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Barriers and strategies in the nursing *Handover* of critically ill patients: integrative review

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ABSTRACT

Objective: to verify the main barriers and strategies inherent to the nursing handover of critically ill patients in the scientific literature. **Method:** this is an integrative review of the literature which used a quantitative approach and was conducted between October 19 to November 2, 2018. With the selection of article published between 2002 and 2018. **Results:** 26 (100%) identified articles, all published internationally, among these 16 (62%) were published in the last five years. Among the articles, 38% addressed barriers and 27% handover strategies, 35% of which were related to patient safety. **Conclusion:** the results of this review show the emerging need to develop tools and strategies to assist the Nursing Handover in critically ill patients.

Descriptors: Nursing; Patient Transfer; Communication Barriers; Nursing Care; Critical Care; Patient Safety.

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INTRODUCTION

With the advancement of initiatives for the promotion of safety and quality in health care, investments and improvements are recurrent with the launch of goals and bundles, directed to research related to the theme communication safety, in an attempt to contribute, mainly, to the reduction of harm to patients[2].

A study conducted by Gonçalves (2016) showed that among 263 adverse events analyzed, 187 (71%) were related to some type of communication failure, being divided into 94 (35.7%) events with verbal and written communication failures, 53 (20.2%) with written communication failures and 40 (15.2%) with verbal communication failures. Among those events that presented some communication failure, 154 (82.3%) considered avoidable[3].

In nursing, the communication process is inherent to all activities developed for the provision of care and, among these, handover stands out, which incorporates some determinants of communication that promote the effectiveness, effectiveness and continuity of care[4]. Handover is developed based on three crucial characteristics: the transfer of information, responsibility and authority and aims to pass on relevant information for the continuity and safety of patient care[5].

According to Birmingham (2015) the main barriers that make *handover* difficult, are: the excessive or reduced amount of information; the limited opportunity to ask questions; inconsistent information; the omission or transfer of erroneous information; the non-use of standardized processes; illegible records; lack of teamwork; interruptions and distractions, as well as information lost during the handover process[4].

In the perspective of continuity of care, and consequently, patient safety, *The Joint Commission* highlighted, in its 2017 report, the importance of standardizing the critical content to be communicated during the handover, how to ensure patient care in a timely manner, based on standardization and the use of tools and methods, such as: forms, models, checklists and/or protocols, capable of reaching communication recipients[6].

In search of nursing care continuity for critically ill patients, visibility of clinical nursing practice and participation of nurses in changing paradigms and nullification of adverse events, the following research questions were established: what are the main barriers that compromise patient safety during the nursing handover? What are the existing strategies applicable to the nursing handover?

The objective of this research is to verify the main barriers and strategies inherent to the handover of critical patients in the scientific literature.

METHOD

This is an integrative review of the scientific literature, with a quantitative approach, carried out from October 19 to November 2, 2018. The following steps were followed: elaboration of the guiding question, establishment of the objectives of the review and criteria for inclusion and exclusion of publications; definition of the information to be extracted; selection of publications in the literature; analysis of the results; discussion of the findings and presentation of the review[7].

As inclusion criteria, articles that addressed the theme, in the period from 2002 to 2018, in the search for articles published after the

dissemination of the theme of patient safety, and those involving nursing were selected; and the articles that did not answer the guiding question, reflections, theses, dissertations, editorial, letter to the editor, in addition to duplicate articles and excluded during the sample determination process were excluded.

The searches took place in the electronic databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), SciVerse Scopus (SCOPUS), PubMed and Web of Science. In consultation with Health Sciences Descriptors (DeCS) and Medical Subject Headings (MeSH), namely: "Patient Handoff", "Critical Care", "Continuity of Patient Care", "Nursing Care", "Patient Safety "," Communication Barriers "and" Nursing ", searched together using the Boolean operator AND (Figure 1).

After applying the crossings, the articles were initially selected for relevance to the theme, followed by reading the title and abstract, excluding duplicate articles, as shown in Figure 2.

Concerning the analysis and extraction of the data from the publications included in this review, a script was developed with the following data: identification of the publication, place of study, year of study, objective, methodological aspects, results (strategies, barriers and impacts on patient safety).

For critical evaluation of the studies, the level of evidence (LoE) was identified when considering the research design of each study. They were classified as follows: I - evidence stemming from systematic reviews or meta-analysis of relevant clinical trials; II - evidence derived from at least one well-designed randomized controlled trial; III - well-designed clinical trials without randomization; IV - well-designed cohort and case-control studies; V - systematic review of descriptive and qualitative studies; VI - evidence derived from descriptive or qualitative study; VII - opinion of authorities or report of expert committees[8].

