Nursing handover literature review

The aim of this assignment is to undertake a literature review of nursing handover and determine the effectiveness of nursing handover in improving patient care. A summary of the literature review findings will be present and finally the assignment will outline a strategy of change and how the change can be implemented in practice.

According to Kennedy (1999), handover is an important part of nursing, it is essential for the continuity of care and nurses should aim to improve the efficacy of handover. It is also an important method of passing on essential information from one shift of nurses to the next. Handover should be a critical communication process that explores care, rather than a descriptive historical narrative of what has already happened, (Thurgood, 1995). There are numerous researches that show that handover influences the delivery of care for the following shift (Thurgood, 1995). Kerr (2002), reports that nursing handover plays a role in providing consistent patient care.

The communication that takes place during handover is fundamental to the nursing activity that follows and the care the patients will receive (Sherlock, 1995). However, at times the information given during handover does not help the nurse receiving the handover to care for the patient. Webster (1999), reported that information obtained at handover, provides nurses with little detail about the patient, the nursing needs or the effectiveness of the previous nursing care. Webster (1999) goes on to say that handover is more often no more than an opportunity for nurses to ensure that the patients looks tidy and well presented. Pothier, et al (2005) conducted a pilot into the loss of important data that is lost during nursing handover. In this study they

examined different types of handover methods and the results showed that vital data is lost during the nursing handover.

Background

The rationale for the choice of literature review was the identified gaps in practice with the method of nursing handover used in practice, and the lack of an identified framework and structure for handing over patient care. This led to the question of whether the nursing handover method was based on research. The nursing handover process in my area of practice varies on the shift and how is handing over, it traditionally takes place in an office which is also used the staff room with people coming in and out of the room causing disruptions, and at other times it by the patient's bedside. If there is no structured or focused handover process between nurses, staff will miss the significant information they need to know about the patients they will be taking care of. Kerr (2002), reports that if there is a structured handover method the quality of care is promoted and nurses will have a full understanding and knowledge about the patients. Glen (1998) also discussed the importance of having a structured handover process stating that it will lead to an improvement in the quality of care delivered.

Literature review

The following databases, Ovid, CINAHL Medline, EMBASE and British Nursing Index were used for searching for articles that were relevant. The following search terms were used nursing handover, bedside handover, nurse patient communication, verbal handover. The search was not limited to any particular country or area of practice. Ovid was searched and 5 articles were identified, only 4 articles were relevant; (Mckenna, 1997; Greave, 1999;

Timonen, 1999; Sherlock, 1995). 2 of the articles were looking at patient's experiences of bedside handover and the other 2 articles were looking at the efficiency of patient handover. CINAHL database identified 3 articles (Currie, 2002; Fenton, 2006; Cahill, 1998) 1 article was looking at patient's perceptions of bedside handover and 2 of the articles were looking at ways to improve nursing handover. EMBASE, Medline and British Nursing Index did not yield any results.

The literature review revealed that there are different types of nursing handover and three themes emerged from it, bedside handover, verbal handover (office based handover) and tape recorded handover and bedside handover being the most favoured.

The evidence on the most effective handover method is weak, however the literature review identified that nursing handover influences nursing care provided to patients, but they however failed to show the best form of nursing handover.

The current research available may not be substantial but it does indicate support from the large amount of anecdotal evidence which claims that nursing bedside handover is an effective form of handover process. Literature shows that there are benefits in carrying out bedside handover, it suggests that bedside handover helps to build relationships between nurses and patients' and it also increased patient's satisfaction. The literature favours bedside handover as it;

- prevents nurse’s from stereotyping patient’s and prevents them from making judgemental comments that can give other nurses a negative attitude (Parker et al, 1992).
- out of all the forms of nursing handover, bedside handover is the most time-efficient method (Webster, 1999)
- promotes patient involvement (Walsh and Ford, 1989)

