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COMUNICAÇÃO CLÍNICA (HANDOVER) E SEGURANÇA DOS CUIDADOS DE ENFERMAGEM: REVISÃO DA LITERATURA

CLINICAL COMMUNICATION (HANDOVER) AND SAFETY OF NURSING CARE: A LITERATURE REVIEW

COMUNICACIÓN CLÍNICA (HANDOVER) Y SEGURIDAD DE LOS CUIDADOS DE ENFERMERÍA: REVISIÓN DE LA LITERATURA

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RESUMO

Introdução: O *handover* enquanto processo de transferência de responsabilidades é considerado um momento crucial na prestação de cuidados de enfermagem de qualidade. Os problemas na comunicação são causas major de erros que ocorrem durante situações de *handover*.

Objetivos: Propomo-nos identificar a evidência da relação da comunicação clínica (*handover*) e segurança dos cuidados de enfermagem.

Métodos: Realizámos uma revisão integrativa da literatura usando as bases de dados Pubmed, Web of Science, Scopus e CINAHL. Foi efetuada uma pesquisa com os descritores: "Patient Handoff", "Segurança do Doente", "Comunicação Clinica", "Enfermagem". Mediante a pesquisa bibliográfica nas bases de dados emergiram 137 artigos. Foram selecionados 8 artigos que responderam ao objetivo deste estudo. Estabeleceram-se como critérios de inclusão, estudos publicados entre janeiro de 2010 e março de 2016, disponíveis em Português e Inglês.

Resultados: A análise dos artigos através de convergências críticas permitiu o seguinte agrupamento por temas: *handover* como processo de transferência de responsabilidade, barreiras à comunicação efetiva e estratégias promotoras de um *handover* de qualidade.

Conclusões: A qualidade da informação durante o *handover* permite que os enfermeiros organizem intervenções antecipando riscos. É fundamental identificar barreiras que interferem no processo de *handover* para implementação de estratégias que estruturem o processo de comunicação e promovam a segurança do utente.

Palavras-chave: comunicação clinica; *Handover*; segurança do doente; enfermagem.

ABSTRACT

Introduction: The handover as a process of transference of responsibilities is considered a crucial moment in the provision of nursing quality care. Problems in communication are the major causes of errors that occur during situations of handover.

Objectives: We propose to identify the evidence of the relationship of clinical communication (handover) and safety of nursing care.

Methods: We accomplished an integrative literature review using Pubmed, Web of Science, Scopus, CINAHL data bases. A research across the terms: "Patient Handoff", "Patient Safety", "Clinical Communication", "Nursing" was realized. In studies for research strategy emerged 137 articles. We selected 8 articles that responded to the purpose of this study. As inclusion criteria, studies published between January 2010 and March 2016 were established, available in Portuguese and English.

Results: The analysis of the articles through critical identified convergences allowing the following grouping by themes: handoveras a process of the transference of responsibility, barriers to effective communication and strategies promoting a handover withquality.

Conclusions: The quality of information during the handover allows nurses to organize interventions anticipating risks. It is essential to identify barriers that interfere with the handover process, for being able to implement strategies that constitute an effective communication process and promote the safety of the patient.

Keywords: clinical communication; Patient Handoff; patient safety; nursing.

RESUMEN

Introducción: Como proceso de transferencia de responsabilidades el "handover" se considera un momento crucial en la provisión de cuidados de enfermería de calidad. Los problemas de comunicación son las causas principales de errores que ocurren en situaciones del "handover".

Objetivos: Nos proponemos a identificar pruebas de la relación de la comunicación clínica (handover) y la seguridad de los cuidados de enfermería.

Métodos: Llevamos a cabo una revisión integrativa de la literatura utilizando las bases de datos Pubmed, Web of Science, Scopus y CINAHL. Se realizó una búsqueda con las palabras clave: "Patient Handoff", "Seguridad del Paciente", "Comunicación clínica", "Enfermería". Mediante la investigación bibliográfica en bases de datos surgieron 137 artículos. Se seleccionaron 8 artículos que responden al objetivo de este estudio. Se establecieron como criterios de inclusión, los estudios publicados entre enero de 2010 y marzo de 2016, disponibles en portugués e inglés.

