International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

Increased Errors in Nursing Care due to Ineffective Communication during Nursing Handovers among Staff Nurses at Teerthanker Mahaveer Hospital, Moradabad

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Abstract: ***Nursing handover is, by definition, an inherently communicative event. An effective Nursing handoff supports the transition of critical information and continuity of care and treatment. So this problem solving approach was carried out to establish valid measures of handover quality and safety and effective interventions within and across health - care settings and to maintain high standards of clinical care at Teerthanker Mahaveer Hospital, Moradabad. The sample (staff Nurses of Teerthanker Mahaveer Hospital, Moradabad) was withdrawn by simple random sampling and data was collected by structured handover assessment checklist on nursing handover including Demographic characteristics. The findings of the study reveals all the handovers were at the average level of effectiveness with the Mean of 2.00. The identified causes for effectiveness at average were Omissions, Distractions, Lack of or illegible documentation and Inadequate tools or equipment for effective handoffs. Solutions for the ineffective are grouped into environmental aspects (e. g., interruptions, noise level and workload), behavioral aspects (e. g., shared planning, shared decision making and critical review of existing documentation, verbal report and acknowledgement of information received), Supporting handover processes through technology like EMR - based handover sheets and Use of standard mnemonics for effective communication like I - PASS, ISBR and ISOBAR.***

Keywords: nursing handovers, handoff, communication, nursing shift over.

1. Introduction

Nursing or Clinical handover refers to "*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"*. One study found that only 23 percent of physicians could correctly identify the primary nurse responsible for their patient, and only 42 percent of nurses could identify the physician responsible for the patient in their care. Hence it shows that nurses who are responsible for patient care are lacking somewhere. Similarly, empirical research into patient - centered communication in handover is scant. For some years, research has been suggesting that clinical handover is a critical site for communication problems thus it leads to poor patient outcome. Ineffective shift handover increases the risk of medication error and sentinel events, delays the course of treatment, decreases patient satisfaction, and prolongs the length of hospital stay, so there is a need to look after the handover process to decrease the consequences of errors in patient care.

Literature Survey: Pareshmar k et al conducted a descriptive and cross sectional study i n a 200 bedded Neurosciences Center of an apex public sector Tertiary Care Referral Hospital in New Delhi, India from January 2014 to April 2014. Handovers in each ward were observed both during weekdays and weekends using a pretested checklist for a period of 1 - week from the corresponding Monday of the week to the subsequent Monday. The findings reveals that the overall interaction among all nursing staff during handovers was low (52.8%), Part of the handover occurred at bedside (83%). Overall compliance was 76%. Situation, background, assessment, recommendation (SBAR) process elements were followed the best among all the five categories studied (aggregate 82%). Among the four elements, in all wards and across all shifts, situation (86%) and recommendation (82%) had higher adherence among nurses than background (79%) and assessment (80.4%), among all categories, patient communication was given the least priority (44.4%) and no correlation was observed between elements and wards.

Duhan D, Sembian N, Kumari, Vinay Kumari conducted a study on Effectiveness of shift handover guidelines on handing over practices and work related concerns among staff nurses in adult intensive care units, at Maharishi Markandeshwar Hospital Mullana Ambala Haryana in year 2014. Total 30 sample of Neuro, Surgical and Respiratory ICU nurses. The shift handover checklist was used for data collection. Content validity and Inter rater reliability was 0.86 respectively and employed SPSS 20.0 software, Paired - t test and ANOVA test for data analysis. Study findings revealed that the nurses practice mean score on the shift handover checklist increased significantly from 22.27 (5.09) to 79.33 (6.21) ($p<0.001$). Using a standard handover checklist for shift handover communicates better information and improves nurse's safe practice in areas of basic nursing care.