In order to have consistency in the handover process changes in the current handover process need to introduced in the practice area. There needs to be a set time agreed for the handover this will ensure that nurses pass on identical information to the team members at the same time. Nurses will be encouraged to use bedside handover as the nursing handover process. This change will be piloted on the ward by different working shift patterns; it will be carried out by the afternoon shift staff. Isn’t this contradictory??? You also need to point out the disadvantages of bedside handover i. e. time constraints moving from patient to patient and lack of confidentiality if conducted within an open ward

Bedside handover in nursing is not a new phenomenon; it is one strategy that can improve patient centred care (Rutherford and Greiner, 2004). Advocates of bedside handover state that bedside handover (repetition of the same word in the same sentence) offers nurses with the opportunity to focus on individual patient care, as it involves patient participation this in turn helps patients to have a better insight into their medical problems (Greaves, 1998). Bedside handover as process allows nurses to provide patients’ report at the bedside to allow patients to be involved in their care. Bedside handovers offer an immediate solution to the many problems that

are associated with the traditional handover of office based handover, (Greaves, 1999). Such as what? Greaves, (1999) also states that bedside handover has more emphasis on individualized patients care; it puts the patients central to all care activities and does not rely purely on verbal information. (How?) Patients involved in handovers gain access to information that is thought to provide them with comfort and speed recovery (McKenna, 1997). Is this true even in circumstances where the patients health is deteriorating? Girvin (1997) reported that bedside reporting makes it possible for nurses starting their shift to obtain a better insight into the care each patient requires (in what way give an example). Patients can discuss their health by asking questions and it was found to improve the consistency and continuity of patients care, (Greaves, 1999).

Parker et al (1992) conducted a pilot study of 12 handovers, and observed that bedside handovers offered an opportunity in which nurses can gain support and group solidarity. Chaboyer (2008) carried out research on bedside handover and the results show that bedside handover improves the quality of patient care. Chaboyer’s (2008) study showed that bedside handover improves patient safety, for example it identified that nurses are able to observe observations.-(This statement could be made into one) All these things can be missed in an office based handover.

McMahon (1990), stated that office based handover, focuses on medical diagnosis and treatments, and the participants of the handover often do not have the opportunity to participate in the process. Sherlock (1995) argues that office based handover takes away the psychosocial aspects of patient care, as the information passed from one shift to the next becomes outdated

and irrelevant. Office based handover has been criticised for not putting patients perspectives into view (Paybe et al, 2000). What is your experience of office based handover; does it support or refute the above statements?

Office based handover is often lengthy; this reduces the time spent in direct patient care, with some handovers lasting as longs as 50 minutes this can be attributed to irrelevant information being shared during the handover process (Matthews, 1986). Cahill (1998) evaluated the introduction of a bedside handover as an improvement on the hierarchical and time consuming office based version, resulting in better nurse patient communication and a sense of partnership. This is supported by Watkins (1993), who reported that bedside handover is efficient in terms of time as less time is spent sitting in the office chatting.

Currie (2000) states that if the handover process is too long, there is the potential of information and sensory overload occurring leading to nurses feeling confused. Kassean and Jagoo (2005) implemented change from office based handover to bedside handover (where did they do this?) and evaluation from the change has shown that the new system of handover is working and shown improved patient care. Having long handovers will reduce the amount of time spent in direct patient contact (Currie, 2000). Shorter handovers are likely to reduce information overload and the information given will be precise and accurate ((Prouse, 1995).

Critiques of bedside handover however state that patient confidentiality is compromised as other patients can over hear what is being said about a particular patient (McMahon, 1990). Williams (1998) also discusses concerns

with bedside handover stating that patients may overhear their fellow patients' condition. Chaboyer (2008), however argues that this can be overcome by use of written information, nurses lowering their voices and sharing sensitive information away from the bedside.