RESULTS

It was found that the 26 (100%) articles were published internationally, of these 16 (62%) were published in the last five years. Among the studies, 19 (73%) had a descriptive quantitative methodological approach (level of evidence VI) and only two (8%) with

Bases X Crossings	"Patient Handoff" AND "Critical Care" AND "Patient Safety"	"Continuity of Patient Care" AND "Nursing Care" AND "Patient Safety"	"Communication Barriers" AND "Patient Handoff" AND "Nursing"
CINAHL	2	1	2
Web of Science	0	3	3
PubMed	5	2	0
SCOPUS	4	2	2
Total	11	8	7

Figure 1 - Crossings in databases, distribution of 26 (100%) selected articles. Natal, RN, Brazil, 2018
Source: Elaborated by the authors, 2018.

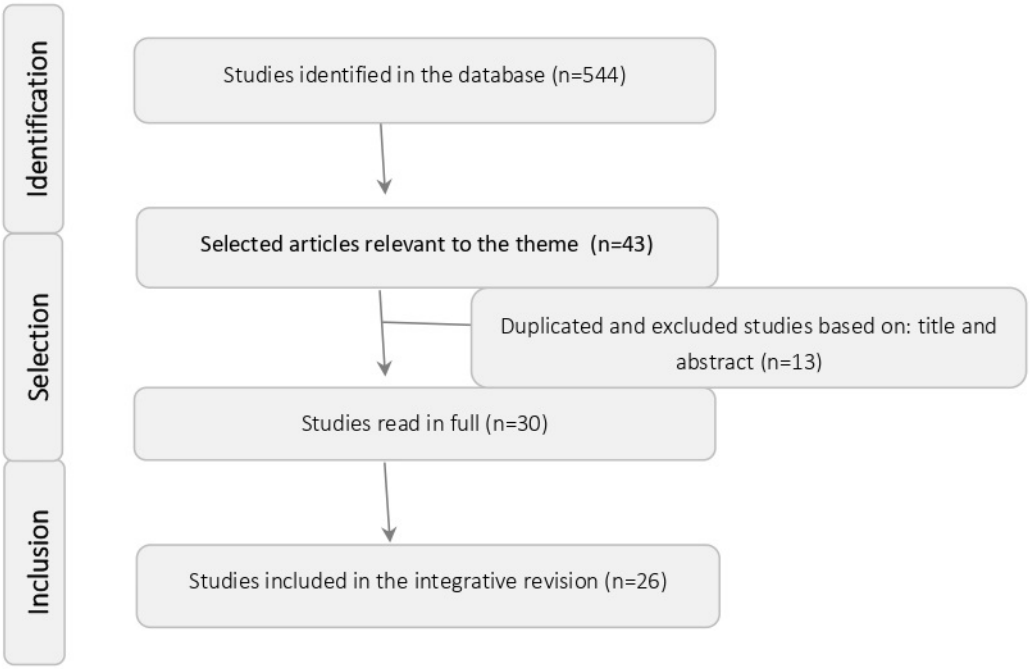

Figure 2 - Flowchart of the article selection process. Natal, RN, Brazil, 2018
Source: Elaborated by the authors, 2018.

cohort methodology and case-control (level of evidence IV). Methodologically, the results were grouped and related, after the selection of the articles, based on two emphasizes for retraction of the nursing handover theme: emphasis 1: barriers and impacts on nursing handover*;* emphasis 2: methods and strategies that promote quality during handover*.* Among the selected articles, 73% addressed emphasis 1, and 27% emphasis 2.

Barriers and impacts involved in nursing *handover*

Among the selected articles, nine (73%) addressed the barriers involved in handover*.* The most cited by the authors were related to the general problems of the communication process, such as: omissions of information (35%); errors (27%) (incorrect, irrelevant or duplicate statements); misunderstood information by the receiver (11%) and disorganized report (29%), involving illegible handwriting, absence of report of the patient's current state, etc[9-16].

In order to interconnect the impacts of existing barriers in handovers with patient safety[4], we demonstrate this relationship in the *Ishikawa* Diagram, popularly known as the "cause and effect diagram" (Figure 3). Due to the main causes raised by the literature[4,9-25], some effects for patient safety can be described, such as: discontinuity of care; prolongation of hospitalization; delay in the identification of diseases; administration of medications erroneously; delays/suspension of tests and procedures; and misunderstandings during communication with family members/patient/team, in addition to the risk of occurrence of adverse events.

