgment and comfort level regarding information sharing. Participants' perception about transferring information was impacted by both their professional judgment and comfort level with information sharing. Participants were willing to transfer information relevant to care in the community and the relevancy of information was determined by professional judgment. An influential factor of knowing what information was relevant for care was understanding the receiver's role and how the information may be used. Participants were concerned that SBAR form could be used inappropriately as a validated assessment tool rather than a communication tool among providers. Some participants believed that patients would likely be dissatisfied with care if health care providers used the checklist

approach on the form to assess psychosocial health. Hence, this notion was associated with the potential for poor outcomes related to patient satisfaction and perceived as a barrier. Directions on the tailored SBAR form and guideline were amended to clearly communicate to front line clinicians that the intended use of the form was a validated communication tool.

Study findings are consistent with scholars who suggest that knowledge about the roles and responsibilities of the receiver influenced provider's perception of what information to share (Barimani & Hylander, 2008; Cummings et al., 2010; Homer et al., 2009). Additionally, a previous quality improvement project and interviews about information transfer between the study settings (Mackay, 2011; Mackay & Stosky, 2011) confirm there is limited knowledge about the PHN's roles and responsibility that inhibit information transfer.

Attitudes as well as theoretical and experiential knowledge are all factors that influence professional judgment (Tanner, 2006). In healthcare, professional judgment is necessary because providers face an unlimited number of scenarios that require decision making to achieve the best possible health outcome for the patient (Thompson & Dowding, 2009). Professionals are responsible to make appropriate decisions and are accountable to those decisions. Professional judgment and comfort level with information sharing was a main theme and is linked to attitude.

The impact of not sharing adequate information has been noted by a number of authors. Inadequate information may negatively influence collaboration and coordination of care between settings and other agencies (ACSQH, 2010; Oandasan et al., 2006). The hesitation about sharing information is often related to understanding and interpretation of acts and professional regulations. Health information shared among care providers is guided by the Health Information Act (HIA) (Government of Alberta, 2011) which emphasizes that health care providers are to only share the minimal amount of information necessary to provide care.

Compliance with this principle presents challenges for providers because the sender of information may not know what and how much information the receiver requires to provide care. Therefore, professional judgment is an important element of deciding what and when to share information and with whom. Providers need to judge whether information is relevant for providing care and then make a decision whether or not to share that information. Professional judgment and comfort level with sharing information could either be a facilitator or barrier to transferring information pending each provider's confidence and judgment about sharing this information. Influential factors such as awareness of the receiver's role and compatibility with the sender's judgment regarding relevant information correspond with the same theoretical barriers and facilitators identified by Légaré (2009) related to knowledge and attitude.

Main theme 3: Motivational factors. Motivational factors were the third key theme that emerged. Satisfaction, time, and enthusiasm were important factors that could impact the sustainability of the tailored SBAR form if implemented into practice. Participants' perceptions in this study correspond with Moseley et al.'s (2012) findings that indicated SBAR communication significantly ($p < .002$) increased provider's overall satisfaction with clinical handover.

Participants perceived that time efficiencies were a positive motivator for using the tailored SBAR form, especially because of the heavy workload. Heavy workloads and resultant time constraints posed a strong motivational barrier which could negatively impact the use of the form. This finding is consistent with the literature (ACSQH, 2010; Gravel et al., 2006; Machaczek, Whietfield, Kilner, & Allmark, 2013; Riesenberg et al., 2010) and the initial quality improvement project (Mackay & Stosky, 2011) that preceded this research. In Gravel et al.'s (2006) review of barriers and facilitators, time constraint was identified as the most frequently

cited barrier across multiple settings. Participants in the quality improvement project also reported that time pressures due to heavy workloads impact the quality of information transferred. Therefore, time constraint is viewed as a strong barrier to information transfer regardless of the tool.

The third motivational factor was enthusiasm which included a willingness to use the tailored SBAR form. Participants were keen to use the form to improve clinical handover between the postpartum settings. Consistent with change experts (Langley et al., 2009, Chapter 4), satisfaction and enthusiasm were described as intrinsic motivational factors that could facilitate how readily the form is accepted if implemented in practice.

Rigorous development of this communication tool helped to strengthen the usefulness of the form. Findings from this study suggest that the tailored SBAR form could offer a plausible solution for improving the quality of clinical handover between the postpartum acute care and community settings. The tailored SBAR form could potentially facilitate communication and inform decision making which in turn could enhance the quality and safety of care.

Next Steps

The goal of this study was to develop a rigorous communication form to transfer maternal psychosocial information between acute care and community settings. The tailored SBAR form developed for this thesis was perceived to improve the overall quality of information transferred and resultant care. Given this understanding by providers and experts, it is proposed that the SBAR form has the potential to be a useful tool for clinical handover between the postpartum acute care and community setting.

Engagement and involvement of the stakeholders is critical to implementing a practice change (ACSQHC, 2011a; Straus et al., 2009). As suggested by ACSQHC (2011a), strategies

were used to engage key stakeholders that had a vested interest in improving information transfer. These strategies included face-to-face contact with relevant stakeholders, initial project briefing, project involvement, and continued updates. Leaders (clinical leads, nurse educators, and unit and program managers) were contacted in the planning stages of this study and participated in face-to-face meetings about project details and anticipated outcomes. Leaders also vetted the tailored SBAR form during the planning stages and suggestions were incorporated into the design. Electronic mail was used to update leaders as the study progressed. End-users were involved by participating in both the initial quality improvement project and in determining the usefulness of the SBAR form. To facilitate continued engagement, the results from this study will first be disseminated to the key stakeholders involved and then to broader group of knowledge brokers and knowledge-users.

Initially, a presentation of study findings will be offered to relevant leaders and decision makers involved with Women's Health in acute care and Public Health within Calgary Zone of AHS. The purpose of the presentation will be to build understanding and discuss with leaders and the decision makers the potential for the SBAR form to be a plausible solution to the existing clinical handover issue. Required Organizational Practice (Accreditation Canada, 2011) require health care organization to improve information transfer. This innovation is aligned with this requirement.

The end-users of this form are also important stakeholders. A presentation will be offered to participants and their interest will be sought in possibly participating in presentations for other end-users. Posters that indicate clinicians' involvement will be placed in visible locations on the respective study units to help disseminate study findings. Sharing the findings

in this visual way demonstrates clinicians' efforts to engage in innovations targeted at improving practice and patient outcomes.

Following dissemination of the results with key stakeholders, a presentation will be offered to the Provincial Clinical Handover working committee. The purpose of this presentation is threefold: (a) to follow-up from an initial presentation regarding this proposed study, (b) to consult with the working committee regarding potential pilot implementation, and (c) to explore and facilitate further dissemination possibilities with AHS. Additionally, a study abstract or manuscript will be submitted to academic journals and conferences related to patient safety and quality, women's health, public health, or pediatrics.

If leaders agreed to pilot the final SBAR form in the practice setting, a business case would be developed and presented to the relevant stakeholders. As suggested by implementation science experts (Brach, Lenfestey, Roussel, Amoozegar, & Sorensen, 2008; Castiglione & Ritchie, 2012), the business case would define the vision as well as identify the requirements for success; resources needed; potential risks and benefits; and possible required structural and process changes.

Implementation can be guided by the KTA framework by identifying interventions that would target specific barriers identified by this study related to external factors (time constraint), knowledge (i.e., lack of knowledge of PHN role, lack of familiarity of CFSA terminology), and attitude (i.e., professional judgment regarding relevant information, lack of expected positive outcome). Interventions would also need to address potential barriers related to the opportunity to trial the tailored SBAR form on a small scale and observe positive outcomes from using the tailored SBAR form. Strategies would be selected in consultation with the stakeholders and based on the likelihood of achieving a positive impact along with practicalities of the work

environment (i.e., time constraint, need for quick learning) (Wensing et al., 2009). Time constraint was a strong barrier to using the tailored SBAR form. Organizational interventions aimed at policy (i.e., guidelines and service provision) (Michie, van Stralen, & West, 2011) and resources (workload) would be required (Wensing et al., 2009) to positively influence the use of the form and relieve time pressures. Additionally, several multicomponent KT interventions would be required including: education (i.e., use of the tailored SBAR form, role of the PHN), training (i.e., simulated information transfer, interactive learning activities), and visual reminders (i.e., posters on the unit, reminders on the chart and fax machine) (Davis & Davis, 2009); audit and feedback (i.e., summarize information transfer performance) (Eccles & Foy, 2009); and linkage and exchange activities (i.e., unit champions, knowledge broker and outreach visits) (Foy & Eccles, 2009).

Monitoring and evaluating knowledge use are the next two steps in KTA action cycle that would require consideration. Change experts (Brach et al., 2008; Langley et al., 2009) recommend to initially implement change on a small scale and then quickly assess the change such as in the Plan-Do-Study-Act (PDSA) tool. Trialing the tailored SBAR form in this iterative way would be recommended to help minimize the barriers early on by providing prompt feedback and adapting the form as needed in the practice setting. In consultation with the stakeholders, consideration to structure, process, system, and patient outcome measures would be determined. Structural domain measures could include provider awareness of the form, provider satisfaction, and patient safety culture. Process measures could include the accuracy, completeness, and consistency of using the tailored SBAR form. Exemplars of system outcomes could be measures of time such as time spent completing the form, retrieving missing

information, and delays in care. Patient outcome measures could include satisfaction, timing, and type of care.

Sustaining knowledge use is the last step in the KTA cycle and consideration was given to this step during the initial planning stages. As suggested by Davies and Edwards (2009), sustainability planning needs to consider several key factors. Strategies (Davies & Edwards, 2009) to sustain the effective use of the tailored SBAR form in practice could include: integrating knowledge into policies and procedures regarding information transfer for Women's Health; incorporating knowledge into orientation; providing periodic reminders especially prior to predictable peaks in birth rate; sharing success stories; continuing engagement with key stakeholders including change champions (educators), opinion leaders (study participants, charge nurses, team leaders), and the provincial clinical handover committee; initiating engagement with networks of leaders and decision makers across Women's Health and Public Health.

Upon agreement to the implementation plan, the final tailored SBAR form would be forwarded to AHS forms management team to comply with the next steps in the organization's controlled form approval process. The existing transfer of information form would need to be replaced if the tailored SBAR form was implemented. The existing form includes physical and limited psychosocial maternal health concerns. Therefore, development of a tailored SBAR form regarding maternal physical concerns would be required. Transforming the tailored SBAR form to an electronic tool could be pursued to minimize barriers to information transfer such as confidentiality and legibility concerns.

Implications for Practice

This study was informed by a practice issue and in turn now has the potential to inform practice. Several important practice implications were highlighted. First, this study was action

oriented and demonstrated that the KTA framework was useful for guiding the systematic development and evaluation of a communication form. Consistent with the description of the KTA framework, the research process for this study was iterative and moved fluidly between the knowledge creation and action steps. The end product was the final tailored SBAR form. Incorporation of document design principles, content validity measures, and focus group interactions were all important steps for creating this rigorous communication form. The process of trialing the tailored SBAR form during the simulation was also an important part of creating the final product because the mock scenario provided a more in-depth understanding. The iterative and dynamic process required by the KTA framework added an element of complexity to the research process.

Second, this study showed that an SBAR form that was strength based and tailored to maternal psychosocial health information has the potential to improve information transfer between postpartum settings and consequently the quality of care. This is an important finding given that socially at-risk women are at higher risk for poor health outcomes (Kurtz-Landy et al., 2008; Myors et al., 2012) and patient care transitions between the acute care and community settings are a high risk point for patient safety (Wong et al., 2008). A tailored strength based psychosocial communication form may help guide providers' thinking regarding what information to transfer as well as shift thinking toward a balanced understanding of the patients' needs. This finding has implications for clinical handover practice as well as patient and family centered care.

Third, in this study professional judgment and comfort level with sharing information was an important factor for determining what health information was shared. Furthermore, knowledge of the receiver's role influences the sender's understanding of what information is

relevant. The tailored SBAR form helps address the sender's understanding by outlining the psychosocial information relevant to care in the community. Study findings also have implications for practice regarding the need for inter-professional education to improve communication and teamwork across the continuum. Inter-professional education may facilitate understanding about providers' roles at the next point of care and shared scopes of practice between nursing and social work. As a result, providers from a specific unit may be able to visualize a broader picture of the cross-continuum team. A broader understanding may facilitate teamwork and collaboration which are known to promote positive health outcomes for the patient, the provider, and the system (Oandasan et al., 2006).

