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ORIGINAL ARTICLE

Attitudes of emergency department patients about handover at the bedside

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Aims and objectives. To explore patients' perspectives of bedside handover by nurses in the emergency department (ED).

Background. International guidelines promote standardisation in clinical handover. Poor handover can lead to adverse incidents and expose patients to harm. Studies have shown that nurses and patients have favourable opinions about handover that is conducted at the bedside in hospital wards; however, there is a lack of evidence for patients' perspective of nursing handover in the ED environment.

Design. Qualitative descriptive study.

Methods. Semi-structured interviews with 30 ED patients occurred within one hour of bedside handover. Data were analysed using thematic content analysis.

Results. Two main themes were identified in the data. First, patients perceive that participating in bedside handover enhances individual care. It provides the opportunity for patients to clarify discrepancies and to contribute further information during the handover process, and is valued by patients. Patients are reassured about the competence of nurses and continuum of care after hearing handover conversations. Second, maintaining privacy and confidentiality during bedside handover is important for patients. Preference was expressed for handover to be conducted in the ED cubicle area to protect privacy of patient information and for discretion to be used with sensitive or new information.

Conclusions. Bedside handover is an acceptable method of performing handover for patients in the ED who value the opportunity to contribute and clarify information, and are reassured that their information is communicated in a private location.

Relevance to clinical practice. From the patients' perspective, nursing handover that is performed at the bedside enhances the quality and continuum of care and maintains privacy and confidentiality of information. Nurses should use discretion when dealing with sensitive or new patient information.

Key words: bedside handover, emergency department, nursing care, patient, qualitative study, quality assurance

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Introduction

A significant part of day-to-day nursing practice involves passing on written and verbal information about a patient's condition, plan or treatment to other nurses or healthcare professionals. This is described as clinical handover, which the Australian Commission on Safety and Quality in Health Care (2010, p. 4) defines as 'The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of

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patients, to another person or professional group on a temporary or permanent basis'.

Handover style and location vary depending on the clinical environment. The most common forms of handover consist of face-to-face group handovers in the office, audio-recorded handover and, more recently, bedside handover. The most traditional form is face-to-face group handovers which excludes the patient from participation, as it is conducted in a room away from the bedside. Nurses on the oncoming shift are given relevant information about every patient in the ward or department, often supported with an electronic printout of patient details. This type of handover removes a large group of nurses away from the clinical area, which may pose a threat to safety, continuity of care and patient participation.

Handover conducted at the bedside has been identified as a contemporaneous and inclusive nursing practice that advances the patient-as-partner notion (McMurray *et al.* 2010). Numerous studies have shown that when patients contribute to conversations between healthcare professionals, a potential advantage of bedside handover, there are reduced risk of adverse events and enhanced continuity of care (Wong *et al.* 2008b).

Background

Nursing handover in the emergency department (ED) is carried out in a different context than nursing handover performed in the ward setting. The ED has a higher patient turnover and unpredictable patient flow, more nursing interventions per patient and an increased likelihood of changes in a patient's condition. This can lead to an elevated risk of inadequate transfer of information between healthcare professionals during handover. ED patients are often acutely unwell require rapid healthcare decisions with time constraints and are often cared for by multiple healthcare professionals. According to Calleja and Forrest (2007), the different nature of the ED compared with the ward clinical settings demands modified nursing practices to suit the ED environment.

Various acronyms have been used to describe established handover models such as ISOBAR (Yee *et al.* 2009); iSoBAR (Porteous *et al.* 2009); ISBAR (Thompson *et al.* 2011); SBAR (Velji *et al.* 2008); and SHARED (Hatten-Masterson & Griffiths 2009). These handover models have been developed for the ward environment and may not be appropriate for the ED setting. Concerns about missing information, distractions and lack of confidentiality in nursing handover in the ED setting have been raised in the UK (Currie 2002). Currie (2002) recommended the development of specific guidelines for the ED setting as a tool to improve nursing handover. In the Australian context, PVITAL (Wilson 2011) was designed to improve handover processes in the ED; the foci of this pneumonic include: Patient Presentation, Visualisation of patient and orientation to oncoming shift, Vital signs, Input and output for fluid balance, Treatment and diagnosis, Admission or discharge, and Legal issues. PVITAL has yet to be externally validated.

