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Nurse perceptions of person-centered handovers in the oncological inpatient setting – A qualitative study

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ABSTRACT

Background: Deficient communication during shift change can cause negative patient outcomes and hinder person-centeredness in care. Person-centered handover is performed together with the patient at bedside, with the intention of providing a safe and efficient handover while promoting patient participation. The knowledge about nurse perspectives on handover models that involve patient participation is sparse.
Objective: To describe registered nurses' perceptions of person-centered handover in an oncological inpatient setting.
Design: A qualitative interview study.
Setting: The study was undertaken at two oncological inpatient wards at the Karolinska University Hospital, Stockholm, where person-centered handover was implemented in 2015.
Participants: Registered nurses who had worked at the wards for at least six months. We aimed for a full sample investigation. All eligible nurses (n = 13) were approached, and 11 chose to participate. Participants' age ranged from 23 to 60 years, the mean work experience was 10 years, and 4 out of 11 nurses were oncology nurse specialists.
Methods: Semi-structured interviews were performed by an independent researcher. The data was analyzed using content analysis with an inductive approach.
Results: Three main themes with ten subsequent subthemes emerged from the data. The main themes were: clinical communication and assessment; opportunity for patient participation; consequences for nursing care. In general, the nurses were positive towards person-centered handover, but they expressed concerns regarding patients' integrity and insecurities regarding bedside communication. All nurses described how they aimed at enhancing patient participation and viewed person-centered handover as an opportunity, but still perceived it difficult to succeed due to drawbacks and factors hindering nursing care. Overall, the nurses were positive regarding the involvement of patients in the handover procedure. Information provision from nurse to patient, as opposed to information exchange, was predominant.
Conclusions: The intentions of person-centered handovers differed from the way it was actually performed, especially in regards to the obtained levels of patient participation, as described by nurses. Professional insecurity in relation to bedside communication with patients and their visitors is a novel finding that should be considered when implementing person-centered handovers. Overall, the perceptions of person-centered handovers, as expressed by the nurses, enhance our understanding of what to consider when implementing the model and why compliance may vary.

What is already known about the topic?

- Information exchange during intershift handovers in the inpatient setting is a core nursing task with the potential of enhancing or obstructing patient care.
- There is a widespread dissatisfaction among nurses regarding the

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effectiveness of intershift handovers.
- Bedside handover models have shown benefits for inpatients and nurses, and are being implemented in various settings.

What this paper adds

- A description, from the perspectives of registered nurses in the oncological inpatient setting, of nurses' perceptions of patients' and their visitors' participation in intershift handovers.
- Descriptions of nurses' professional insecurity when performing handovers together with patients and colleagues, which could hamper patient participation and hinder successful implementation of a new handover style.
- Person-centered handovers have the potential of providing a daily opportunity for enhanced patient participation in the inpatient setting.
- A presentation of several issues that need to be addressed to reduce the gap between the intentions of person-centered handover, and how it is carried out.

1. Background

Over the past decades, increased attention has been paid to communication in health care. Not only is effective communication a prerequisite for safe care, but also for promoting participation and partnership between health care professionals and patients. The nurse-to-nurse handover performed in inpatient settings has been identified as a weak link, where faulty communication having a negative impact on both nurse and patient outcomes (Cohen and Hilligoss, 2010; Anderson et al., 2015).

Being a core task, the effectiveness and structure of nurse handovers affect the quality of care provided during the following shift (Manias et al., 2016). Nurse satisfaction with shift handover was investigated in a study including 22,902 nurses from 10 European countries (Meissner et al., 2007). In total, 39% of the nurses were dissatisfied, ranging from 22% in England to 61% in France. The leading explanations for dissatisfaction were: 'Lack of time' and 'Too many disturbances'. A variety of nurse handover models, designed to promote patient participation, safety and nurse satisfaction, have been developed in response to the need for improvement. One strategy was to relocate the handover from the nurses' station to the patient's bedside, commonly named 'bedside handover' or 'bedside handoff'. This involves the off-going and the on-coming nurse performing an oral handover in the presence of the patient, with varying levels of patient activation. Quantitative evaluations of these models have mainly focused on patient satisfaction (Sand-Jecklin and Sherman, 2014; Kullberg et al., 2017; Ford et al., 2014), participation (Tobiano et al., 2017a), aspects of patient safety (Kerr et al., 2016) and effectiveness (Cairns et al., 2013), with results favoring bedside handovers.