Cahill, (1997) carried out a study on patients' perceptions of bedside handover and the study showed that most patients do want to be involved in nursing handover process. However (Greaves 1999), carried out a similar study and the results seem to conflict with Cahill's (1999). Greaves's (1999), study concluded that patient's wanted to be involved in their care. (Join sentence, the years for Cahill are different- which is correct) Timonen et al's (1999) study of patients' views of bedside handover concurs with Greaves (1999). The study showed that bedside handover encourages patients' to participate in their own care as they are given the opportunity to ask nurses questions pertaining to their care during handover.

Change in practice

As suggested by Mathaws and Whelan, (1993) the nursing profession has acknowledged that it is in an era of change. In this era of change, emphasis is placed on quality, efficiency and effective management. Audit tools are the common instruments used for the review of these and the concept of review and appraisal is central to the issue of quality in practice and the same tool will be used in this proposed change. Gray and Kron, (1987) points out that if issues of quality in practice go unadvised, there is the likelihood that patient care, staff self-expansion and professional image are compromised. With this in mind the ward sister (change agent) will be approached to discuss the

current situation and future desired goal which is for all nursing staff to use bedside handover as a process.

As suggested by Rolland (1998), a change agent is needed when trying to implement change, the change agent acts as a catalyst and as such requires particular qualities (ability to listen, to establish and maintain comfortable relationships with staff and to be aware of personal strengths and weakness), the change agent must be someone with authority and leadership skills. According to Lancaster and Lancaster (1982), there are two types of change agent, external and internal.

There are many theorists who have developed processes of change, but Lewin's (1951) theory is perhaps the one that is most recognised. Karl Lewin (1951) addresses three phases of change: unfreezing, moving and refreezing, which are based on two concepts identified as driving and restraining forces, also called a force field analysis framework for looking at problem solving and change, (Lancaster J 1999). Lewin proposes that when implementing any change there are a number of factors that help to achieve change, this would be the driving concept, for example the aim to improve patient care.

Conversely, a restraining factor could be unwillingness to change or poor staff morale (Cork 2005). Other theorists include Lippett (1973) who identified seven stages in the change process and Rogers (1962) who expanded on Lewin's three phases of change with five phases by emphasizing both the background of the people participating and the environment in which the change takes place. The five stages in Rogers

change cycle are awareness, interest, evaluation, trial and adoption (Lancaster 1999).

For the benefit of this essay, the Lewin's Force Field Model of Change (1951), will be used the rationale being that Lewin's theory is not complicated it only has 3 phases. Although Lippett's theory is consistent with the nursing process it is too wordy making it hard to use comprehend. Roger's theory was similar to the stages in Lewin's but the unfreezing stage was broken down into three smaller stages as Roger's believed the process of adopting change was more complex that the three steps discussed by Lewin's (Lancaster 1999).

The process of change has been characterized as having three basic stages, unfreezing, moving and re-freezing, this view draws heavily on Kurt Lewin's adoption of the systems concept of homeostasis or dynamic stability (Lancaster, 1999). Unfreezing involves finding ways of making the need for change obvious that most people can readily understand it and accept it. For the unfreezing phase to be successful, an accurate assessment of the problem must be made along with a decision to change. During this phase people become disenchanted and aware of a need for change, the through three stages (Lewin, 1951). Hein and Nicholson, (1994) identify the first occurring when the individuals expectations fail to be met. The second occurs when the individual feels uneasy about a certain action or lack of action and the third is when an obstacle to change has been removed.

The second process of Lewin's (1951) theory which is the moving stage, Broom (1998) points out that there is a plan to implement change, as well as

analysing and discussion of information and pre-testing the change. This stage involves making the actual changes that will move the team to another level, identifying and scanning problems such as employees that will make up the critical mass and those for the change. The values and attitudes of those involved in the change needs to be acknowledged, barriers discussed and solutions identified (Broom, 1998). Refreezing is the final stage in the change process, this involves stabilizing or institutionalizing changes by establishing systems for example, redesigning the training needs and processes (Lewin, 1951). It can be argued that changes occur because one has knowledge, positive attitude and experience on this new behaviour. Rolland (1998) suggests that this stage occurs when behaviour becomes part of the daily activities.

