in progress ... work in progress ... work

BEDSIDE HANDOVER

BREAKING DOWN THE BARRIERS TO EFFECTIVE COMMUNICATION

Brighton ● Camberwell ● Southport ● West Dorset

BEDSIDE HANDOVER

BREAKING DOWN THE BARRIERS TO EFFECTIVE COMMUNICATION

SHARON WAIGHT

KING's FUND CENTRE

Published by the King's Fund Centre
126 Albert Street
London
NW1 7NF
Tel: 071-267 6111

© King's Fund Centre 1992

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic or mechanical, photocopying, recording and/or otherwise without the prior written permission of the publishers. This book may not be lent, resold, hired out or otherwise disposed of by way of trade in any form, binding or cover other than that in which it is published, without the prior consent of the publishers.

ISBN 1 85717 033 4

A CIP catalogue record for this book is available from the British Library

Distributed by Bournemouth English Book Centre (BEBC)
PO Box 1496
Poole
Dorset
BH12 3YD

The King's Fund Centre is a service development agency which promotes improvements in health and social care. We do this by working with people in health and social services, in voluntary agencies, and with the users of these services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences, information services and publications. Our aim is to ensure that good developments in health and social care are widely taken up. The King's Fund Centre is part of the King's Fund.

Printed by Multiplex medway ltd

BEDSIDE HANDOVER

BREAKING DOWN THE BARRIERS TO EFFECTIVE COMMUNICATION

SHARON WAIGHT
Sister

West Dorset Nursing Development Unit

West Dorset Nursing Development Unit
Maud Alexander Ward
Weymouth and District hospital
Melcombe Avenue
Weymouth
Dorset
DT4 7TB
0305 772211

A common understanding about care

Our unit is a ward of twenty-four acute medical beds in Weymouth District Hospital. The unit is a very busy one, admitting acutely ill patients requiring multidisciplinary care around the clock. Although we are designated a female ward, when male acute beds are full we also admit men.

Weymouth is a seaside resort, so many of our patients have had their holiday or day trip unexpectedly interrupted by their sudden illness. The area is also popular for people to retire to, so a large proportion of the patients whom we nurse are elderly.

We believe that underpinning all the care we give is nurse to patient and patient to nurse communication. We are also aware of the complexity of the communications process as the variables include ourselves, on one side of the equation, and our diverse patient population — patients of differing ages, cultural background, gender and health related problems — on the other.

As our philosophy is continually to strive for improved patient care, so equally is it to strive for improved communication in terms of clarity, accuracy and appropriateness. We want the messages between ourselves and our patients to be based upon genuine openess, non-judgemental assumption, understanding and suppport. We also want to maximise the opportunities to get to know our patients and share with them experiences and achieve a common understanding about care.

To do this we realise that we need the ability to understand ourselves as nurses and individuals, just as much as the patients in our care.

I felt that by examining the practice of patient reporting by the

nurses on our unit, we would identify how shared experiences, common understanding and accurate communication could be activated in clinical practice.

The limitations of our practice

The introduction of primary nursing in our unit, three years ago, led us to examine a host of nursing issues and practices, sometimes using research methods. One such practice has been patient reporting and the communication between patients and their primary nurse. As we developed our primary nursing over the first two years, we became increasingly aware of limitations in this area of our practice.

The reporting tended to be similar to that of many other wards in the country[1]. Precious time was being spent in the ward office on a detailed description of care that had been carried out on the previous shift. Our nursing handovers centred on nurses and what they had done, which mainly involved descriptions of events which had taken place. These focused on medical diagnosis and treatment.

Regular discussions took place at our ward meetings on how our nursing practice could increase patient involvement in the planning and evaluation of the care that they received. It became obvious that one method of increasing patient participation and improving nurse/patient interaction would be the move from nurse-dominated and office-centred handovers to patient-centred handovers located at the bedside. We would, therefore, bring ourselves into closer contact with our patients and increase our understanding of patients in our care.

I carried out a literature search and found that, at that time, not much had been published, although what was found was very much

in sympathy with the thoughts and philosophy of the nursing team. Mathews[2] and Burnard[3] describe the developmental approach which patient-centred handovers encompass, this being a conceptualisation of patients' problems and nursing intervention, an approach enabling nurses to be proactive and prospective, regarding present and future care.

Importantly, discussion centres on the patient's achievements and potential. This was already being reflected in how some nurses were keen to discuss 'their' patients at report.

