

Nursing Handover Research Project

How is nursing handover talked about in the
literature?

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A research project submitted to Waikato Institute of Technology in partial fulfilment of the
requirements for the degree of Master of Nursing Waikato Institute of Technology 2010

Abstract

How is nursing handover talked about in the literature?

Aim

The aim of this research project is to explore how nursing handover is talked about within current, scholarly, peer reviewed, published nursing literature from 2004-2010.

Background

Part of most nurses' daily reality is nursing handover. In each hospital where I have worked there seemed to be no clear policy for delivering handover and each nurse chose their own method, making handover inconsistent. The value placed on handover varied from nurse to nurse, and area to area.

Method

A constructionist and social constructionist epistemology was used to support this research. A constructionist viewpoint allows nursing handover reality to gain meaning in a social context. The analysis focused on the literature's discursive constructions of nursing handover. The first three steps of Gee's (2005) discourse analysis framework; significance, activities and identities were used to look at the constructs of handover and what is gained by such construction.

Recommendations for practice

It is important to value nursing handover and its place in contemporary nursing. Handover serves other functions other than just the communication of information, and important aspects such as debriefing and reflection need to be respected. There is professional practice anxiety associated with nursing care and handover allows time for the psycho/social aspects of nursing to be provided for.

Conclusion

This research project considers perspectives that are different from traditional positivistic approaches by analysing discourses that construct nursing handover. Recommendations to positively impact patient outcomes through improved nursing handover, language and format can be informed by these perspectives.

Keywords: constructionist, discourse analysis, social constructionist, nursing handover

Acknowledgements

I would like to acknowledge the following people for their assistance in the development of this paper:

Clinical Training Agency and Lakes District Health Board- without financial and work place support I never could have under taken my Masters.

Carolyn Paulsen and Janet Arnet- such amazing librarians who are a credit to their profession. Nothing was ever too much.

Helen Nielsen- my supervisor from Wintec. A very special and talented tutor. I know it is your job but you give so much more to the process and for that I am very grateful.

Patricia McClunie-Trust- my course tutor from Wintec. A very knowledgeable and bright tutor who can conceptualise ideas. Thank you for helping in the eleventh hour. Just when I thought I had nothing left you encouraged and supported me to continue.

Anna Dawson and Cheryl Atherfold- two very talented and exceptional nurses who I am lucky to have read my work.

Lorna Holdsworth- for checking my referencing but more importantly walking with me and listening to my journey.

My family *Adam, Jack and Billy*- Very irreplaceable individuals who always make me smile.

Table of contents

Abstract	ii
Acknowledgements	iii
Table of contents	iv
Chapter One	1
Introduction and background	1
Introduction	1
Aim	1
Questions	2
Scope	2
Purpose	2
Background	3
My positioning/background	4
Summary	6
Chapter Two	8
Methodology	8
Introduction	8
Epistemology-constructionist/social constructionist approach	8
Methodology	9
Method	10
Ethics	10
Reflexivity	11
Summary	12
Chapter Three	13
Analysis	13
Introduction	13
Identifying the constructs within nursing handover discourse	14
<i>Significance</i>	14
<i>Activities</i>	18
<i>Identities</i>	21
Summary	25

Chapter Four	26
Discussion and recommendations	26
Introduction	26
Discussion.....	26
Recommendations	29
Challenges	30
Summary	30
Conclusion.....	31
References	32

Chapter One

Introduction and background

Introduction

“There are situations which by their very nature give rise to the question and suggest the beginnings of an answer” (Merleau-Ponty & Morando, 1976, p.6).

Globally, patient handover has caused alarm with a link between poor communication and sentinel events (World Health Organisation [WHO], 2007). Ron Paterson, Health and Disability Commissioner, found grave flaws in the care a 50 year old man received at Wellington Hospital prior to his death, and linked some of the condemnation to the Registered Nurse who failed to monitor the patient's condition adequately, and gave an inadequate handover to the night staff (Health and Disability Commissioner, 2007). It was highlighted that national collaboration is needed stating standardised handovers of both nursing and medicine are a priority (Health and Disability Commissioner, 2007a). Safety of Patients in New Zealand Hospitals: A Progress Report showed that handover practices and the information that was handed over ranged widely with no consistency of practice (Seddon, 2007).

Nursing has had a long relationship with handover. Handover is a historic, institutionalised ritual that has remained part of nursing culture throughout the decades. Its roots lie deep in nursing tradition and nursing handover practice continues without questioning its purpose in contemporary times. Historical traditions such as nursing handover have to be reviewed to highlight the discourse. It is not so much what handover is but more why it exists, why it is maintained and how it affects current healthcare (Cheek, 2000).

Aim

In this research project I aim to explore how nursing handover is talked about within current, scholarly, peer reviewed published nursing literature from 2004-2010.

Questions

The research questions are stated as:

How is handover constructed?

What is gained by such a construction?

Scope

This research project will be informed by a discourse analysis approach to the review of nursing handover literature from 2004-2010. This literature will be reviewed using James Gee's framework (2005) as a guide for identifying the constructs that appear within nursing handover discourse.

Purpose

The purpose of this project is to understand more about the discourses that construct nursing handover and to realise improved patient outcomes through dissemination of this knowledge. When improving patient outcomes through improved handover language and format, there is a need to understand current discourses to create effective change to the process.

Nursing handover is viewed as a 'significant' practice in that it is a historical practice that has maintained a place in modern times (Evans, Pereira & Parker, 2008; Sexton et al., 2004). Handover is a critical nursing function that directly impacts on patient care (Fenton, 2006). There is associated risk to the patient with poor nursing handover. Handover could be improved by relaying the right information in a professional manner. Language is used to communicate and receive information, but it also has other functions. These functions are "to support the performance of social activities and social identities and to support human affiliation within cultures, social groups, and institutions" (Gee, 2005, p.1).

There is little research on nursing handover that has used a discourse analysis approach. Evans et al., (2008) speak of the discourse of anxiety in nursing practice within the change of shift handover ritual. There is a paucity of New Zealand studies on handover. Wynne-Jones (2009) carried out study around the development and implementation of a framework for best practice with regard to nursing/midwifery shift handover. McCann, McHardy and Child (2007) discuss results of a survey between house officers and nurses in relation to clinical

handover in particular timing, structure and content. Radka (2003) looked at handover with a focus on the nurses' and consumers' voice within the process where the main construct was the 'importance of knowing'. According to Radka this knowing extended to the patient in the form of communication, continuity and competence in relation to patient care and the nurse. Rowe (2001) completed an ethnography of the nursing handover within a large New Zealand base hospital which showed handover is still relevant to practice today. Rowe constructed handover as having other functions for nurses apart from handing over patient care such as communication, education and socialisation.