Resultados: El análisis de los artículos a través de convergencia crítica y cualitativa de lectura identificada, permitiendo la siguiente agrupación por temas: handover como proceso de transferencia de responsabilidad, las barreras a la comunicación efectiva y es

trategias de promoción de un handover de calidad.

Conclusiones: La calidad de la información durante el handover permite a los enfermeros conocer a los pacientes, organizar intervenciones, anticipando los riesgos. Es esencial identificar las barreras que interfieren con el proceso de handover para la aplicación de estrategias que fomentan el proceso de comunicación efectiva y así se promuebe la seguridad del paciente.

Palabras Clave: comunicación clínica; Handover; seguridad del paciente; enfermería.

INTRODUCTION

Currently, in healthcare, the large volume of scientific information points to the need for summaries, conclusions and guidelines based on a combination of results from multiple studies and can contribute to the consistency for the reasons for a clinical decision that is to evidence-based practice, and consequent improvement of practices (Pereira, Gaspar, Reis, Barradas & Nobre, 2012).

Every day, nurses are challenged with the taking of decisions that are directly related to the safety of the patient being in need of updated scientific evidence and it is in this sense that the systematic review of the literature identifies, evaluates and summarizes the findings of several empirical studies. The nurses are the professional group that establish an interaction with the patients, that boosts their safety in all aspects of care, including the reporting of risks and the possibility of these being reduced.

The International Council of Nurses (2012) also recognizes that although care has aimed to generate benefits for patients, the complex combination of processes, technologies and human factors in the provision of health care can lead to adverse events.

The Joint Commission on Accreditation of Healthcare Organizations, observed that 65% of the events are associated to miscommunication and reported that in the first months of 2013, miscommunications were the second cause of sentinel events (Fay Hillier, Regan & Gallagher, 2012). Communication between nursing professionals, has exposed numerous shortcomings over the years, concerning the difficulties of dialogue between the various health team professionals, the lack of written records related to patients that are incomplete, inaccurate, or even hidden. Failures in communication are the cause of a decreased quality in care, errors in the treatment and a potential harm to patients (Quirino, Collet & Neves, 2010).

The passing over of shifts designated in the literature by 'handover', are particularly vulnerable times for the occurrence of errors. Despite being an ancient practice in the nursing care process, there continue to be failures in the organization and structuring of information and its content (Azevedo & Sousa, 2012).

The purpose of this study is to identify the evidence of the relationship of clinical communication (handover) and safety of nursing care.

1. METHODS

We accomplished an integrative literature review defined as a method that aims to summarize results that are obtained in research in a topic, in a systematically, orderly and comprehensive way. It is called integrative because it provides further information on a problem, therefor constituting a body of knowledge. Thus, the researcher can develop an integrative review for different purposes and can be directed to the definition of concepts, review of theories and methodological analysis of the included studies of a particular topic.

For the construction of the integrative review it is necessary to go through six distinct stages, namely: identification of the research question; establishment of criteria for inclusion; definition of information to be extracted from selected studies; assessment of included studies; interpretation of results and presentation of the review (Mendes, Silveira & Galvão, 2008).

Following this approach, it was possible to identify the main studies to answer the purpose of this study: identify the evidence of the relationship of clinical communication (handover) and safety of nursing care. A research was executed across the terms: "Patient Handoff", "Patient Safety", "Clinical Communication", "Nursing", obtaining as a result the following MeSH terms shown in Table 1.

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Table 1 - MeSH Terms

Health Communication	Patient Safety	Patient Handoff	Nursing
MeSH Terms "Health Communication"[Mesh] AND "Patient Safety"[Mesh] AND "Patient Handoff" [Mesh] AND "Nursing" [Mesh]			

As inclusion criteria, studies, to answer the question of research published between January 2010 and March 2016, were established, available in Portuguese and English, from scientific databases. The scientific databases were PubMed, Web of Science, Scopus and CINAHL, identified as A1, A2, A3 and A4 respectively, as outlined in Table 2.