However, there was something missing. Again the literature highlighted how bedside handovers could facilitate nurse/patient communication and emphasise the here and now, focusing on feelings, helping us to develop our empathetic understanding and reinforce the patient as being central to the conversation. According to Burnard[3] a bedside handover could increase the incidence and quality of a therapeutic conversation between nurses and patients.

As a team we were expressing concerns about how we reported about patients. Our discussions were more patient-centred, but they were also taking much longer. We no longer wanted to increase the amount of time we were isolated from our patients which was valuable communication time. To be separated from the patients when discussing their nursing care no longer fitted in with our philosophy.

Following my observation of our existing practice, a review of the literature and discussion among the nursing team, we decided to move forward with the introduction of a bedside handover.

Closer contact with patients

Our report session has now structurally changed from all reporting being done in the office by nurses who have administered care on one shift to those coming on duty. We now have a short introduction to patient's names and diagnosis in the office, so all staff know who is a patient on the ward. This is followed by a detailed report at the bedside involving patients and their respective primary nurse groups.

The main patient report is done at lunchtime, between the morning and afternoon shifts, when planning and evaluation of care given on the morning shift is discussed. Any problems are then shared between, and solved by, patients and their care givers, as well as those about to take over care and the implementation of the agreed solutions.

Patients are now very much part of the process. They 'tell their story' and help solve their own concerns and health problems. However, the communication skills, verbal and non-verbal, of the nurses very much underpin the success of our development.

Our nursing team now experienced in this style of handover. We now start our patient reports with introductions and a friendly yet purposeful approach, creating a comfortable relaxed atmosphere in which conversation can take place.

Questions are asked, for example, 'How are you feeling, what would you like to tell us about?', which set the scene for effective communication. Our non-verbal responses play an important role. We position ourselves near or at the same level as the patient. This facilitates our patients' response and gives them the positive cue to talk. We ensure that reports are restricted to care givers and patient, facilitating privacy, a friendly atmosphere and safety, enabling free discussion for both nurses and patients.

Nurses have become skilled in looking for signs of uneasiness in patients during discussions, for example, restlessness, patients looking away from nurses, or sitting upright and straight, frightened to move. We now know that these need to be solved or remedied, otherwise effective comunication will not take place. The care givers will respond by saying one of them will return alone, after the report session has finished, and answer any questions the patient may have.

As far as possible, when they are admitted we discuss with patients our philosophy of including patients in their own care, explaining that one way we can do this is bedside handover. We ask them if they would like to be involved. To date, no one has ever refused or wished to stop their involvement, once started.

Consideration and co-operation

This style of handover can be difficult to facilitate. At its best, this type of handover helps us mobilise the communication skills required to nurse well. As such, it is a valuable learning tool for student nurses developing their own skills and it gives them the opportunity to observe at first hand those communication skills developed in experienced nurses. However, communication skills can become inappropriate when less experienced or less skilled nurses take part. Student nurses will have had little experience of this approach and may find security in the traditional style of reporting.

There is an optimum number of people to have at the bedside. If three or more nurses are at the bedside, there can be positional distancing from the patient, together with nurse to nurse interactions taking place at the same time as patient communication. Discussion then becomes fragmented by different

conversations taking place similtaneously. Hence we are very keen on restricting the number of nurses taking part and including at least one of our experienced nurses in the report to help direct, facilitate and support nurses and patients.

Pressures of time and increased workload can also have a detrimental effect. Nurses under pressure to complete the report may direct the handover to become nurse-oriented, as nurses tend to take over and describe what care has been given during the shift. McMahon[1] describes this behaviour as including the patient only in a token way.

Patients can become tired of, and frustrated by, nurses coming to the bedside and introducing themselves and asking patients to repeat themselves at every shift change. As we have three shift changes a day, we only initiate a full bedside report at the lunchtime handover. Our night staff handover to the morning shift lasts fifteen minutes, so only changes in a patient's medical condition and new nursing information are reported from care giver to care giver. However, this may not take place at the bedside, so the patients are not woken unnecessarily. The night staff introduce us to, and give a more comprehensive handover on, those patients admitted during the night.

For patients, this enables continuity of care. It stops repetition of information and, importantly, it allows patients to sleep and rest if they wish. For the night staff it has an enormous advantage as they now leave their shift on time. After ten hours night duty this is most welcome. Their reports have become more concise and relevant to the appropriate primary/associate nurse.

Our end of evening shift handover to oncoming night staff remains predominantly office-centred owing to the reduction in the number of nurses at night, which means they need to receive information on all patients as the nurses assist each other. We are currently reviewing this with the night staff.

