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# **An Ethnography of the Nursing Handover**

**A thesis submitted in partial fulfillment of the  
requirements  
for the degree of  
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## Abstract

The purpose of this study was to enable nurses to recognise the significance of their role in delivering the nursing handover, and the impact this has on direct patient care. The aims of the study were: To identify how prepared nurses perceived they were for the next shift at the end of the nursing handover; to describe what nurses identify as important to handover to the nurse on the next shift; and to examine the processes by which nurses deliver the nursing handover. The research question was: Does the nursing handover adequately prepare the nurse for the next shift?

This qualitative study using an ethnonursing approach investigated the nursing handover in a large base hospital in New Zealand between the morning and afternoon shifts. Research data were collected during 5 non-participant observations of the nursing handovers between morning and afternoon shifts, and 10 nurses were interviewed using a semi-structured interview schedule. The interview questions emerged from the non-participant observations. The data was analysed using Leininger's 4 phases of ethnonursing.

The findings identified that the nurses in the study perceived they were not always adequately prepared during the nursing handover for the next shift. They frequently needed to access further information from a variety of other sources to ensure the provision of safe care to their patients. My observations showed, that the majority of these nurses when handing over recited the list of tasks and procedures they had completed during their shift, rather than prospectively providing the information required by the incoming nurses.

The findings also indicated that the nursing handover is still a key component of nursing practice, and serves purposes other than just handing over patient care. It is important for the communication, education and socialisation of nurses.

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## Glossary

<b>ABs</b>	antibiotics
<b>CT</b>	computed tomography
<b>IDC</b>	indwelling catheter
<b>IVs</b>	intravenous therapy
<b>leur</b>	cap attached to the end of an intravenous line
<b>neg</b>	negative
<b>obs</b>	measuring temperature, pulse and blood pressure
<b>post op</b>	after operation
<b>Resus</b>	resuscitation
<b>tds</b>	3 times a day
<b>UTIs</b>	urinary tract infections

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# **Chapter 1**

## **Introduction**

### **Introduction**

This thesis investigates the nursing handover used in hospital settings. Time is allocated toward the end of each shift for nurses completing their shift to hand over to incoming nurses the care required for patients for the next shift. This is generally a verbal handover that takes place in the nurses' office, though there are some variations to this. My aim was to explore what nurses believe is important to know during the nursing handover that adequately prepares them to work the next shift.

The focus was on the information contained in the nursing handover that adequately prepares them to care for their patients during the following shift. The method used for this study was Ethnonursing. This method allowed me to carry out my research within the culture of nursing that I was already part of, through observations of the handovers and interviewing of the nurses.

This introductory chapter outlines the background to the thesis, the setting for the research, and the purpose of the study. It also includes a brief description of the research approach used, and explains the structure of the thesis.

### **Background**

#### **The Researcher**

I have been a registered nurse for the past sixteen years. Most of this time I have worked as a medical nurse in a medical nursing scope of practice. I currently work as a Community Resource Nurse for the Rehabilitation Service at a large base hospital in New Zealand and remain part of this culture of nursing. I have taken part in nursing handovers for the majority of the past sixteen years.

While working as a Charge Nurse I became concerned about the inadequate and inappropriate information that the nurses were sharing at handover. They were using this time to justify what they had been doing for the last eight hours, not what needed to be achieved during the next shift. Changing the method of handing over care, and minimising the length of time allocated to complete the handover, did not make a difference.

Raising the nurses' awareness of what was important to handover to the incoming nurses only worked for a short period of time before they would return to outlining the tasks they had performed during their shift. Up to date care plans, patient's clinical records and recordings did not stop the nurses from repeating this information during the nursing handover. This learned social behaviour or way of thinking had become part of the culture to such an extent that the nurses continually reverted back to it, even when they understood the reasons why they needed to hand over what was important to know for the next shift.

As my attempts to change the way the handover was delivered within the ward failed I became more interested in exploring the handover, how it was delivered, why it was delivered in that way, the appropriateness of the information being shared, and why some days it worked better than others.

## **The Nursing Handover**

The nursing handover has historically been the method of handing on information about patient care from one shift of nurses to the next in an inpatient environment. Currently nurses in most hospitals in New Zealand have a 30–60 minute overlap in shift time between morning and afternoon duties. This time is used to prepare the incoming nurses for the following shift, to deliver inservice education, and for participation in ward meetings. The process of handing over patient care generally takes 30–45 minutes to complete and usually occurs in the ward office.

Nurses believe that by changing the method of handing over patient care, the handover will become more effective (Mosher & Bontomasi, 1996). However,

changing the method does not always mean that the nurses are delivering a handover that is adequate to care for their patients for the next 8 hours.

Over thirty years ago, Clair and Trussell (1969) wrote that the extent to which the registered nurse going off duty gives a complete, accurate, and concise report affects directly the ability of the incoming registered nurse to carry out her responsibilities effectively and efficiently. Thirty years on, this is still appropriate. Nurses still struggle with the giving of appropriate information that ensures the next nurse delivers safe nursing care for their shift, in a timely manner, which meets the needs of the patient, the nurse, and the organisation (Parker, 1996).