Implications for the Supporting Infrastructure

In this study, from initiation to production of the tailored SBAR form, there was an integrated approach to the development of the form. Institutions (health care organizations and educational institutions) need to create conditions where multiple professions can come together to address clinical and provider concerns and build safer systems. The KTA framework was extremely useful in this study and can provide direction for both the scale-up of this existing form as well as the development, implementation, and evaluation of tools on a larger scale (i.e., clinical practice guidelines). Leaders (i.e., clinical nurse educators) should consider using the KTA framework as a guide to successfully plan, implement, and sustain evidence informed practice.

The tailored SBAR form could potentially be a useful way to facilitate effective communication and teamwork between health care settings and in turn influence the earlier identification of psychosocial risk factors, facilitate the coordination of care, and enhance PHN safety along with the safety and quality of care along the continuum. Both structures (i.e.,

leadership support, team training, and resources) and processes within and between organizations influence teamwork (Oandasan et al., 2006; Stead et al., 2009). Organizational silos and communication gaps exist between the postpartum acute care, CFSA, and community setting. Commitment from the supporting infrastructures is needed to positively influence inter-professional teamwork and decrease the existing silos. Leadership needs to prioritize inter-professional teamwork and focus resources on strategies for designing effective teams between the settings that may improve performance and outcomes (Agency for Healthcare Research and Quality [AHRQ], 2005; Stead et al., 2009). Training is a known way to improve teamwork and consideration needs to be given to enhancing key competencies including: knowledge (i.e., common goals, shared inter-professional roles between settings, and agencies); skill (i.e., written communication, anticipating what other clinicians may need to provide care) and attitude (i.e., shared vision, motivation to collaborate) (AHRQ, 2005). Training may help to build the respect and trust necessary to foster positive relationships between the teams in an effort to improve the safety and quality of care.

Another structural influence on clinical handover is the Health Information Act (HIA) (Government of Alberta, 2011). This act emphasizes that providers are to only share the minimum amount of information required to provide care. Therefore, the senders of information need to be clear about what information is required to provide care. Tailoring an SBAR form to a specific context may therefore be considered a useful strategy to inform providers about what information to share. Policy at all levels needs to consider how the HIA legislation influences inter-professional communication and teamwork in order to promote positive health outcomes for socially at-risk women and their families.

Time is a valuable resource. Findings from this study indicated that time constraints due to workload were perceived as a strong barrier to communicating through the tailored SBAR form. Time pressure is a real threat to teamwork and therefore the safety and quality of care. As such, time required for clinical handover needs to be prioritized and included in the resource allocation for direct patient care. Health care leaders face difficult decisions given limited resources and need to strongly consider the benefits of teamwork and communication.

Practice standards for the maternal/child population include health promotion, identification of risk, early intervention, and coordination of services across the system (Accreditation Canada, 2009). Information transfer is a Required Organizational Practice (ROP) linked to this standard of practice. A compliance measure of this ROP is documented evidence that indicates health care providers use a tool that results in adequate information transfer (Accreditation Canada, 2011). Therefore, findings from this study may contribute to health care policy in Alberta, if leaders decide to implement the tailored SBAR into clinical practice.

Implications for Research

This study addressed an existing knowledge gap regarding communication tools for transferring maternal psychosocial information from acute care to the community setting and contributed to the body of knowledge about SBAR communication. Future research is needed to evaluate the tailored SBAR form in the clinical setting. Similar to this study, a mixed methods approach (i.e., focus groups, chart audits) could be used to design the study. Considered outcome measures could include provider satisfaction; adequacy and accuracy of information transfer; and impact of the form on the safety and quality of care. In addition, the transformation and evaluation of an electronic version of the tailored SBAR form may be worthwhile.

Study Strengths and Limitations

Study rigor is determined by assessing the reliability and validity of study results (Streubert & Carpenter, 2011). Specific elements of this assessment include: consistency, credibility, dependability, confirmability, and generalizability or transferability of study findings.

The consistency and impartiality of research personnel may influence trustworthiness of the study findings (Krueger & Casey, 2009; Streubert & Carpenter, 2011). The research personnel were consistent throughout the study which was seen as a positive influence on the reliability of the findings. The researcher moderated all focus groups and analyzed the results while the trained research assistant recorded the field notes and participated in each debriefing. The researcher made a conscious effort to maintain neutrality throughout the study to minimize bias and enhance the reliability of the findings. The consistency of only one researcher examining and interpreting the data may also be viewed as a limitation.

Groupthink and social desirability were considered potential biases. The anonymous questionnaire was administered in an attempt to minimize both of these biases. Triangulation of both the quantitative and qualitative results helped to minimize potential biases and therefore contributed to the credibility and dependability of the results (Creswell & Clark, 2011; Loiselle et al., 2011). Member checking at the conclusion of each focus group along with data saturation also enhanced the credibility.

Confirmability of findings is demonstrated by following the research protocol (Krueger & Casey, 2009) and transparent outlining of the process used to draw study conclusions (Streubert & Carpenter, 2011). Throughout this study, the researcher precisely followed the protocol and took rigorous steps to help ensure reliability and validity. In Phase One, the researcher took an additional step to confirm the findings by comparing the I-CVI to the

modified kappa evaluation. Additionally, item and scale level content validity were both reported to provide clear information about the content validity of the risk and protective factors.

In Phase Two, the sequential and continuous data collection, systematic and continuous analysis (constant comparative technique), and subsequent audit trail (SPSS records, transcripts, field notes and debriefings) were important steps in assuring rigor. Data collection tools may also influence the dependability of the results. The tools for this study were not validated which was a drawback; although, the focus group questionnaire and interview guide were vetted and revised to improve clarity.

Generalizablity refers to a broader use of the knowledge beyond the study setting, whereas transferability refers to the use of knowledge in a similar setting and is determined by the knowledge-/end-user (Krueger & Casey, 2009; Streubert & Carpenter, 2011). The results from this study are not generalizable but may be considered transferable. Convenience sampling limited to one postpartum acute care site and three public health sites, participation rate, small number of participants (especially among social work participants) along with the small size of one group limited generalizablity. However, data saturation was achieved with data supporting the identified themes. This study did not occur in the real life setting which also limited generalizablity.

Conclusion

Clinical handover between postpartum settings is important to the safety and quality of care along the continuum and is particularly important when mothers with socially complex needs transition from the acute care to community setting. This study contributed to the clinical handover literature about SBAR communication and the application of the KTA framework.

A knowledge gap was identified regarding existing communication tools along with the usefulness of tailored SBAR communication between postpartum acute care and the community settings among inter-professionals. This biphasic descriptive mixed methods study addressed this knowledge gap by developing and evaluating the usefulness of an SBAR form that was tailored to communicate the socially complex needs of mothers. There was excellent item and scale level content validity of the tailored SBAR form. Nurses and social workers indicated that the tailored SBAR form would be useful for improving the quality of clinical handover between the postpartum acute care and community setting. The findings from both Phases informed the transformation of the initial tailored SBAR form to the final version. The overall positive response from participants could indicate how readily the form would be accepted if implemented into practice.

Transition to home and adaptation to life with a new baby is stressful for families. This adjustment may be further complicated by psychosocial challenges experienced by women. Findings from the study provided insight into a possible solution to improve clinical handover between the postpartum acute care and community settings that may facilitate this transition home. Although time intensive, rigorous development of the tailored SBAR form was an important initial step for creating a useful communication form.

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Appendix A

Postpartum Referral to Postpartum Community Services

calgary health region

Women's Health Portfolio

Postpartum Referral to Postpartum Community Services

From:

☐ **FMC** ☐ **PLC** ☐ **RGH**

☐ **Rural** _____

(Specify site)

ADDRESSOGRAPH

To be used ONLY if more space required than what is provided on NOB

The following concern(s) were identified during the client's postpartum acute care stay.

Concern	*Description & Interventions Initiated*
☐ **Breastfeeding**	
☐ **Infant Health**	
☐ **Maternal Health** ☐Physical Health ☐Mental Health	
☐ **Postnatal Specialty Appointments**	
☐ **Parent/Child Interaction**	
☐ **Social Issues*** ☐Financial/Food Security ☐ Family Violence ☐ Child & Family Services ☐ Past ☐Present ☐ Limited Social Support	***Provide description and/or social work summary**
☐ **Intrapartum/Delivery Complications**	
☐ **Other**	

Potential safety risk for visiting PHN ☐ no ☐ yes

If yes, please describe:

_____

Personnel completing the form: _____/_____

☐ RN ☐ LPN ☐ IBCLC ☐ Social Work

Appendix B

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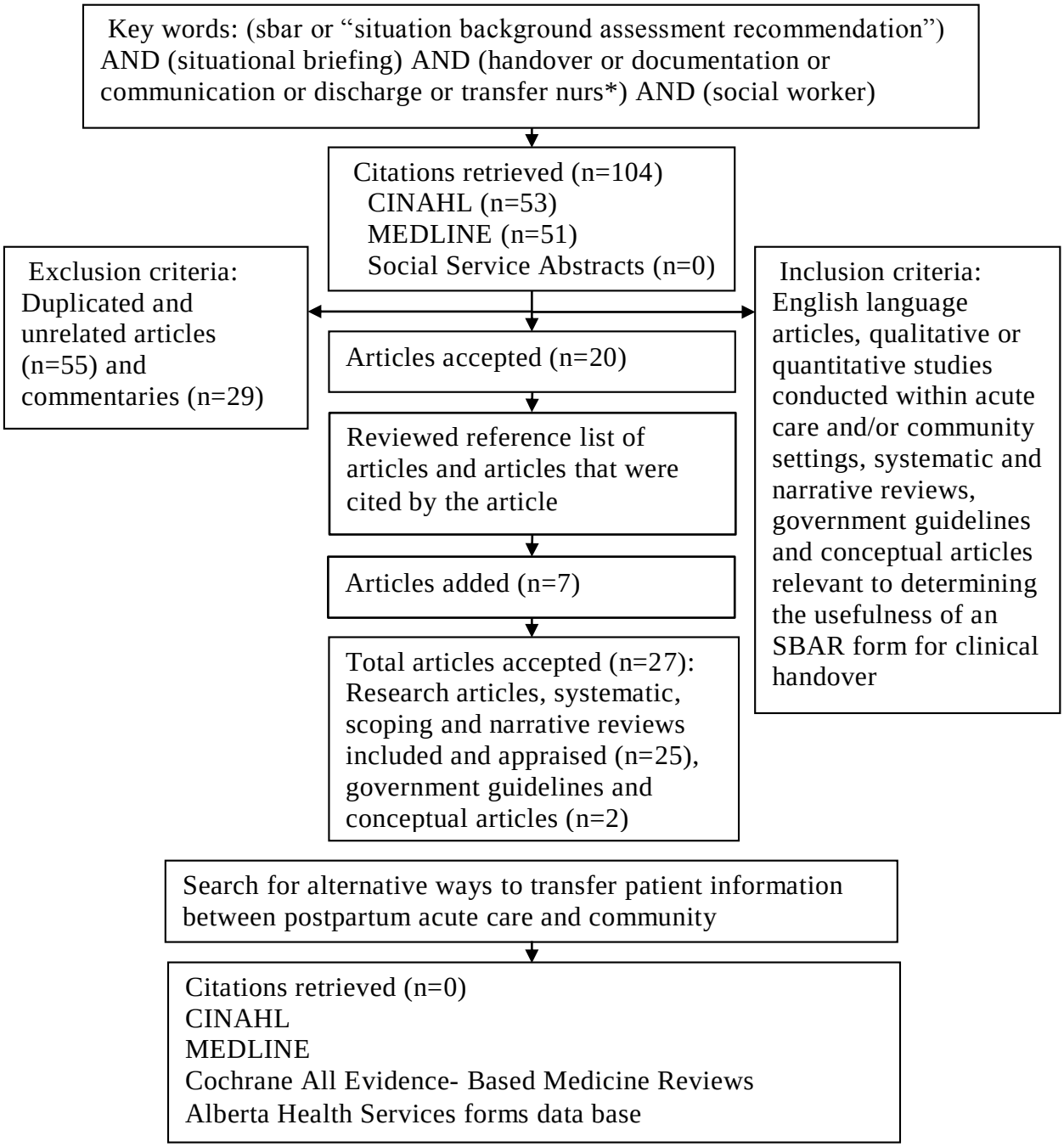
Type of use	Dissertation/Thesis
Requestor type	University/Academic
Format	Print and electronic
Portion	Figure/table
Number of figures/tables	1
Original Wiley figure/table number(s)	Figure 1
Will you be translating?	No
Order reference number	2
Total	0.0 USD