2. Methods/approach

The study Design/approach was Quantitative descriptive research design. Samples were Staff nurses and setting was Teerthanker Mahaveer hospital, was withdrawn by simple random sampling technique and data was collected by Structured handover assessment checklist on nursing handover was used to collect the data. It consists of two

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parts: Part 1 deals with the demographic characteristics and Part 2 structured handover assessment checklist.

3. Result

Description of Demographic Characteristics - The majority of participants were of 20 - 25 years age, 60% having the General nursing and midwifery diploma and 30% were having B. Sc. Nursing degree. Majority (60%) were having ≤ 5 years working experience and currently posted in 40% medical surgical wards, 40% OBG and Pediatric ward and 20% from ICU & HDU. %0% Samples were from Morning and Evening Shift.

Table 2: Percentage of distribution of effectiveness nursing handovers among staff nurses of different wards

Level of effectiveness	Percentage (%)	Mean
Good	0	2
Average	100%	
Poor	0	

Causes Identified

Failed communication, Omissions, Distractions, Lack of or illegible documentation, Incomplete medical records, Lack of easy accessibility to information, Cultural differences, Lack of integrated systems, Language problems may contribute to problems during handoffs in several ways, Increased errors are noted in nurses working prolonged shifts. Novice nurses may encounter issues with handoffs, Lack of time, Inadequate tools or equipment for effective handoffs, Lack of technology may create voluminous paper records (medication records, lab reports) with multiple reports to be referenced for handoffs to another unit, setting, or facility, Staffing shortages may contribute to gaps in transmission of information in handoff, Persons entering into a handoff situation may not be clear on when responsibility of patient/situation is transferred, which can lead to a "fumbled" handoff, if the responsibility for care of patient and of follow up is not clearly delineated, Lack of adequate Explanations about what has and will be done for the patient, Excessive reliance on memory without reference to written documentation and Lack of patient involvement

Desired Outcome: solution for achieving the goal: Environmental aspects - Handover process measures can be grouped into environmental aspects (e. g., interruptions, noise level and workload) and in behavioral aspects (e. g., shared planning, shared decision making and critical review of existing documentation, verbal report and acknowledgement of information received). **Standardizing handover communication:** There are two approaches to the standardization of handover communication. **The first approach defines** specific information content and order and generates handover protocols that are quite specific to the clinical setting. For example, introduced a specific handover protocol regarding handovers from the operating theatre to the cardiac intensive care unit. Their protocol includes the handover preparation, the clinical handover tasks to be completed before the verbal handover (e. g., connecting monitoring equipment, ventilator and so on), and defines an order in which the verbal handover is conducted and specific information that has to be handed over. **The second approach** to handover standardization focuses on general interaction structures that do not define the exact content, but the topics to be covered and their order. Such structuring aids may, for example, advise the transferring person to first provide the information regarding the mechanism of injury/illness, followed by the injuries, followed by observations and vital signs and finally the treatments given. **Supporting handover processes through technology:** Electronic medical record (EMR) system: A seemingly straightforward way to use technology during handover is to extract a handover sheet from the hospital's electronic medical record (EMR) system. EMR - based handover sheets were also found to improve completeness of handover information. **Continuous monitoring, Training of staff and** Use of standard mnemonics for effective communication like I - PASS, ISBR and ISOBAR.

4. Conclusion

The findings of the study reveals all the handovers were at the average level of effectiveness with the Mean of 2.00. The identified causes for effectiveness at average were Omissions, Distractions, Lack of or illegible documentation and Inadequate tools or equipment for effective handoffs. Solutions for the ineffective are grouped into environmental aspects (e. g., interruptions, noise level and workload), behavioral aspects (e. g., shared planning, shared decision making and critical review of existing documentation, verbal report and acknowledgement of information received), Supporting handover processes through technology like EMR - based handover sheets and Use of standard mnemonics for effective communication like I - PASS, ISBR and ISOBAR.

5. Future Scope

Experimental studies can be conducted for the knowledge improvement of staff nurses at different rural and urban areas

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