### **The setting**

This study took place in a large base hospital in New Zealand in a medical ward with 24 beds and 23.2 full time equivalent nursing staff. Although I have not worked in this particular ward, I have in the past worked in the medical area in the same hospital as a staff nurse, nurse educator, and a Charge Nurse.

### **Purpose of the study**

The purpose of the study was to enable nurses to recognise the significance of their role in delivering the nursing handover, and the impact this has on direct patient care. The aims of the study were:

- To identify how prepared nurses perceive they are for the next shift at the end of the nursing handover.
- To describe what nurses identify as important to handover to the nurse on the next shift.
- To examine the method by which nurses deliver the nursing handover.

### **My research question is:**

Does the nursing handover adequately prepare the nurse for the next shift?

## Research approach

Since each ward environment represents a subculture within the culture<sup>1</sup> of the organisation, ethnography was considered the best approach for investigating this aspect of nursing practice. Ethnography is the study of the learned social behaviour or way of life of a particular group of people. Ethnography provides knowledge that can be used to help us understand our own culture and those of others (Germain, 1985).

My aim was to capture the cultural context in rich detail by observing the events of the subculture. With the help of the cultures' members, the ethnographer looks for themes, patterns, connections, and relationships that have meaning for the people in it (Germain, 1985).

The goal of nursing ethnography is advancement in clinical practice. Nurse ethnographers differ from other ethnographers in that they only 'live' with the participants during their working day, and spend their private lives away from the location where the research takes place (Muecke, 1994). I did not work in this ward during the day, but spent time on the ward observing the handovers and interviewing the nurses.

My intention was that the research study would provide a basis from which nurses may better understand their current handover practices, be able to identify what influences how they deliver the nursing handover, and improve their ability to share information appropriately during this time.

Using non-participant observations, 5 handovers were observed, and the information gained from the observations was used to guide the semi-structured interview questions. Ten registered nurses were interviewed, guided by these semi-structured questions. I focused on the handover of patient care, and what the nurses identified as being necessary to adequately prepare them

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<sup>1</sup> Culture is defined on page 23.

for the next shift. Both observations and interviews were analysed using

<sup>2</sup>Leininger's 4 phases of ethnonursing analysis for qualitative data.

## Structure of the thesis

This thesis is structured in the following way:

**Chapter Two** presents an overview of the literature that relates to nursing handovers. It outlines the history of the nursing handover, rituals, information sharing, socialisation aspects of the nursing handover, plus a description of the different types of methods used for handing over patient care.

**Chapter Three** describes the method and study design used. Ethnography as described by Spradley (1979) is outlined as the framework for the study. Data analysis is based on the nursing theorist Leininger's 4 phases of ethnonursing analysis for qualitative data (1985). The chapter also outlines non-participant observation, interviewing techniques, and the ethical issues and concerns related to the study.

**Chapter Four** provides a description of the ward and the nursing handover, and in **Chapter Five** the data is analysed. **Chapter Six** discusses the findings in relation to the literature, and **Chapter Seven** is the conclusion to the study, where recommendations are made for practice, education and further research.

## Conclusion

This chapter has outlined the background to the study, the setting where the research took place, and the purpose of the research study. It has also presented an overview of the research approach that was used. A brief outline of the structure of the thesis is also given.

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<sup>2</sup>Leininger's 4 phases of Ethnography analysis for qualitative data is outlined on page 33.

# Chapter 2

## Literature Review

### Introduction

This chapter examines the literature on the nursing handover during the past half a century. Firstly, the history of the nursing handover is explored. The role of rituals in the nursing handover is outlined, along with links to information sharing and socialisation. Four different methods of handing over care are examined, and finally the gaps in the current literature are identified.

### The history of nursing handover

Over half a century ago, Barrett (1949) recognised the importance of adequately handing over care to the next shift of nurses to ensure that nurses had the necessary information to provide appropriate and safe care for their patients. Barrett explained “ It is true, also, that patients receive better care when reports are thorough and give all pertinent data. When they are inadequate it is possible for medications or treatments to be duplicated or omitted ” (Barrett, 1949, p. 171). She also believed that oral reports should be well organised, presented in an interesting manner, and important points should be emphasised.

Barrett described a good report as unhurried and not interrupted, as this could lead to important points being forgotten. She concluded by saying that the importance of reports being given on time could not be overemphasised, and that delays wasted the time of nurses who are coming on duty.

A good report [handover] is unhurried. It is well to set aside a block of time to be kept for report purposes. It should be an unbroken rule that

reports are not interrupted except in an emergency for if continuity is broken important points may easily be forgotten (Barrett, 1949, p. 173).

Nine years later Scales (1958) wrote similar guidelines for report giving. She recommended that report time was a very responsible and valuable experience for the senior student nurse. According to Scales:

Not only must she [sic] train her memory and quicken her [sic] intelligence, but also she must learn to exhibit powers of leadership and cultivate certain teaching and administrative qualities, because so much is left for her [sic] to explain and arrange. A good senior student would give her [sic] staff opportunity to ask questions and this would become a test of her own knowledge (Scales, 1958, p. 96).

Prior to the 1970's in New Zealand there was hospital based apprentice style nurse training. The nursing handover was an important tool for learning, and an avenue for sharing knowledge between junior and senior staff members. Senior student nurses were in charge of wards, and were responsible for the supervision of junior student nurses.

