Going the extra mile - cross-border patient handover in a European border region

Going the extra mile — cross-border patient handover in a European border region: qualitative study of healthcare professionals' perspectives

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ABSTRACT

Background Cross-border healthcare is complex, increasingly frequent and causes potential risks for patient safety. In this context, cross-border handovers or the transfer of patients from one country to another deserves particular attention. Although general handover has been the topic of extensive research, little is known about the challenges of handover across national borders, especially as perceived by stakeholders. In this study, we aimed to gain insight into healthcare professionals' perspectives on cross-border handover and ways to support this.

Methods We conducted semistructured interviews with healthcare professionals (physicians, nurses, paramedics and administrative staff) in a European border region to investigate their perspectives on cross-border handover. The interviews were aimed to investigate settings of acute and planned handover. Informed by the theory of planned behaviour (TPB), interviews focused on participant perspectives. We summarised all interviews and inductively identified healthcare professionals' perspectives. We used elements of the TPB as sensitising concepts.

Results Forty-three healthcare professionals participated. Although respondents had neutral to positive attitudes, they often did not know very well what was expected of them or what influence they could have on improving cross-border handover. Challenges covered five themes: *information transfer*, *language barriers*, *task division and education*, *policy and financial structures* and *cultural differences*. To overcome these challenges, we proposed strategies such as providing tools and protocols, discussing and formalising collaboration, and organising opportunities to meet and get to know each other.

Conclusion Healthcare professionals involved in cross-border handovers face specific challenges. It is necessary to take measures to come to a shared understanding while paying special attention to the above-mentioned challenges. Meeting in person around meaningful activities (eg, training and case discussions) can facilitate sharing ideas and community building.

INTRODUCTION

Patient mobility is increasing and centralisation of specialised healthcare calls for an optimal use of international resources. In Europe, a relatively large number of people are already receiving cross-border healthcare, with over 160 000 patients crossing borders to Belgium, Germany, France, Luxembourg and the Netherlands each year to receive elective or acute healthcare.[1] Consequently, patient handover—'the transfer of information and professional responsibility and accountability between individuals and teams, within the overall system of care'[2]—in a cross-border setting is common.

Patient handover is a complex event that causes risks to patient safety when performed suboptimally. Information may be lost due to inefficient or non-existent communication between healthcare professionals.[3] Moreover, handover has been associated with inaccurate or delayed clinical assessment and diagnosis, medication errors, duplication of tests, increased length of stay, increased in-hospital complications and decreased patient satisfaction.[4 5] When patient handover is performed in a cross-border setting (with the patient going from one country to another), additional barriers arise, such as language barriers, cultural barriers, differences in healthcare systems, unfamiliarity with other teams, medication safety risks at discharge and difficulties in arranging medical back transfer.[6 7]

Despite these additional risks to patient safety, little research is available on cross-border handover from a stakeholder

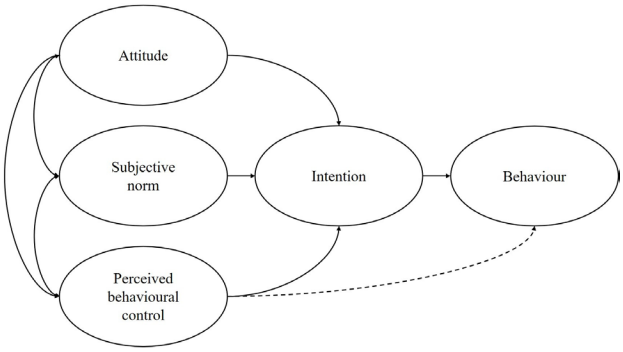

Figure 1 Theory of planned behaviour.[14]

perspective. Existing literature on cross-border healthcare essentially focuses on European law and policy[8–11] and does not sufficiently elaborate on the practical needs of stakeholders involved. Studies that did involve healthcare professionals seem to focus on general aspects of cross-border healthcare and provide little insight into the practical challenges (and solutions) of cross-border handover.[12 13] One study that included multiple stakeholders in cross-border handover all across Europe[6] suggested that issues of organisation and communication had a potential impact on quality and safety. This study concludes that cross-border healthcare requires particular attention in medical practice and calls for further research. Hence, these studies had a general focus and did not explore perceptions of handover in medical practice. Since healthcare professionals are directly involved in cross-border handovers, it is important that we embed their perspectives in research on this topic. Understanding their perspectives can give essential leads for practical improvement.