Appendix C

Literature Search Method and Selection Process for SBAR



Appendix D

Summary of Literature Related to SBAR

Author	**Design**	**Intervention**	**Data Collection**	**Key Findings**	**Comment**
Anderson & Helms (1998/USA)	Retrospective descriptive design Sample: Convenience sample of 455 referral records from nursing homes and 300 referral records from home health agencies Time frame: 6 months	Not applicable	Referral Data Inventory (RDI) was used to identify amount and type of information. RDI had established content validity; inter-rater agreement of RDI scores was > 92%	Psychosocial information was the least transferred in comparison to background, medical and nursing data. More information was transferred using a standardized form and a verbal handover than verbal only	Nursing homes received formal communication more often than home health agencies which may have been related to organizational factors such as fiscal ability Limitations: sample from single urban area
Andreoli et al. (2010/Canada)	Mixed method approach Phase 1: Implemented SBAR Phase 2: Evaluated safety culture; safety reporting; and situational use of SBAR Sample: Clinicians, support staff and leaders (n=85) from a geriatric and	SBAR education session	Pre-post survey: Hospital Survey for Patient Safety Culture; Team Orientation Scale Pre-post tracking of on-line safety reports Individual and focus group interviews	Post survey results for Hospital Survey for Patient Safety Culture: significant improvement (z >1.96) in 2/12 dimensions compared to rest of hospital (organizational learning continuous improvement, teamwork across hospital units) Study team pre-post Team Orientation Scale	Strengths: Compared study unit Hospital Survey for Patient Safety Culture results to rest of the hospital Limitations: Threats to internal validity (history) due to concurrent patient safety initiatives; small sample size

Author	Design	Intervention	Data Collection	Key Findings	Comment
	musculoskeletal rehabilitation unit Time frame: 6 months			survey: significant change (z >1.96) in 4/10 dimensions (effective communication with team, clear communication, standardized communication, individual team member role's valued) Major falls and near misses decreased in hospital and study unit but total falls increased in study units Focus groups results indicated that SBAR was used for debriefing, challenging, urgent and non-urgent communication	
Arora. et al (2005/USA)	Qualitative study: Critical Incident Review technique Sample: 26 general medicine interns	Not applicable	Interview data collected through critical incident technique	Poor Communication resulted from omitted content, illegible notes, and lack of face to face communication Inter-rater agreement of critical incident categories (k= 0.78-1.0)	Strengths: provided detailed description of data collection and analysis Limitations: critical incident technique relies on the participant

Author	Design	Intervention	Data Collection	Key Findings	Comment
					memory and ability to report incidents. Focus is on critical incidents and limits understanding on non-serious adverse events
Becket & Kipnis (2009/USA)	Mixed method approach Sample: Convenience sample of 215 staff (not defined) and 30 physicians in one hospital Time frame: 3 months	SBAR education session	Observation, interviews, Pre-post Safety Attitudes Questionnaire: Teamwork and Safety Climate Survey	Statistically significant improvement in 12/27 teamwork and safety climate dimensions; Qualitative findings suggested improved communication	Limitations: uncontrolled; low response rate (pre survey [n=141]; post survey[n=71]); Physicians did not participate in education session
Clark et al. (2009/Australia)	Action research Sample: Nurses and visiting medical officers in a hospital Time frame: 8 months	Assertive communication and patient assessment training Implemented SBAR handover template and prompt card	Questionnaire; focus group discussion	Reported improvements to handover (68%); confidence (80%); communication effectiveness (72%). 62% reported that SBAR guided communication	Limitations: limited study information (i.e., development of the tailored SBAR tool; no mention of findings for physicians); Multiple interventions limited evaluation of SBAR; 28% response rate (attributed response rate to concurrent

Author	Design	Intervention	Data Collection	Key Findings	Comment
					external events such as hospital renovations, change in questionnaire distribution)
Compton et al. (2012/USA)	Descriptive after only design Sample: Random selection of nurses (n=156) and Convenience sample of Physicians (n=155) within Baylor Health Care system (a range of nursing units Time frame: 1 month	Implementation of SBAR package (poster, presentation, CD worksheet, videos)	Nurse Audit tool: 2 structured interview questions; Physician survey tool: 3 questions and section for comments	Nurses: 97.4% received SBAR education; 58.3% used SBAR; Physicians: SBAR handover was more likely to be perceived as adequate (97.8%, $p <$ .0001); 92.6% of inadequate handovers were not in SBAR format. The primary reason for nurses not using SBAR was lack of comfort	Limitations: Limited study information; short time frame; inconsistent SBAR training among nurses; no SBAR training among physicians Authors identified possible response set bias among physicians
Cunningham et al. (2012/Australia)	RCT; Simulation setting Sample: Interns within 1 hospital (n=91) Time frame: 2 years	SBAR education (10 minute session)	Pre-post questionnaires (demographics, communication skill, level of assertiveness using the Validated Rathus Assertiveness Scale); blinded reviewers rated	Reviewer inter-rater reliability acceptable (Cohen $k > 0.7$); internal consistency between objective rating and global rating scales (Cronbach $\alpha > 0.7$). No change ($p = .051$) in objective rating score (amount of data provided) (SBAR group	Inconsistent findings with other studies Strengths: Study design Limitations: generalizability (single setting, simulation); experience within intern groups

Author	Design	Intervention	Data Collection	Key Findings	Comment
			presence of data items and global rating score of communication impact (measurement of clarity); duration of telephone referral; self-rated performance score	8.5 [IQR 7.0-9.0], control group 8.0 [IQR 6.5-8.0]); significant improvement (p = .003) in Global rating score (SBAR group 3.0 [IQR 2.0-4.0, control group 2.0 [IQR 1.0-3.0]); No significant change in duration (p = .852)	differed at time of testing
Dingley et al. (2008/USA)	Uncontrolled pre-test post-test design; Phase 1 of 2 Sample: Nurses in MICU and ACU units in one hospital, 495 communication events Time frame: 2 years	Implemented a communication tool kit including SBAR, team huddles, multidisciplinary daily goal sheet, escalation process	Phase one: observation of communication events, interviews.	MICU: significant decrease in mean time for communication (p = .01, 4.52 minutes to 3.37 minutes) (adjusted for time measurement issues i.e., failed attempts to contact provider), significant increase in resolution of clinical issue (67.7% to 80.2%, p = .04), no change in satisfaction. ACU: no statistically significant changes	Limitation: multiple communication strategies limited evaluation of SBAR alone

Author	Design	Intervention	Data Collection	Key Findings	Comment
Donahue et al. (2011/USA)	Mixed method study Sample: Paraprofessional staff at 1 hospital (n=280) Time frame: 2 years	Phase 1: EMPOWER (Educating and Mentoring Paraprofessionals On Ways to Enhance Reporting) module (training scenarios, pocket cards, information sheets, champions) developed through focus group feedback, usability testing and content analysis Phase 2: Implementation of EMPOWER module	Pre-post survey: Hospital Survey on Patient Safety Culture Follow-up focus groups	Pre-response rate (65%); Post response rate (41.1%) Use of SBAR increased following training (74% to 90%). Patient safety culture changes: decreased perception of being written up for reporting event (33% to 21.7%); increased perception that hospital management prioritizes patient safety (78% to 86%); increased the number of times communicated with physicians (18.6% to 30%); focus group findings indicated an increased satisfaction and confidence	Limitations: Limited reported results; multiple communication strategies simultaneously introduced along with leadership Walk Rounds
Field et al. (2011/USA)	RCT Sample: 26 nursing homes with 435 nursing home residents Time frame: 1 year	SBAR communication protocol (i.e., training, tracking patients on warfarin)	Retrospective form review and then data categorized by blinded physicians.	International normalized ratio (INR) within therapeutic range 4.5% more often than control group (95% CI, (0.31%-8.69%)	Strengths: Study design Limitations: Insufficient power due to small sample size; Wide

Author	Design	Intervention	Data Collection	Key Findings	Comment
			Data was adjusted for clustering within the nursing homes, length of time on warfarin as well as patient and abstractor attributes. Inter-rater reliability ranged (k = 0.61-0.93)	achieved statistical significance	confidence interval therefore cannot be certain of the effect of SBAR
Freitag & Carroll (2011/USA)	Failure mode and effect analysis approach Uncontrolled pre-post-test design Sample: Nurses at 1 hospital Time frame: 3 months	Implementation of a tailored electronic SBAR including education and coaching	Press-Ganey patient satisfaction scores; Nursing Quality Indicators (patient falls, restraint rate usage, catheter associated urinary tract infections) reported to National Database	Overall patient satisfaction improved with hospital bedside handover (4.4%); health outcomes: fall rate decreased (5 %), patient restraint rate decreased (31%), catheter associated urinary tract infection rate decreased (34%)	Limitations: limited study information; Authors identified several confounding factors (i.e., new staff)

Author	Design	Intervention	Data Collection	Key Findings	Comment
Haig et al. (2006/USA)	PDSA methodology Uncontrolled pre-test post-test design Sample: St. Joseph's hospital-across disciplines Time frame: 1 year	Training included SBAR education and strategies to promote SBAR (i.e., reminders, posters)	Global trigger tool; medication reconciliation	Admission medication reconciliation increased from 72-88%, discharge medication reconciliation increased from 53-89%, adverse events decreased from 89.9-39.96/1000 patient days and adverse drug events decreased from 29.97-17.64/1000 patient days	Limitation: Insufficient study information to understand conclusions
Marshall et al. (2009/Australia)	Controlled post-test only design; simulation setting Sample: Random assignment by an independent educator; final year medical students, intervention group (n=83), control group (n=85)	ISBAR education session	20 item researcher developed scoring sheet to analyze presence of content	Blinded reviewers demonstrated an adequate inter-rater reliability [mean kappa value (0.87)]; Clarity and content of communication was significantly higher in the intervention group ($p < .001$)	Strengths: randomization, controlled Limitation: No baseline measures, Simulation setting limited generalizability
Moseley et al. (2012/USA)	Uncontrolled pre-test post-test design Sample: Neurology residents at 1 hospital (n=33) Time frame: 3 months	Implementation of a tailored SBAR formatted sign-out	Pre and post-test electronic survey	Significantly more likely to share test results with patients ($p = .037$) and update electronic service list ($p = .045$); significant increase in perception that transferred data was	Limitations: Limited study information Authors identified a possible sampling (61% post response rate) and reporting bias

Author	Design	Intervention	Data Collection	Key Findings	Comment
				complete (49%-80%, [p = .041]); satisfaction (scale from 1-10) (6.2$\pm$ 1.6-7.4$\pm$1.3, [p = .002])	
Pothier et al. (2005/England)	Post-test only; simulation setting Sample: Nurses (n=5)	Random assignment of scenario and clinical handover method: verbal only, verbal and note taking or written	Blinded reviewers evaluated and compared the content of each clinical handover	Written handover patient information was least likely to be lost followed by verbal and written and then only verbal handover. More background and medical information was transferred than social and nursing information	Strength: Randomization, blinded reviewers Limitations: Short time frame between handovers not reflective of clinical setting which may influence patient information recall; small sample size
Telem et al. (2011/USA)	Controlled pre-test post-test design Sample: Surgical residents from 1 hospital Intervention group (general surgery residents, n=45); Control group (subspecialty surgical residents, n=20) Time frame: 2 months	SBAR education session	Survey about perceived handover challenges; order entries electronically identified; sentinel events identified through a morbidity and mortality database	Significant decrease in wrong order entries (14.5% to 12.2%, p = .003) in the intervention group and no change in control group (12.9% to 13.6%, p = .47) No statistical difference in sentinel events between groups	Strengths: Controlled study Limitation: limited information about survey; short timeframe

Author	Design	Intervention	Data Collection	Key Findings	Comment
Thompson et al. (2011/ Australia)	Mixed method approach Uncontrolled pre-test-post-test design, Sample: Junior medical officers (n=44) in one hospital Time frame: 11 weeks	ISBAR education session	Audiotape recording of handover.19 core data categories were scored. Likert scale survey used to measure perception of handover and educational session	Statistically significant increase in information transferred;71% perceived improved handover and 80% found education improved skill and confidence of handover; no change found in duration of handover	Limitations: No mention of pre-testing of questionnaire; small sample size; 55 % of medical officer fully participated in the intervention; short timeframe
Vardaman et al. (2012/USA)	Qualitative Case Study Sample: Nurses (n=66), nurse managers (n=9) and physicians (n=5) from 2 hospitals	Not applicable	Semi-structured interview, observation of activities and documentation	4 themes identified: schema formation (provides a cognitive template for decision making), development of legitimacy (fosters credibility), development of social capital (fosters trust, legitimacy and teamwork), reinforcement of dominant logics (standardization)	Strengths: provided detailed description of data collection and analysis Limitations: study design limits generalizability; researcher reflexivity not provided