Recent literature suggests that handover performed at the bedside enhances patient-centred care. McMurray *et al.* (2010) described bedside handover as being based on patient-centred care, whereby patients participate in communicating relevant and timely information for care planning. They suggest that patient input reduces care fragmentation, miscommunication-related adverse events, readmissions, duplication of services and enhances satisfaction and continuity of care. Other studies have shown that patients are comfortable with bedside handover (Wong *et al.* 2008b, McMurray *et al.* 2011). McMurray *et al.* (2011) found that bedside handover provides an opportunity for patients to be involved as active participants in their care who value having access to information about their treatment, condition and plan of care on an ongoing basis. Although not all patients prefer the same level of interaction, they see their role as important in maintaining accuracy, which promotes safe and high-quality care. According to Chaboyer and Blake (2008), the bedside handover process ensures that patients remain at the centre of their care.

Bedside handover is a relatively new strategy in EDs. It has been found that nurses can experience fear and anxiety whilst performing handover at the patient's bedside. Manias and Street (2000) found that some nurses interpret the experience of handover as a critique of their nursing care. Nurses of the oncoming shift can be dismissive, 'indicating that upheaval and inaccuracies associated with the previous shift would now be corrected' (Manias & Street 2000, p. 377). An earlier study, conducted in the organisation in which this current study was performed (Kerr *et al.* 2011), found that nurses do not prefer bedside handover. In that study, only 11% expressed a preference for bedside handover. From an ED perspective, nurses may be concerned about privacy and confidentiality of patient information during bedside handover in a busy environment.

Wong *et al.* (2008a) described that the role of patients and their perceptions towards handover remains complex and under-researched. In particular, evidence is lacking regarding patients' perspective in the ED setting. Moreover, few studies have incorporated a qualitative paradigm,

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despite the importance of this approach for providing a rich insight into the under-researched area of the experiences and opinions of patients towards bedside handover. The aim of this study was to explore the perspectives of patients about bedside handover by nurses in the ED.

Methods

Setting

The study was conducted in a tertiary urban mixed adult and paediatric ED that sees approximately 80 patients per day and has 40 emergency care beds. The population catchment has a diverse social and economic status, with a community that speaks more than 100 different languages.

Design

Data collection and analysis used a qualitative descriptive method (Sandelowski 2000, Neergaard *et al.* 2009). In this method, accounts of phenomena are captured by structured interviews or focus groups. Applied to this study, data collection using semi-structured interviews and thematic content analysis focused on the perceived benefits and limitations of bedside handover by nurses from the ED patients' perspective. Neergaard *et al.* (2009) recommend qualitative description as an appropriate methodology for research projects that aim to explore firsthand knowledge of patients' experiences with a particular topic. In contrast to other qualitative methods that aim for thick description (e.g. ethnography), theory development (grounded theory) or interpretation (e.g. phenomenology), qualitative descriptive methods aim to describe the participant's experience in their language. The interview schedule is often more structured compared with other qualitative methods (Neergaard *et al.* 2009).

Procedure

A tailored model of ED nursing handover was implemented in the organisation in which this study was conducted in October 2011. The new model of ED handover included five features. First, it took place in the cubicle (at the bedside). Second, it involved the patient and relative. Third, at the time of handover, the patient's individual charts were reviewed. Fourth, a structured and systematic handover guide was used. Finally, nurses received important information for specific cases at the commencement of the shift in the form of a brief group handover.