A prominent theory that helps to provide insight into stakeholders' perspectives on complex events is the theory of planned behaviour (TPB)[14] (figure 1). This theory suggests that someone's attitudes (What do I think of this?), subjective norms (What do others think of this?) and perceived control (Can I control this?) determine their intended behaviour in certain situations. The theory has previously been used to understand and change people's behaviour, such as discriminatory (eg, stereotyping) and organisational (eg, job performance) behaviour, in a large variety of situations.[15] Thus, knowing healthcare professionals' attitudes, subjective norms and perceived control may help us to understand their perspective on cross-border handovers and ultimately to develop ways to support this complex communication task.

In order to mobilise support for this complex and increasingly frequent event, it is imperative that we gain more insight into healthcare professionals' perspectives on cross-border handover. The present study therefore explored healthcare professionals' perspectives with the aim to identify challenges of and ways to support cross-border handover. Our research questions were 'What are the perspectives of healthcare professionals on cross-border handover?' and 'What do they see as challenges inherent in cross-border handover and opportunities for its improvement?'

METHODS

Design

We adopted a constructivist perspective, choosing a qualitative approach with semistructured interviews. Healthcare professionals (doctors, nurses, paramedics, specialty trainees and administrative staff) working in three different settings in the Meuse-Rhine Euregion were included.

Setting

The Meuse-Rhine Euregion is a border region where the borders of Germany, Belgium and the Netherlands meet. The broad variety in language, culture and healthcare systems (including three academic hospitals) made this region a very interesting setting to investigate cross-border handover. We selected three handover settings in this region: (1) an emergency department in the French-speaking part of Belgium (Wallonia) that admits patients from French-speaking and Dutch-speaking Belgium, (2) an emergency department in Germany close to the Belgian and Dutch borders receiving patients from emergency services in Belgium and the Netherlands and (3) a fixed collaboration between a Dutch and German clinical department whereby patients are referred to Germany for specialised treatment. Settings 1 and 2 are considered acute handover, and setting 3 is considered planned.

Data collection

Data collection took place between February and November 2018. Recruitment procedures were adjusted to local preferences (eg, via emails, internal communication platforms and newsletters). We recruited people from different disciplines (ie, nurses, doctors and administrative staff) and with varying years of experience, with a minimum of 1 year of clinical experience. Additionally, respondents had to be involved in handovers. We conducted convenience sampling. We provided respondents with information about the research aims (information letter) and informed consent forms prior to the interview, and gave them the possibility to opt out at any time.

The interview guide was based on the TPB, addressing attitudes (eg, *How do you experience cross-border handover?*), subjective norms (eg, *How do others handle cross-border handover?*) and perceived behavioural control (eg, *Are you content with the way in which cross-border handovers are handled?*) as experienced in cross-border handover (see online supplementary appendix 1). The interview contained a short introduction, followed by seven main interview questions and complementing subquestions. Since we conducted the interviews in the native language of respondents, we

had a professional translation company translate the interview guides. At each interview, two researchers (JB, DV, LvK or MB) were present, one acting as the interviewer and the other one as an observer. The interviewer consulted the observer to make sure all questions were answered. When needed, a translator assisted them. Most interviews lasted between 30 and 45 min. The researchers conducting the interviews had no previous connection to the respondents. Three researchers (JB, LvK or MB) or the translator recorded and summarised all interviews. Parts of the interviews were transcribed to support statements made in the summary. All summaries were checked against recording by a second researcher and, if necessary, translated. Summaries were sent back to respondents, who were asked to agree, adapt or reject the summary within 2 weeks. If their reply was not forthcoming, we assumed agreement.

Data analysis

We analysed the summaries in two phases. The first phase was an inductive analysis based on the following the steps proposed by Braun and Clarke[16]: (1) familiarise yourself with your data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) define and name themes, and (6) produce the report. Authors who coded the data (JB, DV, DD, LvK, XL, LV and MB) in this phase had a variety of backgrounds, specifically in healthcare (XL and LV), psychology (LvK and MB), educational sciences (DV and DD) and health sciences (JB). Some authors had previous experience with qualitative research (JB, DV, DD, LvK and MB). Other authors were instructed about the coding procedures. Authors each coded a number of the interviews according to their own perspectives. Thereafter, the authors discussed their findings and constructed overlapping themes through several rounds of coding and identification of themes. Special attention was payed to interconnectedness between appearing themes (ie, double coding of data). After these two rounds of coding, no new themes were identified. In the second phase, the TPB informed further scrutinising of the data. Authors (JB, DV and MB) used the elements of the TPB as sensitising concepts[17] and analysed coded data again, focussing on indicators for respondents' attitudes, subjective norms and perceived control concerning cross-border handover.