Author	Design	Intervention	Data Collection	Key Findings	Comment
Velji et al. (2008/Canada)	Multiphase study Phase 1: Adapted SBAR tool through focus groups and patient safety experts Phase 2: Implemented SBAR Phase 3: Evaluated SBAR using a controlled pre-test-post-test design Sample: Clinical and non-clinical staff on a stroke rehabilitation unit (n=43); Patients on study unit Time frame:1 year	SBAR education session	Hospital Survey for Patient Safety Culture Client Perspectives of Rehabilitation Services questionnaire Hospital on-line safety reporting	Post unit survey: Significant improvement ($p < .05$) in 5/12 dimensions (organizational learning, communication openness, feedback and communication about error, staffing, management support for patient safety); Significant improvement in 2/12 dimensions in comparison to rest of hospital (organizational learning, feedback and communication about error); patient satisfaction minimally improved	Limitations: Threats to internal validity (history) due to concurrent patient safety initiatives; small sample size

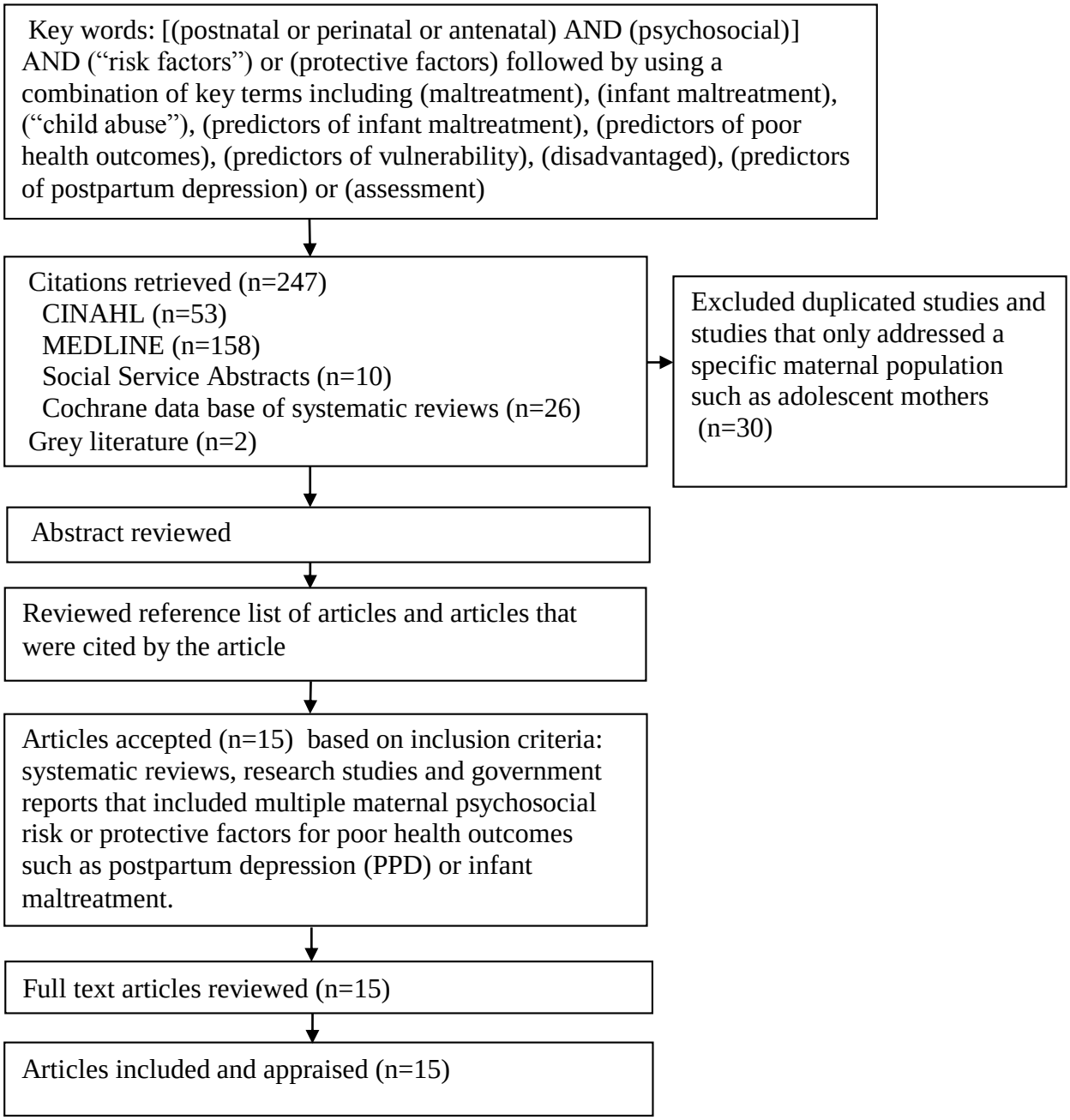
Author	Design	Intervention	Data Collection	Key Findings	Comment
Wentworth et al. (2012/USA)	Uncontrolled pre-test post-test design Sample: Nurses (n=138) in a Progressive care unit (PCU) with medical and interventional cardiology	Participatory approach to tool development; Implementation of an electronic SBAR tool	Pre-post electronic survey	Response rate (37%) Participants reported that the SBAR tool was more efficient (especially for workflow) and useful than traditional verbal handover; no change in duration of form completion; Electronic SBAR showed improved compliance in comparison to the initial paper version	Strengths: Survey vetted by experts for clarity and completeness Limitations: Limited study information including reported results
Woodhall et al. (2008/USA)	Uncontrolled pre-test post-test design Sample: Nurses and Physicians within 1 hospital Time frame: slightly more than 1 year	SBAR education session (posters, pocket cards)	Pre-post survey	Physicians reported improvement to information conciseness (60 to 90%); clarity (76 to 100%); organization and preparedness (53 to 90%); accuracy (64 to 90%); satisfaction (64 to 100%). Nurses reported increased confidence in handover	Limitations: Limited study information

Author	Type of Article	Comments
Australian commission on Safety and Quality in Health Care (2010/Australia)	National Clinical Handover Initiative Implementation guide. OSSIE (Organizational leadership, Simple solution development, Stakeholder engagement, Implementation, Evaluation and maintenance) Guide to clinical handover	Step by step guide to clinical handover improvement that encompassed emotional intelligence principles, empowerment, flexible standardization, iterative process, minimum data set. Suggested that standardization provides a common understanding of the purpose and required content for clinical handover. Handover content should be determined by what information is required to transfer responsibility and accountability.
Leonard et al. (2004/ USA)	Descriptive document on clinical projects aimed to improve teamwork and communication and the understanding of human factor	Recommended to change language from discharge to patient transfer. Findings from clinical projects: Transfer checklist with force functions increased information transfer, improved communication and decreased readmissions. Perioperative briefings resulted in eliminating wrong site surgeries, improved nursing retention
Manser et al. (2011/Switzerland)	Narrative literature review on improvements to clinical handover	Identified that there is limited research on clinical handover content; handover processes; strategies to improve handover and outcomes directly related to patient safety.

Author	Type of Article	Comments
Riesenberg et al. (2009/USA)	Systematic literature review	Mnemonic handover literature review. Literature included articles from 1987-2008. Authors found limited rigorous research on the effectiveness of mnemonic handover. The most cited mnemonic is SBAR. Limitations: limited information to assess quality of review
Riesenberg et al. (2010/ USA)	Systematic literature review	Literature included articles from 1987-2008; only included USA studies. Thorough review and description of method. Identified strategies for effective handovers including: standardized minimum data set communication tool; standardized process; staff engagement in improvement strategies. Authors identified that most of the existing handover research lacks rigor.
Wong et al. (2008/Australia)	Scoping literature review	Written for the Australian Commission on Safety and Quality in Health Care. Authors suggested that the rigor of existing research is limited. Focus has been on the errors within handover and future research needs to include interventions to improve handover. Limitation: limited information provided about quality appraisal method

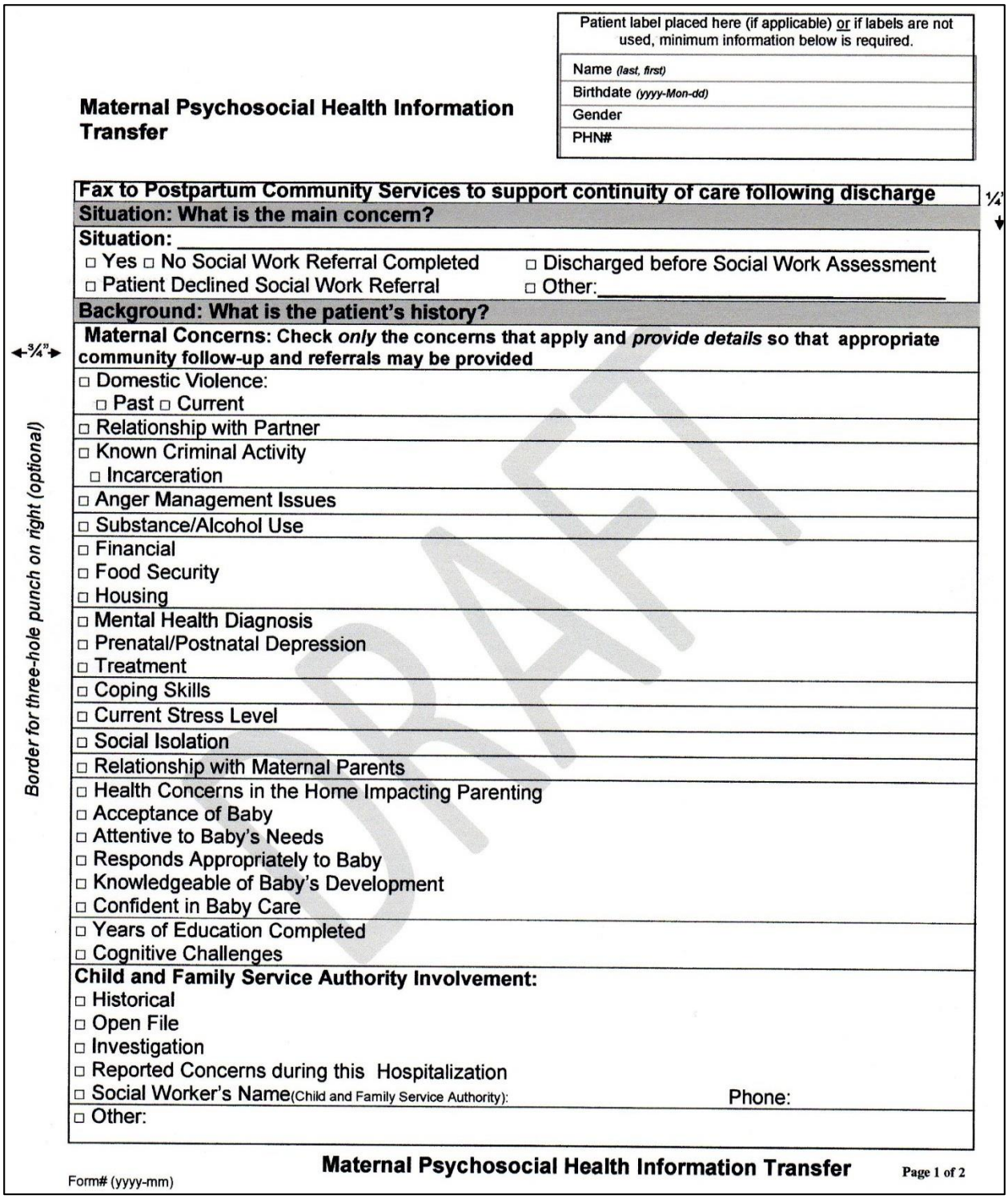
Appendix E

Literature Search Method and Selection Process for Maternal Psychosocial Risk and Protective Factors



Appendix F

Initial Tailored SBAR Form



Patient label placed here (if applicable) or if labels are not used, minimum information below is required.

Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Maternal Psychosocial Health Information Transfer

Fax to Postpartum Community Services to support continuity of care following discharge

Situation: What is the main concern?

Situation: _____

□ Yes □ No Social Work Referral Completed
□ Discharged before Social Work Assessment
□ Patient Declined Social Work Referral
□ Other:_____

Background: What is the patient's history?