Table 2 - Studies that have been recognized since the introduction of descriptors

CODE	DATA BASE	KEYWORDS	RESULTS
A1	PubMed	"Patient Handoff"[Mesh] AND ("Patient Safety"[Mesh] AND "Nursing"[Mesh]) AND "Health Communication"[Mesh])	33
A2	Web of Science	(handoff) *AND* (patient safety) *AND* (nursing) *AND* (communication)	76
A3	Scopus	(title-abs-key (handoff) and title-abs-key (patient safety) and title-abs-key (nursing) and title-abs-key (communication)) and doctype (review) and pubyear	10
A4	CINAHL	handoff AND patient safety AND nursing AND communication year_cluster:("2011" OR "2012" OR "2013" OR "2014" OR "2015"	18

In studies for research strategy emerged 137 articles. After reading the titles, 43 articles were selected. These articles were part of the criteria for analysis and after reading the summaries 32 articles were selected, for their content was of interest to this review. We obtained 15 articles that met the pre-established criteria, but we were only able to include 8 articles in the study, of which one we had access to the full text, presented in Table 3.

Table 3 - Results of studies in analysis

REFERÊNCE	DOCUMENT TYPE	ABSTRACT
(Birmingham et al., 2015) United States	Research Paper	A qualitative study with 21 nurses of a public hospital in the United States, using grounded theory to explore the perspective of nurses on the handoff processes and identify situations that create risks to patient's safety.
(Streeter et al., 2015) United States	Research Paper	Quantitative study with 286 nurses who used the Nursing Handoff Communication Competence Scale, to evaluate the experiences and perceptions that constitute a competent handoff of nurses.
(Drach-Zahavy et al., 2014) Israel	Research Paper	Study of qualitative character with 18 nurses of a hospital in Central Israel, conducted during a 10-month period from 2011 to 2012, which enabled us to understand how the nurses were managing the time of handover and identifying working strategies they used to promote patient safety.

(Sand-Jecklin & Sherman, 2014) United States	Research Paper	Quasi-experimental study in seven medical-surgical units in a university hospital in West Virginia, with a sample of 250 patients during the pre-implementation of an intervention program and 250 patients during the post implementation of the program, in order to quantify the results of a change of practice moments of handover.
(Gonçalves et al., 2016) Brasil	Research Paper	Quantitative, descriptive and exploratory study with 70 nurses 3 neonatal intensive care units, in order to identify the factors related to the patient safety with regard to communication in the Nurses shift change process.
(Street et al., 2011) Austrália	Research Paper	Quantitative study with 259 nurses of an Australian Public Hospital in the 3 shift changes during a day to identify the strengths and limitations in current handover practices and implement a new process of handover in order to improve the patient safety.
(Johnson & Cowin , 2012) Austrália	Research Paper	A qualitative study with 6 focus groups in 3 major hospitals in Sydney, with the objective of exploring the perspectives of nurses on the handover from patients and the use of written notes during the handover.
(Holly & Poletick, 2013) United States	Review article	Systematic review of study consists in 29 qualitative studies between 1988 and 2012, which describe the qualitative evidence on the dynamics of knowledge transfer during the handover process.

2. RESULTS

The analysis of the articles through critical and qualitative reading identified convergences allowing the following grouping by themes: handover as a process of the transference of responsibility, barriers to effective communication and strategies promoting a handover with quality.

Handover as a process of the transference of responsibility

One of the crucial moments of communication between nurses happens during the handover, which is constituted as a process of care responsibility transfer and transmission of information on aspects related to the patient (Johnson & Cowin, 2013). This process calls for an interactive communication function as a triad: the patient, the nurse who finishes the shift and the nursing team that starts the new shift (Johnson & Cowin, 2012).

It is a process of interaction that puts a huge responsibility on the nurse as holder of information of decisions to be transmitted to continuity of care (Holly & Poletick, 2013). If we refer to Kerr (2002), it references the handover as having three main functions: to express communication, which includes information about aspects essential objectives care; covert information that integrates the psychological and social elements of care and cultural integration that aims the construction of the professional identity.