RESULTS

We conducted interviews with 43 respondents (see table 1). In the following paragraphs, we will first elucidate respondents' perspective using concepts from the TPB (research question 1) before presenting respondents' perceived challenges and opportunities of cross-border handover (research question 2).

Table 1 Demographics

	n=43	%
Occupation		
Physician	15	34.9
Nurse/nurse practitioner	11	25.6
Paramedic	12	27.9
Physician in training	2	4.7
Administrative	3	7.0
Country		
Belgium	9	20.9
Germany	26	60.5
The Netherlands	8	18.6
Language		
Dutch	9	20.9
French	8	18.6
German	26	60.5

Attitudes, subjective norms and perceived control

To describe healthcare professionals' perspectives on cross-border handover, the following will elaborate on their attitudes, subjective norms and perceived control regarding this topic. To this end, we present the findings pertinent to each of the TPB-inspired sensitising concepts.

Attitudes: what do I think of cross-border handover?

When asked about their perceptions of cross-border handover, healthcare professionals expressed relatively neutral to positive attitudes. Most respondents described cross-border handovers as 'no different from regular handovers' and used positive words (eg, 'polite', 'specialised' and 'fast') to describe their neighbouring colleagues. Some respondents, however, shared negative experiences, such as healthcare professionals refusing to communicate with them or impolite behaviour (eg, being yelled at). Yet others felt that cross-border collaboration held great promise for improving healthcare. These respondents were often involved in improving cross-border handover and expressed enthusiasm to increase cross-border collaboration: 'In the Euregion, collaboration between these … academic hospitals is crucial for further international development. Those chances are not optimally used at the moment'. (Physician working in the Netherlands and Germany)

Subjective norms: what do others think of cross-border handover?

Many respondents first declared cross-border handover similar to regular patient handover. However, they subsequently discussed differences in expectations between healthcare professionals involved in handover, for example, in what language the handover should take place. This reflects a strong local subjective norm and the absence of shared subjective norms of cross-border handover. Healthcare professionals were unaware or unsure of what other healthcare

professionals involved in cross-border handover thought and expected, and therefore acted in accordance with local assumptions when dealing with cross-border handover. In discussing differences, healthcare professionals often differentiated between 'how *we* do it' and 'how *they* do it', articulating division rather than collaboration:

> We have a routine in [the Netherlands]; we have a routine in [Germany]. … Those are completely different organisations with completely different organisation structures, and because of those organisations it is often difficult to come together and really do things … together. (Physician working in the Netherlands and Germany)

Some respondents worked or had worked in two countries. They shared subjective norms more explicitly and understood the perspectives of the healthcare professionals involved in both countries. Because of their international experience, they seemed to be more aware of their own role in cross-border handover and considered it their responsibility to establish collaboration and improve cross-border handovers.

Perceived control: can I control cross-border handover?

Almost all respondents felt they had little control. This was strongly related to the many challenges that respondents described and to the control they *actually* had when dealing with certain challenges (eg, being unable to speak the other language or to transfer information via digital systems): 'There is often a little bit of a language barrier, since I do not always understand everything, and also not everybody speaks English. My English is also not so good'. (Nurse working in Germany)

In the face of practical challenges, respondents sought ways to 'work around it', for instance, by communicating through hand gestures (when language skills were insufficient) or by transferring information onto compact discs (when a digital system was not available). However, when the problem was less clear, respondents felt less able to influence the situation. This was the case when differences between countries were not well understood, leaving healthcare professionals feeling unable to change this.

Challenges and proposed strategies

Our exploration of the perceived challenges and opportunities for improvement led to the identification of eight themes. Challenges covered the following five themes: information transfer, language barriers, task division and education, policy and financial structures, and cultural differences. The opportunities for improvement, hereinafter referred to as 'proposed strategies', covered three themes: provide tools and protocols, discuss and formalise collaboration, and get to know each other (see table 2).