For all our us, the introduction of a bedside handover has been a teaching and learning experience. Our communication skills have been developed; we use open questioning and active listening, try to ensure we concentrate and are as aware as possible. Equally important are the skills of responding sensitively, supporting patients in what they say, and understanding patients and what it is that is being communicated. The emphasis in our communication is on our continued search to reach common understandings with our patients.

The effectiveness of our bedside communication is fostered by an atmosphere of warmth, friendship and comfort which allows discussion not only on factual information, but also on feelings and emotions. The content may also include helpful suggestions and practical hints on joint problem-solving.

Nurses and patients appear to adopt skills of consideration and co-operation when in a small group. Patients are enabled to feel part of a team and therefore more responsible for their own recovery. We very much feel that this method promotes the concept of patient partnership in care and improves our patient/nurse relationships — an important factor in the therapeutic care of patients.

Feedback and stage fright

To introduce the bedside handover and to evaluate how far we were meeting our goals, we used an action research approach, suitable for the development of a practical change in a clinical setting.We employed four methods to collect information to be fed back to the team as we introduced the change.

Participant observation

When we first moved to the bedside, I undertook some participant observation. As an associate nurse, I took part in the handover of my own group of patients and those of my peers. Initial findings, fed back to the team, enabled us to concentrate on problem solving, on barriers to our effective and productive communication, and on identifying further strategies, techniques and skills to be employed: for example, the behavioural responses of both nurses and patients at the bedside, whether nurses were sitting close to or standing away from the patient and whether patients were relaxed or anxious. I also collected verbal communication data: the types of questions asked and how they were structured.

Maps

At the same time, Joy Warren, the nurse researcher based on the NDU, mapped out some of the handovers (see appendix). Our ward layout makes it possible for someone to sit and observe the handover process while not participating. While unable to hear the content of verbal communications, Joy was able to map the number of verbal interactions, who they were between, body positioning of the nurses, including levels and proximity. She was also able to observe the patient's non-verbal responses such as laughter. The maps highlighted for us the importance of being physically on the same level as patients, of positioning ourselves appropriately and of directing our communication towards patients.

Joy and I fed back to the team our observations at ward and NDU meetings. All members of the team were able to contribute to the data analysis. The nurses could relate their own experience of the handover to our feedback and we were able to introduce changes as we went along.

Questionnaires

We used questionnaires to gain valuable information from patients and nurses on their views and feelings. Themes which emerged from the data collected from the nursing staff were: the numbers of nurses who need to be involved, time allocated, content of what was said, embarrassment, confidentiality, advantages and disadvantages. Patients' responses were favourable; they liked 'knowing about their care','feeling cared for and involved', 'knowing exactly who is giving care'. However, criticisms made were the embarrassment felt when too many nurses were around the bed, and discussing the same information three times a day was too excessive — hence the modification to a single bedside handover each day.

Tape recordings

An attempt to tape record office handovers was unsuccessful, as nurses suffered 'stage fright'. Also, the rapid adaptations made in response to problems encountered by the change in practice, rendered this method unsuccessful at the beginning of the research. To date, we have not used tape recording again..

I feel these evaluation methods gave our change in practice a developmental approach. This approach helped the nurses during the change, as they felt supported. The use of questionnaires, and the meetings at which we analysed the data collected by the observation and communication maps, meant that the nurses were contributing to the analysis and problem-solving which enabled them to integrate their own solutions into their practice.

'Not just the object of attention'

When asked about bedside handovers, most patients had simply not thought about whether it was good or bad, they had just accepted it. When we asked patients, we explained that we were

trying out this system and that keeping it depended on whether patients and staff felt it was a good idea. After having time to think, and to reply to the questionnaire, most patients seemed to like the idea. The following reasons were put forward:

Knowing who would be caring for them:
'I like to know the nurses' names.'
'I know who to ask.'
'It's nice to know who is going to care for you.'

Knowing about their care:
'At least I know what is going on.'
'They do ask me how I feel.'
'I now know what is happening to me and feel more involved.'
'It makes you feel as though they really care about you.'
'Relationships have improved between nurses and patients. I feel part of the team and not just the object of attention.'

Mostly patients felt that their nurses were always in the ward and were there for them. As more of the care was discussed with them, it helped them to feel more in control of what was happening and more responsible for their recovery.

Bedside handovers appear to demonstrate to patients that nurses will continually strive to arrive at the common ground of authentic communication, continually working together, searching and exploring to reach trust and equality within their relationships.

The outcome of this development project demonstrates that bedside handovers can improve and sustain effective nurse and patient communication. Benefits to patients were demonstrated by their increased satisfaction in being involved in care, their willingness to participate in their own care, their increased knowledge of care and treatments and their adjustment to hospital life and ultimately their illness.

