Communication in nursing handover

Communication is a very important aspect of medical training. Poor communication is the root cause for the majority of complaints against the National Health Service (NHS) (Pincock S. , 2004). Communication is especially important at handover to ensure continuity of appropriate medical care and to ensure safety of patients. The added constraint in medical handovers is that the process is limited by time. The SBAR (Situation, Background, Assessment and Recommendation) tool is intended for effective transfer of information between health professionals in a concise, factual and standardised structure. This article assesses the importance of teaching communication in medical education with particular emphasis on handover, the available literature on SBAR and the author’s view on SBAR as a communication tool for medical students and trainee doctors.

Introduction

Communication lies at the heart of good medical practice. The General Medical Council has mandated the need for good communication skills to ensure that patients are kept informed of their condition, progress, investigations, treatment and progress. Good communication skills are also necessary to ensure continuity of patient care and to ensure patient safety. The introduction of the shift system has made effective communication more important (General Medical Council).

Poor communication is the root cause for the majority of complaints in the National Health Service. Poor communication between health professionals, failure to take informed consent and improper handling of complaints are the major reasons and effective communication could have reduced the disputes and complaints (Pincock S. , 2004).

Teaching communication to medical students in UK medical schools

The UK council of communication skills in undergraduate medical education was established in 2005 with the aim of raising awareness, to improve current teaching, to improve and to develop consensus on the communication training provided to medical students (The UK council of communication skills in undergraduate medical education). This in the author's opinion represents a major step towards recognition of the need for training medical students in communication skills training. In addition to the benefits which better communication has in relation to patient safety and reducing complaints, research has indicated that teaching communication skills to medical students improved their overall performance (Smith, Hanson, & Tewskbury, 2007).

The medical handover: communication is vital

The National patient safety agency (NPSA), London has defined handover as " The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis" (National Patient Safety agency, 2007).

Medical handover is one of the most important procedures and has the potential for causing errors and harm if done improperly. It is also a very frequent occurrence with the advent of the shift system of working. The General Medical Council has also recognised the importance of a good handover and explained that "' keep colleagues well informed when sharing the care of patients" (General Medical Council).

Benefits of a good handover

Good handover has several benefits both for the doctor and the patient. For the doctor the handover session can be used to improve communication skills and can also be used to teach clinical medicine. A good handover also makes working less stressful as the doctors on the shift have will have good knowledge about the patients and their management plans. The British Medical Association has also opined that clear communication at handover will protect the doctor against blame for errors (British Medical Association, 2004).

Good handover also benefits the patient by providing continuity of care, providing safety, decreasing repetition and in providing better service satisfaction. There are several critical incidents of patient safety being compromised because of the lack of clear handover between teams (British Medical Association, 2004).

Constraints to good handover

There are several constraints to a detailed handover. In the author's own experience of handover in an intensive care area, the time allocated for handover is often insufficient to handover all details of patient care. Although the morning handover is led by the consultant on call and attended by a multidisciplinary team involving the physiotherapist and the in charge nurse, evening handover often involves only the junior doctors on call. Because of the complex problems which most patients on intensive care have, the handover often extends beyond the allocated time of 30 minutes. This means that the doctors who are leaving are unable to do so on time and those who are starting are not able to get on with their duties on time; both

these situations lead to a sense of dissatisfaction with the job. The handover venue varies from the patients' bedside to the doctors' office and therefore lacks uniformity and continuity. Further the handover can be interrupted by non-emergency calls from different parts of the hospital. On some occasions handover is taken by one team while the other team is setting up the ventilator and this results in an unsatisfactory handover.

Because of the presence of personnel from paediatric, intensive care, anaesthetic, nursing and other allied health back grounds at the morning handover, there are significant differences in the style, length and the importance which different people place on different aspects of the handover. Also the experience levels of the different trainees are variable and they vary in the ability to highlight important aspects of patient care and in their ability to summarise the progress of a patient in a concise way.

Need for a structure to handover

One of the criticisms of handover among healthcare professionals is the " hint and hope" approach where one person hints at what might be going on without giving any specific details and hopes to get a specific response or action (Featherston, 2005).

The handover process needs to be streamlined to allow transfer of a large amount of information regarding very sick patients with complex needs in a time limited manner. This means that there is a need for a system of handover which is structured, complete, relevant and concise to ensure uniformity of the process and to ensure continuity of patient care.

Literature of handover in other hospital settings

A study of handover of clinical care from ambulance crew to the emergency department personnel showed that there were concerns regarding the quality and quantity of handover, the staff perception of handover and staff education. This study also identified the need for a standardised handover process which would enable smooth transfer of patient care and also provide opportunity for the receiving team to assess and prioritise their work (Bost, Crilly, & Wallis, 2010). The British Medical Association (British Medical Association, 2004), The General Medical (General Medical Council) and the National patient safety agency (National Patient Safety agency, 2007) have all emphasised the need to develop a system of effective handover.

SBAR

SBAR (Situation, background, assessment, recommendation) is a communication technique that provides a structure for communication between healthcare professionals. SBAR was developed by Dr. Leonard and colleagues in 2006. It is useful for handover from nurse to nurse, doctor to doctor and doctor to nurse. SBAR enables healthcare professionals to communicate in a specific framework.

When applied to handover communication, S stands for situation which is a short description of the problem, its severity and when it started. B stands for pertinent background describing the admission diagnosis, results of investigations and other clinical information. Details of current resuscitation status could also be included in this. A stands for the handing over team' assessment of the patient status and R stands for recommendation on how the patient should be managed. Recommendation can also be used to

update the team receiving the handover on how quickly a patient needs to be seen and this can help them prioritise their tasks.