Background

The formal part of handover is transferring patient care and responsibility from one nurse to another thus enabling the nurse to deliver safe and ultimately quality nursing care. Handover is described as "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" (Australian Commission on Safety and Quality in Healthcare [ACSQHC], 2009, p.6). Language is used to communicate patient information, but this is not its only function. With language there come other consequences. One such consequence is the ability of language to connect the nurse, the group and the institution (Gee, 2005; Walsh, Jordan & Apolloni, 2009). The institution and nurse create handover but conversely handover creates the nurse and the institution. Handover is both constructed and constructive (Potter & Wetherell, 1987).

However there is a common language used in handover which transports meaning from nurse to nurse. It offers the nurses shared meaning. "Language works for communication because it is a vehicle for meaning" (Taylor, 2001, p.6). Nurses are influenced by past experiences and already established morals, ideals and values. The language that nurses use is shaped by each nurse, group and institution. For an outsider to the group it could be difficult to follow as nurses have been immersed in the process creating a special dialogue between them. New language is always being created and it is crucial to mention that language is not clear or impartial but in fact constitutive (Potter & Wetherell, 1987; Taylor).

There are many methods of formal nursing handover including verbal, tape recorded, beside handover and written (Fenton, 2006; O'Connell, Kelly & MacDonald, 2008; Scovell, 2010;

Sexton et al., 2004). There are also a variety of environments for handover delivery to take place, these being bedside, office or staff room (Kerr, 2002; O'Connell et al.). The nursing handover occurs between nurses at the change of shift. There are usually three shifts; morning, afternoon and night. The handover typically includes the handing over of patient care and therefore 'duty of care' and responsibility to the next shift. The information handed over can include patient name, age, diagnosis and then a variety of information pertaining to the patient and their care. Nurses use models that employ an acronym to enable systematic information to be transferred such as SOAPIE (Subjective, Objective, Assessment, Plan, Intervention, Evaluation) or ISOBAR (Identification of patient, Situation and status, Observations, Background and history, Assessment and Action, Responsibility and risk management) (ACSQHC, 2009) to guide their handover, or alternatively a systems approach for example body systems or head to toe (Wilson, 2007), but more often they use no tool at all. There is no standard method of delivery that all nurses recognise so therefore no commonality of practice.

Handover can be described as a ritual as it is performed as if there are unwritten rules and regulations (Evans et al., 2008). Handover has evolved to the present day shape and each new nurse learns the patterns of behaviour that has gone before and so on. Handover involves power relationships where each nurse is socially positioned. Rituals appear to function as a form of social policing of each other and in turn reinforce the view of control and passivity (Cheek, 2000).

My positioning/background

"A good report is unhurried. It is well to set aside a block of time to be kept for report purposes. It should be an unbroken rule reports are not to be interrupted except in an emergency for if continuity is broken important points may easily be forgotten" (Barrett, 1949, p. 173).

From the historical to modern day, handover practice has seen little change and this extract could still be relevant today yet it was penned in 1949. Historically when I started nursing in the late 1980's handover has remained comparable to current practice. I cannot recall being taught handover and with each of my nursing positions I have not been educated about handover when completing an orientation process within a new environment and role. Little change has infiltrated the act of nursing handover. It has become a "taken for granted

practice” (Parker & Gardner, 1992, p.3). The value placed on nursing handover may vary from nurse to nurse, and area to area.

I have worked for 20 years as a registered nurse and during this time I have witnessed and experienced much frustration around the handover process. This frustration stems from handover taking too long, and not gaining the right information needed for client care. In fact at times the information is colourful and interesting but maybe not helpful in establishing patient care for the next eight hours. Clinical assessment information is often ad hoc and the purpose of handover is difficult to ascertain. I have also witnessed and experienced the positive supportive nature of handover fulfilling a debriefing and nurturing function. It can be a time for reflection. This extends to the sharing of narratives that allow nurses to process nursing care without the associated anxiety that comes from practice (Parker & Wiltshire, 2004). The nature of nursing care which involves human beings is unpredictable and complex. Working as a clinical nurse educator and a Registered Nurse in the emergency department, I have encountered handover practice that highlights a need for change. Handover content often can include subjective data, the use of jargon, the use of nursing’s own language to describe things and negative stereotyping of patients (Parker & Wiltshire).

I am not exempt from flaws in handover practice and as I read about poor handover practices and language in use I think about instances where I too have done a less than perfect handover. I realise I am part of the culture, constructed by a variety of discourses, including gender, medical, power, science, nursing and caring to name a few. These discourses can influence me in positive and negative ways and can even create new discourse (Gee, 2005).

During my nursing career as a registered nurse I have worked in a variety of fields including continuing care, orthopaedics, medical and emergency and one thing that has remained constant is nursing handover. I have been part of the handover culture for over 20 years. Each area has its own style of handover which I quickly try to emulate to become socialised into the nursing culture. Handover practice constructed a reality and offered me a common way of understanding the world as a nurse (McCloskey, 2008). A special club so to speak.

Summary

The aim of this project is to explore the discourse of nursing handover within current, scholarly, peer reviewed, published nursing literature. The first three steps of Gee's (2005) framework for discourse analysis are used to guide this analysis to understand the purpose and nature of nursing handover in relation to significance, activities, and identities surrounding the practice. This analysis may potentially help improve practice and patient outcomes by giving meaning to how handover is and explaining what nursing handover discourse does. Chapter one commenced with an introduction of this project and a background look at my positioning within the topic. It also defined and discussed the concept of nursing handover and presented the aim and scope of the project. To follow there is an overview of the project and the subsequent chapters will be revealed.

Chapter two will discuss and illuminate the methodology chosen for this project. A social constructionist approach will support the analysis in this research project. This analysis will be informed by discourse analysis using three of Gee's seven step approach to guide the analysis. The literature from the search will become the data and aspects of this data will be analysed. The analysis will look at text and how it is presented. Nursing certainly has its own language and way of presenting this language, and sometimes it is difficult to see this construction because we as nurses are placed in this reality. It is paramount to look at discourse as this is particularly important in seeking change to historical practices. The structure used to support the analysis of this data will be Gee's (2005) approach that language is constructed by seven building tasks; significance, activities, identities, relationships, politics, connections/signs systems and knowledge. Reflexivity will also be discussed. Finally ethical considerations will be identified and reflected on.

Chapter three will critically review current literature on nursing handover from 2004-2010. This will be a focused examination of nursing, verbal, ward clinical handovers and excludes medical, emergency department, specialist department, and ambulance handovers. Also not included are inter profession, inter hospital and hospital to other agency handovers. This literature search will consider handover history and the concept of it as a ritualistic practice. It will also reflect on current practice in contemporary times and consider how theory influences handovers place as a "taken for granted" practice (Parker & Gardner, 1992, p.3). How the text is positioned in relation to Gee's (2005) first three steps; significance, activities

and identities will be presented. Gee's first three steps will be used as they best fit the research project questions around handover constructs.

Chapter four will synthesize the ideas developed from the textual analysis. These key ideas will be discussed and recommendations to practice will be noted. It is important to highlight challenges to this research project and these will be shown. A conclusion will be developed based on practice recommendations.