Clair and Trussell (1969) supported Scales eleven years later by proposing that the extent to which the nurse going off duty gave a complete and accurate report affected directly the ability of the oncoming nurse to carry out their responsibilities effectively and efficiently. They commented that nurses seemed to learn about the change of shift report from the repetitive experience of giving and receiving them.

Using a questionnaire, they asked ten Charge Nurses what they believed should be included in the change of shift reports in a hospital in St. Louis. They then audiotaped the ten Charge Nurses as they gave report. The findings of their study revealed great inconsistency between what the Charge Nurses said they believed should be included in the report, and what they did in fact include in their report. Clair and Trussell found extrinsic factors such as the nurses being

rushed, not ready, tired, and being unfamiliar with the patients, influenced the nurses' performance.

The outcome of this study led to the development of guidelines for delivering the nursing handover on all care units. The question raised was "Should the incoming nurse interact with the charge nurse giving report, perhaps even ask questions to clarify information being given?" (Clair & Trussell, 1969, p. 95).

Judith Parker has made a significant contribution to the research on the nursing handover. Parker, Gardner and Wiltshire (1992) wanted to answer the question of why the nursing handover retained such salience in the organisation of nursing, and why with changes to technology and institutions it had survived. In a large metropolitan hospital in Australia twelve handovers were observed in 5 different work areas over a 24-hour period. Some of the observations also included bedside handovers.

Parker et al., (1992) claimed that as a group nurses at handover construct a 'collaborative narrative' about the patients, and like all narratives there were positive and negative aspects to this narrative, and that patients became packaged and stereotyped. They suggested that one function of the handover was to construct 'stereotypical identities' for patients so the incoming nurses felt immediately familiar with the ward environment.

They also suggested that much of the information given at the handover the nurses were unlikely to retain, and therefore this information functioned to settle them in, and give them a sense of familiarity and initiation into the social group. The findings identified that the nursing handover served to construct patient identities, ensure solidarity and cohesion among nurses. They believed that it brought a sense of "closure to the departing shift, not unlike a debriefing mechanism, so the nurses did not take their work home" (Parker et al., 1992, p. 33).

Parker (1996) was concerned that the responsibilities and functions of the nursing handover had become unclear and that questions were being raised

about the appropriateness of the traditional structure of the handover process. Parker and Wiltshire in 1995 conducted a National Survey of the nursing handover in two teaching hospitals in different states in Australia funded by the Australian Research Council. Handovers at each change of shift were observed and tape-recorded for 3 consecutive days in 2 general wards. A selection of the patient's clinical notes was also examined. However, their relationship to the handover material was not analysed for this study (Parker & Wiltshire, 1995, p. 153).

The data collected revealed many handovers tended to reinforce aspects of hierarchical and segmented hospital structures. It also indicated that many handovers were highly professional. Six patterns were identified to show the ways in which the nurses managed to convey information at handover. In summary they were: The nurses' knowledge of the patients, the nurses' portrayal of the patients, the information imparted by the nurses, the documentation used, the portrayal of the medical staff, and patient allocation.

The study identified 4 types of handovers, traditional, ad hoc, collaborative and professional bedside handovers. The emerging patterns showed that during the 'best' handovers, the nurse responsible for direct nursing care handed over at the bedside. They suggested education to support this type of handover was essential. Parker recommended that this was the model for hospital nursing in the future.

It is timely to address the question of whether the nursing handover is an outdated, costly, and time consuming ritual of dubious value in the current climate of breakdown of traditional boundaries in health care and changing work practice, or whether it continues to serve vital and significant functions which are crucial for ensuring appropriate continuity of patient care (Parker, 1996, p. 23).

Since Parker and Wiltshire's study many studies have taken place investigating the nursing handover process (Lamond, 2000; McKenna & Walsh, 1997; Miller,

1998; & Webster, 1999). The remainder of this chapter highlights some of these studies where a variety of approaches were used.

## **Nursing handover as ritual**

Helman (1990) describes ritual in his book on culture, health and illness as “A form of repetitive behaviour that does not have a direct overt technical effect” (Helman, 1990, p. 192). Because of this he explains that western culture places little value on this type of behaviour and considers it to be primitive. Helman suggests that “A key characteristic of any rituals is that they are a form of repetitive behaviour” (Helman, 1990, p. 192).

The ritualistic elements of the nursing handover are often discussed in articles describing handover techniques. The debate is generally around the argument of whether the handover should be labelled a ritual or not. Using an ethnographic approach, Strange (1996) set out to analyse the function and meaning of the nursing handover in a hospital ward in Devon, to see if it warranted the label of ritual.

Strange was a participant observer in the ward where he worked. No field notes were taken, as he did not want to identify the nurses. Strange described the setting and the handover using what he could remember from his observations. Analysis of the data showed that the nursing handover had both technical (information regarding age, condition of patients and care they received) and ritualistic (language used, format, set space and time) functions, and separating them merely reduced our understanding of the purposes of these behaviours.

The multiple functions of the ritual of the nursing handover were developed into 3 categories: Psychological, social and protective functions. Strange said that information had a psychologically protective effect in that it reduced uncertainty, and made the world more predictable. He stated “the nursing handover is the time when the power, control and responsibility for the care of patients is transferred from one shift to another” (Strange, 1996, p. 110).