Maternal Concerns: Check *only* the concerns that apply and *provide details* so that appropriate community follow-up and referrals may be provided

□ Domestic Violence:
□ Past □ Current
□ Relationship with Partner
□ Known Criminal Activity
□ Incarceration
□ Anger Management Issues
□ Substance/Alcohol Use
□ Financial
□ Food Security
□ Housing
□ Mental Health Diagnosis
□ Prenatal/Postnatal Depression
□ Treatment
□ Coping Skills
□ Current Stress Level
□ Social Isolation
□ Relationship with Maternal Parents
□ Health Concerns in the Home Impacting Parenting
□ Acceptance of Baby
□ Attentive to Baby's Needs
□ Responds Appropriately to Baby
□ Knowledgeable of Baby's Development
□ Confident in Baby Care
□ Years of Education Completed
□ Cognitive Challenges

Child and Family Service Authority Involvement:

□ Historical
□ Open File
□ Investigation
□ Reported Concerns during this Hospitalization
□ Social Worker's Name(Child and Family Service Authority): Phone:
□ Other:

Border for three-hole punch on right (optional)

Form# (yyyy-mm)

Maternal Psychosocial Health Information Transfer

Page 1 of 2

DRAFT

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.
Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Maternal Psychosocial Health Information Transfer

¼" ↓

Maternal Strengths: Check all strengths that apply and provide details so that appropriate community follow-up may be provided

- □ Financial Ability to Meet Basic Needs
- □ Community Resources Already in Place (*Specify*):
- □ Support Network (*Who*):
- □ Coping Skills
- □ Attentive to Baby's Needs
- □ Responds Appropriately to Baby
- □ Knowledgeable of Baby's Development
- □ Confident

Other:

Assessment: What do you think the concerns are?

Concerns identified:

Action taken in hospital including a safety plan if required:

Patient's response:
□ Yes □ No Concerned about Issues
□ Yes □ No Receptive to Support

Recommendation: What do you think the Community Healthcare Provider needs to follow-up on?

Check all that apply to support continuity of follow-up care and referrals

- □ No Further Follow-up Required
- □ Planned Child and Family Service Authority Follow-up:
- □ Domestic Violence
- □ Substance/Alcohol Use
- □ Finances
- □ Housing
- □ Mental Health
- □ Relationship with Partner
- □ Social Isolation
- □ Parenting
- □ Other:

Social Worker:_____ Nurse:_____
(Printed name/signature) (Printed name/signature)

Date:(yyyy-Mon-dd)	Time:(hh:mm)	Phone: Pager:

Maternal Psychosocial Health Information Transfer Page 2 of 2

←¾"→

Page two (if needed) - Border for three-hole punch on right (optional)

Form# (yyyy-mm)

DRAFT

Appendix G

Study Invitation

Actual date

To (expert reviewer),

I am a Masters student at the University of Calgary, Faculty of Nursing with an interest in patient safety and quality care. Currently, I am employed as a public health nurse in Postpartum Community Services in Calgary. I am inviting you to participate as a content expert in a study titled 'Usefulness of a Tailored *'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings'*.

Information transfer as part of clinical handover is imperative to continuity of care and ultimately patient safety. Research suggests that a tailored Situation-Background-Assessment-Recommendation (SBAR) form may improve the quality of clinical handover. The aim of this study is to evaluate the content validity of a tailored SBAR form as well as understand clinicians' perception of the usefulness of the form to transfer maternal psychosocial information between the postpartum acute care and community.

I am developing a tailored SBAR form that is intended to be used as a written communication tool for transferring maternal psychosocial health information from postpartum acute care to the community setting. The tailored SBAR form is meant to facilitate communication along the continuum of care and designed to create a common understanding of the patient's needs for follow up care and support in the community.

The tailored SBAR form is to be completed when maternal psychosocial concerns are identified by either nursing or social work from acute care. The social worker is to complete the form on each postpartum patient assessed. Nursing staff is to complete the form in situations where nursing has identified concerns but social work will not be assessing the patient.
The design and content of the form is based on evidence from the literature and offers a structured guide to summarize and standardized the content of information to be transferred such as maternal psychosocial risk factors, protective factors and recommendations for continued care.

You are being asked to be a content expert because of your clinical expertise of postpartum women and their babies. Your participation is important to evaluating the content of the tailored SBAR form for relevancy and completeness. Participation will require you to review the tailored SBAR form and then complete a questionnaire related to the clarity, relevancy and completeness of the maternal psychosocial risk and protective factors that make up the background section of the form. You will be asked to complete a second questionnaire if any additional content is suggested by the expert review panel.

Participation in the study is voluntary and you may withdraw from participating in the study at any time and without penalty. You may withdraw from the study by contacting the researcher by either telephone or email. If you decide to withdraw from participating, the information you have provided will be retained and may be used in the research. Your completion of the questionnaire will imply tacit consent. The data collected and your participation will be kept anonymous and confidential where possible. The information collected may only be accessed by those who are involved in the research project. The University of Calgary Conjoint Health Research Ethics Board will have access to the records. Your information will be kept for 5 years.

This study has been granted permission by Alberta Health Services and has been approved by the Conjoint Health Research Ethics Board (Ethics ID: # 24956 Version number: 1.0 date: September 10, 2012).

Please contact me if you are willing to be a content expert or would like more information about the study. You can contact me by e-mail jennifer.mackay@ucalgary.ca or by phone at 403.208.2074.

Sincerely,

Jennifer MacKay RN, BSN, IBCLC
Master of Nursing Student, University of Calgary

Principle Investigator: Dr. Debbie White
Associate Dean Research
dwhit@ucalgary.ca, 403. 210.9627

Appendix H

Expert Questionnaire

UNIVERSITY OF CALGARY

FACULTY OF NURSING

This questionnaire is intended to provide the study with information about your judgment of the background content of the tailored SBAR form. Maternal concerns represent psychosocial risk factors that may increase the probability of negative maternal or newborn health outcomes. Conversely, maternal strengths represent maternal psychosocial protective factors that may buffer the level of risk.

Language barrier, lack of prenatal care and education, age of mother, smoking and medical needs of the infant such as those related to prematurity are risk factors that were intentionally excluded from the tailored SBAR form because this information is transferred to community through the Provincial Notice of Birth.

Consider your recent review of the form. Please circle the number that best describes your judgment of the items' relevancy to maternal psychosocial risk and protective factors that influence maternal or newborn health outcomes.

Content item	Relevancy			
Maternal concerns				
Domestic Violence: Past or Current	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Relationship with Partner	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Known Criminal Activity	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Incarceration	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Anger Management Issues	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Substance/Alcohol Use	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant

Financial	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Food Security	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Housing	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Mental Health Diagnosis	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Prenatal/Postnatal Depression	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Treatment for Mental Health Diagnosis	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Coping Skills	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Current Stress Level	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Social Isolation	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Relationship with Maternal Parents	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Health Issues in Home Impacting Parenting	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Acceptance of Baby	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Attentive to Baby's Needs	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Responds Appropriately to Baby	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Knowledgeable of Baby's Development	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Confident in Baby care	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Years of Education Completed	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Cognitive Challenges	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Child and Family Service Authority Involvement: Historical	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Child and Family Service Authority Involvement: Open file	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Child and Family Service Authority Involvement: Investigation	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Child and Family Service Authority Involvement: Reported Concerns during this Hospitalization	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant

Maternal strengths				
Financial Ability to Meet Basic Needs	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Community Resources Already in Place	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Support Network	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Coping Skills	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Attentive to Baby's Needs	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Responds Appropriately to Baby	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Knowledgeable of Baby's Development	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant
Confident	1 not relevant	2 somewhat relevant	3 quite relevant	4 highly relevant

Please check the response that best describes your judgment of the forms clarity and completeness of maternal psychosocial risk and protective factors for poor maternal or newborn health outcomes.

1. Each content item is **clear** to understand.
□ Yes □ No
If no, specify what item is not clear and comment of possible revisions to the item:

2. Critical psychosocial maternal information is **omitted** on the form.
□ Yes □ No
If yes, specify what information is missing

Appendix I

Focus Group Study Invitations

Actual date

To the postpartum RNs and LPNs,

I am a Masters student at the University of Calgary, Faculty of Nursing with an interest in patient safety and quality care. Currently, I am employed as a public health nurse in Postpartum Community Services in Calgary. I am inviting you to participate in a study titled *'Usefulness of a Tailored 'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings'.*

Information transfer as part of clinical handover is imperative to continuity of care and ultimately patient safety. Research suggests that a tailored Situation-Background-Assessment-Recommendation (SBAR) form may improve the quality of clinical handover. The purpose of this study is to further develop the content of the tailored SBAR form as well as to understand clinicians' perception of the usefulness of the form for transferring maternal psychosocial information between the postpartum acute care and community setting.

Participation in the study is voluntary and you may withdraw from participating in the study at any time and without penalty. If you consent to participate you will be required to participate in a focus group. If you participate in this study you will be given a $25.00 stipend as support for any potential costs you may incur.

The focus group will require two hours of your time and will take place in a convenient location. Participation will include instruction on the use of the form, a simulation involving using the tailored SBAR form followed by a questionnaire and discussion. The data collected and your participation will be kept anonymous and confidential to the extent possible.

This study has been granted permission by Alberta Health Services and has been approved by the Conjoint Health Research Ethics Board (Ethics ID: # 24956 Version number: 1.0 date: September 10, 2012).

Please contact me if you would like to participate or would like more information about the study. You can contact me by e-mail jennifer.mackay@ucalgary.ca or by phone at 403.208.2074.

Sincerely,

Jennifer MacKay RN, BSN, IBCLC
Master of Nursing Student, University of Calgary

Principle Investigator: Dr. Debbie White
Associate Dean Research
dwhit@ucalgary.ca, 403. 210.9627

Actual date

To the regular postpartum social workers,

I am a Masters student at the University of Calgary, Faculty of Nursing with an interest in patient safety and quality care. Currently, I am employed as a public health nurse in Postpartum Community Services in Calgary. I am inviting you to participate in a study titled 'Usefulness of a Tailored *'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings'.*

Information transfer as part of clinical handover is imperative to continuity of care and ultimately patient safety. Research suggests that a tailored Situation-Background-Assessment-Recommendation (SBAR) form may improve the quality of clinical handover. The purpose of this study is to develop the content of the tailored SBAR form as well as to understand clinicians' perception of the usefulness of the form to transfer maternal psychosocial information between the postpartum acute care and community setting.

Participation in the study is voluntary and you may withdraw from participating in the study at any time and without penalty. If you consent to participate you will be required to participate in a focus group. If you participate in this study you will be given a $25.00 stipend as support for any potential costs you may incur.

The focus group will require two hours of your time and will take place in a convenient location. Participation will include instruction on the use of the form, a simulation involving using the tailored SBAR form followed by a questionnaire and discussion. The data collected and your participation will be kept anonymous and confidential to the extent possible.

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Please contact me if you would like to participate or would like more information about the study. You can contact me by e-mail jennifer.mackay@ucalgary.ca or by phone at 403.208.2074.

Sincerely,

Jennifer MacKay RN, BSN, IBCLC
Master of Nursing Student, University of Calgary

Principle Investigator: Dr. Debbie White
Associate Dean Research
dwhit@ucalgary.ca, 403. 210.9627

Actual date

To the PHNs in Postpartum Community Service,

I am a Masters student at the University of Calgary, Faculty of Nursing with an interest in patient safety and quality care. Currently, I am employed as a public health nurse in Postpartum Community Services in Calgary. I am inviting you to participate in a study titled 'Usefulness of a Tailored *'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings'*.

Information transfer as part of clinical handover is imperative to continuity of care and ultimately patient safety. Research suggests that a tailored Situation-Background-Assessment-Recommendation (SBAR) form may improve the quality of clinical handover. The purpose of this study is to develop the content of the tailored SBAR form as well as understand clinicians' perception of the usefulness of the form to transfer maternal psychosocial information between the postpartum acute care and community setting.

Participation in the study is voluntary and you may withdraw from participating in the study at any time and without penalty. If you consent to participate you will be required to participate in a focus group. If you participate in this study you will be given a $25.00 stipend as support for any potential costs you may incur.

The focus group will require two hours of your time and will take place in a convenient location. Participation will include instruction on the use of the form, a simulation involving using the tailored SBAR form followed by a questionnaire and discussion. The data collected and your participation will be kept anonymous and confidential to the extent possible.

This study has been granted permission by Alberta Health Services and has been approved by the Conjoint Health Research Ethics Board (Ethics ID: # 24956 Version number: 1.0 date: September 10, 2012).

Please contact me if you would like to participate or would like more information about the study. You can contact me by e-mail jennifer.mackay@ucalgary.ca or by phone at 403.208.2074.

Sincerely,

Jennifer MacKay RN, BSN, IBCLC
Master of Nursing Student, University of Calgary

Principle Investigator: Dr. Debbie White
Associate Dean Research
dwhit@ucalgary.ca, 403. 210.9627

Appendix J

Recruitment Poster

UNIVERSITY OF CALGARY NURSING

Faculty of Nursing

PARTICIPANTS ARE NEEDED FOR RESEARCH ON A TAILORED SBAR FORM

You are invited to participate in a study!

This study will investigate the usefulness of a tailored Situation-Background-Assessment-Recommendation (SBAR) form to transfer information between the hospital and Postpartum Community Services for socially high-risk mothers.

Participation in the study is voluntary. If you consent to participate you will be required to participate in a focus group.