Participants

A purposive sampling technique was used. Thirty ED patients who had witnessed a nursing bedside shift-to-shift handover were studied. A research assistant approached adult patients during their stay in the ED and offered verbal and written information about the study. To be eligible, patients were required to be able to communicate in conversational English, be mentally alert and clinically stable, and at least 18 years of age. Patients were excluded from participating if they had severe pain, acute mental illness, confusion or were medically unstable.

Ethics approval was obtained from the institutional ethics panel. Patients in the ED received both verbal and written information about the study, including a description of the aims, their involvement and that information would be reported in a confidential manner. Written consent was obtained from patients who voluntarily agreed to participate.

Data collection

Individual semi-structured, audio-recorded interviews were conducted in December 2011, approximately two months after the introduction of bedside handover in the ED. An interview schedule (Table 1), based on previous research investigating bedside handover by Chaboyer *et al.* (2010), was used. Questions included risks, benefits and limitations of bedside handover. In addition, opinion was sought

Table 1 Interview schedule*

Can you tell me your understanding of nursing bedside handover?
What do you think about nurses undertaking their shift-to-shift handover at your bedside?
From your perspective, what are some of the benefits of bedside handover?
What are some of the limitations of bedside handover?
Do you think that a patient has a role in nursing bedside handover? If yes, how do you currently participate?
What do you think your role as a patient could be in the bedside handover (i.e. how do you think you should/could participate)?
What role do you think your family members might have in bedside handover?
Do you think that nursing bedside handover compromises your privacy or confidentiality (please explain)?
Do you feel uncomfortable when nurses are discussing you and your medical condition during handover?
Are there topics you think should be excluded from the nursing bedside handover? If so, what are they?
Is there any extra information you think should be included in the nursing bedside handover?

*Based on McMurray *et al.* (2011).

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regarding the perceived impact on privacy and confidentiality. Whilst the interview schedule generally guided the interview approach, issues raised in the interview could be further explored at that time by the interviewer.

The one-on-one taped interview was performed in a private cubicle with the curtain drawn, and the staff were informed that the interview was taking place. Duration of interviews was approximately 20 minutes.

Data analysis

After the interviews were transcribed, thematic content analysis, a commonly used method in nursing research (Elo & Kyngäs 2007), was performed to identify themes and patterns in the text, following the four-step approach outlined by Taylor *et al.* (2006, pp. 459–460). The main feature of content analysis is to reduce many words into smaller content categories that describe the phenomenon under investigation (Elo & Kyngäs 2007). First, the complete transcript was read and reread several times to gain a general sense of the overall accounts and familiarity with the data. Second, transcripts were examined using line-by-line analysis. Notes indicating interesting issues were made in the margins as a form of coding, with the development of themes to reflect the researcher's interpretation of the data. Third, themes were clustered together and re-developed as main themes and subthemes. Themes not supported by sufficient data were omitted. In the fourth stage, themes and subthemes were tabulated in a summary table after careful scrutiny for clarity and order. The same process was followed by a second researcher who independently identified themes and subthemes. After a period of time to allow for reflection and re-examination of the transcripts, a consensus meeting was held to reach a joint thematic framework regarding the themes and subthemes. Finally, the representativeness of themes were determined using criteria by Hill *et al.* (1997, pp. 550–551): 'general' referred to for all cases; 'typical' referred to for at least half the cases; and 'variant' referred to for greater than two but less than half the cases. Data referred to by one or two cases were not reported.

Rigour

Trustworthiness of the data was maintained in three ways: dependability, credibility and transferability. Dependability was established by the development of an audit trail that links raw data and codes with themes (Guba & Lincoln 2005). The process of coding and thematic analysis was independently replicated by another researcher. To establish credibility, a semi-structured interview guide was used to create a consistent approach to interviewing (Holloway & Wheeler 2010). To satisfy the criteria of transferability, sufficient data are presented in this paper to provide readers the opportunity to evaluate the findings and consider their significance for other settings and populations.