Strange considered that one of the main social functions of ritual is the establishment of group cohesion, and that the nursing handover does appear to perform some group bonding functions. The findings also indicated that the nursing handover did warrant the label of ritual, that nurses needed to increase their understanding of the rituals surrounding nursing knowledge, and that rituals should not be seen as unimportant because they do not hold a technical function.

Strange suggested that there are values and rules that govern everyday life and commented: "The actions performed and words spoken within the special context of ritual are afforded greater kudos. Through the shared context of ritual the novice is initiated into the language, values and culture of the expert" (Strange, 1996, p.111).

This study was only conducted in one ward, where the researcher was also a staff member, and no time frame is given for the observations. No interviews were undertaken to support the evidence collected during the observations. The rigor therefore in this study is not evident.

Elkman and Segesten (1995) used participant observation to study the nursing handover. They observed and recorded ten shift reports in a Swedish University hospital in an attempt to identify, describe and explain embedded rituals. The themes that emerged in the data analysis were: Accountable-prepared, handing over-receiving, delegated power and control, and discharge-reincorporated.

They suggest:

According to the RNs, diagnoses were among the most important message to convey in the shift report. Although the reporting nurse repeatedly pointed out that this or that patient was well known to everyone, she carefully enumerated all diagnoses in every case. The receiving nurse invariably wrote down every diagnosis in her notebook (Elkman & Segesten 1995, p. 1008).

They found a considerable range of ritualistic elements associated with certain symbols; such rituals reflect social and cultural transitions. In the study the main

symbol was described as 'the deputed power of medical control' (Elkman & Segesten, 1995, p. 1009). They claimed that in receiving the shift report, the nurse "assumed the deputed power of medical control, and that the nurse was well aware of what this implied in terms of obligations and responsibilities. Rituals seemed to be necessary for the process of transferring authority and responsibility and maintaining control" (Elkman & Segesten, 1995, p. 1010).

They also suggested that the shift report had hidden functions, such as the socialisation of new nurses for their professional role, the upholding of norms, and the maintaining of responsibility for the patients. They claimed that "in order to be in charge of deputed power, the nurse had to command a wide range of knowledge about the past and current medical status of each patient" (Elkman & Segesten, 1995, p. 1010).

They proposed that since this appeared to consume considerable time and energy, the nurse paid less attention to the nursing care. Nursing as an autonomous professional discipline, they believed, was "demonstrated to a modest extent only, and then mostly in relation to what a doctor prescribed. While the medical paradigm dominated, nursing was virtually invisible" (Elkman & Segesten, 1995, p. 1010).

They claimed that nurses were caught in a system organised to facilitate medical and administrative efficiency. They argued that it was crucial for nurses to develop an awareness of factors such as power, status, authority, and the effect these factors have on the quality of patient care. They suggested that the "predominant role of the deputed power of medical control and the invisibility of nursing care in the shift reports do not necessarily mirror a lack of excellent nursing" (Elkman & Segesten, 1995, p. 1010).

What it did show, however, was that the reports were not used as a means for developing, improving, making visible, and upgrading the status of knowledge in nursing care. They argued that "the deputed power of medical control has to be assigned, assumed, and carried out, but nursing care certainly is an equally

essential, or even more essential, aspect of the nurses' work" (Elkman & Segesten, 1995, p.1010). In their conclusion they wrote:

A striking impression was that the reports were mainly retrospective, the nurse reported what had happened and describes the current situation. Thus, she [sic] limited the information to what had happened and was happening, cautiously avoiding any demonstration of her [sic] own attitude towards the patients' future care and treatment" (Elkman & Segesten 1995, p. 1010).

Elkman and Segestens (1995) findings were reinforced 5 years later by Payne, Hardey and Coleman (2000) who conducted a study in a hospital in Southampton to determine how nurses defined and communicated information about patients and the delivery of care. The study covered 5 wards, a total of 23 handovers was observed and tape recorded and 34 semi-structured interviews were completed. They found that the use of medical terminology had been an indicator of status and experience amongst nurses involved in handovers (Payne et al., 2000, p. 279).

Communication was further constrained by a concern not to delay the departure of nurses at the end of their shift. They suggested that this reinforced a desire by nurses not to enter into a more rambling or complex narrative about patients that could be viewed as inappropriate by colleagues.

## **Nursing handover as information sharing**

In 2000 Lamond studied how the nursing handover content aided nurses in processing information when planning patient care. She perceived the nursing handover as a communication that occurs between 2 shifts of nurses, where the purpose was communication of information about patients under the nurses' care. She believed that it was central for maintaining the continuity and quality of care which patients receive.

Lamond (2000) highlighted the main function of the nursing shift report as one of communicating vital information about patients from one shift of nurses to

another. She also suggested that the nursing shift report could be considered as a form of communication that needed to be considered within a wider information-processing framework.

Another area of importance identified by McMahon (1990) was that the nursing handover was a place where nurses could debrief any events occurring during their shift with their colleagues, so they could support each other. This has been mooted as one reason why the nursing handover takes so long to complete (McMahon, 1990, p. 39).

McMahon (1990) claimed that the handover report was a precious time, which was specifically devoted to nurses' communication with each other and emphasises their therapeutic role. He proposed that the afternoon nurses do not necessarily need to know which patients have had a bath, and suggested that nurses felt they must demonstrate that they had been busy during the shift. He proposed that maybe the "time had come to re-examine what nurses were saying... this is enormously time consuming and may well be unnecessary " (McMahon 1990, p. 39).