Information transfer

Respondents described many situations in which procedures for transferring information between institutions or professionals were not aligned. Challenges were often the result of mismatches in the communication protocols (face-to-face information transfer) and information systems used (digital information transfer). More specifically, the communication protocols used (such as Situation, Background, Assessment and Recommendations (SBAR), Airway, Breathing, Circulation, Disability, Exposure (ABCDE) and Identify, Mechanism, Injuries, Signs, Treatment (IMIST)) differed between countries (and institutions). Especially when one party involved in handover never used any protocol, there were mismatches in expectations of each other, and misinterpretations occurred. Respondents feared that this could lead to a loss of information:

> Because we sometimes get the impression that they are not listening, right? So that we mention things that we find very important, and structured, and on the other side someone is standing there, saying: 'yeah, okay, yeah, yeah, and what more?' … So that is of course received very differently if you are not counting on that structure. (Paramedic working in the Netherlands)

Many respondents mentioned the challenge that comes with incompatible digital systems. In the Netherlands, for instance, information transfer was digitalised, and documents were not printed for handover. This complicated the exchange of patient information in acute handovers to Germany that did not have such digital system in place. Certain rules and regulations could also act as impediments. For instance, since the emailing of patient information was prohibited, MRI results could not be shared in an information system. Consequently, these results had to be stored on compact discs and physically transferred by healthcare professionals or patients themselves.

Language barriers

Another challenge frequently mentioned was language barriers, resulting from the encounter of the three different languages spoken in the border region

Table 2 Schematic overview of the themes identified

Challenges	Information transfer	Language barriers	Task division and education	Policy and financial structure	Cultural differences
Proposed strategies	Provide tools and protocols (eg, procedures, language)		Discuss and formalise collaboration (eg, collaboration agreement)	Get to know each other (eg, exchanges, training)	

(Dutch, French and German). Although most respondents had some understanding of English and some of the other languages (due to similar dialects), they were rarely fluent in more than one of these languages. According to respondents, this situation sometimes led to misinterpretations or a loss of information, such as misjudgement of the severity of a patient's health status with potential fatal outcome. This was especially challenging in acute situations, since professional translators were not always available. As one respondent described, emergency services sometimes diverted to a domestic hospital to avoid language barriers in a foreign hospital that was closer:

> … you also hear colleagues who sometimes avoid the hospital … because they don't speak the language 100%. For example, if I have an accident [on the Dutch-German border] with a very bad patient, I go to [Germany] very easily. Other colleagues say oh, gosh, [Germany), well, you know what, let's go to [the Netherlands]. You are just twenty minutes longer on the road. So the language problem does play a role. (Paramedic working in the Netherlands)

Task division and education

Differences in the level of education and task division between healthcare professionals from different countries presented a third challenge complicating cross-border handover. Respondents described differences in the amount and kind of training that nurses and paramedics received. Consequently, healthcare professionals with similar job descriptions had very different levels of skills and knowledge. This variety in training led to differences in task division, in turn creating more obstacles because healthcare professionals did not know when and how to communicate what information to whom. One respondent explained how their occupation, nurse practitioner, did not exist in another country. When handing over the patient to the other country, it was challenging to locate someone with similar training and tasks. 'It all starts with their unfamiliarity with our system. Many of our German colleagues do not know that we have virtually the same powers and responsibilities as their emergency physician'. (Paramedic working in the Netherlands)

Policy and financial structures

In a similar vein, differences in policies on measurements and tests used in diagnosis and treatment could pose a challenge to cross-border handover. For example, regulations to prevent bacterial infections (eg, Methicillin-resistant Staphylococcus aureus) differed between the three countries, causing cross-border handovers from Belgium to the Netherlands to be usually rejected for fear of infection, as one respondent suspected:

> It's not always accepted normally … because I think it's a matter of quarantine. But we have asked. I think that it is allowed that we make transfers to Maastricht, but it is very rare … It is rarely accepted. (Nurse working in Belgium)

Differences in financial structures (eg, Who is paying for healthcare?) seemed to influence the decision to seek or avoid cross-border handover as well. Especially in acute care, respondents mentioned that—depending on the patient's status—they took insurance-related issues into account when deciding where to transport the patient: 'With international stuff, insurance-related issues always come up with the insurance provider. … In terms of effort, it [national handover] is just easier for the patient'. (Paramedic working in Germany and Belgium)

Cultural differences

Cultural differences constituted the fifth challenge in cross-border handover. This challenge seemed strongly related to respondents' beliefs of what healthcare should look like and how this image did not fit healthcare in another country. When discussing culture and its associated challenges, respondents typically described interactions with colleagues and patients, referring to different nationalities and speaking of differences between 'them' and 'us'. Culture often seemed to be entangled with, and expressed in, other themes. For instance, when addressing different uses of procedures, respondents expressed this as a cultural difference. While one respondent spoke of a 'strict handover culture', another one attributed the difference in protocol use to standardised protocols being coloured by personal differences:

> To have a handover that is … objective and neutral is difficult; since it is not necessarily … clean, but also an interaction between people. The handover in relation to … the person, the collaborations in itself, will not be the same. It will be biased. (Physician working in Belgium)

Provide tools and protocols

To overcome many of the aforementioned challenges, healthcare professionals suggested that sufficient resources be developed and implemented. More specifically, information systems should be made compatible and patient information forms made available in different languages for easy translation: 'We do not have digital, secured exchange of diagnostics. That would be really good, if we could look at images of scans in [Germany] and [the Netherlands]. Basically, for [our department] that would solve many problems'. (Physician working in the Netherlands) Additionally, respondents stressed the importance of preparing healthcare professionals to work with these new resources. In order to execute cross-border handovers successfully, healthcare professionals must possess certain skills, such as the command of a language, but also the ability to deal with the protocols

(eg, SBAR) and systems prominently used in the region. Hence, respondents emphasised a need for training to make accurate use of resources, such as new ways to transfer information.

Discuss and formalise collaboration

Challenges such as differences in education, policy and culture, however, were difficult to control or change. According to respondents, in these circumstances, it is crucial to know how healthcare professionals in other organisations work and to create a shared understanding of cross-border handover. That way, they would know what was expected of them across the border in terms of policy, financial structure, education and culture: 'That you know exactly who is allowed to do what, who knows what, who has which task, that you can recognise people well'. (Paramedic working in Germany) Respondents also suggested that agreements be made about how to execute cross-border handovers in practice. One respondent had already sat together with collaborating partners in their setting to create an agreement that was available in two languages and was updated regularly. Their precondition for such arrangement was to sufficiently and frequently inform the stakeholders involved about the agreement.

Get to know each other

To pursue the two strategies previously addressed, many of the respondents advocated meeting professionals from other countries. They considered face-to-face meetings as essential to facilitate sufficient resources and to create a shared understanding of cross-border collaborations. Respondents who mentioned training of skills also stressed the importance of doing this together, in interprofessional as well as intercultural settings. They mentioned successful examples: students going to other countries for short-term or long-term exchanges and meetings to discuss handovers. Professionals who already met regularly saw 'personal contact' as the key to good collaboration:

> You see that if you come together in person, you can also discuss things well. You can do a lot by phone and secure mail, but you see that personal contact and going there or them coming here, that I see as the key to success. (Nurse practitioner working in the Netherlands)

DISCUSSION

Healthcare professionals in a European border region have positive attitudes towards cross-border healthcare and have seen many similarities with regular handover. However, we also revealed that professionals had different expectations about how those handovers should be handled (ie, different perceived norms) and found it difficult to influence current cross-border handover procedures themselves (ie, low perceived control). They mentioned challenges specific to cross-border handover (information transfer, language barriers, variety in task division and education, differences in financial and political structure, and cultural differences) and several ways to overcome these (providing tools and procedures, discussing and formalising collaborations, and getting to know healthcare professionals across the border).

The findings bear resemblance to previous studies on cross-border healthcare by, among others, Groene *et al*[6] and Footman *et al*,[13] who also mentioned challenges related to language barriers and differences in procedures and systems. This is on top of challenges that are associated with 'regular' handover. For example, Sarvestani *et al* reported that unstructured handover of shifts led to difficulties in information transfer.[18] They also identified communication, organisation and culture as important leads for improving patient safety during handover in a variety of in-hospital settings.[18]

Handover is always a vulnerable event associated with loss of information and miscommunication. These risks seem to be amplified in handovers across the border, possibly due to professionals' lack of knowledge about their colleagues across the border. Besides, this study has demonstrated that handover across borders presents unique and additional challenges (eg, level of training and cultural differences). Certain conditions must be met for effective cross-border collaboration, such as finding connections between the different health systems, involvement of committed individuals and alignment of partners' interests.[12] Explicit attention for these complex handovers is required. Our study provides better insights into the challenges and proposes strategies to overcome these.