With this theory, Lewin had condensed his force field analysis (Huber, 2006), force field analysis is a tool that takes into consideration hindrance and enhancing factors to every change. Lewin identified that change is the result of completion between two forces, which he identified as the driving forces and the restraining forces. This is when one set of influences or pressures are pushing for change and a different set is pushing for things to remain as they are at ‘ status quo’. Lewin’s force field analysis enables the practitioner to work out the forces that are driving the desired change and those that are opposing and to take actions which are likely to produce movement (Naylor, 2004). It also takes into consideration hindrance and enhancing factors. This helps to get an overview of the obstacles to the change that exist within the individuals as well as the positive factors, which will aid the change process.

The force field analysis also identified staff reluctance to change as a resisting factor the way they are currently working. Iles (1997) compares the change process with the grief process and that any change will ultimately mean the disappearance or refinement of one thing and the introduction of something new. According to Deegan et al (2004) implementing change can quickly move to resistance when external and internal values conflict. Nurses who favour office based handover may have different values to that of the change agent.

Any change is likely to produce resistance, employees' resistance can be traced back to the assumptions organizations make about people and change. Many of those assumptions are misleading, outmoded or simply unfounded. ' Resistance to change' is often used as a convenient catch-all way to explain results that change agents/managers did not expect or understand, because it is a simple description of a complex set of human responses to new situations. Ashkanasay et al (2004), suggests that people's largely unconscious reactions to change may not be based on wilful obstinacy but may in fact be the result of assertions of their own sense of dignity, autonomy and integrity.

Considerable research supports the existence of strong link between employee participation and commitment to change, but some researchers noted that commitment is really a by product of genuine respect for individuals and their values. The level of resistance to change depends mainly of the type of the proposed change, employee's values, educational levels, cultural and social backgrounds and previous experience of change will have tremendous impact on their resistance.

Using the abilities linked to emotional intelligence, workers would become more attuned to both their own emotions and other's emotions, and use that information to regulate those emotions to enhance relationships between employees (Martin et al 1998). Taking responsibility for one's own emotional displays becomes an important part of emotional regulation. This would decrease dysfunctional conflict during times of change and include engaging in positive coping behaviours that enables employees to maintain their self-esteem (Ashkanasy et al, 2004). More specifically, it would be beneficial to measure employees' coping strategies in terms of specific workplace change scenarios and examine how these strategies link to the ability of those employees to engage in organizational learning.

The culture of an organisation is important to it and will influence the way that change happens within that organisation (Corrigan and Kleiner, 1989). The NHS is considered by Bryman (1986) as an organisation characterised as being bureaucratic and hierarchical in nature, and as such Bryman believes its ability to change is challenging. Ootim (1997) believes that the more nurses learn to adapt to new situations, the more they become confident in their ability. This in turn can contribute to more effective healthcare organisations. Once effective systems of practice and professional development, research development, clinical risk and clinical audit have been established, the overall cultural emphasis shifts from reactive, to proactive. Part of the organisational culture of school nursing is that staff are quite satisfied with the status quo and they will probably be resistant to the suggestion that they change the way in which they work. This then leads the

discussion to different leadership styles and how they influence change with in the culture of the nursing team

Leadership is an important part in change management, (Rolland 1998) argues that, there is no consistent set of personality traits that tells leaders from others. Mathews and Whelan (1993) however points out that a strategic leader requires three characteristics. These are sense of direction, team building and creativity. He further suggests that no individual could posses all these qualities but it is important that the change agent recognise them in other members in the team. He also points out that the change agent should also be able to create a dynamic and cooperative environment in which these skills are recognised, directed and managed. Armstrong (1994) is also with the opinion that telling, selling, participation and delegation are also important in the change process therefore the change agent will adopt them to link the appropriate change strategy to the needs of those involved.