Parker and Wiltshire (1995) concentrated their study on understanding the knowledge embedded in practice exchanged in nursing handovers. They found that the handover enabled the nurses going off duty to 'paint a verbal picture' of the area in which the incoming nurses would work, a kind of map of the site (Parker & Wiltshire, 1995, p. 152).

Parker and Wiltshire (1995) explained that during the nursing handover nurses communicated 3 modes of nursing practice knowledge, 'reconnoitre' (the nursing scan), 'savoir' (the nursing gaze), and 'connaissance' (the nursing look). They then described how these aspects could be incorporated into 'reconnaissance' (nursing practice knowledge). In their conclusion they suggested that the oral transmission of nursing practice knowledge during the nursing handover provided an important means of ensuring continuity of nursing practice knowledge (Parker & Wiltshire, 1995, p. 167).

## **Nursing handover as socialisation**

Nursing language can be learnt by the new graduate nurses during the nursing handover. Wolf (1989) explains that "When information is exchanged about the status of patients during shift report, the distinctive language of the working nurse is used as seasoned nurses teach novice nurses what it means to be a nurse" (Wolf, 1989, p. 78). Wolf suggested that this special language that nurses use incorporate colloquial, scientific, technical, descriptive and abstract words and phrases.

Du Toit (1995) defined professional socialisation as

The complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into 'the persons' own behaviour and self conception... a person gives up the societal and media stereotypes prevalent in our culture and adopts those held by members of that profession.

At 2 universities in Brisbane du Toit asked the students to complete a questionnaire to determine the extent of professional socialisation of respondents. Reoccurring themes outlined by du Toit were values and behaviours (du Toit, 1995, p. 165).

The findings indicated that novice nurses enter the nursing schools with a set of values, which may change during the socialisation process to reflect values the profession holds in high esteem. When values change so do behaviours. A third theme identified was that individual concepts of self changed to such an extent that a nursing identity developed (du Toit, 1995, p. 169).

## **Methods of handover**

There are 4 main styles of handover reported in the literature. These are verbal bedside handovers, tape recorded handovers, silent written handovers (sometimes called computer generated shift reporting), and verbal traditional

handovers. The verbal bedside handover is the method most research is based on.

### **Bedside handovers**

As suggested by its title, the bedside handover occurs at the bedside and involves the nurse handing over nursing care to the receiving nurse and it included the patient. In a study in 1999, Webster used an action research method to study nursing handovers in a medical ward in a hospital in England. He decided to move away from the traditional handover and introduce a bedside handover. The 4 key problems identified at the 3-month review were: Access to information, patient orientation, confidentiality and communication (Webster, 1999, p. 1380).

After evaluation at 6 months, access to information had improved, although a lack of time to access it was identified. Staff orientation to patients had also improved, except for when the ward was very busy. Nurses still had a problem with not knowing enough about every patient. Communication also increased with the introduction of weekly team meetings to discuss issues not related to the nursing handover. The emphasis of the weekly team meeting was to reflect on practice, and promote team cohesion. Confidentiality remained a problem with bedside handovers. It was established that it was the individual team member's responsibility to ensure that confidentiality was not broken (Webster, 1999, p. 1380).

To deal with the concern that confidentiality could not be maintained with the bedside handover, Howell (1994) decided that any distressing or sensitive information should be given away from the bedside, and that consideration should be given to the content of the report and the method used. Her study indicated that the main problem with lack of confidentiality was that patients listened to other patients' reports (these patients were in 4 – 6 bedded rooms). The patients in the study said that they never listened to others reports, but felt that others listened to theirs. Some even said that the reports were too full of jargon and repetitive to warrant listening to every time.

Howell's (1994) findings included some areas for further improvement. These included "Trivia, skipping the facts, retrospective information, staff digression and the patient's token involvement were factors that suggest that future improvement were necessary" (Howell, 1994, p. 45). Parker (1996) supports this by saying, "the bedside handover with patient participation is an extremely complex undertaking for which nurses receive no formal training" (Parker, 1996, p. 25).

### **Tape-recorded handovers**

When using this approach the nurse responsible for direct patient care records the handover report onto a tape, and staff coming on duty listen to it. Interruptions and questions are eliminated, discussion and/or debriefing are not allowed for. The nurse also needs to be adequately prepared before the recording starts to ensure a smooth delivery of information.

Mosher and Bontomasi (1996) point out that it is what is communicated in the report, not the reporting method itself that determines the effectiveness of the handover process. McKenna's (1997) article on the nursing handover reinforces this by saying that if the nurse is unable to do this, crucial patient information may not be passed on. McKenna also states that "although it has a number of advantages the tape-recorded handover also has some complicating factors. As with the written approach, the tape-recorded handover does not allow for discussion or debriefing" (McKenna, 1997, p. 638).

Prouse (1995) provided a list of benefits of tape recorded handovers which included such things as: The nurse handing over could record their report at a time that suits them; and the tape could also be repeated to allow flexibility for start of shift times.

