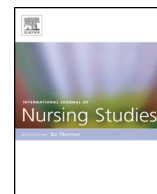




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Nursing team leader handover in the intensive care unit contains diverse and inconsistent content: An observational study

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ABSTRACT

Background: Despite a proliferation of evidence and the development of standardised tools to improve communication at handover, evidence to guide the handover of critical patient information between nursing team leaders in the intensive care unit is limited.

Objective: The study aim was to determine the content of information handed over during intensive care nursing team leader shift-to-shift handover.

Design: A prospective observational study.

Setting: A 21-bed medical/surgical adult intensive care unit specialising in cardiothoracic surgery at a tertiary referral hospital in Queensland, Australia.

Participants: Senior nurses (Grade 5 and 6 Registered nurses) working in team leader roles, employed in the intensive care unit were sampled.

Method: After obtaining consent from nursing staff, team leader handovers were audiotaped over 20 days. Audio recordings were transcribed and analysed using deductive and inductive content analysis. The frequency of content discussed at handover that fell within the a priori categories of the ISBAR schema (Identify-Situation-Background-Assessment-Recommendation) was calculated.

Results: Forty nursing team leader handovers were recorded resulting in 277 patient handovers and a median of 7 (IQR 2) patients discussed at each handover. The majority of nurses discussed the *Identity* (99%), *Situation* (96%) and *Background* (88%) of the patient, however *Assessment* (69%) content was varied and patient *Recommendations* (60%) were discussed less frequently. A diverse range of additional information was discussed that did not fit into the ISBAR schema.

Conclusions: Despite universal acknowledgement of the importance of nursing team leader handover, there are no previous studies assessing its content. Study findings indicate that nursing team leader handovers contain diverse and inconsistent content, which could lead to inadequate handovers that compromise patient safety. Further work is required to develop structured handover processes for nursing team leader handovers.

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What is known about the topic?

- Inconsistent communication at clinical handover is a major contributing factor to patient harm and one of five priority areas for patient safety improvement worldwide.
- The Australian Commission on Safety and Quality in Health Care introduced the National Safety and Quality Health Service Standard 6 – Clinical Handover, to improve communication practices at handover.
- There are limited handover resources specific to critical care.

What this paper adds

- Our research identifies the content of information discussed during senior nurse handover in an adult intensive care unit, not previously investigated.
- Findings indicate that critical patient information is either absent or not consistently transferred at handover, which has the potential to significantly compromise patient safety.
- This study will inform the development of a minimum dataset for senior nurse handover in the intensive care unit to improve communication at handover and the quality of care provided to patients.

1. Background

Clinical handover is “the transfer of information, responsibility and accountability between individuals and teams” (British Medical Association, 2006) and is an inherent part of patient care. Handovers predominantly occur at shift changes, when clinicians take breaks, when patients transfer between wards or hospitals and on discharge. In recent years, poor clinical handover practice has been identified as a major contributing factor to patient harm, with 80% of serious errors in healthcare attributed to communication errors between care givers during the transfer of patients and approximately one in five patients experiencing an adverse event (Australian Commission on Safety and Quality in Health Care, 2011a,b; Joint Commission on Accreditation of Healthcare Organizations, 2012).

Clinical handover is listed as one of five priority areas for patient safety improvement worldwide (World Health Organization, 2007). Over the last decade the Australian Commission on Safety and Quality in Health Care has taken an active role in piloting research projects and developing handover resources to improve communication practices in healthcare facilities nationally (Australian Commission on Safety and Quality in Health Care, 2011a,b). More recently, the Australian Commission on Safety and Quality in Health Care introduced the National Safety and Quality Health Service Standard – Clinical Handover, Standard 6, whereby all health care facilities are required to have structured handover processes in place (policies and procedures, work unit guidelines, minimum datasets) to meet accreditation standards.

National and international strategies to improve clinical handover practices and reduce adverse events

associated with inconsistent communication have led to major changes in handover processes (Australian Commission on Safety and Quality in Health Care, 2010a,b; Institute of Medicine of the National Academies, 2008; Jorm et al., 2009). One recent initiative is the movement of the handover location from offices and desk spaces to the bedside, facilitating face-to-face interactions among both clinicians and patients as opposed to written, recorded or phone handover. Although clinicians have reported concerns regarding patient confidentiality (Anderson et al., 2015; Mardis et al., 2016) and frequent interruptions with bedside handovers, there is a general belief that bedside handover is beneficial to both patients and staff. Patient benefits include increased patient and family involvement with clinicians during handover and reports of higher satisfaction between patients and families with communication during handover (Anderson et al., 2015; Mardis et al., 2016; McMurray et al., 2011). Staff benefits include enhanced prioritisation of patient-centred care (Anderson et al., 2015; Chaboyer et al., 2010); improvements with completion of nursing care tasks and documentation (Kerr et al., 2013); decreased overtime (Anderson et al., 2015) and increased safety, efficiency and teamwork (Chaboyer et al., 2009).

Alongside the implementation of bedside handover, the need for structured handover has been identified. Clinicians find handover challenging if there is no structure to follow as they are forced to decide what information to include or hold back and how the information should be conveyed (Holly et al., 2013). Consequently, unstructured handovers have been reported to contain too much or not enough information, irrelevant details, repetitive information and content that varies between clinicians (Benson et al., 2006; O’Connell et al., 2008). In the last decade numerous handover tools have been implemented to improve communication at handover (Australian Commission on Safety and Quality in Health Care, 2010a,b; Craig et al., 2012; Joy et al., 2011; Kaufmann et al., 2013; Zavalkoff et al., 2011). Introducing a structured handover process, alongside bedside handover has been linked to increased confidence among clinicians (Chu et al., 2009), improved communication (Craig et al., 2012), decreased medical and technical errors and reduced omissions of critical information (Joy et al., 2011).

While there are a multitude of handover tools available for healthcare areas to adopt, authors commonly acknowledge a single tool may not suit all areas. Communication tools need to contain flexible frameworks that can be modified or used in conjunction with other tools to ensure handover content is relevant to the clinical context (Alem et al., 2008; Anderson et al., 2015). Furthermore, clinicians need to be engaged in the development of resources to meet user needs at handover (Alem et al., 2008; Miller et al., 2009). Although various tools have been implemented in ward areas (low acuity patients), tools specific to the intensive care unit (high acuity patients) are limited.

The intensive care unit is an event-driven, time-pressured environment prone to continuous distractions. Patients are critically ill and require timely care at a moment’s notice (Smith et al., 2008). The complex and multidisciplinary nature of the intensive care environment

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