During the handover there are three types of exchanges of information: the information given by the nurse who ends the shift, the information requested by the nurse who starts the shift and verified information, which consist in a brief repetition of information (Streeter, Harrington, & Lane, 2015). The informations that were considered important to the nurses during the shift change were: the clinical condition of the patient and the complications during the shift, reported by 55% and 50% of nurses, respectively (Gonçalves, Rock, Anders, Kusahara & Tomazoni, 2016).

There are several methods for the handover, these include written, oral and face-to-face communication with the patient or the location away from the patient (Birmingham, Buffum, Blegen, & Lyndon, 2015). Most nurses of research of Gonçalves et al. (2016), state that the method that is most commonly used to pass the shift is the verbal type, but they find weaknesses in this type of method when used isolated due to the large amount of data that is transmitted, making it difficult to hold all the information. Street et al. (2011), mentions another study that nurses recognize that the most effective method of handover is the use of verbal and written communication to convey information.

Although the main purpose of the handover is to be provided accurate, complete and timely information, this process also gives nurses the opportunity to socialize, discuss feelings and concerns related to the organization of care to increase the cohesion and professionalism. This current discovery about the importance of socio-emotional handover process observed in the study Streeter et al. (2015), is in line with other studies that analyzed the relational value of the handover in nursing. According to Holly & Poletick (2013), nurses used the time during the change of shift to discuss the difficulties that caused discomfort due to their difficult resolution and considered this process as a facilitator of staff cohesion and orientation of new nurses to the

institutional culture and care procedures. The relational aspects linked to the handover, the complexity of the type of information to be transmitted, the adopted media and the characteristics of the various caregivers impacts the effectiveness and efficiency of this process and, consequently, safety and quality of care of the patient (Santos, Andrade, Guimarães & Gomes, 2010).

Barriers to effective communication

The passing of shifts is often described as informal, unstructured, with discrepancies between the information transmitted by the nurse that is leaving the shift and the actual conditions of the patients, resulting in errors (Streeter et al., 2015). A large group of nurses reported in a study that the way that the information was presented during the handover was not easy to be understood, and that there were inconsistencies between the written records and verbal information that was transmitted. The written data has more information than the one that is transmitted during the handover, however during this process we have to consider important situations as i.e. emotional state, family dynamics, which usually are not registered in the nursing process (Holly & Poletick, 2013). According to Welsh (2010), about 9% of the shared information is irrelevant and only about 6% of the information refers to the patients continuing care.

The main handover problems are related to the lack of structure, cohesion and clarity in oral information that is shared, inconsistent and / or insufficient, distractions, noises, illegible records, time constraints and the use of confusing language or jargon (Gonçalves et al., 2016). In the method of written handover, the use of descriptors poorly defined as “good”, “okay”, or abbreviations is common, and recent studies have shown that these inaccuracies can lead to problems of interpretation (Santos et al., 2010).

Many of the nurses reported that interruptions in the practice room and during the handover, prevented them from retaining full information and made it impossible to clarify the information, thus bringing risk to the continuity of care (Birmingham et al., 2015). According to a study of Street et al. (2011) the average time of handover per patient had an average time of 5.5 minutes in daytime shifts. A significant percentage of nurses said that the period of the handover was too long. This sometimes happens due to the delay of nurses when entering the shift, 34.8% of nurses mentioned this as a barrier to effective clinical communication, delays between colleagues (Gonçalves et al, 2016).

Another situation that is considered as a barrier is the place where the handover is held. Nurses consider that the handover of the patient, does not allow the necessary silence to interpret the information received, because it is not a private place for there are other patients in the infirmary and the standing position in the room is not a comfortable position to be able to make written notes (Johnson & Cowin, 2012; Sand-Jecklin & Sherman, 2014; Birmingham et al, 2015.).