### **Silent handovers**

This method involves the documentation of relevant information according to a set of criteria or format. Nurses commencing their shift can then use the documentation to access the necessary information. Written report sheets, white boards, and computer generated report sheets are simply given to the

nurses as their handover. This method encourages a formal approach to handover that other systems lack and provides a concise, consistent and permanent record.

The goals of Baldwin and McGinnis's (1994) questionnaire in a hospital ward in Florida were: To introduce a silent handover process using a computer-generated shift report that would ensure the completion of the nursing handover in 30 minutes; To provide pertinent necessary patient information; and to allow work in the ward to continue during handover time. The results of the questionnaire indicated a reduction in overtime, increased direct patient care at handover time and improved communication of pertinent patient data.

Baldwin and McGinnis (1994) found when using written handover sheets instead of a verbal handover there was less chaos and noise and that work continued uninterrupted on the floor. However, nursing care plans and clinical records were not always up to date. This was highlighted as important for this method to have any merit. They also reported that the legal risk of breach of patient confidentiality due to overheard conversations had been greatly reduced using this method.

McKenna (1997) however, argued that this system could be viewed as impersonal, and with face-to-face discussion reduced, there may be less opportunity to ask questions and clarify details. In addition she claimed that the debriefing function of handover could be lost, which meant that additional meetings might need to be held for any concerns to be resolved on a regular basis.

### **Verbal handovers**

The traditional verbal handover usually takes place in the ward office. Each individual nurse verbally hands over the care of their group of patients to the nurse who is allocated to care for them for the next shift. Verbal handovers provide a place for nurses to discuss aspects of their work they would not generally talk about to their families. Apart from the ethical considerations,

Parker (1996) suggests that it is due to “the disgust, distaste and strong mixed feelings they arouse ” (Parker, 1996, p. 22).

In her study of traditional verbal handovers Parker argued that many of the handovers were highly professional, that they showed responsibility and accountability. She explained that they communicated highly relevant information presented in a systematic and focused way, they were open to scrutiny and participation by others, and they demonstrated the transmission of what was described elsewhere as authentic nursing knowledge (Parker, 1996, p. 23).

McKenna (1997) proposed however that the verbal handover was unnecessarily lengthy, and could lead to sensory and information overload. It is interesting to note however that this is still the most common form of handing over patient care.

Miller (1998) recommended that regular reviews of handovers are held, written guidelines for the content are developed, and the use of formally sanctioned pre-prepared handover sheets upon which each nurse can make their notes should be implemented. McKenna and Walsh (1997) added to this that staff needed to be able to test a number of options for changing the handover process before settling on one particular mode.

## **Conclusion**

The literature highlights the links between the nursing handover being a ritual that nurses take part in on a daily basis, an avenue for sharing information, a debriefing mechanism, and a socialisation process for new nurses. Literature reviewed highlights the need to examine the content of the nursing handover instead of the mode of delivery.

The purpose of this chapter has been to examine the nursing handover by reviewing the literature. The literature on nursing handovers and its role in enhancing care identifies that there are a number of problems associated with all forms of delivering the nursing handover. There is however gaps in this area

of research, particularly in nursing within a New Zealand context. There are no studies in this country of the nursing handover, nor any studies that look at how the handover content effects the nurses' ability to work effectively for the next shift. The debate has been generally around what is the best method to use for handing over care, rather than examining if the content of the handover is adequate for nurses to deliver that care.

There is no literature to suggest that the content of the nursing handover adequately prepares the nurse for the next shift. Many of the articles discussed focused on changing the methods of handing over patient care, however, they did not link these to long term nurse driven initiatives that would ensure better outcomes for patients. Chapter 3 outlines the research study and design, which has been selected for this study.

## **Chapter 3**

### **Research study and design**

#### **Introduction**

The purpose of this chapter is to outline the methodology of the study. The chapter begins by discussing qualitative research, ethnography, culture, and the links between ethnography and culture. Ethnonursing as defined by Leininger is outlined and how the data will be analysed using this method. The data collection section includes non-participant observation, locating the social situation, interviewing techniques and accessing participants. Issues of ethical concerns are also considered.

#### **Qualitative research**

Qualitative research is the term used for any type of research that produces findings not arrived at by statistical procedures or other means of quantification (Strauss & Corbin, 1998). It can refer to research about people's lives, lived experiences, behaviours, emotions and feelings. Qualitative research covers such topics as the functions of an organisation, social movements, cultures and interaction between nations. Data is generally gathered by means of interviews and observations (Strauss & Corbin, 1998).

The purpose of qualitative research is to discover concepts and relationships in the raw data collected. It can be used to explore areas which little is known about, or to obtain the details about phenomena such as feelings, thoughts and emotions. There are many different approaches to doing qualitative research. These include grounded theory, phenomenology and ethnography (Benner & Wrubel, 1989; Chenitz & Swanson, 1986; Denzin & Lincoln, 1994; Leininger, 1990; Morse & Field, 1996; Spradley, 1980; & Strauss & Corbin, 1998). Ethnography is part of the qualitative paradigm.

## Ethnography

The central concept of ethnography is culture, broadly defined as the learned social behaviour or the way of life of a particular group of people (Germain, 1985). Rountree (1993) suggests that ethnographies provide knowledge that can be used to help understand our own culture as well as the culture of others. They also provide a basis for planned cultural change. She explains:

Ethnographies are not partial representations, but alternative constructions. Each is 'whole' in so far as it represents the way an Ethnographer sees and makes sense of the society/culture under study, but the number of alternative ways of doing this is potentially unlimited (Rountree, 1993, p. 155).