Results

The sample included 18 females and 12 males. Patients reported their opinion about the benefits and weaknesses of nursing handover performed at the bedside. Two dominant themes and related subthemes were identified in the data: (1) Patients perceive that participating in bedside handover enhances individual care and (2) Maintaining privacy and confidentiality during bedside handover. Themes and subthemes are shown in Table 2.

Patients perceive that participating in bedside handover enhances individual care

There was general consensus that handover performed at the bedside is a positive experience for patients whilst receiving care in the ED. Participants reported increased confidence in nurses' competence and assurances of their continuing care after listening to the handover conversation. Overall, patients perceived that listening and contributing to nursing bedside handover enhanced their overall experience in the ED. Three subthemes were identified: (1) Opportunity to clarify and contribute further information; (2) Increased confidence in nursing and continuum of care; and (3) Inclusion of the patient and, sometimes, relatives is important.

Opportunity to clarify and contribute further information
Participants reported that they valued the opportunity to provide nurses with additional information during the

Table 2 Themes and categories

	Themes	Subthemes
1	Patients perceive that participating in bedside handover enhances individual care	Opportunity to clarify and contribute further information Increased confidence in nursing and continuum of care Inclusion of the patient and, sometimes, relatives is important
2	Maintaining privacy and confidentiality during bedside handover	Preference with handover in the cubicle Nurses should use discretion to manage sensitive issues

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verbal handover exchange. This information may have been missed from the handover exchange or the patient identified that the information was incorrect:

I think it's good. I think it's needed, because if there is something that's wrong, you can always pipe up [speak out]…Just so that they've definitely got an understanding of what has happened to you and make sure that it is correct rather than slightly off key [incorrect]…I think it's good and I prefer it. (Patient 11)

Hearing handover is wonderful because I can turn around and say you forgot something. (Patient 14)

…when they change it over, if they miss something, you can say something about it. Like they were saying I was diabetic, but I'm not diabetic - and they were telling the other nurses I am. (Patient 15)

Increased confidence in nursing and continuum of care

Being able to listen to the nurses' handover reassured patients that nurses have adequate knowledge about their presentation, condition and plan. This reassured the participants that nurses have enough information to competently care for them:

I can hear what they know like…I know what's wrong with me. I can hear, okay, this is her temperature, this is what she's feeling, this is what I've done for her, this is where she was admitted, this is what she's told us. (Patient 18)

I want to hear handover because I would rather know that the nurses know what's going on. (Patient 9)

Patients raised the significance of continuum of care for them. They favoured observing and hearing that all of their relevant information was being passed on to the nurses of the next shift. After listening to bedside handover, they were confident that transition of care was maintained between shifts:

So, it's good for me to…hear…what they've been doing to me, so the next person knows exactly what's been going on. So, it's a smooth transition so, I wouldn't have to re-explain myself again. (Patient 18)

It's just nice to hear that the nurses are doing a proper handover and that the next nurse knows what you're going through and what care you need. (Patient 17)

Inclusion of the patient and, sometimes, relatives is important

Whilst the majority of participants agreed that they should participate in the handover, there were contrasting views about whether relatives should be routinely included. Conscious that nurses may not be aware of all details relating to their condition, some patients recalled that they, and their family members, were comfortable asking questions. This improved their understanding of their condition or ongoing plan of care:

I like it as I can ask them questions if I don't understand something and I will tell them how I am feeling at present. (Patient 12)

It is good for my immediate family to get involved because when I don't feel good they will understand more and listen more carefully and they have a right to ask questions. (Patient 1)

Of note, patients discussed a feeling of importance when included in the handover process. They recalled feeling involved in the verbal exchange, which improved their understanding of their medical condition and made them feel valued by nurses:

[Hearing handover] gives a friendly kind of feel, rather than being just a number. [You feel like] an actual person rather than just somebody with something. (Patient 11)

When it's done outside behind the curtain it's very secretive and you don't feel like your apart of it – I definitely prefer hearing it and being involved. (Patient 12)

It's good, the patient feels involved in what actually is happening and what care they are giving you. (Patient 14)

