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Guest Editorial

Moving from rhetoric to reality: patient and family involvement in bedside handover

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GUEST EDITORIAL

Moving from rhetoric to reality: patient and family involvement in bedside handover

Patient and family involvement in bedside handover enables patients and families to interact with health professionals. Active participation only occurs through reciprocal relationships of dialogue and shared decision-making (Bolster and Manias, 2010). Rather than being an information-giving exercise or just a chance to exchange greetings, patient and family involvement is an opportunity to make an important contribution to patient care (Thompson, 2007). While much has been written about the need to include patients and families in bedside handover, it is not clear whether in actual practice their views are considered at all, or indeed, whether health professionals really want them to be involved in the first place.

A recent survey of Australia-wide data (N=707) showed that while 43% of health professionals believed that involving the patient made handover more effective, the majority believed it either made no difference or it was actually less effective (Geddes, 2014). This result demonstrates that the jury is still out on the effectiveness of bedside handover in terms of patient involvement. For this editorial, we define clinical handover as the general term for the handover process, while bedside handover relates to the handover process that occurs at the patients’ bedside.

Policy makers and hospital managers pay enormous attention to encouraging health professionals to follow standardised skills in presenting and delivering clinical handovers (Bradley, 2014). Definitions of handover focus on the transfer of responsibility and accountability between incoming and offcoming health professionals – in these definitions, patient and family participation is not generally mentioned (Evans et al., 2010). It is our contention that patient and family involvement in handover is based on rhetoric rather than
reality. Complex barriers impeding patient and family involvement need to be unpicked before active participation can occur to the point where it makes a difference to patient care.

Does it really matter whether patients and families are involved in bedside handover? By considering the number of clinical handovers that occur and the number of adverse events attributed to handovers, it is possible to gain insight into this question. Within Australia alone, it is estimated about 7,068,000 clinical handovers take place every year in Australian hospitals and about 26,200,000 clinical handovers are carried out in community care settings (Manias et al., 2008). Clinical handover is also a major source of communication breakdown and serious adverse events. In a comprehensive quality improvement project involving ten hospitals in the United States, the Joint Commission Center for Transforming Healthcare (2013) set out to reduce breakdowns in communication that occur during clinical handover. During the baseline phase of the project, results showed that for more than 37% of the time handovers were defective and they did not enable incoming health professionals to safely care for patients. For many of these breakdowns in communication, involvement by patients and families could help to reduce their occurrence.

Over recent times, many patient safety organisations have devised guidelines and policy documents aimed at reducing communication breakdown during clinical handover. Patient and family involvement in bedside handovers is one strategy identified to address communication breakdown. In the National Safety and Quality Health Service Standards of Australia (Australian Commission on Safety and Quality in Health Care, 2012), there is a standard devoted to clinical handover. Within this standard, health service organisations are required to establish mechanisms to include patients and carers in bedside handover processes. In order to obtain accreditation, health service organisations are expected to demonstrate adherence to the standards. For the Clinical Handover Standard, health professionals need to develop and implement strategies to include patients and families.
Similarly, the WHO Collaborating Centre for Patient Safety Solutions (2007) advocates patient and family involvement in bedside handover as an important aspect of care delivery.

Many barriers exist to involving patients and families in bedside handover. Indeed, there may not be many opportunities for patients and families to have their views heard. Location at the bedside does not automatically equate with involvement. In their observations of over 500 bedside handovers in medical, surgical and rehabilitation wards across two hospitals, Chaboyer et al. (2010) found that active patient involvement occurred between 32% and 57% of the time. In their study, active participation occurred when patients were observed to ask questions or to make comments about their conditions. If they made superficial comments or merely nodded, they were regarded as passive participants. Interestingly, for the ward environments observed, the bedside handover was promoted as a patient-centred approach to care. At interview, nurses identified several reasons for lack of patient participation, which included patients who were asleep at the time of the handover, hard of hearing, confused, comatose, situated in isolation wards, and those who had no desire for clinical handover to take place at their bedside.