Chapter Two

Methodology

Introduction

Discourse analysis does not seem to be the choice of method of many texts in the literature search. One discourse analysis on nursing handover looked at anxiety in nursing practice (Evans et al., 2008). However there are many research articles that integrate components of discourse as language in use. Language in use can stand alone or be made significant by the related social interaction. As discussed in the previous chapter, nursing handover is the communication of information from the outgoing nurse to the incoming nurse. Whether this is the only function of language or if it serves other purposes in a social, cultural and institutional sense will be developed. A social constructionist lens forms the epistemological viewpoint for this research using Gee's (2005) framework to discourse analysis as a guide for the methodological approach. Ethics and reflexivity will also be discussed in the context of this research.

Epistemology-constructionist/social constructionist approach

"All reality, as meaningful reality, is socially constructed" (Crotty, 1998, p.54). It is important to explore the construction of nursing handover and to understand how this reality has come to hold a place in contemporary practice. This research takes account of power dynamics within the social situation but this is not its major focus (Phillips & Hardy, 2002). Knowledge and meaning are not viewed singularly but in fact are seen in the context they present. From a constructionist viewpoint, knowledge only has "meaningful reality" if it is placed within its context (Crotty, 1998, p.42). In this research project nursing handover is in part constructed by the nurses who participate daily in the process within that professional and social context with what is accessible to them such as language, ideas and values. Nursing handover alone has no one true meaning; it is only in its interaction or engagement with nurses that it begins to construct meaning. As Crotty suggests often subjectivity and objectivity are presented separately, but a constructionist viewpoint allows them to share a mutual space together rather than them being fractured and viewed singularly.

Developing this viewpoint further with a social constructionist lens, the analysis in this project has three dimensions incorporating text, context and discourse (Phillips & Hardy, 2002). The textual dimension will be emphasized. Nursing handover has been constructed prior to the nurse entering the culture and institution. The nurse then has to make sense of the world she is part of, and process the encounter (Crotty, 1998). Culture gives the situation of handover meaning in that “culture directs behaviour and organises the experience” (Crotty, p.53). The nurses’ behaviour is led by “a system of significant symbols” that makes up the culture and determines what is important (Geertz, 1973, p.373). “Social realities, therefore, are constructed and sustained by the observation of the social rules obtained in any social situation by all the social interactors involved” (Crotty, 1998, p.54).

Methodology

As previously stated, discourse analysis will inform the methodology for this research project. The research method of discourse analysis is gaining popularity in its usage particularly in nursing (Traynor, 2006). Using a different methodology to the more traditional positivistic methodologies gives a different perspective in that it encompasses social and cultural context (Crowe, 2005; Phillips & Hardy, 2002). There are different types and forms of discourse analysis, the one used in this project incorporates views from the disciplines of sociolinguistics, education, psychology, anthropology and communication (Gee, 2005; Polit & Beck, 2006). A variety of texts construct nursing handover discourse and a social reality is created (Phillips & Hardy, 2002). “Discourse analysis is thus interested in ascertaining the constructive effects of discourse through the structured and systematic study of texts” (Phillips & Hardy, p.4). Gaining insight into nursing handover reality and what phenomena are constructed, maintained and ultimately become the ‘norm’ will be central to the analysis (Phillips & Hardy).

“Discourse analysis illuminates aspects of practice experiences that may not become apparent with other research methods, and provides an opportunity for identifying oppressive clinical practices and facilitating more enabling ones” (Crowe, 2005, p.55). With health service organisations transforming quickly in modern times it is vital to view old processes such as handover with fresh eyes (Phillips & Hardy, 2002). Utilising discourse analysis will show the construction of the handover process to uncover its multiple realities and fit within the

contemporary nursing world. This may highlight power positioning and who does or does not benefit from the current construction. Therefore discourse analysis is important in the challenge to seek long lasting change to existing policy on nursing handover. It is these features of discourse analysis that will enable me to question beyond what is handover to answer how and why.

Method

Gee's (2005) approach to discourse analysis implements a cognitive and social lens on language in use (discourse) noting that when it is blended with other non language features such as culture, social and institutional elements then (*discourse*) is implicated. How the text is positioned historically, socially, politically and culturally is significant in uncovering meaning of experiences (Cheek, 2000). The words or language alone are meaningless, it is their fit within the society in which they are placed that is crucial. Understanding how nurses "pull off" being a nurse within nursing handover, is not just about the use of the correct language during nursing handover but about the other factors which are; "ways of acting, interacting, feeling, believing, valuing, use of various sorts of objects, symbols, tools and technology" that become meaningful (Gee, 2005, p.7).

The literature that constructs handover reality which will be analysed using the first three steps of Gee's (2005) framework; Significance, activities, identities:

Step one - Significance. How is the writing about nursing handover being used to make certain things significant or not and in what way?

Step two - Activities. How does the literature on nursing handover construct the activity?

Step three - Identities. What identity or identities are being constructed in the literature?

(Gee, p.11-12).

The first three steps were chosen as they potentially answered my original questions; how is handover constructed and what is gained by such a construction? I acknowledge that further research could be conducted to encompass the other four steps; relationships, politics, connections, sign systems and knowledge in the future.

Ethics

As no human participants were directly involved, approval from an ethics committee was not required to conduct the research. However, I am mindful I am using others' work as the data

for analysis and my intention is to give an ethical and thoughtful representation ultimately adding to the body of knowledge on nursing handover. I am also aware that it needs to be established that I am a nurse and part of the nursing profession, and not judging nursing or nurses, but in fact examining nursing handover discourse. The importance of this research project is the focus on construction and function of nursing clinical handover rather than nurses as subject. My intention is to compliment other work on nursing handover and make practical recommendations that could improve handover.

The Ministry of Health and Nursing Council New Zealand (2008) nursing workplace survey showed that 7.2% of New Zealand's Nursing workforce identify as Maori, and so potentially participate in some form of patient care handover. This research will have implications for Maori particularly as their voice is absent from the literature on this topic. This will be noted and Maori will be included in this research project process, showing a commitment to the Treaty of Waitangi and its principles; partnership, participation and protection. Reciprocity is a key function for Maori in that ideas, words and actions are exchanged respecting and valuing each person's world view making sure the relationship is mutually beneficial (Hudson & Russell, 2009; Te Whakaruruhau, 2004,). Social and cultural sensitivity will be valued realising and appreciating individual difference. It is always important to value others contribution being truthful and working towards the common good. This process will be crucial as information is disseminated to all nurses including Maori.