Please contact me if you are a social worker, RN, LPN or public health nurse and you would like to participate or would like more information.

Contact information:

Jennifer.Mackay@ucalgary.ca

Phone: 403.208.2074

This study has been granted permission from Alberta Health Services and approved by the Conjoint Health Research Ethics Board.

Ethics ID: #24956
Study Title: Usefulness of a Tailored 'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings
PI: Dr. Debbie White
Version number: 1.0 date: September 10, 2012

Appendix K

Maternal Psychosocial Health Information Transfer Guideline Instruction

Background (30-40 minutes)

Purpose of this study:

- to further develop a written communication form to transfer information between postpartum acute care and community settings

- to describe providers' perception of the usefulness of the form for improving the quality of clinical handover between the acute care and community settings for women socially at risk

Plan:

- The results from this study will be used to revise the communication form

- Then it is anticipated that the revised form and results from this study will be presented to leaders and decision makers in Calgary including Allied Health, Women's Health and Public Health with the intent that this tailored SBAR form may possibly be used beyond the study setting and may look at possibly implementing the tailored SBAR form within other Women's Health acute care across Calgary Zone and possibly within Public Health settings such as Alberta Vulnerable Infant Response Team, Best Beginnings and Well Child.

Importance of this study:

- Communication and teamwork is key to patient safety and the quality of care provided.

- This is particularly important for socially at-risk mothers.

- In 2011, as part of a course, I co-led a patient safety and quality project on your unit around the transfer of patient information from acute care to community.

- Some of the staff on your unit participated as well as PHNs (or acute care).

    - Process mapping was completed at both sites.

    - The project showed that there were many instances where insufficient patient information was transferred from the different acute care sites in Calgary to the community setting.

- The project demonstrated that it was difficult for acute care health providers to know what information to send to community nurses and the current form may be an ineffective way to transfer information.

Build understanding

- As a result of findings from the patient safety and quality course and other graduate work, an SBAR form for transferring maternal psychosocial health information was developed.

- As part of this study, I would like to understand health care providers' perception of the usefulness of the tailored SBAR form for improving the quality of clinical handover between the acute care and community settings for women socially at risk.

SBAR:

- SBAR stands for 'situation, background, assessment, recommendation'.
- Many of you may know of and practice SBAR communication already.
- 'S' stands for Situation: What is the main concern?
- 'B' stands for Background: What are the facts? or patient's history?
- 'A' stands Assessment: What do you think the problem is? What is your overall assessment/concern?
- 'R' stands Recommendation: What is the plan moving forward?
- SBAR provides a guide for the way healthcare providers communicate and may help organize the information to be shared.
- SBAR may help healthcare providers communicate the problem clearly and concisely.

Design and development of the tailored SBAR form:

- I have developed a content specific SBAR form for socially at-risk mothers.
- The tailored SBAR form is a communication tool and <u>not</u> an assessment tool.
  - The tailored SBAR form was created to meet the design criteria set by AHS's forms management design program.
  - The form is structured according to SBAR format and then each section has check boxes specifically related to maternal psychosocial health information.
  - The content of the form is based on evidence from the literature and an expert review panel.
  - The content of the form includes psychosocial risk factors that influence poor health outcomes such as postpartum depression and infant maltreatment and also includes to maternal strengths that may buffer the risk.

- Review Maternal Psychosocial Health Information Transfer Guideline and provide time for discussion.

- Briefly review the SBAR form (section and purpose of each section)
- Hand out practice scenarios
- Provide 5-10 minutes for participants to gain familiarity with the form.
- Review two practice scenarios and then discuss when, how and what patient information from the scenario may be transferred.

Social work practice Scenario

A 20 year old primiparous woman presented to the postpartum unit following the delivery of a 37 week gestational age female infant. She had little prenatal education, grade 10 education and a history of cocaine and marijuana use in the first trimester of her pregnancy. The mom disclosed to the health care provider that the father of the baby was physically abusive toward her before she was pregnant. She reports that she feels safe to go home with her partner following discharge. The mom reported having some depression as a teenager and felt this may have been related to the physical abuse she experience as a child by her dad beating her when he was drunk. She had tried antidepressants but did not like the way they made her feel and stopped taking them after two months. Currently, the mom denies any depressive symptoms. She and her partner moved to Calgary from British Columbia two months ago to find employment. She does not know anyone in Calgary. She told the health care provider she is so happy to be a mom and wants to 'do it right' for her baby. The mom asked the health care provider for help with breastfeeding. On several occasions the health care provider observed her softly speaking while holding the baby with skin to skin contact. The health care provider identified that the mom was able to provide baby care appropriately and confidently. The mom's partner is unemployed and she identified they are going to have difficulty paying the 'bills' this month. She is aware of the Interfaith Food Bank and received a hamper last month. The mom told the health care professional she is concerned about lack of money to buy more diapers and clothes for the baby. The mom reports that she has two packages of diapers and has baby clothes at home. She would like to talk to someone who could help her with more baby supplies. Discharge is planned for later today.

The health care provider discussed the following resources: Connect family and sexual abuse network, emergency women's shelters, Neighbor Link and adult addiction services. The brochures and phone numbers of these community agencies were given to the mom and she was receptive to the resources. As part of the safety plan, the health care provider also discussed transportation options for getting to the shelter and what to bring. The health care professional called Child and Family Service Authority to report the concerns. Jane Smith is the Child and Family Service Authority social worker assigned to the case and her phone number is 403 222 5555. Child and Family Service Authority social worker was agreeable to planned discharge for later today. The Child and Family Service Authority social worker scheduled a home visit with the family for tomorrow morning.

- What is the nurse's role in completing the form?
- What is the social worker's role in completing the form?
- Review form completion based on the scenario information.

Nursing practice scenario

A 32 year old woman is admitted to the postpartum unit following the delivery of twin boys. She moved to Canada four months ago from China. She and her husband speak limited English. Their only support is her husband's brother. Her husband is currently unemployed. They have some money saved but finances are very limited. They received a food hamper last month and they have a few cans of tomato sauce, two packages of pasta and a box of granola bars left. The mom reports they have two packages of diapers and a few sleepers. She tells you that she is so happy to be a mom although she is feeling stressed about being in a new country. Her husband is very supportive. Both parents are confident in caring for the babies and knowledgeable of the babies' needs. You completed a social work referral. The mom left before the social worker could complete the assessment because her brother in-law came to drive them home and he was unable to wait.

- What is the nurse's role in completing the form?
- What is the social worker's role in completing the form?
- Review form completion based on the scenario information.

Appendix L

Maternal Psychosocial Health Information Transfer Guideline

The guidelines were adapted from the Documentation Guidelines for Completion of Public Health Nursing Referral (AHS, 2008).

PURPOSE

The Maternal Psychosocial Health Information Transfer form is a written communication tool meant to facilitate communication along the continuum of care and designed to create a common understanding of the patient's needs for follow up care and support in the community. The form is structured to provide standardized relevant information that is to be transferred to community health care providers.

PROCEDURE

The Maternal Psychosocial Health Information Transfer form is to be completed when maternal psychosocial concerns are identified by a health care provider. The social worker is to complete the form for each postpartum patient assessed. Nursing staff is to complete the form in situations where nursing has identified concerns but the social worker will not be assessing the patient.

Guideline to Complete the Maternal Psychosocial Health Information Transfer form

1. Review relevant parts of the patient's chart.
2. Addressograph the form.
3. Complete each section on both pages of the form.
4. Place a check mark in each box that applies to the patient.
5. Provide details in the spaces provided.
6. Fax the form to the appropriate Postpartum Community Services site upon patient discharge as per Alberta Health Services policy Transmission of Information by Facsimile or Electronic Mail document # 1113.
7. Place the original copy of the form in the patient's chart.

Table to describe each section on the Maternal Psychosocial Health Information Transfer form.

Section	Item Description
Patient Identification	
Patient Identification	Identify the patient by using the Addressograph label.
Situation	
Situation	Specify the overall concern. Indicate if the patient was referred to social work. • Yes or no • If no, indicate if the patient declined the referral or if the patient was discharged before the assessment • Other (any other scenario regarding social work referral)
Background	

Maternal Concerns	Indicate the maternal concern by placing a check mark in the corresponding box.
	Provide details in the space provided.
	• Domestic violence (such as past or current physical, verbal, emotional, sexual or financial domestic abuse or concern for personal safety)
	• Psychosocial risk factors of partner (such as concerns about partner's influence on parenting including substance use, criminal activity, incarceration, anger management issues or recent separation)
	• Known criminal activity
	  ○ Indicate if the woman has been or is incarcerated and specify the activity
	• Anger management issues (such as poor impulse control, agitation)
	• Substance/alcohol use (such as drug and alcohol use)
	  ○ Specify the type, frequency and when used last
	• Mental health disorder (including self-reported or diagnosed disorders such as anxiety, depression, bipolar, personality disorder, eating disorder, psychosis, schizophrenia)
	• Prenatal/postpartum depression (such as depression in pregnancy or history of postpartum depression)
	  ○ Indicate treatment (such as name of medication, counseling)

Section	Item Description

	• Coping skills (such as limited ability to manage stress, self-harming)
	• Current stress level (such as a recent stressful event)
	• Social isolation (such as lack of existing social support, recent immigrant with limited social support or language barrier)
	• Acceptance of baby (such as the woman not wanting baby at this time, negative feelings toward baby)
	• Attentive to baby's needs (such as not touching and holding baby)
	• Responds appropriately to baby (such as not responding to baby's cues)
	• Expectations and perceptions of baby's feeding, crying and sleeping patterns (such as unrealistic expectations of baby's feeding, crying and sleeping patterns)
	• Confident in baby care (such as concerns about skills and ability to provide baby care)
	• Financial (such as limited ability to meet basic needs)
	• Food security (such as limited food available in the home)
	• Housing (such as homelessness, transitory housing, environmental safety concerns)
	• Cognitive challenges (such as limited problem solving skills, limited ability to learn new information)
	• Child and Family Service Authority involvement
	  ○ Reported (reported to Child and Family Service Authority during current hospital stay)
	  ○ Investigation (investigation is currently being conducted by Child and Family Service Authority)
	  ○ Open file (current involvement with Child and Family Service Authority with other children)
	  ○ Recent history (such as involvement in the last two years with the Family Enhancement program, supervisory orders or previously apprehended children)
	  ○ Social worker's name (name of Child and Family Service Authority social worker)
	  ○ Phone number (phone number of Child and Family Service Authority social worker)
	• Other (such as any concerns not identified)

Section	Item Description
Maternal Strengths	Indicate maternal strengths by placing a check mark in the corresponding box. Provide details in the space provided. • Support network (such as extended family or friends) • Community resources and professionals already in place ○ Specify resources (such as name and phone number of Psychiatrist; engaged with adult addiction services, Parent-Child Assistance Program, Calgary Urban Projects Society; accesses Food Bank) • Coping skills (such as ability to manage stress) • Attentive to baby's needs (such as touches and holds baby) • Responds appropriately to baby (such as responds to baby's cues) • Realistic expectations and perceptions of baby's feeding, crying and sleeping patterns • Confident (such as confident in skills and ability to provide baby care) • Financial ability to meet basic needs (such as ability to meet basic needs) • Other (such as any strengths not identified)
Assessment	
Assessment	Specify healthcare professional's assessment of the overall situation by giving consideration to maternal strengths and concerns Indicate the actions taken in the hospital. • If applicable include the safety plan developed with the woman. Indicate if the woman is concerned about the issue(s) • Yes or no Indicate if the woman is receptive to the support(s) offered • Yes or no

Section	Item Description
Recommendation	
Recommendation	Identify the suggested categories that may require further follow-up by the community healthcare provider by placing a check mark in the corresponding box. Provide details in the space provided. • No further follow-up required • Planned Child and Family Service Authority follow-up (such as a scheduled contact with the woman) • Domestic violence • Psychosocial risk factors of partner • Substance/alcohol Use • Mental health • Social isolation • Parenting • Finances • Housing • Other (such as items not included in the previous check boxes)
Signature	
	Provide your printed name, signature and professional designation in the corresponding space. Provide current date and time. Provide unit phone number and pager if applicable.