Alternative ways of doing ethnography, as mentioned earlier can look at themes, patterns, connections, and relationships that have meaning for the people in them (Germain, 1985). As a product, ethnography is a description and analysis of aspects of the way of life of a particular culture, subculture or subcultural group. As a research process, it is the traditional approach used for the development of theories of culture that deals with living people. Ethnography has been traditionally associated with remote, foreign or primitive cultures such as those of early anthropologists. Today it is more concerned with the culture in which we live, and our own daily working lives. This is the reason why I chose to use this method to investigate the nursing handover.

The ethnographic approach requires the researcher to enter the world of the study participants, to watch what happens, to listen to what is said, to ask questions, and to collect whatever data is available (Boyle, 1991). Ethnography concentrates on the individual view and the shared view and values of a particular culture, and aims to describe the cultural knowledge of the participants.

Instead of seeking out the unusual, ethnographic studies concentrate on the routine, daily living of people, allowing for a number of views to be examined at the same time. By encouraging participants to describe their culture, the

researcher can build up an overall picture of the language, rituals and relationships within a community. Gehring (1973) supports this by describing ethnography as:

The art and discipline of watching and listening and of trying to inductively derive meaning from behaviors initiated by others. One must see the general in the rich, particularising detail of good ethnography. To watch and to listen must come before interpretation and analysis (Gehring, 1973, p. 1223).

The major ingredient of the research process is that one becomes part of the subculture being studied by physical association with the people in their setting during a period of fieldwork (Germain, 1985). Doing ethnography refers to a prolonged, systematic in-depth study.

When doing ethnography, the researcher seeks to understand the cultural perspective of the group using participant observation, interviewing and field-notes. Ethnography is always holistic, contextual, reflective and presented in the form of the 'emic' (insider) point of view. To study a culture the researcher must spend time in the field (Morse & Field, 1996).

Ethnography starts by the researcher experiencing, enquiring and examining the culture under study and consists of description, analysis and interpretation. (Wolcott, 1990). Ethnographers describe what they see and hear while studying a culture, identify its main features and uncover relationships between them through analysis. They interpret the findings by asking for meaning and making conclusions from the data.

## **Culture**

Culture is defined as acquired knowledge that people use to interpret, experience and generate social behaviours (Spradley & McCurdy, 1979).

Culture, the most central concept in anthropology can be described as a way of life belonging to a designated group of people, a blue-print for living which guides their thoughts, actions and sentiments (Burns & Groves, 1995).

Ethnographic research in nursing is used to increase cultural awareness and enhance the provision of quality health care for all patients.

Burns and Groves (1995) suggest that culture is both material and nonmaterial. Material culture consists of all created objects associated with a given group. Nonmaterial culture consists of social relations, and beliefs as reflected in social and political institutions. Symbolic meanings, social customs, and beliefs are essential elements of any culture.

As mentioned above, culture can be defined as a total way of life of a group. The life experiences of members of the group include the communication system that they share, common values individuals hold, and ideas acquired through learning from other members of the group (Holloway & Wheeler, 1996). An organisation such as a hospital can be viewed as a socio-cultural institution; a ward environment as a subculture; and nursing as a professional culture. Therefore the nurses working in the wards are part of the culture of the hospital, the subculture of the wards and the professional culture of nursing.

## **Ethnography and culture**

Anthropologists developed ethnographic research as a mechanism for studying cultures. Ethnographic fieldwork is the hallmark of cultural anthropology. Whether in a jungle village in Peru or on the streets of New York, the anthropologist goes to where people live, to do fieldwork (Spradley, 1980). This involves participating in eating the food, learning the language, observing play, etc. However this vast range of activities can often obscure the nature of the most fundamental task of fieldwork - doing ethnography.

Ethnography is the work of describing a culture (Spradley, 1980). The central aim of ethnography is to understand another way of life from the 'native' point of view, and to realise 'his' (sic) vision of 'his' (sic) world. Fieldwork can then be described as a study of what the world is like to people who have learned to see, hear, speak, think, and act in ways that are different. Rather than studying people, doing ethnography means learning from people (Spradley, 1980).

The central core of ethnography is concern with the meaning of actions and events to the people that we seek to understand. Some of these meanings are expressed in language, and some are taken for granted and shown through words and actions. In every society people make constant use of complex meaning systems to organise their behaviour, to understand themselves and others, and to make sense out of the world in which they live. A combination of these systems of meaning forms their culture; ethnography always implies a theory of culture (Spradley, 1980). The nursing handover is expressed in language and actions. There is complex meaning in the words nurses use to describe the care they deliver. A combination of language, words and actions forms the culture of nursing, and the culture of the ward.

This study is based on the ethnographic method of James Spradley, an ethnographer whose main work was completed during the 1970s. Spradley researched men who had lived long years on skid row as alcoholics. He used many examples from this study in his books on ethnographic interviewing and participant observation. Spradley's explanations of ethnography are easy to understand and follow for a beginning ethnographer. This is the reason why I chose this approach as the basis of my research methodology. However this is different to my ethnography, as I will not be living with the participants during my study.