Reflexivity

Language in use is automatic in that nurses participate in nursing handover numerous times each day. I am positioned in the reality of nursing handover every day when I work a nursing shift, and it is difficult if not impossible, to separate myself from being a nurse and more so being a nurse who participates in handover. I am constructed by my past experience, my values and my beliefs and I realise my role as researcher will create some partiality due to my positioning within that society (Carolan, 2003). So this research project is my thoughtful analysis at this time only, and may not reflect the view of others. It comes from a social constructionist viewpoint and it is understood there is no real truth just multiple realities (Crotty, 1998; Phillips & Hardy, 2002; Taylor, 2001). Reflexivity ensures principles of self reflection and self awareness are central to this project as handover is socially situated and deals with elements of subjectivity (Findlay, 2003). This was applied by journaling my

experiences, thoughts and feelings during the process and linking these experiences in practice. Opportunities were explored in regular structured sessions with my mentor where there was support of my thinking. There is co-construction from the text that surrounds me and my own experience of handover (Findlay). So it is vital to look back “upon oneself” to gain greater perspective (Findlay & Gough, 2003, p.ix).

Summary

This chapter has established the methodological approach for the research project. Underpinning this approach is a constructionist/social constructionist epistemology. A constructionist viewpoint allows nursing handover reality to be understood as having meaning in a social context. Discourse analysis is the methodology that guides this research project and Gee’s (2005) seven step approach will be tailored to create a framework for data analysis. The first three steps; significance, activities and identities will be used to explore the multiple realities around handover construction.

Chapter Three

Analysis

Introduction

With handover taking place numerous times a day in hospitals all over the country; the practice of handover has gained global attention as an area needing quality improvement due to the high associated patient safety risk (ARCHI, 2010). WHO (2007) has recognised communication during patient care handovers as one of its top five priorities in its 'Action on patient safety- high five' campaign. This focus on the importance of handover by WHO has led to worldwide attention and focus on the topic with a proliferation of research being conducted. This chapter presents the analysis of the textual data that was derived from a literature search. It presents an analysis of nursing handover text using the first three of Gee's steps; significance, activities and identities to identify the constructs within the nursing handover discourse.

To establish the text for analysis, a literature search was conducted and the following databases were searched CINAHL, OVID, proquest, EBSCOhost, google scholar and subsequent reference list searches. The search was narrowed to 2004-2010 scholarly research to focus on current literature. The word 'handover' was used. This led to other terms being highlighted such as handoff, shift report, continuity of patient care, patient centred care and more broadly communication, personnel staffing/scheduling and nursing care plans. These terms were searched and then combinations of each term depending on the database. Specialist areas were not included such as emergency, mental health, intensive care, maternity as each of these areas use a specific handover and have their own specific issues. The focus for this research was on nursing handover so medical handover was not chosen. Also excluded were inter profession, inter hospital and hospital to other agency handovers.

From this literature search, 42 texts were chosen. These texts included a mixture of primary research, secondary analysis and opinion articles. Also included were three New Zealand theses specifically on nursing handover; two qualitative and one of mixed methodology. I chose also to include Parker, Gardner and Wiltshire's (1992) foundational work, a qualitative observational study on nursing handover and also other seminal work from Parker and Gardner's (1992) qualitative content analysis which explored the nursing report experience.

Following these studies was an article by Wiltshire and Parker (1996) which discussed handover as a site of containment in relation to anxiety in nursing practice which I included. In addition it seemed vital to include subsequent work an edited book of collective writings on nursing in which Parker (2004) had co authored two chapters on handover.

These texts were then read in their entirety and then re read analysing the different discursive constructions of nursing handover, using the first three steps of Gee's (2005) framework; significance, activities and identities to question how handover is constructed and to explore what is gained by such a construction.

Identifying the constructs within nursing handover discourse

Significance

Step one- Significance. How is the writing about nursing handover being used to make certain things significant or not and in what way? (Gee, 2005).

“Clinical handover is a high risk scenario for patient safety with dangers of discontinuity of care, adverse events and legal claims of malpractice” (Wong, Yee & Turner, 2008, p. 3). The three main discursive constructions within the texts are patient safety, sentinel events and professional/legal discourse. These constructs have blurred boundaries and are very much inter-related. The language used in the texts evokes fear into nurses at many levels, in an effort to seek change to practice. Nurses are constantly bombarded with new ideas and concepts and are expected to be flexible in amongst constant change. With increasing patient hospitalizations, higher acuity patients, decreasing length of stays, changing workforce dynamics the global reality is nurses have more pressure put on them (Anthony & Preuss, 2002).

Patient safety

“Effective communication at clinical handover is important for improving patient safety and reducing adverse outcomes” (Porteous, Stewart-Wynne, Connolly & Crommelin, 2009)

The texts construct patient safety as significant to handover. The patient safety construct is utilised in many of the texts emphasizing the need to implement a standardised approach to nursing handover (ACSQH, 2009; Alvarado et al., 2006; Caruso, 2007; HDC, 2007a;

Johnson & Barach, 2009; O'Connell et al., 2008; Porteous et al., 2009; Wilson, 2007; WHO, 2007). Other high risk professions, for example aviation, believe that standardising handover by using known familiar language and allowing the time for questions can enhance communication (WHO, 2007). By applying this learning to nursing handover and standardisation of practice this could mean more time for patient care that incorporates critical thinking (Hansten, 2003). The texts build on the idea of patient safety through improved patient care when seeking change or assessing current form of handover (Benson, Rippen-Sisler, Jabusch & Keast, 2007; Fenton, 2006; Munn, 2008; O'Connell et al, 2008; Pothier, Montteiro, Mooktiar & Shaw, 2005 Strole & Ottani, 2006). Subsequently a poor handover lacking in pertinent information can have a detrimental effect on patient care (Alvarado et al., 2006). The texts construct quality as significant but there is concern about independent variables affecting handover content and structure (Scovell, 2010).

“Resilience has the potential to provide significant advances in patient safety by shifting the focus from an emphasis on ‘human error’ and error counting towards preventing these errors from being repeated” (Jeffcott, Ibrahim & Cameron, 2009, p.256).

Patterson (2008) talks of nursing handover standards and suggests that these should not be written with safety as the only objective as this would be short sighted. Patient safety is not the only reason for handover and it serves many other functions that should not be suppressed or have less value placed on them (Cohen & Hilligoss, 2009). In an adverse event, a strict format for handover could create a blame culture, if the format was not followed (Patterson, 2008). Some texts construct handover attaching blame to the ‘system’ in an attempt to detract from individual blame or human error focus. HDC, 2007 and Johnson & Barach, 2009 attribute blame to the handover ‘system’ in an attempt to detract from individual blame. Resilience is required to shift away from a blame focus to a more successful focus on handover accomplishments that reflect quality care and mistake prevention (Jeffcott et al., 2009). Nurses do make human errors, and it is relevant to create systems that encourage a safety culture. Seddon (2007) identifies that in an effort to prevent negative implications for patients prior to an incident, systems such as handover and its construction should be assessed.

Sentinel events

“When information is missed in patient handovers, people die” (Wilson, 2007, p.201).

There is a strong construction of error leading to adverse events in the texts. Errors in patient care or negative patient outcomes can be attributed to poor communication of information during nursing handover (Johnson & Barach, 2009; McCann et al., 2007; Strople & Ottani, 2006). The texts use real life narratives of patient misfortune to tell the story of a poor handover (Wilson, 2007). Nurses come from an ethical stance to “above all do good” and “above all do no harm” (Johnstone, 2009, p.40, 42) to patients according to the principles of beneficence and maleficence so errors and sentinel events may be used to generate an emotive reaction.