Appendix M

Simulation Scenarios

Social Worker Simulation Scenario

A 25 year old woman was admitted to the postpartum unit following the delivery of a 39 week gestational age male infant. Her other three children were apprehended two years ago because of domestic violence. She is no longer with that partner and denies any contact with him. Her three children were returned to her care 1 year ago. She has an open Child and Family Service Authority file. The Child and Family Service Authority social worker's name is Betty Jones and her number is 403 777 4444. The father of this baby is not involved. The mom denies any drug or alcohol use during her pregnancy. She was diagnosed with depression at age 15 and occasionally talks to a counselor. The counselor's name is Sophia Smith and her phone number is 403 777 1234. The mom is currently taking Effexor, an antidepressant. She is receiving social assistance and tells you that she has difficulty paying for food and other basic needs. The mom also told the health care provider that she is concerned about lack of money to buy more diapers and clothes for the baby. Her mother is very supportive and will be living with her for the next few months or until she no longer needs support caring for the children. The health care provider often observed the mom gazing at her baby while she held her baby with skin to skin contact. The health care provider identified that the mom responded to the baby's feeding cues and was able to provide baby care appropriately and confidently.

A social work referral was completed. As the social worker, you completed the assessment and then discussed and provided the phone numbers for Connect family and sexual abuse network, emergency women's shelters and Neighbor Link. The social worker suggests that the community health care provider may want to follow up on domestic violence, parenting, finances and mental health. The Child and Family Service Authority social worker has a scheduled visit planned for two days following discharge from hospital.

Complete the form based on the scenario presented.

Nursing Simulation Scenario

A 25 year old woman was admitted to the postpartum unit following the delivery of a 39 week gestational age male infant. Her other three children were apprehended two years ago because of domestic violence. She is no longer with that partner and denies any contact with him. Her three children were returned to her care 1 year ago. She has an open Child and Family Service Authority file. The Child and Family Service Authority social worker's name is Betty Jones and her number is 403 777 4444. The father of this baby is not involved. The mom denies any drug or alcohol use during her pregnancy. She was diagnosed with depression at age 15 and occasionally talks to a counselor. The counselor's name is Sophia Smith and her phone number is 403 777 1234. The mom is currently taking Effexor, an antidepressant. She is receiving social assistance and tells you that she has difficulty paying for food and other basic needs. The mom also told the health care provider that she is concerned about lack of money to buy more diapers and clothes for the baby. Her mother is very supportive and will be living with her for the next few months or until she no longer needs support caring for the children. The health care provider often observed the mom holding the baby with skin to skin contact while kissing her baby's head. The health care provider identified that the mom responded to the baby's feeding cues and was able to provide baby care appropriately and confidently.

You complete a social work referral; however, the mom needs to leave prior to assessment because one of her children has a scheduled appointment with the pediatrician that she does not want to reschedule or miss. As the nurse, you discussed domestic violence resources including Connect family and sexual abuse network and the emergency women's shelters and provided the mom with the Connect family and sexual abuse network brochure. The nurse suggested that the community health care provider may want to follow up on domestic violence, parenting, finances and mental health. The Child and Family Service Authority social worker has a scheduled visit planned for two days following discharge from hospital.

Complete the form based on the scenario presented.

Appendix N

Focus Group Questionnaire

Questionnaire for acute care health providers

Please check the response that best describes you.

1. What is your profession?
   - □ Registered Nurse
   - □ Licensed Practical Nurse
   - □ Social Worker

2. What are your total years of experience as a Registered Nurse? (*Check if applicable*)
   - □ Less than 1 year
   - □ 1 year - 4 years
   - □ 5 years - 9 years
   - □ 10 years - 14 years
   - □ 15 years - 20 years
   - □ Greater than 20 years

3. What are your total years of experience as a Licensed Practical Nurse? (*Check if applicable*)
   - □ Less than 1 year
   - □ 1 year - 4 years
   - □ 5 years - 9 years
   - □ 10 years - 14 years
   - □ 15 years - 20 years
   - □ Greater than 20 years

4. What are your total years of experience as a social worker? (*Check if applicable*)
   - □ Less than 1 year
   - □ 1 year - 4 years
   - □ 5 years - 9 years
   - □ 10 years - 14 years
   - □ 15 years - 20 years
   - □ Greater than 20 years

5. What is your education level?
   - □ Diploma
   - □ Undergraduate degree
   - □ Master degree

6. Your gender:
   - □ Male
   - □ Female

This questionnaire is intended to provide the study with information of your perception and experience with the <u>tailored SBAR form</u>. Consider your recent completion of the form. Please <u>check</u> the response that best suits your perception and experience with form.

1. The form is **easy** to complete.
   □ Yes □ No
2. The **amount of time** it takes to complete the form is **acceptable**.
   □ Yes □ No
3. The form is **user friendly**.
   □ Yes □ No
4. The **reason** for completing the form is **clear**.
   □ Yes □ No
5. The form guides me to **clearly identify** which **patient situations** require the form to be completed.
   □ Yes □ No
6. The **instructions** on the form clearly **guide how** to complete the form.
   □ Yes □ No
7. The form provides **consistent information** for each patient.
   □ Yes □ No
8. The form requires me to provide **too much** psychosocial information.
   □ Yes □ No
9. The form requires me to provide s**ufficient** psychosocial information.
   □ Yes □ No
10. The form requires me to provide **too little** psychosocial information.
    □ Yes □ No
11. **Important** psychosocial patient information is **omitted** on the form.
    □ Yes □ No
12. The recommended **plan of care** is **sufficiently** documented on the form.
    □ Yes □ No
13. The **design** of the form is useful to **guide** what information Postpartum Community Services **needs** to provide care.
    □ Yes □ No
14. In my opinion, **the tailored SBAR form** would overall **improve the quality of information** received by Postpartum Community Services.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

15. The information provided on this form **increases my confidence that community care providers** will have an **overall understanding** of the patient in order to **continue care.**

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

16. In my opinion, the **tailored SBAR form** would improve the **quality and safety of patient care.**

1	2	3	4	
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

17. In my opinion, the **tailored SBAR form** would **improve patient transitions** along the continuum of care.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

18. In my opinion, the **tailored SBAR form** is a **useful** way to transfer information.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

19. In my opinion, the **tailored SBAR form** is **too complicated** to transfer information.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

20. In my opinion, providing the **specific psychosocial information** on the SBAR form is **within my scope of practice**.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

21. I **would be willing** to use **the tailored SBAR form** to transfer information to community care providers.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

22. In my opinion, use of the **tailored SBAR form** would be **sustainable** on our unit.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Thank you for completing this questionnaire. Your responses are valuable to the accuracy of the study.

Questionnaire for public health nurses

Please check the response that best describes you.

1. What are your total years of nursing experience?
   - □ Less than 1 year
   - □ 1 year - 4 years
   - □ 5 years - 9 years
   - □ 10 years - 14 years
   - □ 15 years - 20 years
   - □ Greater than 20 years

2. What is your education level?
   - □ Undergraduate degree
   - □ Master degree

3. Your gender:
   - □ Male
   - □ Female

This questionnaire is intended to provide the study with information of your perception and experience with the tailored SBAR form. Consider your recent review of the completed form. Please check the response that best suits your perception and experience with the form.

1. The form is **easy** to read.
   □ Yes □ No
2. The **amount of time** it takes to read the completed form is **acceptable**.
   □ Yes □ No
3. The form is **user friendly**.
   □ Yes □ No
4. The form provides **consistent information** for each patient.
   □ Yes □ No
5. The information on the form is **relevant** to providing care.
   □ Yes □ No
6. There is **too much** psychosocial information on the form.
   □ Yes □ No
7. There is **too little** psychosocial information on the form.
   □ Yes □ No
8. **Important** psychosocial patient information is **omitted** on the form.
   □ Yes □ No
9. The **recommended** plan of care is clear.
   □ Yes □ No

10. There is **sufficient psychosocial information** on the form to make **decisions** about determining appropriate **care setting** such as a home visit or clinic visit.
    □ Yes □ No
11. There is **sufficient psychosocial information** on the form to make **decisions** about determining **timing of care** such as contacting the family the next day or potentially deferring contact.
    □ Yes □ No
12. There is **sufficient psychosocial information** on the form to make decisions about determining **what follow-up care and support** maybe required.
    □ Yes □ No
13. The **design** of the form is **useful** to direct what information I may **expect** to receive from acute care providers.
    □ Yes □ No
14. In my opinion, the **tailored SBAR form** would **overall** improve the **quality of information** received from acute care providers.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

15. The information received on the form provides an **overall understanding** of the psychosocial health of the client and **increases** my **confidence** in **assuming** responsibility for care.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

16. In my opinion, the **tailored SBAR form** would improve the **quality and safety of patient care.**

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

17. In my opinion, the **tailored SBAR form** would **improve patient transitions** along continuum of care.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

18. In my opinion, the **tailored SBAR form** is a **useful** way to transfer information.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

19. In my opinion, the **tailored SBAR form** is **too complicated** to transfer information.

1	2	3	4	5
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Thank you for completing this questionnaire. Your responses are valuable to the accuracy of the study.

Appendix O

Focus Group Interview Guide

1. What do you think about the tailored SBAR form?

2. What was using the tailored SBAR form like for you?

    a. Is it clear how to complete the form? If not, what sections require clarification and how could this be accomplished?*(Possible probe for acute care providers)*

    b. Is the information on the form clear to you? If not, what sections or items require clarification and how could this be accomplished?

    c. Are multiple examples of each risk and protective factor in the guideline helpful for you?

    d. Do you believe the form flows easily? If not, what would you do to facilitate the flow? *(Possible probe)*

    e. Do you believe you the form offers you an opportunity to share individualized patient information?

3. What did you find most useful about the tailored SBAR form?

    a. Can you tell me what you think is useful in the (situation, background, assessment, recommendation) section? *(Possible probe)*

    b. Do you believe the form will capture all the psychosocial information needed to provide continuity of care? If not, what would you add? *(Possible probe)*

    c. Do you believe information gathered on the form is relevant for continuity of care? If not, what information is not relevant? *(Possible probe)*

4. What did you find least useful about the tailored SBAR form?

    a. Can you tell me what you don't find useful in (situation, background, assessment, recommendation) section? *(Possible probe)*

5. Can you describe for me how you believe the tailored SBAR form may make a difference in communication between the hospital and community setting?

a. Do you believe there may be a difference in adequacy of patient information transferred? *(Possible probe)*

b. Do you believe there may be a difference in the consistency of information being transferred? *(Possible probe)*

c. Do you believe there may be a difference in time efficiency in using the form? Why or why not? *(Possible probe)*

d. Do you believe there may be a difference in the number of times PHNs contact acute care health providers to retrieve missing information? *(Possible probe)*

e. Do you believe the tailored SBAR form may help create a common understanding of the patient? *(Possible probe)*

6. How may the tailored SBAR form influence the care you provide?

    a. Do you feel the tailored SBAR form provides clarity to understanding what the patient's needs may be? Why or why not? *(Possible probe)*

    b. Do you feel the tailored SBAR form may facilitate a better plan of care? Why or why not? *(Possible probe)*

    c. Do you feel the tailored SBAR form may facilitate continuity of care? Why or why not? *(Possible probe)*

    d. Would you feel confident that community care providers would have an overall understanding of the patient to provide follow up based on the information sent? *(Possible probe for r acute care providers)*

    e. Would you feel confident in providing follow up care based on the information received? *(Possible probe for PHNs)*

7. Can you tell me how the tailored SBAR form may or may not influence the quality and safety of patient care?
    a. How may the SBAR form influence decisions about care such as timing, setting or type of support required? *(Possible probe for PHNs)*

8. What revisions would you like to see made to tailored SBAR form?
    a. Do you see either relationship with maternal parents or health issues in home impacting parenting or years of education completed as relevant to care? If so, how are these items relevant to care? *(Possible probe)*

   b. Are there items that you believe should be added, deleted or combined? *(Possible probe)*
   c. Are the different Child and Family Service Authority items clear to you? If not, do you have any suggestions? *(Possible probe)*

9. Are you comfortable sharing the information requested on the tailored SBAR form? Why or Why not?
   a. Do you feel providing psychosocial information is part of LPN's, RN's and social worker's scope of practice? *(Possible probe) (acute care providers only)*

10. Do you think the tailored SBAR form is a workable solution to improve information transfer? How so?

11. What would motivate you to use the tailored SBAR form? *(acute care providers only)*

12. What do you believe would encourage other members of the inter-professional team to use the tailored SBAR form? *(acute care providers only)*

13. I would like to use the information gathered from the focus group to improve the form. Is there anything that we haven't discussed and that you would like to add?

Appendix P

Consent

UNIVERSITY OF CALGARY

FACULTY OF NURSING

TITLE:

Usefulness of a Tailored 'Situation Background Assessment Recommendation' Form for Clinical Handover between Postpartum Settings

INVESTIGATORS:

Principle Investigator: Dr. Debbie White, Associate Dean Research, Faculty of Nursing, University of Calgary , dwhit@ucalgary.ca, (403) 210-9627

Co-Investigator: Jennifer MacKay, Master of Nursing Student, University of Calgary, jennifer.mackay@ucalgary.ca , (403) 208-2074.