Most nurses in the analyzed studies identify the importance of involving the patient in the handover, because he is the only one who has information about himself. However, they consider the patient in this type of process as an interference, as it prolongs the time of passing the shift, because they want to share much information with the nurses and the fact that the nurses may use technical language to limit evidence of patients and leave them confused (Drach-Zahavy et al., 2014). However, from the observation of Nurses in Birmingham et al research. (2015), during the handover in several shifts, it was notorious, that there were tiny existing interruptions when this process is carried out with the patient, in opposition to the interruptions that existed when this process took place in the nursing room. The perception of an effective handover is different depending on the experience of the nurses, and some report that, when they do not trust colleagues, when they begin the shift they re-evaluate information immediately (Drach-Zahavy et al., 2014).

Strategies promoting a handover with quality

The nursing teams become more cohesive as a result of exposure to the same rules and procedures that lead to shared meaning for the development of a group identity (Holly & Poletick, 2013). Thus it is important to standardize the information content of the clinical communication times using specific tools in order to anticipate the risks of the patient, recognize and detect unexpected changes.

The standardization, repeatability and routines, the use of checklists and mnemonic allow better moments of handover (Drach-Zahavy et al., 2014). One of these mnemonic is the SBAR communication technique (Situation, Background, Avaliation, Recommendation). This technique provides a standardized framework with a logical sequence of issues to be addressed, it structures the information to be transmitted to not have to remember everything only by memory and facilitates the establishment of dialogue. It allows to set expectations for what will be communicated and how it will be communicated, which is essential for the development of teamwork (Holly & Poletick, 2013; Birmingham et al, 2015.). However, there seems to be no evidence to suggest that SBAR is more effective than any other handover tool (Streeter et al., 2015).

The notes written by nurses were considered as a structured approach to help retain large amounts of information (Birmingham et al., 2015). A multimodal approach, combining verbal and written elements (shift change sheets or information sheets summaries),

was also reported by other nurses' groups as a tool to maximize the effectiveness of the transmission of information (Johnson & Cowin, 2012; Streeter et al, 2015).

Another strategy that studies analyzed is how the shift change affect the patients. Some nurses prefer to perform the handover from patients directly, referring thus improving their confidence in them (Birmingham et al., 2015). This can be beneficial, because the nurse joins verbal information within the view of the patient, thus improving the memory of the information transmitted (Drach-Zahavy et al., 2014). The issues related to information gaps are minimized when the handover is performed with the patient, because the family will be present at this time (Gonçalves et al., 2016). In the study by Street et al. (2011), changes were mentioned in the handover process after an intervention project that aimed to make the change of shifts with patients. Nurses found a marked and steady improvement in time and of clinical communication process after using this method.

To provide clinical communication quality, the nurses mentioned how important continuity of care with the same patients in multiple shifts is, positive working relationships, open dialogue among professionals, human resources that are adequate to the ratio of patients and continuous training (Birmingham et al., 2015). In the study of Sand-Jecklin & Sherman (2014) professionals bet on training using educational videos that included guidelines and examples of the changes of shifts of nurses with the patients. The perceptions of these nurses together with the views of the patients, allowed to verify that there was greater patient satisfaction by the fact that he could participate in the care and know at the beginning of the new shift who his reference nurse is, better nurse-patient relationship and better results in terms of reduction in communication-related errors.

CONCLUSIONS

Communication is the key in promoting continuity of nursing care and it is the basis of care and requires a high performance by the nurses. In order for nursing care to have a safe development and to be valued it is essential to value the wealth of information and documentation options in practice contexts. The quality of the information transmitted during the handover depends on the competence of the professionals, team cohesion, the chosen mode and on your time. According to the reviewed studies, an effective handover allows the promotion of patient safety and continuity of care, improves communication and teamwork and thus improves work performance.

Studies have shown that there are limitations that may compromise the safety and continuity of care: missing or incomplete information, frequent interruptions, lack of involvement of the patient, delays and early departures, noise and time limits.

The results of this research alert us to the need to: create communication tools to standardize the information to be transmitted producing a structured handover, providing a continuous update on the topic in health institutions encouraging multidisciplinary work and allow schools and universities to provide a theoretical and practical support on the issue of patient safety and communication skills. In this way we can make safer health care both for patients and for professionals.

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