The texts directly link handover to sentinel events. In New South Wales, a clinical management root cause analysis of 300 incidents showed that many were attributed to poor communication and insufficient handover (ARCHI, 2010). It was recognised that shift to shift handover was one of ten types of handover that need to be assessed and evaluated (ARCHI). Another review in Australia showed poor communication as a causative factor in approximately 20-25 % of sentinel events (O’Connell et al., 2008).

The Health and Disability Commissioner (HDC) report on a sentinel case in a New Zealand hospital where a 50 year old man died, highlighted serious failings in handover and communication (HDC, 2007). A further report (Seddon, 2007) in relation to this case also identified handover as an area that needed improvement and asked each DHB to respond by examining their handover practice acknowledging that national input into standardisation of nursing handover practices would be valuable. Seddon further noted the language used to respond and observed three types of thinking these were; great understanding of a safety culture and system thinking, surface use of a safety and quality culture but no depth to action plans and an individual blame culture.

Sentinel events are linked to the broad category of communication in particular breakdowns in communication (ACSQH, 2009; Alvarado et al., 2006; Porteous et al., 2009) It has been noted that 70% of sentinel cases were due to breakdowns in communication (Joint Commission on Accreditation of Healthcare Organisations (JCAHO), 2003, cited in Alvarado

et al., 2006, p.75). The text use the broad category of communication but this does not necessarily equate to handover. Communication is a blanket term used to cover many aspects of practice within nursing. If history shows a pattern then communication and its link to patient safety is probably destined to the same fate that human error previously succumbed to when it tried to standardise practice and thus created a new way to blame (Patterson, 2008).

Legal/professional

Handover has many dimensions including clinical, unit management, personal and professional (Parker et al., 1992). *“The professional dimension which functions as a venue for demonstration of professional competence, peer assessment and enhancement of collective professional identity”* (Parker et al., p. 32). The texts construct handover as a time for professional role development with an occasion for formal and informal education (Rowe, 2001). Handover makes available to nurses a place to show their practice competence and receive peer support or critique (Parker et al., 1992; Parker & Wiltshire, 2004). Radka (2003) discusses how nurses during handover perform peer assessment in relation to patient care. The texts construct handover as having a vital role in how nurses create their professional self (Scovell, 2010).

“It is here that the new nurse is initiated into the language, values and culture of the professional nurse” (Rowe, 2001, p.77).

Those nurses who are part of the nursing handover culture teach those that are new to the area and socialise them to the process. The text establishes handover as a place for professional relationship development (Benson et al., 2007).

“When I write a report, I always think that the patient may read this document” (Engesmo & Tjora, 2006, p.182).

Legal implications are on nurses minds when documenting (Engesmo & Tjora; Tucker, 2009). The literature talks of oral handover being a forum for subjective material that cannot be included in the documentation due to legalities. Handover in this instance then allows time to verbalise issues that cannot be documented yet are important for continuity of care (Engesmo & Tjora). The text constructed the subjective information important to practice reality as psycho/social, uncertain information and additional information (Engesmo & Tjora).

“While nurses had difficulty writing about episodes of caring, intuitive judgement, sensitive patient issues and potential legal situations, they had no difficulty talking about these aspects of their practice in handover” (Radka, 2003, p.161).

Handover is constructed in the text as a means to pass on responsibility and with that the handing over of the legalities associated with nursing and patient care (Cohen & Hilligoss, 2009). Professional practice is reliant on information communicated during handover as this information is related to patient care (Alvarado et al., 2006). Handover allocates a time and space for nurses to fulfil professional and legal requirements (Wilson, 2007). Benson et al., (2007) talk of legal and professional compliance.

“There is potential for patients to be harmed despite high levels of competence” (Carthy & Clarke, 2009, p.13).

Scovell (2010) raises the issue of nurses and requirements of the Nursing and Midwifery council in relation to communication linking this to patient health and well being. Castledine (2006) recognised that one of the main reasons for disciplinary referral to the British Nursing Midwifery Council was issues around communication. Linking handover to nursing council competencies encourages professionalism and accountability (Clemlow, 2006). Issues surrounding nurse competence may create a reaction that makes nurses defensive in relation to their practice.

Activities

Step two- Activities. How does the literature on nursing handover construct the activity? (Gee, 2005)

Communication

Handover is constructed to conduct both spoken and unspoken functions. Communication is constructed strongly in the text as a main function. However there are other hidden actions to handover such as ritual and psycho/social aspects that also construct the act. These constructs of ritual and psychosocial are functions of handover yet do not have the same value placed on them.

“Handovers explicit function is to communicate information from one nurse/shift to the next and formally hand over responsibility for patients” (Evans et al., 2007, p.40).

Communication is a main construct found in the literature. It is well understood the main activity of handover is to communicate information and transfer responsibility (Cohen & Hilligoss, 2009; Meibner et al., 2007). It is the transfer of patient care, responsibility and accountability (Alvarado et al. 2006; Johnson & Barach, 2009; Meibner et al.; Munn, 2008; Patterson, 2008; Strople & Ottani, 2006). Cohen and Hilligoss (2009) construct handover as communication inciting the transfer of patient control. Control and responsibility are terms used almost interchangeably yet have very different implications particularly when talking about patients. Communication as a mode for information exchange seems clear and simple, in fact quite linear, yet the process is not as linear as it first appears (Strople & Ottani, 2006). The social, cultural and institutional elements that are vital ingredients of handover need to be recognised as major facets in communication (Gee, 2005). However, often communication is constructed as a singular act of just delivering information.

“They talk together about their workaday world-support and help each other to understand it. This process cannot be communicated beyond the nursing culture because others find it gross, bizarre and frightening” (Parker & Gardner, 1992, p.8).

Nursing has long favoured the oral tradition for communication (Parker & Gardner; Radka, 2003; Rowe, 2001; Scovell, 2010). Historically the oral culture that nursing has aligned itself to allows private and temporary information exchange (Parker & Gardner). The text talks of written report and oral handover varying in content and that oral handover provides time to talk holistically about patient care encompassing the very important psychosocial elements (Meibner et al., 2007). The use of oral language allows the nurse to construct the patient as person (Radka, 2003). Oral communication allows the nurses to construct their world as they choose and allocates a time to process some of the out of the ordinary experiences that they as nurse have encountered (Parker & Gardner, 1992). Talk is a central element to nursing care and helps to make the extra ordinary, ordinary so that patient care continues (Parker & Gardner). Nurses talk and support each other within the nursing culture almost failing to recognise the importance of what they do day in and day out (Parker & Gardner).