Comparing this handover to other hospitals where you don't get to hear it I was like WOW, it's really really good. (Patient 14)

There was variable opinion, however, in response to the question about whether patients have a role in handover. Some participants expressed the view that patients should only contribute to the handover discussion when asked by the nurse:

Well the only thing, personally for myself, I mean really it should be left to the nurses. At the end of the day you are the patient, I mean you might not be feeling well, you can't get up. I mean technically I think this is the whole nature of it, it should be done by the nurses. (Patient 26)

No, only if you're asked to [participate in handover discussions]. I mean that just, I don't need to participate, no. (Patient 22)

In addition, at times patients expressed the view that they might not always understand what is being said during handover, and this can cause them some anxiety. This issue

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may be of greater significance for patients in whom English is not their first language:

> Well, I understand some things - just simple things. But in very few words - if [nurses] talk too many words, I don't know what [they are] talking about. (Patient 4)

Some patients did not support family or visitor presence during handover in the ED. They expressed a preference for nurses to ask visitors to leave the room:

> They should use their own discretion and ask visitors to leave before discussing hand over. (Patient 11)

> I would prefer the nurse to ask my visitors to leave. (Patient 12)

> I don't know if I would want my friends to hear and I think that I should be given the option or asked if I want them to stay or not. (Patient 28)

Maintaining privacy and confidentiality during bedside handover

When asked whether bedside handover compromised their privacy, the majority of participants reported that they did not feel compromised about confidentiality of their information, provided that the handover conversation occurred at the bedside. They were more concerned about the management of personal and sensitive information. This theme contained two subthemes: (1) Preference for handover to occur in the cubicle and (2) Nurses should use discretion in dealing with sensitive issues.

Preference for handover to occur in the cubicle
Patients in this study reported that they preferred handover to be carried out in the cubicle bedside their bed, as it helped to protect their privacy and confidentiality. Several participants reported that they were concerned when doctors and nurses discussed their condition outside their cubicle area which may be heard by others, potentially breaching their confidentiality:

> The only bad thing is that other patients can hear when they do it outside the cubicle. (Patient 18)

> Handover is bad when they do it outside the room and you feel that the person in the next cubicle can hear and you don't feel comfortable with them knowing your business. (Patient 18)

> I prefer nurses to talk about personal information here in the cubicle not outside where other patients can hear. (Patient 12)

Nurses should use discretion to manage sensitive issues
Of note, no patient recalled an incident during bedside handover where their information was inappropriately discussed. However, they did discuss that nurses should exercise discretion with sensitive information during bedside handover such as sexual health and drug and alcohol issues. Ways in which nurses should communicate this information during handover were discussed, including speaking quietly or moving away from the patient's bedside:

> Nurses should be sensitive when discussing gynaecology issues that should be a bit more private. (Patient 9)

> I think nurses already act discreet[ly] with sensitive issues and don't vocalise it for everyone to hear. (Patient 11)

> There are some topics that shouldn't be spoken about, mainly drug use and things like that; it could make you feel uncomfortable. (Patient 23)

Likewise, they expected nurses to deal with new or upsetting information in a professional manner. In their opinion, there is a need for sensitivity when patients are not aware of information in relation to their condition, suggesting that patients should not hear this new or disturbing information during the nurses' handover conversation:

> Handover is only bad if they are discussing something that you were not aware of yet. (Patient 26)

> If your condition is getting worse it makes you feel upset if they talk about it in handover and you didn't know already. (Patient 15)

Discussion

This qualitative study focused on the opinions of patients in the ED about bedside handover. Participants preferred listening to the handover conversation at the bedside, as it provided an important opportunity for them to clarify and contribute further important information. Participants appreciated the opportunity to listen to the exchange of handover information, which assures them that nurses have adequate knowledge about their condition and plan, and that an effective continuum of care has been established. From their perspective, bedside handover does not threaten privacy and confidentiality of their information, provided nurses use some discretion to manage sensitive and personal issues.