The change agent's leadership style plays a vital role in managing the change process, the importance of leadership style in the management of change is well established (Blankenship et al 1990). Walton (1997) defined leadership style as " the way in which the functions of leadership are carried out"(Pg. 145). He further points out that, there is a strong subjective element, which shows that leadership needs vary from group to group and problem to problem. One can therefore suggest that the nature of the intended change plays a large part in determining the manner in which leadership style is incepted.

Cole (2004), concluded that the suggesting that leadership is a dynamic process implies that there is no one best way of leading, therefore leading is essentially about striking the right balance between the needs of the people, task and goals in a given situation. Also some theories do not fit well in terms of their difficulty in implementation in practical situations, as in practice, staff responds differently to certain styles of leadership and approaches.

Heresy and Blanchard's situational leadership is one of the most popular and it is known as the life cycle theory of leadership, (Mosley et al 2001; Cole, 2004). The situational model assumes that leadership behaviours fall into two main areas, which are task or relationship behaviours. Relationship behaviours entail providing people with support, positive feedback, seeking their opinions and ideas. Whilst tasks behaviours include job clarification, telling people what, how, when to do and providing follow up and taking corrective action (Mosley et al 2001).

Situational leadership model shows the relationship between the readiness of followers and the leadership style, if a team is fairly new or less ready and performance or standards are going down, then a structuring and telling approach will be more suitable. This means that you are likely to achieve high tasks and low relationship situation. As the group gradually matures and the motivation levels are correct, then coaching and selling approaches become the most appropriate as it produces high task and high relationship situation.

Critics of leadership theories further suggests that, a more visionary and empowering leadership must suit the world of rapid turbulent change. Burns and Bass identified transformational leadership and explored its differences with transactional leadership. The idea behind the transformational leadership is that it converts the followers into leaders and may convert leaders into moral agents (Burns and Bass in Mosley et al, 2001). It can still be argued that not everyone in the group will be aspiring to move higher in their position. It can also be argued that the transformational leadership skills are essential for leaders to disseminate a shared vision within an organization and to achieve affective commitment (Allen and Meyer, 1990) to ensure that employees take ownership of that shared vision.

Wright (1994) states that they are three strategies which can be used in implementing change; empirical rational, rational re-educative and power coercive. He further points out that the empirical rational is based on an assumption that people are rational, this approach can also be viewed as a top-down approach but may involve the change agent asking staff to perform a new duty in a more effective and efficient way. Hence if change is justified and beneficial, individuals will adopt the change. With the normative, re-educative strategy, Wright (1994), goes on to say that people take action according to their devotion and commitment to socio-cultural norms. The final one he discusses is power coercive strategy, in which according to Wright (1994), the manager/change agent demands compliance from junior staff. If the proposed change is initiated by the ward managers nursing staff might view the change as coming from a top-down approach,

this approach might not be so applicable for the change proposal as staff can view it as a destructive approach.

Although power coercive change strategy is acknowledged to be predominant in the NHS (Rolland, 1998), the change agent should use the normative, re-educative approach. Rolland (1998), suggests that education is needed as part of this process, this will replace the existing attitude, knowledge and skills. Armstrong (1994) addresses the importance of education in terms of change as a process. He appears to suggest that in this process there is a need for education, which will then replace the existing attitude, knowledge and skills. In this view, the change agent makes the staff aware of research based on the benefits of bedside handover an attempt to raise their awareness of the need to use this approach and also to dispel fears and uncertainties the staff may have. As a strategy for change this approach is in line with the notion of planned change occurring within a deliberate and collaborative framework (Broome, 1998). Approaching change from a normative re-educative perspective strengthens the case for a shared approach to introducing change, this strategy is more likely to be accepted and the change will be sustained.