Communication in handover also has unhelpful negative constructions in that some of the information handed over is superfluous and could be found elsewhere (Benson et al., 2007). Most of the information that is handed over during handover could be found in the patient

notes (Meibner et al., 2007; Sexton et al., 2004). The text constructs nursing handover as very subjective (Kelly, 2005; McCann et al., 2007), mainly retrospective (Clemlow, 2006; Davies & Priestly, 2006) and task orientated (Radka, 2003). In delivering retrospective information in handover, nurses could be trying to justify their day to their peers. Nurses spend a great deal of time writing their notes yet many do not use these in handover (Clemlow, 2006).

Ritual

“The nursing handover is a ritual and clearly one such discursive formation” (Evans, et al., 2008, p.46).

Many texts construct nursing handover as a ritual (Clemlow, 2006; Davies & Priestly, 2006; Evans et al., 2008; Fenton, 2006; Kassean & Jagoo, 2005; Meibner et al., 2007; Munn, 2008; Parker & Gardner, 1992; Parker & Wiltshire, 2004; Pothier et al., 2005; Radka, 2003; Rowe, 2001; Scovell, 2010; Sexton et al., 2004; Wiltshire & Parker, 1996; Wynne-Jones, 2009). The texts use adjectives prior to the word ritual such as important (Fenton, 2006; Munn, 2008; Scovell, 2010) and positive (Meibner et al., 2007) to secure handover as a helpful activity. Rituals such as handover are talked about in the literature as having unwritten laws and certain characteristics (Evans et al., 2008, p.41), such as a ban on interruptions during a ritual and the presence of others is not being welcome (Evans et al., p.43). Rituals often disguise negative stereotyping of patients as acceptable practice (Evans et al.).

“Through the shared context of ritual the novice is initiated into the language, values and culture of the expert” (Strange, 1996, p.111 in Rowe, 2001, p.11)

The handover group construction allows teaching and education for novice nurses (Meibner et al., 2007). The ritual of handover may aid in the development of teamwork meshing this group together due to these compulsory group gatherings (Meibner et al.). The formation of handover as a ritual allows the nurse to be part of a group (Parker et al., 2004). Handover as a historic ritual has created the notion of handover as a “religious rite” (Scovell, 2010, p.35). Many nurses will not forgo nursing handover as they hold it in high esteem and place value on the insight and information gained (Scovell).

Psycho/social

“Handover has a role in social cohesiveness and group formation, social and psychological protection, debriefing and emotional support” (Evans et al., 2008, p.41).

The text supports that handover construction encompasses a psycho/social element. Handover is constructed showing a protective action that protects nurses in a social and psychological manner (Evans et al.). The text creates handover as a place to ‘validate’ nursing in particular aspects of the nurses’ shift, and also extends its function to include nurse mentorship, education and team building (ASCQHC, 2009; Strople & Ottani, 2006). Handover is constructed as a safe place for nurses to debrief and share emotions (Parker et al., 1992). Nurses often deal with the harsh realities of patient illness with professionalism, containing emotions of distress and anxiety (Parker et al.). It puts the nurse in a unique position as part of the patient’s lived experience and reality at that time. They have to be able to “make ordinary” extra ordinary events (Parker & Gardner, 1992, p.8). The nursing handover activity facilitates nurses in supporting each other (Rowe, 2001).

Identities

Step three-Identities. What identity or identities are being constructed in the literature? (Gee)

Handover creates a stage and an audience which has great effect on the content of handover (Engesmo & Tjora, 2006). There are many actors or identities in handover including but not exclusive to the absent identity, the group identity and the anxious nurse identity.

The absent identity

The nurse is absent from the ward and from the patients during handover (Engesmo & Tjora, 2006). The text constructs handover as pulling nurses away from their work, in particular all incoming nurses and some or all of the outgoing nurses, three times a day (Clemlow, 2006). If the nurses are ‘pulled away’ then they are unable to meet their patients’ needs at this time (Sexton et al., 2004). By constructing handover this way as ‘pulling away’ from the patients it does not give importance to nursing handover in fact it highlights handover is not valued. The value is placed on patient care time and not nursing handover. ARCHI (2010) recognise

the value in handover and construct handover as a respected and crucial aspect of nurses' work.

“Communication is of direct interest to patients and of direct relevance to their care” (Dodwell, 2008).

The patient is absent from many handover systems. The text constructs the patient as separate from the process (Caruso, 2007), yet they are the main feature of handover discussion, and in an era of person centred care, they are noticeably missing. Dodwell (2008) talks of the nurse as the custodian of the handover message but having no ownership of the message as that belongs to the patient. Patient and family centred care has gained popularity as a preferable model of care, as the patient and family are the constant within the hospital experience (WHO, 2007). Nurses come and go but the patient remains giving them the opportunity to be in charge of their care.

Bedside handover concept is constructed positively as another way of handing over information but the central difference is the patient is part of the process so can have input into their own care (Fenton, 2006; Seddon, 2007). Seddon suggests it is also good time for nurses to check equipment, medications and invasive adjuncts, for example intravenous lines. With the strong focus on equipment and technology, this is not the engagement with the patient that one would expect. Bedside handover was also viewed negatively in relation to patient privacy issues (Seddon). This could also detract from the importance of nurse to nurse communication.

“Nurses at handover construct a collaborative narrative about the patients and like all narratives, this one has heroes and villains. The patients become packaged and stereotyped” (Parker et al., 1992, p.33).

Handover is used to construct the patient in ways that can be negative or positive. Patient construction has a direct connection with nurse anxiety rather than patient specific judgement (Evans et al., 2008). Using stereotypes to construct patients in handover positions the patient as known and eases the nurses' fear and anxiety (Evans et al.). This construction allows the nurse to feel comfortable to start the shift armed with a 'sense of familiarity' of the ward and the patients within (Parker et al., 1992). Parker and Wiltshire (2004) coined the term 'nursing scan' or 'reconnoitre' to describe the phenomenon of giving the incoming nurses a mental picture of the ward prior to them commencing their shift. Patient construction within

handover is a form panoptic surveillance that may ultimately be trying to incite patient compliance (Parker & Wiltshire).

The patient is also absent when labelled through the use of the medical diagnosis or room number to name them (Parker, 2004; Radka, 2003). Derogatory labelling is also used calling patients and/or family 'needy or demanding' which can affect the incoming nurses' opinion of the patient (Strople & Ottani, 2006). It is interesting that less patient contact and nursing time is spent with patients labelled as 'difficult' (Strople & Ottani).

"The patient looks, but at the same time, simultaneously as part of the same linguistic gesture, is looked at" (Parker & Wiltshire, 2004, p.151).

The text talks of the use of subjective language to describe aspects of the patient and patient care; words such as OK, good and fine, are used (Davis & Priestly, 2006; Fenton, 2006). Parker and Wiltshire (2004) describe this as the 'nursing look' or 'connaissance' as an informal less medical use of language. Personalising the language establishes the relationship is between the nurse and the patient (Parker & Wiltshire). In a way it could be trying to establish a relationship with the patient when they are absent.