Strategies that promote quality in nursing *handover*

Six[13.26-31] (100%) mnemonic-form strategies were found, all related to and applicable to critically ill patients. According to authors who

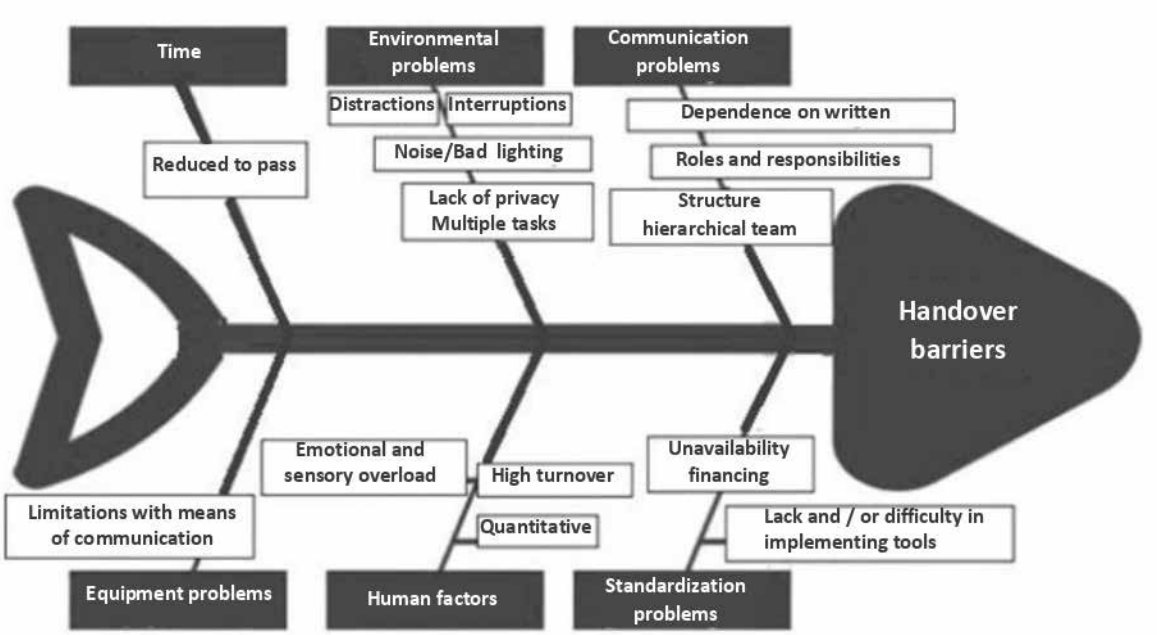

Figure 3 - *Ishikawa* diagram, cause involving barriers in the *handovers* of the critical patient, data from the articles surveyed[4,9-25]. Natal, RN, Brazil, 2018
Source: Elaborated by the authors, 2018.

described these tools, their applicability in the daily routine of clinical nursing practice was quite satisfactory (Figure 4).

The tool highlighted in the literature was the SBAR[13,26-29] (**S** - Situation; **B** - Background; **A** - Assessment; **R** - Recommendation), among the articles that addressed the strategies, five (19%) used this approach. Other strategies were identified, such as application of software and institutional electronic systems of exclusive use, not shared with the scientific community.

DISCUSSION

In the nursing context, communication is a basic instrument for care, and a primary tool for bonding, meeting the needs of the patient and the team in the continuity of care. This care is an immense task, in which all aspects must permeate throughout the hospitalization period in critical units[32,33].

In this sense, handover is considered as fundamental for achieving continuity of care. Complex process that demands knowledge about patients' needs and attention to the message being shared, in order to ensure the quality of care[33].

However, as communication is a process that involves interpersonal relationships, stressful and troubled environments, as well as patient severity, it is common that problems, difficulties or restrictions occur that prevent the message from being transmitted correctly[34].

The included studies[13,26-31] in this study demonstrated some of the barriers most commonly associated with communication, which contribute to the discontinuity of care, to inadequate treatment, which has become a current concern regarding patient safety[33].