References

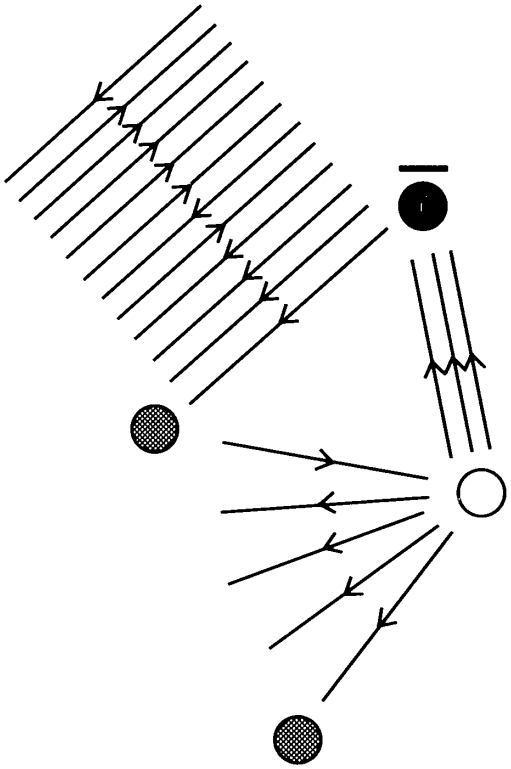
1 McMahon R. What are we saying? Nursing Times 1990;86 (30): 38-40.

2 Mathews A. Patient-centred handovers. Nursing Times 1986;82 (24): 47-8.

3 Burnard P. Meaningful dialogue. Nursing Times 1987;83 (20): 43-5.

Appendix: *Some examples of the communication maps*

Example 1: A midday handover



Patient in chair

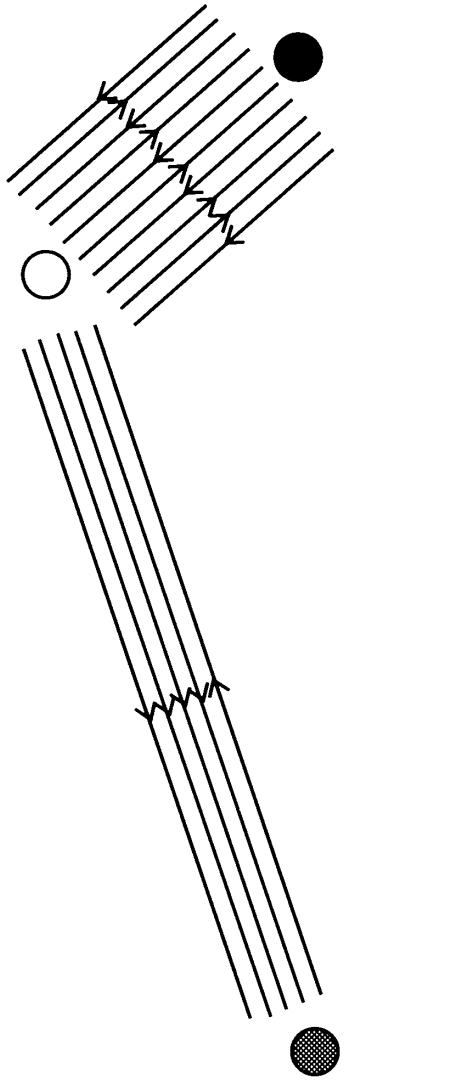
Nurse handing over

Nurses receiving report

Lines indicating how often people spoke and to whom

Appendix continued: *Some examples of the communication maps*

Example 2: An evening handover



Patient laughing

Day nurse

Night nurse

Night auxiliary

Lines indicating how often people spoke and to whom

BEDSIDE HANDOVER

BREAKING DOWN THE BARRIERS TO EFFECTIVE COMMUNICATION

This series looks at some of the ways nurses in Nursing Development Units (NDUs) have tried to make their nursing more beneficial for patients. The nurses assess to what extent their initiatives really do contribute to patient well-being and what has helped them bring about the changes. Each book will help nurses to introduce new ideas to their work and will suggest ways to evaluate changing practices.

The four NDUs which have contributed to this series have been supported by the King's Fund Centre and the Sainsbury Family Charitable Trusts since 1989 as part of a three-year project. A further 30 new projects have just received funding from the Department of Health and join the growing network of Nursing Development Units.

In this booklet, Sharon Waight, a sister, describes how the ward team introduced bedside handover and used 'maps' to evaluate their practice.

KING's FUND CENTRE