The employee does not have the responsibility to manage change – the employee’s responsibility is no other than to do their best, which is different for every person and depends on a wide variety of factors (health, maturity, stability, experience, personality, motivation etc). Responsibility for managing change is with the change agent and management; they must manage the change in a way that staff can cope with (Naylor, 2004). The change agent has the responsibility to facilitate and enable change, and all

that is implied within that statement, especially to understand the situation from an objective standpoint (to ‘ step back’, and be non-judgemental), and then to help people understand reasons, aims and ways of responding positively according to team member’s own situations and capabilities. Increasingly the change agent’s role is to interpret, communicate and enable – not to instruct and impose, which nobody really responds to well (Mosley et al 2001).

Crucial to the success of change in practice, is communication between the change agents and the other participants. Clear consistent communication that effectively describes the vision of the change can bring clarity to confusion. One of the most common ways to overcome resistance to changes is to educate people about it beforehand, communication of ideas held people to see the need for in the logic of the change. As part of the strategy in overcoming the restraining forces the change agent can have informal talks with the nursing staff about the identified change and how it is intended to be implemented it. After the informal talk the change agent could begin communicating her desire to make changes by having formal talks at team meetings Consultation meetings will also allow staff to think about the change and how it will affect them and they will also have an opportunity to ask questions and to voice their opinions.

Employees are more likely to be committed to their work if they have a say in it, they are more inclined to believe and support decision which they have had some input. Poor communication between professional colleagues during a change process can impede an effective result. If thoroughly planned and organised change to practice could be relatively straight

forward, however if communications systems are not effective, it could have serious implications for the proposed change and for practice in general.

Fretwell(1985 cited in Cork, 2005) argues that nurses appear to have an inherent resistance to change and questions whether they are in a position to effect change. Nursing staff are constantly experiencing change in order to keep up with the organisations (NHS) goals, which is highlighted through Clinical Governance However, Ewles et al. (1999) states that educating and communicating to people about change before it happens can limit resistance. However, Ewles et al. (1999) goes on to caution that often this can be a time consuming process. (Sullivan and Decker 1997, Pryjmachuk, 1996) have recognised that the utmost influence on change is achieved when group members discuss issues that are perceived as important and make relevant central decisions based on those discussions.

The change agent should ensure that a steering group is created, the steering group will help her in taking the change proposal forward. The steering group should have a nursing staff of different grades. Delegation is an important aspect of organisation and effective management (Tomey, 1993). Without delegation the change agent will be responsible for everything and will be the only person with authority to do everything, consequently nothing much would ever be done. Management is the act of getting things done through the work of other people it is obvious that management could not succeed without delegation. Hence the change agent will delegate throughout the process, more specifically in controlling and monitoring the change.

Evidence based practice is a key element of clinical governance. Within the framework of clinical governance (DoH, 1999) decisions for clinical practice must be based upon the most up to date evidence (Chilton et al. 2004). Clinical governance is also about changing the way people work; demonstrating that leadership, teamwork and communication is as important to high quality care as risk management and clinical effectiveness. According to Major (2002) and Bulley, (2005) by influencing the team and developing staff, direct influence and change can be made on the quality of patient care. Introduction of change will be met with unwelcome behaviours, evidence will be required to support the way the introduction of change.

Change needs to be introduced gradually, management needs to remain constantly aware of the feelings and concerns of all the staff to the proposed change. Curtis and White (2002) propose that motivation of staff is a basic need for change and that participants should not feel that the change agent is crucial to the success of any change. The change agent will need to be sympathetic and understanding of feelings of the team and their perspectives of the change, being non-judgemental and avoiding criticism (Hunt and Pearson, 2001), this will create positive reinforcement and can create ownership of the change within the staff resulting in staff believing that the innovation for change emanated from them. Staff will be encouraged to ventilate their concerns and identified barriers through debate to the proposed change and to identify strategies to overcome them.

An inappropriate change strategy and poor leadership style may contribute to resistance and conflict to change but the nature of this resistance may also be more ingrained within the indi