Several researchers have approached the perspectives of nurses working with bedside handover, using qualitative methods. In an Australian study, 500 handover observations and 34 interviews with nurses were conducted to describe consequences of bedside handover (Chaboyer et al., 2010). Three main outcomes were presented; improved accuracy of information and service delivery, as well as promotion of patient-centered care. Regarding information accuracy, the visualization of the patients was described as informative, and objectivity enhanced as nurses tended to convey only relevant information. Nurses also perceived the care provided as more holistic when shaped by input from the patients, ameliorating the quality of care services. The observations, however, showed that patients only participated in half of the handovers, indicating that nurses need to actively involve them further (Chaboyer et al., 2010). Similar results were found in another Australian study, comprised of 30 interviews with nurses and midwives, exploring their perceptions of bedside handover (Kerr et al., 2014). Foremost, the findings illustrated how the participants perceived that the quality of care improved, for example through better continuity and documentation, promoting safety. They also described the handover as facilitating the healthcare partnership between professionals and patients by creating an opportunity for both patients and their visitors to contribute with their perspective. Concerns about confidentiality towards other patients and visitors were, however, raised together with various strategies to prevent disclosure of sensitive information. In summary, many benefits can be achieved with bedside handovers, for example seeing the patients, and inspecting their wound dressings and infusions. However, bedside handovers only indicate the location for the handover and do not *necessarily* involve patient participation (Manias and Watson, 2014).

A core concept in person-centered care is the patient taking on an active role as a partner in and co-creator of health care (Ekman et al., 2011). Ethnographic studies of the Swedish inpatient ward environment have shown how both the physical form of the wards and the culture counteract patient participation (Wolf et al., 2012). It has also been reported that nurses tend to be task-oriented, prioritizing completing medical tasks instead of building caring relationships with patients (Liu et al., 2012). Person-centered handover (PCH) is an example of a handover model to promote active patient participation. In contrast to bedside handovers, PCH cannot be performed without patient participation. Moving towards person-centered communication requires a shift in both behavior and attitudes among nurses. Introducing a new model of e.g. shift handover could facilitate this transition, providing a frame for person-centeredness. The quality of the communication might, however, depend on the nurses' perceptions regarding challenges and benefits of the handover model. Previous evaluations of PCH have focused on the patient perspective, and increased attention to the nurses' perceptions is needed. Nurses are key professionals to succeed in implementing and maintaining PCH.

2. Aim

The aim of the study was to describe registered nurses' perceptions of PCH in an oncological inpatient setting.

3. Methods

3.1. Design

A qualitative method with semi-structured interviews was used.

3.2. Setting

The study was undertaken at the Department of Oncology, Karolinska University Hospital. The nurses were recruited from the two inpatient wards, providing acute oncological care to adult patients with any type of solid tumors. Admitted patients were treated with either a palliative or curative intention and receive chemo-, target- and/or radiotherapy. In addition to planned treatments, the most common reasons for admissions were infections, neutropenia, nausea and vomiting. In total, the two wards had 36 beds distributed on both single and shared rooms. In the shared rooms, there were curtains between the beds preventing patients from seeing each other. Registered nurses (RNs) at the wards worked both day- and evening shifts. They cared for 3–6 patients each, together with an assistant nurse. Each shift was about 8–9 h with 1–2 h overlap with morning- and evening staff present at the ward.

At both wards, PCH was conducted at bedside between the morning and the evening shift, with the patient's own perspective and preferences in focus. The handover was performed using a checklist, focused on relevant clinical information and the development of a care plan for the next 24 h. In addition to the off-going and the on-coming RNs, the assistant nurses, ideally, from both the morning and evening shifts took part in the PCH. PCH was introduced at the wards in 2015.