In the current study, we identified challenges amplified by cross-border aspects like language, different healthcare organisation structures and overall unfamiliarity on both sides. A noteworthy challenge we identified was cultural differences. Even though our respondents often did not explicitly use this term, they often implicitly addressed cultural aspects in relation to other challenges. They were, for example, inclined to talk in terms of 'how they do it' versus 'how we do it'. Sometimes, the interviewers noticed differences that the interviewees did not seem to notice, for example, regarding expectations about the role of the patient (eg, 'We expect patients to actively indicate their need for pain medication' versus 'We actively ask the patients if they require pain medication'). Since culture greatly affects a person's attitudes, subjective norms and perceived control, and, hence, their behaviour,[15] cultural differences inevitably lead to different ideas about how to deal with certain situations,[19] increasing chances of miscommunication. Cultural differences should thus be considered carefully in the process of designing and implementing strategies of support for cross-border handovers.

Another remarkable result is the paradox between low perceived control on cross-border handover

articulated by many of the respondents and their simultaneous ideas about how to overcome the challenges they face. The low perceived control might be attributed to factors that are indeed hard to change (such as healthcare systems and policies) or overall complexity of cross-border handovers. We strongly believe that discussions between healthcare professionals about collaborating internationally may unravel the complexity and increase their perceived control of these situations. Once they are aware of, or even understand, differences in expectations and approaches, peer discussions can help build a community of practice[20] in which healthcare professionals who collaborate across borders share ideas about how cross-border handover can be improved. To strengthen this community-building process, it is vital to include and empower healthcare professionals who are aware of cultural differences.[21]

Limitations

Our study has several limitations. First, we studied cross-border handover in a unique setting: a border region that has an elaborate history of cross-border collaboration.[22] Notwithstanding this, the challenges identified in the present study are likely to also arise in other border regions. Second, although gaining insight into healthcare professionals' individual perspectives on cross-border handover was our explicit aim, perceptions may differ from what actually happens in practice. Last, we focused on healthcare professionals' perspectives, without addressing the needs of other essential stakeholders in cross-border handover.

Future research

Observational or ethnographic research into cross-border handovers would be suitable to study how professionals interact in practice. Such an approach could provide better insight into cultural aspects of cross-border collaboration in healthcare and could shed light on the inherent risks to patient safety and associated implications. Future research should also focus on the perspectives of patients and other stakeholders in cross-border handover (eg, healthcare insurers and general practitioners).

Practical implications

Cross-border healthcare is complex, and some factors cannot easily be changed. This research points to several measures that could be taken to align procedures and come to explicit agreements on cross-border collaborations. However, we foresee improving cross-border collaboration in different settings requires a tailored approach. It is thus important to establish contact and arrange meetings between healthcare professionals around meaningful activities, such as case discussions, joint training and formalised collaboration, to build community for cross-border collaboration.

CONCLUSION

Although healthcare professionals have positive attitudes towards cross-border patient handover, they also have different expectations of how those handovers should be handled and feel they have limited control. They face specific challenges in cross-border handover, such as differences in formal structures (task division, policies and financing) and in culture. We suggest discussing these specific challenges to come to a shared understanding of cross-border handovers. Meeting in person around meaningful activities (eg, training and case discussions) could facilitate shared ideas and community building. This way, healthcare professionals establish shared expectations and can take control of healthcare professionals in cross-border handover.

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Appendix 1 - Interview guide (shortened)

Basic questions

1. Could you tell us something about the work you do?
2. Could you describe a cross-border handover as they generally happen in your unit?
3. Could you describe the most recent cross-border handover you were involved in?

   Could you describe the situation you're thinking of? *(Situation)*

   Could you describe your role in this situation? *(Task)*

   Could you describe what you did? *(Action)*

   Could you describe what the result was? *(Result)*

   In hindsight, is there anything you would do differently?
4. Why do you handle cross-border handover the way you do?

   How do you experience cross-border handover? *(Attitude)*

   How do others handle cross-border handover? *(Subjective norm)*

   Are you content with the way in which cross-border handovers are handled? *(Intended and actual behaviour)*

   Do you feel like you are able to influence cross-border handovers? *(Perceived behavioural control)*
5. What do you need to be able to optimise cross-border handover?

   What is the role of training in optimising cross-border handover?

Additional questions

These questions can be asked when the previous questions have been answered, and there are more than five minutes left.

6. Could you describe a more remarkable or exceptional cross-border handover you were involved in? (sub-questions of question 3 apply)
7. Why did you/others handle this situation in a certain way? (sub-questions of question 4 apply)
8. Are there any lessons learnt from this situation?