With the dissemination of the effects of communication in the provision of safe patient care, in 2017, *The Joint Commission*, through the publication Sentinel *Event Alert,* reported on the potential harm to patients related to

Mnemonics	Description
Sbar[13,26-29]	**S**ituation (Situation) **B**ackground (History) **A**ssessment (Evaluation) **R**ecommendation (Recommendation)
I-SBAR-Q[30]	**I**ntroduction **S**ituation (Situation) **B**ackground (Historical) **A**ssessment (Evaluation) **R**ecommendation (Recommendation) **Q**uestions (Inquiries)
	Introduction (Presentation)
"I pass thebaton"[28.29]	**P**atient (Patient) **A**ssessment (Evaluation) **S**ituation (Situation) **S**afety concerns (Safety precautions) **The** **B**ackground (Background) **A**ctions (Shares) **T**iming (Coordination) **O**wnership (Responsibility) **N**ext (Follow-up)
PACE[29,31]	**P**atient / Problem (Patient / Problem) **A**ction **C**ontinuing care / Changes and **E**valuation
STICC[29]	**S**ituation **T**ask **I**ntent **C**oncern **C**alibrate (Goals)
GRRRR[29]	**G**reeting (Presentation) **R**espectful listening (Listening) **R**eview **R**ecommendation or request more information **R**eward

Figure 4 - Strategies in the "mnemonic" model effective in nursing *handover.* Natal, RN, Brazil, 2018
Source: Elaborated by the authors, 2018.

the communication process, when the recipient receives information that is inaccurate, incomplete, untimely, misinterpreted or not necessary[6].

A clear example is the omission of information during the handover, which impacts patient safety and exposes them to risks and prolonged hospitalization. A Study[39] conducted in an Intensive Care unit, reported that communication failures prolonged patient hospitalization on average 10 days, and in the hospital institution up to 20 days, with the occurrence of 45 adverse events in a sample of 81 incidents.

Among the actions suggested in the handover process by The Joint Commission, the standardization of critical content to be communicated by the sender stands out, making sure to safely care for the patient in a timely manner, based on the standardization in the use of tools and methods (forms, templates, checklists, protocols, mnemonics, etc.) capable of reaching the recipients of communication[6].

As in some cases, handovers are conducted casually, when they should be structured and centered to ensure continuity of care and

patient safety. During a situation of illness or hospitalization period, a patient goes through a series of professionals and care sectors, moving between diagnostic and treatment areas, following a network of professionals, in different shifts, which leaves him vulnerable to harm[35].

These conditions linked to critically ill patients in the Intensive Care Unit (ICU) corroborate the occurrence of AE, given instability, dependence and the need for interventions in these individuals [36]. One of the strategies evidenced by the studies is to standardize the handover of critical patients, either with the application of mnemonics or computerized tools that help in the organization of the content to be communicated[17].

In a study conducted in a university hospital in Belgium using the MNEMonic SBAR, a significant sample in this study demonstrated that after the implementation of this tool there was a higher frequency in nursing records from 4% to 35% ($p<0.001$) providing greater continuity of care, in addition to reducing serious adverse events, with the reduction of unexpected deaths from 0.99 to 0.34 per 1,000 inpatients[37].

This practice allows the professionals involved in the process to share the same mental model and not forget any relevant item[38]. Thus, it improves the professionals´ understanding regarding the patient's health conditions and provides a reduction in sharing time[35].

In a study on the perception of nursing professionals about communication during shift handover, the team recognizes the points necessary for good communication, namely: an organized and systematized dynamic, with the participation of all team members complementing the information; factors pointed out by professionals that reduce the chance of loss of information[35].

The absence of information about patients, incongruity in medical records, insufficient information, noise and interruptions prevent the message from reaching the recipient clearly, causing risks to patient safety during care[39]. It is concluded that, when it comes to critical patient care, nursing professionals play a crucial role in conducting and continuing care throughout the hospitalization period, as well as in the occurrence of events that are undesirable to patients resulting from handover[34].

CONCLUSION

This integrative review identified six main situations as barriers during the handover, which were: communication problems, lack of standardization, human and environmental factors, time and equipment used in the transition. Among the strategies involving mnemonics, SBAR was the most cited, when directed to the critical patient. Corroborating the initial objective of this research to verify the main barriers and strategies inherent to the nursing handover of critical patients in the scientific literature.

The results of this research draw attention to the emerging need to develop communication tools and standardize transmitted information, in order to provide a continuous update on the theme in health institutions, working and allowing schools and universities to provide theoretical and practical support on the issue of patient safety and communication skills. Thus, making health care safer for both patients and professionals.

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