

A critical phase of nursing communication nursing essay



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Patients handoffs is a traditional clinical practice in nursing that permits the transfer of patients information and care responsibility from the off going nurse to upcoming nurse; and this handover has an essential role in the continuity, safety, and quality of the patient care. Literature highlighted that failure in communication between shifts is one of the contributing factor in several accidents (Johnson & Arora, 2009). Moreover handover is critical point in patient care; insufficient care transition can result in preventable patient harm, suboptimal care, medical error, longer hospital stay and a lower patient and provider satisfaction (Johnson & Arora, 2009). Handover is a crucial part of providing quality nursing care and maintaining continuity in care, but any error and omissions during hands off can lead to the dangerous and life threatening consequences.

Similarly, the opportunity of working at intensive care unit in one of the tertiary care hospital allows me to observe and reflect on the importance of handoffs and impact on patient care and nurses satisfaction. During clinical I observed so many interruptions during the process of handoffs. From a distance nurses were talking to each other like usual chatting, chaos and noisy environment, and physician's orders just dilute the essence and importance of effective communication during hand-off. Besides this, when I was taking over the other nurse was also chatting with nurse around the bedside which is not related to patient's information and care and this was very much distracting to concentrate and grasp the information which further leads disorganized care and can lead to any life threatening situation where patient is intubated with full inotropic support. This is not the one time problem, but it occurs daily during the time of shift hand over. Although,

there is no formal format for shift handover, but traditional method is also not followed properly during handoffs.

This scenario raised many questions in my mind that what is going on during handoffs? How can one person entertain many people at a time? Does nurses are really aware the importance of shift hand over? Do they really realize that miscommunication and omission of important information can lead to any kind of dangerous situation or dissatisfaction of nurse and patient care? What is the role of nurse leader in providing safety during patient care? Moreover, how they have been mentored and trained during their internship? Do we have the role of training schools and what special aspect during the training of nursing students can bring a change in their future practices? Thus, Study highlighted that failure in communication and misunderstandings between shifts have led to loss of life, property damage, serious injury, lost production and adverse environmental impact (Blouin, 2011).

On analysing the scenario, the thought came into my mind is that the scenario is occurring due to lack of importance of effective communication during handoffs. This also reflects the quality of training and mentorship provided to the trainees during their internship. Moreover, the lack of appropriate role modelling by the senior staff in the unit is also not evident, therefore the practices continue in a vicious cycle. Since the skills of shift handover never taught in the schools, nurses learn this process in the actual ward setting and the culture of discussing patient information is not very evident in the scenario which actually enhances the learning of the new comers. Performing handoffs and transferring information in one breath <https://assignbuster.com/a-critical-phase-of-nursing-communication-nursing-essay/>

really question the quality of care provided by the upcoming shift. Most of the time lack of sufficient time and busy duties used to be common excuses for the quick and inappropriate shift handover, but I do not agree with this justification of nurse as shifts handover should not be compromise at any cost.

Nursing shift handover is the most commonly occurring handover process in inpatient units which allows the transfer of pertinent patient's information between nurses at the end of the shift to maintain continuity and safety of patient care. The primary purpose of shift handover is to transfer the accurate information about patient's care, current condition, and any anticipated changes, which leads to maintain continuity of care and patient's safety. Nursing handover has received considerable attention in the literature and it estimates that 80% of serious medical errors involve miscommunication between care givers during the transition of care (Blouin, 2011). However, high quality handover practices may assist in providing safe and efficient care to the patient; and this can result in better patient's health outcomes (Patterson & Wear 2010). Hands-off process is the crucial point of patient care when patient is being handed over to other health care professionals with its complete information. According to the Joint Commission the issues of communication, continuity of care, or care planning are the root cause of errors in more than 80% of the reported sentinel events (Streitenberger et al., 2006). In addition, Greenberg et al. (2007) examined the errors occurred in a surgical department, and indicated that 43% of surgical errors occurred because of inappropriate handover communication, which result in injury to the surgical patients. Moreover,

Suresh et al. (2004), in their study of medical errors and their contributing factors at neonatal intensive care unit concluded that out of 584 voluntary reported medical errors, 5.6% errors occurred due to incomplete information transfer during nursing handover. These evidences from the literature highlighted that communication breakdown during handoffs is one of the causes of medical errors and this signifies the importance of handoffs effective communication in the relation to the patient's safety.

In order to avoid the errors and enhance patient's safety many literature proposed the format to perform appropriate process of handoffs which emphasize on accurate transferring of patient related information through standardized protocol such as SBAR tool and TJC National Patient Safety Goal 2E. Besides this, realizing nurses on the importance of hand-off communication can improve the practices of handoffs among nurse.

Moreover, appropriate mentorship from the senior staff and the training novice nurses can bring a change in the process of hand-off. In addition, the clinical round of the unit head nurse and CNIs can also help bedside nurses to learn from the role modelling to enhance best practices. Handoffs process should not focused only on transferring of information, but it also fulfil the purpose of teaching and support to the novice nurses in maintaining continuity and safety of patient care (Scovell, 2010). Besides this, the dicussion and question answer during shift handover process allow off going nurse to recall her performance and responsibilities which they needs to fulfil during the shift.

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