This consent form is only part of the process of informed consent. It should provide you with a general understanding about the study and what your participation will involve. If you would like more details about something mentioned here, or information not included here, feel free to ask. Please take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

BACKGROUND

Information transfer as part of clinical handover is imperative to continuity of care and ultimately patient safety. Research suggests that a tailored Situation-Background-Assessment-Recommendation (SBAR) form may improve the quality of handover. This study will investigate the perceived usefulness of a tailored SBAR form for clinical handover between acute care and the community setting for socially high-risk mothers. This descriptive study will use a mixed methods approach and include 101 participants from an acute care postpartum unit and 145 participants from Postpartum Community Services in Calgary.

WHAT IS THE PURPOSE OF THE STUDY?

This research is being conducted for a Master of Nursing thesis project. The purpose of this research is to further develop the tailored SBAR form as well as understand clinicians' perception of the usefulness of the form to transfer maternal psychosocial information between postpartum acute care and the community setting.

WHAT WOULD I HAVE TO DO?

You will be required to participate in a focus group. The focus group will require around two hours of your time. Participation will include instruction on use of the form, simulation involving using the tailored SBAR form followed by a questionnaire and discussion. The data collected and your participation will be kept anonymous and confidential where possible but the ability to guarantee anonymity may not be possible because of the participatory approach of the study.

Your participation is voluntary and you may withdraw from participating in the study at any time. You do not need to answer any questions that you do not want to.

WHAT ARE THE RISKS?

You may experience stress as a result of anticipating a change in the way you currently transfer patient information and from the time commitment required to participate in the study.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study there may or may not be a direct benefit to you. If you are in the study it is because you have been identified as a health care provider who is involved with the transfer of patient information from postpartum acute care to community. You may find your confidence and satisfaction with transferring and receiving patient information has increased during the study. You may also find that you perceive an improvement in the quality of information transferred and received but there is no guarantee that this research will help you. The information we get from this study may help us to improve the quality of information transferred between care settings for socially at-risk maternity patients in the future.

DO I HAVE TO PARTICIPATE?

Your participation is voluntary and you may withdraw from participating in the study at any time and without penalty. You may withdraw from the study by contacting the researcher by either telephone or email.

If new information becomes available that may affect your willingness to participate in this study, I will inform you as soon as possible.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You do not need to pay for anything. If you participate, you will be given a $25.00 stipend as support for any potential costs you may incur.

WILL MY RECORDS BE KEPT PRIVATE?

A transcript will be made of the discussion during focus group. The transcript will not contain information that may connect you to the discussion. Your name or other names that you mention in the discussion will be replaced in the transcript with fake names.

Quotes from the transcripts will be used in the writing of thesis and will be presented in a way that will conceal your identity.

No personal identifying information will be collected on the questionnaire.

No personal identifying information will be collected on the tailored SBAR form that acute care providers will complete. The completed tailored SBAR form will be shared with the public health nurse participants in this study.

If you decide to withdraw from participating, the information you have provided will be retained and may be used in the research.

Your information will be kept confidential and anonymous where possible but the ability to guarantee anonymity may not be possible because of the participatory nature of the study. The information collected may only be accessed by those who are involved in the research project. The University of Calgary Conjoint Health Research Ethics Board will have access to the records.

Your information will be kept for five years.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Ms. Jennifer MacKay
Telephone: (403) 208-2074
jennifer.mackay@ucalgary.ca
Or
Dr. Debbie White
Telephone: (403) 210-9627
dwhit@ucalgary.ca

If you have any questions concerning your rights as a possible participant in this research, please contact The Chair of the Conjoint Health Research Ethics Board at the Office of Medical Bioethics, 403-220-7990 or the Ethics Resource Officer, Internal Awards, Research Services, University of Calgary, at 403-220-3782.

Participant's Name	**Signature and Date**
Investigator/Delegate's Name	**Signature and Date**
Witness' Name	**Signature and Date**

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix Q

Final Tailored SBAR Form

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.
Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Maternal Psychosocial Health Information Transfer

Completed communication form to be faxed to postpartum Public Health care providers to facilitate continuity of care. Initial each entry. ¼"

Situation: What is the main concern?	**Initial**
Situation: _____ _____ Social work referral completed □ Yes □ No Discharged before social work assessment □ Patient declined social work referral □ Reason: Other:	
Background: What is the patient's history?	
Maternal concerns: Check *only* the concerns that apply and *provide details* so that appropriate community follow-up and referrals may be provided. Backslash (\) unassessed items.	
□ Domestic violence Past □ Current □	
□ Known criminal activity Incarceration □	
□ Anger management issues	
□ Substance/alcohol use	
□ Mental health disorder □ Prenatal/postnatal depression □ Treatment:	
□ Coping skills	
□ Current stress level	
□ Social isolation	
□ Unacceptance of baby □ Inattentive and inappropriate response to baby's needs □ Unrealistic expectations and perceptions of baby's feeding, crying and sleeping patterns □ Unconfident in baby care	
□ Financial □ Food security □ Housing	
□ Cognitive challenges	
□ Psychosocial risk factors of partner	
□ Other:	
Child and Family Service Authority involvement: □ Reported concerns during this hospitalization □ Current □ Historical Social Worker's name (Child and Family Service Authority): Phone:	

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Patient label placed here (if applicable) or if labels are not used, minimum information below is required.
Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*
Gender
PHN#

Maternal Psychosocial Health Information Transfer

Maternal Strengths: Check (√) *all* strengths that apply and *provide details* so that appropriate community follow-up may be provided. Backslash (\) unassessed items.	**Initial**
□ Support network *(Who):*	
□ Community resources and professionals already in place (*Specify name/phone number if available*):	
□ Coping skills	
□ Attentive and responds appropriately to baby's needs □ Realistic expectations and perceptions of baby's feeding, crying and sleeping patterns □ Confident	
□ Financial ability to meet basic needs	
□ Other:	
Assessment: What is your assessment of the overall situation? Consider *concerns* and *strengths*.	
Action taken in hospital. Safety plan in place □ Yes □ No	
Patient's response: Concerned about issues □ Yes □ No Receptive to support □ Yes □ No	
Recommendation: What do you suggest community healthcare providers may want to follow-up?	
Check all that may apply to support continuity of follow-up care and referrals	
□ No further follow-up required	
□ Planned Child and Family Service Authority follow-up: □ Specific plan unknown	
□ Domestic violence	
□ Psychosocial risk factors of partner	
□ Substance/alcohol use	
□ Mental health	
□ Social isolation	
□ Parenting	
□ Finances □ Housing	
□ Other:	
(Signature/ professional designation) Date(yyyy-Mon-dd) Time(hh:mm) Phone/pager	
(Signature/ professional designation) Date(yyyy-Mon-dd) Time(hh:mm) Phone/pager	

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Appendix R

Final Maternal Psychosocial Health Information Transfer Guideline

This guideline was adapted from the Documentation Guidelines for Completion of Public Health Nursing Referral (AHS, 2008).

PURPOSE

The Maternal Psychosocial Health Information Transfer form is a validated communication tool designed to create a common understanding of the patient's need for follow-up care and support in the community. The intended use of this form is to facilitate inter-professional communication along the continuum of care. This form is structured to provide standardized relevant information that is to be transferred to community health care providers. The Maternal Psychosocial Health Information Transfer form is not to be used as a validated assessment tool.

PROCEDURE

The Maternal Psychosocial Health Information Transfer form is to be completed when maternal psychosocial concerns are identified by the health care provider. The form may be completed collaboratively by social work and nursing. The social worker is to complete the form for each postpartum patient assessed. Nursing staff is to complete the form in situations where nursing has identified concerns.

Guideline to Complete the Maternal Psychosocial Health Information Transfer Form

1. Review relevant parts of the patient's chart.
2. Addressograph the form.
3. Complete each section on both pages of the form.
4. Place a check mark in each box that applies to the patient and provide relevant details.
5. Backslash unassessed items.
6. Initial each entry in the designated column.
7. Fax the form to the appropriate Public Health site upon patient discharge as per Alberta Health Services policy Transmission of Information by Facsimile or Electronic Mail document # 1113.
8. Place the original copy of the form in the patient's chart.

Description of each section on the Maternal Psychosocial Health Information Transfer form

Section	Item Description
Patient Identification	
Patient Identification	Identify the patient by using the Addressograph label.
Situation	
Situation	Specify the overall concern. Indicate if the patient was referred to social work. • Yes or no • If no, indicate if the patient declined the referral or if the patient was discharged before the assessment • If applicable, indicate the reason the patient was discharged prior to assessment (such as patient requested earlier discharge) • Other (any other scenario regarding social work referral)
Background	

Maternal Concerns	Indicate the maternal concern by placing a check mark in the corresponding box. Provide details in the space provided. Backslash (\) any unassessed items.
	
	• Domestic violence (such as past or current physical, verbal, emotional, sexual or financial domestic abuse or concern for personal safety)
	• Known criminal activity
	  ○ Indicate if the woman has been or is incarcerated and specify the activity
	• Anger management issues (such as poor impulse control, agitation)
	• Substance/alcohol use (such as drug and alcohol use)
	  ○ Specify the type, frequency and when used last
	• Mental health disorder (including self-reported or diagnosed disorders such as anxiety, depression, bipolar, personality disorder, eating disorder, psychosis, schizophrenia)
	• Prenatal/postpartum depression (such as depression in pregnancy or history of postpartum depression)
	  ○ Indicate treatment (such as name of medication, counseling)
	• Coping skills (such as limited ability to manage stress, self-harming)
	• Current stress level (such as a recent stressful event)

Section	Item Description

	• Social isolation (such as lack of existing social support, recent immigrant with limited social support or language barrier)
	• Unacceptance of baby (such as the woman not wanting baby at this time, negative feelings toward baby)
	• Inattentive and inappropriate response to baby's needs (such as not touching and holding baby; not responding to baby's cues)
	• Unrealistic expectations and perceptions of baby's feeding, crying and sleeping patterns (such as unrealistic expectations of baby's feeding, crying and sleeping patterns)
	• Unconfident in baby care (such as concerns about skills and ability to provide baby care)
	• Financial (such as limited ability to meet basic needs)
	• Food security (such as limited food available in the home)
	• Housing (such as homelessness, transitory housing, environmental safety concerns)
	• Cognitive challenges (such as limited problem solving skills, limited ability to learn new information)
	• Psychosocial risk factors of partner (such as concerns about partner's influence on parenting including substance use, criminal activity, incarceration, anger management issues or recent separation)
	• Other (such as any concerns not identified)
	• Child and Family Service Authority involvement
	  ○ Reported (reported to Child and Family Service Authority during current hospital stay)
	  ○ Current (such as current involvement with Child and Family Service Authority regarding other children or Child and Family Service Authority investigation is currently being conducted)
	  ○ Historical (prior involvement with Child and Family Service Authority such as previously apprehended children; woman was in care as a child)
	  ○ Social worker's name (name of Child and Family Service Authority social worker)
	  ○ Phone number (phone number of Child and Family Service Authority social worker)

Section	Item Description
Maternal Strengths	Indicate maternal strengths by placing a check mark in the corresponding box. Provide details in the space provided. Backslash (\) unassessed items. • Support network (such as extended family or friends) • Community resources and professionals already in place ○ Specify resources (such as name and phone number of Psychiatrist; engaged with adult addiction services, Parent-Child Assistance Program, Calgary Urban Projects Society; accesses Food Bank) • Coping skills (such as ability to manage stress) • Attentive and responds appropriately to baby's needs (such as touches and holds baby; responds to baby's cues) • Realistic expectations and perceptions of baby's feeding, crying and sleeping patterns • Confident (such as confident in skills and ability to provide baby care) • Financial ability to meet basic needs (such as ability to meet basic needs) • Other (such as any strengths not identified)
Assessment	
Assessment	Specify healthcare professional's assessment of the overall situation by giving consideration to maternal strengths and concerns Indicate the actions taken in the hospital If applicable, indicate if a safety plan is in place • Yes or no Indicate if the woman is concerned about the issue(s) • Yes or no Indicate if the woman is receptive to the support(s) offered • Yes or no

Section	Item Description
Recommendation	
Recommendation	Identify the suggested categories that may require further follow-up by the community healthcare provider by placing a check mark in the corresponding box. Provide details in the space provided. • No further follow-up required • Planned Child and Family Service Authority follow-up (such as a scheduled contact with the woman) o Indicate if the specific plan is unknown by acute care provider • Domestic violence • Psychosocial risk factors of partner • Substance/alcohol Use • Mental health • Social isolation • Parenting • Finances • Housing • Other (such as items not included in the previous check boxes)
Signature	
	Provide your signature and professional designation in the corresponding space. Provide your initials. Provide current date and time. Provide unit phone number and pager if applicable.