Another barrier relates to the development and use of standard operating procedures for clinical handover, which are tools or mnemonics that seek to systematically communicate information effectively and efficiently with the main aim of reducing system failures (WHO Collaborating Centre for Patient Safety Solutions, 2007). One such tool is the SBAR, which involves describing the situation, background, assessment and recommendation of clinical handover (Haig et al., 2006). Another checklist called iSoBAR involves describing identity, situation, observation, background, assessment and read-back (Porteous et al., 2009). But where is the ‘P’ for patient involvement in these acronyms? Patient safety organisations strongly advocate use of these checklists during clinical handover. Unfortunately, these checklists do not identify patient or family involvement as an important criterion. They are
purely constructions intended for bi-directional communication among health professionals. Their goal is to ensure health professionals complete a set of tasks associated with their clinical activities, with no consideration given to gauging patients’ and families’ perspectives. Effective communication requires both the patient and health professional to engage in the interaction. This fact has been recognised for well over 20 years (Street, 2001; Watson and Gallois, 2007). Patient involvement in handover needs to be revisited. Let us ask patients if they feel they have been involved in handover and what difference it made to their care. Let us find out health professionals’ motivations during handover and how much they think the patient is central in the handover process.

Concerns have also been raised about the confidentiality associated with personal and sensitive information conveyed at the bedside handover. In considering legal and ethical perspectives, it has been proposed that patients should be consulted about the level of disclosure they are prepared to have communicated between health professionals at the bedside (Starr, 2014). Otherwise, health professionals would be taking on a paternalistic attitude in assuming they know what information patients and families are willing to divulge. In a survey of 74 patients undergoing surgery, almost 30% indicated they were disturbed by the presence of other patients in the room during bedside handover (Timonen and Sihvonen, 2000). In busy hospital settings, the task of allocating time to consult with all patients about what information should be quarantined, is difficult for nurses to manage logistically. Indeed, past ethnographic research has demonstrated that patients had little spatial control during bedside handovers and that nurses regulated and shaped the spatial orientation during handover (Liu et al., 2012). Patients tended to be confined to their hospital beds while nurses moved between spaces during handover processes. In reflecting on their interactions with patients, nurses commented that they conducted part of the bedside handover in central work stations, especially if they wanted to brainstorm about complex or sensitive issues, and make
key decisions. Nurses gravitated to the bedside only if they wanted patients to answer specific questions. Most importantly, nurses acknowledged they never asked patients what they wanted.

Health professionals make decisions about what information should be conveyed at the bedside, without consulting with patients and families beforehand. Such information could be the disclosure of a patient’s diagnosis or of an unsafe incident (Chaboyer et al., 2010). These paternalistic considerations position health professionals at the centre of the decision-making process, and patients and their families are given little opportunity to gauge their reactions to these situations. In the critical ethnographic study by Liu et al. (2012), nurses chose not to talk about a medication incident caused by a doctor during the bedside handover. In this situation, the doctor mistakenly requested a heparin infusion to be stopped. The doctor eventually recharted its commencement. The offcoming nurse did not believe this was appropriate information to share with the patient and she beckoned the oncoming nurse to leave the bedside in order to discuss the matter. This finding links back to health professionals’ beliefs and motivations about how a handover is conducted and the role of the patient. In a descriptive comparative study conducted in seven intensive care units across three countries (Ganz et al., 2014), quality of care was affected by the way in which handover was conducted. The investigators found quality of care was at greater risk if the nurses did not know the patients in their care. In these instances, nurses tended to exercise some form of discretionary decision-making around handover communication.

So what practical steps can nurses take to promote involvement of patients in handovers? Incoming and offcoming nurses sitting down at the side of the bed rather than standing over the patient, and maintaining direct eye contact indicates to the patient that s/he is an equal partner in the handover. Nurses need to greet and introduce themselves, and encourage questions and opinions from patients and their families. If items of a sensitive nature come up
in a multi-bed room, all party members can relocate to another space for a short period. In particular, it is crucial that patients and families are given the chance to comment on intended plans of care, and to clarify any concerns they have with the care delivered. Such clarifications could identify any breakdowns in communication and possible adverse events.

While some patients may have no desire to take part in handover, it is important to give them the opportunity to participate. Health professionals should ask patients and family members about how involved they want to be in bedside handover. Providing patients and families on admission with written and verbal information about what bedside handover means can help to demystify the process. This information should comprise what they can expect from bedside handover, how patients and families could be involved, and how privacy and confidentiality will be protected. Only by acknowledging patient and family involvement as a vital part of bedside handover and its ability to make communication more effective for patient outcomes, will it be possible to move their participation from rhetoric to reality.
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References


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