Group identity

The construction of the group is through the sharing of sensitive and emotional narratives that bond the group together (Evans et al., 2008). The group develops a social awareness that 'gels' the group, creating an outlet for emotional release (Meibner et al., 2007). The text depicts a group formation at handover and this develops the nurse as part of the team and ward (Evans et al., 2008). Handover is constructed as having significant social and emotional importance to nurses (Meibner et al., 2007; Evans et al.). It offers the opportunity for support and guidance (Evans et al.), and has a positive debriefing quality that is important to nurses (ACSQH, 2009; Parker & Wiltshire, 2004).

When looking to change process such as handover, culture is a key feature (Johnson & Barach, 2009). The literature discusses culture in a positive light in relation to nursing handover (Arora & Johnson, 2009). There are many types of culture within the handover process these being organisational, professional/nursing and unit/ward culture (Rowe, 2001). Each group culture cannot be ignored and each unit/area has its own culture. The group

shares “values, norms and rules of behaviour” and this forms the culture (Schein, 2010, p.320).

Within any culture or group there are different positions that are held and handover is no different. The text constructs expert nurses holding power over novice nurses in their ability to understand and utilise handover information (Meibner et al., 2007). Also nursing students find handover complicated and hard to comprehend as visitors to the process (Meibner et al.).

“The use of technical language during handover denotes an experienced nurse” (Scovell, 2010, p.36).

Jargon used in handover constructs the group. Jargon excludes those that do not understand it and validates those that do (Rowe, 2001). The text talks of common general language in use during handover but also jargon is sprinkled throughout (Fenton, 2006; Radka, 2003). The use of acronyms and abbreviations makes nursing handover language puzzling to those not privy to nursing’s professional world (Fenton; Meibner et al. 2007; Strople & Ottani, 2006). The use of jargon (Fenton) such as STEMI (ST elevation myocardial infarction), CABG (Cardiac artery bypass graft), HONK (Hyper-osmolar non-ketotic acidosis) are types of examples that could be commonly heard in handover. Parker and Wiltshire (2004) called this the ‘nursing gaze’ or ‘savoir’, and the use of language highlights the ever present medical and scientific discourse.

Anxious nurse identity

“In order to remain responsive to individual patients and deliver humanising care, within what are increasingly dehumanising environments, it is important nurses have the opportunity to process aspects of their work that are emotionally disturbing and which they feel unable to disclose to family or friends” (Parker, 2004, p.137).

The construction of anxiety linked to nursing practice is evident in the text. Handover facilitates the ‘off loading’ of this professional anxiety. The handover process also acts a form of anxiety containment (Sexton et al., 2004) or abjection containment (Wiltshire & Parker, 1996). Evans et al., (2008) suggest that anxiety may happen in handover in order to organise nurses’ practice. Being part of this group and culture is supportive and helps process the experience of a difficult duty. Caring for people puts emotional demands on nurses that others may not understand. Handover allows the nurse a place to discuss confidential matters that they cannot discuss anywhere else (Parker, 2004) thus maintaining professionalism

around confidentiality and patient privacy. It is a projection of what has occurred during their day which the incoming shift listen to and in a sense gives the nurse some form of closure. The text discusses positive aspects of nurses being able to offload a shift in that the shift can be 'given away' and so the nurses are not burdened with the realities of what is nursing work (Scovell, 2010). This helps relieve professional anxiety that is part of every nurses' work (Evans et al. 2008; Strople & Ottani, 2006).

Summary

This chapter has explored some of the constructs that make up the nursing handover discourse. From Gee's (2005) first three steps; significance, activities and identities, it was identified that handover performs many functions aside from communication, and that there is also a social and cultural provision for nurses. Handover has obvious constructs such as patient safety, sentinel events and communication, but also has less obvious constructs such as professional, psycho/social and ritual. Also ever present in handover were certain actors creating identities; the group identity, the absent identity relating to both nurse and patient, and the anxious nurse identity. For discussion in the next chapter are the concepts of the two main competing constructs; patient safety/risk management and nursing ritual.

Chapter Four

Discussion and recommendations

Introduction

The constructs from the text are some of the many that inform the discourse of nursing handover. These constructs can stand alone but seem to interlink on many levels. Handover cannot just be seen as handing over information, without seeing it in its entirety. The explicit function of handover is to communicate information, but the construction of handover as just a tool for delivering and receiving information, has the potential to limit its other functions. These are functions that have less value associated with them in the literature, yet not to the nurse. Such functions provide support on a professional and social level, encompassing nurse as nurse, and nurse within the group, culture and institution.

This chapter discusses how handover is constructed with many competing constructs, two of which are patient safety/risk management and nursing ritual. These differing constructs highlight that there are different gains from each construction, but also there are losses. Important nursing functions seem lost in the quest for patient safety and risk management. The human factor for both the nurse and the patient is forgotten. The challenges to this research project will be examined, and finally recommendations for practice will be shown, looking at their significance to practice.

Discussion

In the 21st century there has been a strong movement towards patient safety and risk management. In the pursuit to achieve a safety culture there has also been a strong shift to standardise practice. Standardisation has merits but flexibility is needed within this concept to value local needs (ARCHI, 2010). Health care systems are under pressures; pressures such as technology, many staff/many handovers, communication problems-patient/staff and staff/staff, stress and tiredness, increase in patient acuity and staff shortages all add to the potential for error (Wong, 2002).

Most errors are part of a greater scheme of things. Rather than the individual it is the system that fails (Wong). There also seems to be a lack of understanding around error prevention and system thinking. The 'Swiss cheese model of system failure' describes this well in that lots of different factors may contribute to an error, that one hole in one slice of cheese may relate to individual error but it is when many holes line up that there are grave consequences (Carthy & Clarke, 2009). Strong management and leadership are required in policy development, staff education and resource distribution (Wong, 2002). Limiting the number of contributing factor or by creating fewer holes in the cheese ultimately there is less chance of error (Carthy & Clarke, 2009; Kadzielki & Martin, 2001; Wong).

There are four types of errors; execution error, planning error, active error and latent error (Kadzielki & Martin, 2001). In response to error many health providers concentrate on active error which is error by the on floor nurses instead of latent error which involves procedural problems that lead to nurse error (Kadzielki & Martin). In contemporary practice times an individual blame response to error is not useful. Fair blame rather than no blame has merits (Carthy & Clarke, 2009). Handover is a situation fraught with potential risks so it is important to discuss handover with the nurses involved looking at the strengths, weaknesses, opportunities and threats in relation to the process rather than the nurse.

Nursing handover is a ritual that performs a protective function for nursing in that it meets certain psychological, social and cultural needs for nurses (Strange, 1996). The handover ritual glues the group together, unites them by creating common meaning. Handover creates a place where nursing values and beliefs are shared and passed on (Philpin, 2006). Rituals value nursing knowledge and offer the participants an opportunity for knowledge exchange (Strange, 1996). Nurses do not work in a controlled environment so the handover ritual creates a situation to relieve professional angst (Philpin, 2002). It is a professional space to give away their workload that is free from outsider comment and judgement.