Literature on use of SBAR

SBAR is relatively new and there have only been a few studies looking into its impact on communication and patient safety. One study demonstrated that staff found SBAR tool helpful in team and individual communication. As a result of this the study team using SBAR perceived an improvement in patient safety culture. The study group also showed an improvement in reporting of incidents and near misses in the team and in the institution where study was done (Velji, Baker, & Fancott, 2008).

Another study found fewer missed information at handover and suggested that this improved patient safety. The authors of this study opined that this was the result of information transfer in a concise and organised format (Haig & Sutton, 2006).

Other studies have reported mixed results. A study from Texas found no or slightly negative impact on the nurse confidence while talking to physicians, safety on the unit and satisfaction with working on the unit. However there was some benefit on communication openness and in feedback about errors. It must be noted that this study was based on a comparison of key outcome measures following a four hour classroom training on SBAR which the authors themselves describe as inadequate. The authors have advised caution regarding the widespread use of SBAR despite the lack of evidence of its effectiveness (Carroll, 2006).

The SBAR collaborative communication evidence based practice study (SBAR EBP) showed that use of SBAR resulted in transfer of evidence, knowledge and clinical skills. The second outcome from this study was the benefits noted in communication, teamwork and safety environment. However as the authors of this study note, there are no studies so far which demonstrate benefits in patient outcomes or patient collaboration. This study also noted that no physicians participated in the SBAR collaborative-communication education. The authors also noted that physicians felt that SBAR teaching was meant for nurses and that doctors do not need to attend nursing classes (Beckett & Kipnis, 2009).

Summary of the evidence and opinion

It is the author's view that SBAR as a tool for handover will act as a uniform model around which staff can communicate at handover. It also encourages critical thinking around the time of handover. It allows precise, complete and concise transfer of information at handover. This is likely to improve better team working and ultimately improve patient safety. However there are likely to be impediments to the implementation of SBAR for handover. Doctors especially at more senior levels are likely to ask for evidence regarding the positive effects of SBAR on patient safety before they support its implementation on a wider basis. Therefore there is a need for large well designed studies to demonstrate a significant benefit from use of SBAR not only on the staff perceptions and communication skills but also on patient safety.

Teaching SBAR to medical students and trainee doctors

It is author's opinion that communication models on medical handover should be taught from medical school days. The transition from student to doctor is huge and medical students should be trained to have the skills to make this transition as smooth as possible. There is limited literature available on teaching SBAR to medical students. One study using a simulated clinical setting found that medical students who went through 40 minute training on a modified SBAR model (ISBAR), performed significantly better than controls on a content and clarity global rating score (Marshall, Harrison, & Flanagan, 2009). There is literature available on teaching SBAR to nursing students and the benefits it has had (Thomas, E, & Johnson, 2009), (Wood, 2008) (Kesten & Karen, 2011). The uptake of SBAR seems to be more robust amongst the nursing professionals than the medical professionals. As the uptake of SBAR increases it would become more important that medical professionals also become proficient in the use of SBAR as a model of communication. Therefore there is a need for both doctors in training and medical students to be trained in the use of SBAR.

Recommendations on training in SBAR for use in medical handover

Based on the experience of handover in an intensive care setting and after review of the above literature, it is the author's opinion that systems for handover need a radical overhaul to ensure patient safety and to improve communication within teams. One of the steps is a structure to the handover progress in the form of the SBAR. As a first step junior doctors need training in the use of SBAR for handover. Prior to the intervention, a baseline

assessment of communication skills using an appropriate tool would help monitor progress. This can be in the form of an interactive small group discussion where the process of SBAR is fully explored. It is also important to present the available evidence on SBAR and how it can improve communication outcomes and potentially patient outcomes. A simulation exercise at the end of the discussion will also help doctors understand the skills needed. This teaching session needs to be done on several days and at times and location which facilitate and encourage junior doctor participation. The aim is to ensure that all the junior doctors in the particular unit or institution have the opportunity to attend this session.

A separate session needs to be organised for the consultants who will be supervising the junior doctors as they implement SBAR. Consultants will need to play a major role in enforcing the use of this tool and also to monitor the effectiveness of this tool. Consultant supervision is essential to support the handover process using SBAR and also to facilitate the involvement of multidisciplinary teams at the handover.

Handover based on SBAR should also be accompanied by robust changes like having a dedicated time and place for the morning and night handovers, making sure that the handover is not interrupted for non-emergency reasons and to ensure the availability of electronic resources which can facilitate handover.

After a pre-defined period where SBAR process is implemented, there needs to be an evaluation of the effect SBAR has had on the handover process in particular and communication in general. Evidence of improvement in the

handover process will encourage staff to improve further on their skills. The process of implementation should be dynamic and continuous until the process becomes a part of the working culture.

Summary and conclusions

Inadequate handover poses significant risks to the personnel involved, their organization and their patients. Handover therefore needs to be complete, specific, concise and structured to allow effective transfer of information. Use of SBAR will provide a structure to the handover progress. There is evidence that use of SBAR has positive benefits on team working and communication and it is likely that this has a positive effect on patient safety. The process of implementation of SBAR will involve training of staff with supervision and mentoring from senior members of the team. There is also a need to conduct well designed studies to assess the impact of SBAR on medical handover and to determine potential benefits to patient safety.