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Patients appreciate the opportunity to clarify discrepancies as heard during bedside handover. Through this, they expressed increased confidence as recipients of nursing care. In their view, contribution of this important information enabled a strong continuum of care. According to Laws and Amato (2010), bedside reporting reassures the patient that nurses are working as a team and everyone knows the plan of care.

Most patients in this study expressed a preference to be included in the handover process. Similarly, McMurray *et al.* (2011) found that bedside handover provides an opportunity for patients to be involved as active participants in their care. They value having access to ongoing information, and they see their role as important in maintaining accuracy and relevancy in the handover conversation, which in their opinion, promotes safe and high-quality care. Wilson (2011) found that most patients and their families or carers like to listen to the discussions and have opportunities to contribute. In contrast, this current study found that some patients do not wish to be active participants in their care. Although they want to be able to hear the handover conversation, they would rather be passively engaged. Cahill (1998) commented that there is lack of desire by some patients to be involved in handover. The findings of this current study suggest that nurses should individualise care, as active patient involvement in the bedside handover may not be preferred by all patients.

Some participants expressed the opinion that the handover conversation is only between nurses and, at times, they could not understand the jargon used. In particular, some patients in this study for whom English was their second language expressed difficulty in understanding what was being said in nursing handover. It could be suggested that this issue would be greater for patients who do not speak English. This can increase anxiety for patients. In a survey of surgical patients and nurses by Timonen and Sihvonen (2000), patients were more likely to report that nurses used medical jargon during handover. They recommended the use of everyday language in handover conversations performed in front of the patient to improve active patient participation. Specific training for new graduates and undergraduate students may be needed to increase skills in communicating in simple language which is understandable from a patient's perspective.

There is growing evidence that confidentiality and privacy of information is not a significant concern for patients (Cahill 1998, Timonen & Sihvonen 2000, Kassean & Jagoo 2005, McMurray *et al.* 2011). The lack of concern may be due to the fact that patients are primarily concerned with their medical condition. This contrasts with the findings of this present study, where patients expressed concern about handover conversations being conducted outside the cubicle area with the increased possibility of the information being overheard by others. In their opinion, nurses should be discrete and avoid discussing sensitive issues in front of relatives, such as sexual health issues and drug and alcohol use.

Limitations

This qualitative research presents an in-depth insight into the opinion of ED patients about bedside handover. This study was limited to one ED. Generalisation of the themes cannot be guaranteed from this representative sample. It is possible that recruitment might have led to an atypical sample of patients in the ED. Recruitment was limited to English speaking, alert and orientated ED patients. Although these research findings may be applicable in other similar settings, the views of vulnerable groups (e.g. parents of children, mental health, pregnant women and nonEnglish speaking) may be different. Future research may benefit from having patients with a primary language that is not English and patients with a mental health presentation.

Conclusion

Overall, patients have a positive attitude towards bedside handover in the ED. There is a strong belief by patients that their care is enhanced by opportunities to clarify and contribute information. Patients expressed increased confidence in the competence of nurses and continuum of care after hearing handover discussions. Concern was raised about disclosure of information during handover that is of a sensitive nature, rising from concerns that the information may be exchanged within earshot of other patients and visitors in the ED. Compared with other forms of handover, they prefer that this type of information is communicated at the bedside. In addition, there is a need for sensitivity when patients may not be aware of new information or diagnosis that could be exchanged during bedside handover.

Relevance to clinical practice

Patients in the ED reported increased confidence in their continuum of care and an opportunity to clarify information after witnessing handover at their bedside. Nurses need to be aware that patients prefer their information to be disclosed at the bedside in the ED cubicle, but discretion should be exercised with communication of sensitive and

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new information. Further research is underway to evaluate whether standards of nursing care improved after the introduction of the new bedside handover practice.

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Contributions

Study design: DK, SK, TM; data collection and analysis: DK, KM, SK, TM and manuscript preparation: DK, KM, SK, TM, AMK.

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