Key elements of nursing are lost in the construction of nursing handover. One key element is emotion in particular anxiety. Anxiety is not synonymous with stress (Wiltshire & Parker, 1996). Anxiety relates more to nurse and internal distress whereas stress is associated with the external environment and stressors upon the nurse (Evans, Pereira & Parker, 2008a). The major identifiable stressor to nurses is their workload followed by stressors linked to their workload such as staffing; skill mix, time and role overload (Evans et al.). These stressors

are visible and well talked about. Anxiety and distress are far less visible. Anxiety is discussed as being 'unconscious and unknown' (Evans et al., p.195). Nursing work is constructed by many unknowns on a daily basis. It is these unknowns that make nursing very unique and this affects nurses. The concept of anxiety is not able to be objectified and thus creates difficulty. In a scientific world that wants to standardise everything this concept has no position (Chernomas, 2007). Social systems and group culture work as protection in opposition to anxiety (Menzies-Lyth, 1988).

The emotional element of nursing is core in relation to caring. Without emotion, nursing would be very one dimensional and would change the nurse-patient relationship. Nurses need to be able to share emotion and discuss their work with their nursing colleagues. The face to face handover offers this opportunity to support the nurse to discuss their feelings or experiences associated with death, cardiac arrest or any other of the multitude of events that may occur in the nurses' day (Radka, 2003). A real place, a real time to share creates the potential for the nurse to have some form of control over the experiences that have been encountered (Menzies-Lyth, 1988).

Another noticeable loss in handover construct is the patient. In contemporary times a participatory relationship has merit. A shared relationship between patient and nurse is fundamentally important. Including the patient in their care seems simplistic, yet still remains a difficult ideal to meet. By carrying out person centred care, both the nurses' and patients' psychosocial and cultural aspects are acknowledged (Tonuma & Winbolt, 2000). Person centred care consists of four elements; prerequisites (nurse attributes), care environment (context of care delivery), person centred processes (care delivery through different activities) and expected outcomes (results of care) (McCormack & McCance, 2006). Nurse attributes include professional competence, advanced interpersonal skills, job dedication, transparency of values, and beliefs consolidated in the concept of 'knowing self' (McCormack & McCance). The context of care comes from an institutional/environment level incorporating skill mix, shared decision making systems, good staff relationships, supportive management, power sharing and valuing innovation (McCormack & McCance). Person centred processes look at care through patient engagement, cultural safety valuing the patients values and beliefs, meeting physical needs, sympathetic presence and shared decision making on care (McCormack & McCance).

A key element to person centred care is patient engagement, so their inclusion in the handover process could be advantageous. Alvarado et al. (2006) discuss a transfer of accountability (TOA) model that introduces a bedside patient safety check which encompasses checking the patient's wrist band, intravenous (IV) medications in line with medication chart, allergy status, monitor alarms set, and any risk concerns. This process engages the patient into communication around their care and also fulfils a safety element reducing risk. This process the TOA handover approach also includes a face to face handover and a handover sheet (Alvarado et al.).

Recommendations

Change to nursing handover requires more than linear thinking around its process and content. Looking at the constructs that create handover has given me greater understanding of nursing handover. From this recommendations have been made to acknowledge the significance of handover, the activities that relate to it and the identities that occur within the process.

1. *Value the significance of handover.* Nurses are attached to and value the significance of handover. Within this patient safety is paramount but also equally as important is nurse safety. Resilience is required to move away from a blame culture to a focus on handover accomplishments that reflect quality care and mistake prevention. Handover allows time for nurses to develop their professional identity through education and discussion.
2. *Protect the activities in handover.* In valuing nursing handover there needs to be consideration to the other functions it serves other than just the communication of information. This includes the protection of significant aspects of handover such as ritual and psychosocial elements. To allow time and space for handover is crucial so that nurses have a place to debrief and reflect on the nursing shift. This creates a professional space to give away their workload free from outsider comment.
3. *Honour the identities within handover.* Nursing handover should not be seen as pulling nurses away from patient care. The patient and the nurses are both central identities in nursing handover. Person centred care incorporates both in the relationship and encourages their identities to flourish. There can be professional anxiety associated with nursing care and acknowledgement of these identities ensures that the need for emotional support is not devalued. Flexible standardisation would

meet the needs of nurse, patient and the institution. It would also recognise the importance of the different nurse relationships and culture that exist from area to area.

This project has the potential to inform practice by implementing these recommendations. Globally there is much work being done around handover with a focus to implementing standardisation of practice. In considering changes to current practice there needs to be attention given to the reasons for change and valuing the time nurses spend together. This avoids the application of superficial solutions to perceived challenges associated with handover as it is not just the communication of information to the next shift and has psychosocial implications that need to be respected. Nurses deal with very unusual elements in their day to day jobs that need to be expressed to relieve some professional anxiety.

Challenges

Handover discourse affects how nurses practice and this ultimately affects the patients' experience of being cared for (Crowe, 2005). Discourse analysis is abstract in that there is no recipe to follow and this created difficulty. As a novice researcher it was extremely challenging to analyse language in use using text without a strict framework. However to over simplify the method would detract from the process and what can be gained by looking at nursing handover constructs.

I used discourse analysis to give another viewpoint analysing how nursing handover text is constructed and what is gained by such a construction. Discourse analysis was a good fit as it takes into account the text, context and discourse. It connected the social, cultural and institutional components with the process. Gee's (2005) approach provided the ideal support in particular the first three steps; significance, activities and identities to answer the research questions.

Summary

This chapter discussed patient safety and risk management as one of the main constructs in handover. As patient safety and risk management consume the institution in the effort to

better systems some elements within handover are lost. There is great importance of handover to the nurse as a ritual that nurtures and protects. Handover serves to support nurses within their social system and group culture thus relieving associated workplace distress that is associated with nursing. The group can work together in the environment they know with their experiences to look at their successes and the potential for risks. Handover offers valuable time for this. Handover actually can support many different constructs.

Conclusion

In contemporary times of technological advances such as e mail, face to face communication is being used less and less. Nursing handover remains one of the few face to face communications left. Handover occurs numerous times each day and is part of most nurses' reality. It has become a taken for granted practice without taking the time to really look at how it is constructed. When looking at practice development around handover it is important to look at its construction.

This research project has come from a constructionist and social constructionist epistemology. Nursing handover alone has no meaning and meaning is only constructed by the nurses themselves and their social interaction. Using Gee's (2005) first three steps significance, activities and identities it has illuminated the different constructs that make up nursing handover and what is gained or lost by such construction. Favouring one construct over another it places less value on some of the other constructs. Nursing handover is such a vital form of communication and it is crucial that the different constructs are not competing against each other. Patient safety has become a major focus which is honourable but other important aspects that effect nursing need not to be competing with this construct. Equally as important are the aspects of the nursing handover ritual that act to support and nurture the nurse, the group and the culture.

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