### **The Ethnographic Research Cycle**

The ethnographer has much in common with the explorer trying to map a wilderness area. The explorer begins with a general problem to identify the major features of the terrain. Similarly the ethnographer wants to describe the cultural terrain. Then the explorer begins gathering information, going first in one direction, and then retracing that route, then starting out in a new direction. After weeks of investigation, the explorer would probably find it difficult to answer the question, "what did you find?" like an ethnographer, the explorer is seeking to describe a wilderness area rather than trying to 'find' something (Spradley, 1980).

The cycle begins with selecting an ethnographic project, taking into consideration the scope of the investigation. The scope can range along a continuum from a macro-ethnography (complex society, for example a hospital) to a micro-ethnography (a single social situation, for example a ward). Topic orientated ethnography narrows the focus to one or more aspects of life known to exist in the community (for example the nursing handover).

The next step is asking ethnographic questions. Unlike other forms of social scientific research, the questions asked by the researcher come from inside the cultural scene. Both questions and answers must be discovered in the social situation being studied. As data is collected new questions will develop, these will then guide the data collection.

Step 3 is collecting ethnographic data. The ethnographer observes the activities of people, the physical characteristics of the social situation, and what it feels like to be part of the scene. During the course of fieldwork the types of observation change and become more focused.

Step 4 is making an ethnographic record. This includes the taking of field notes, making maps, and interviews. This ethnographic record builds a bridge between observation and analysis.

Step 5 involves analysing ethnographic data. By analysing the field data compiled from participant observation, questions can be discovered. This needs to be done after each observation in order to know what to look for during the next period of participant observation and interviewing.

Step 6 is writing ethnography. This occurs towards the end of the research project. This generally leads to new questions and more observations. Writing ethnography forces the investigator into a new and more intensive kind of analysis (Spradley, 1980). Leininger (1985) used an ethnographic approach to advance clinical nursing practice. Her ethnonursing approach is directed towards discovering the people's cultural needs, views, beliefs, and patterned ways of life.

## Ethnonursing

Studying ethnography and using nurses as my research participants, I chose to use the approach of the nursing theorist Madeline Leininger. During the 1950s and 1960s she made the links between nursing and anthropology, formulating transcultural nursing concepts, theoretical principles and practices (Leininger, 1985). Nurses have used her theory and the conceptual framework for 'Cultural Care Diversity and Universality' worldwide for the last forty-five years to study culture.

Most of the nursing texts on qualitative research include at least a chapter on the ethnographic method (Leininger, 1985; Morse, 1989; & Morse & Field, 1996). These authors subscribe to the basic assumption that the goal of ethnography is to uncover the shared meanings of a cultural group via the methods of participant observation and interview.

Ethnonursing deals with studies of a culture like other ethnographic methods, but it is useful for understanding nursing practice and therefore generating nursing knowledge. It is a specific research method focused on documenting, describing and explaining nursing practice. This method was developed in conjunction with Leininger's theory of cultural care, diversity and universality, and the use of the method is guided by this theory.<sup>3</sup> Nursing practice guided by Leininger's theory is directed toward the provision of culturally congruent care (Leininger, 1985).

Ethnographic nursing research promotes understanding of the meaning of health and illness experiences for patients and providers. It can yield insights that are useful for promoting cultural change to improve nursing practice, for influencing health policy, and for addressing a wide range of problems in our society and health care systems. Every ethnography researching nursing practice, with its vividly detailed description, becomes a piece of nursing history.

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<sup>3</sup> See Leininger, M. (1985). *Qualitative research methods in nursing*. (Eds.). Orlando: Grune & Statton, for an explanation of Leininger's theory of Cultural Care Diversity and Universality.

The goal of nursing ethnography is more than increasing the understanding of nursing or patient culture; it should lead to an advance in clinical practice (Germain, 1985). Nurse ethnographers differ from other anthropologists in that they usually only live with informants in their working day and spend their private lives away from the location where the research takes place (Holloway & Wheeler, 1996). As I have mentioned earlier, I did not work in the ward during my data collection, merely visited to observe and interview.

### **Leininger's Phases of Ethnonursing**

The data analysis for this study was undertaken using Leininger's 4 phases of ethnonursing data analysis guide. This guide was developed and refined over several decades as part of the ethnonursing method to provide rigorous, in-depth, and systematic analysis of the data collected by qualitative ethnonursing research methods. Data analysis begins on the first day of the study and continues with regular data coding, processing, and analysis. The researcher uses the 4 levels of data analysis, and the data is continuously processed and reflected on by the researcher at each phase.

#### **First Phase**

*Collecting, Describing, and Documenting Raw Data.*

The researcher collects, describes, records, and begins to analyse data related to the purpose, domain of inquiry, or questions under study. This phase includes: Recording interview data; making preliminary interpretations; identifying symbols; and recording data related to the phenomenon under study, mainly for an emic (inside) focus, by attention to etic (outside) ideas.

#### **Second Phase**

*Identification and Categorisation of Descriptors and Components.*

Data is coded and classified as related to a domain of inquiry and sometimes the question under study. Emic and/or etic descriptors are studied within the context and for similarities and differences. Recurrent components are studied for their meanings.

### **Third Phase**

#### *Pattern and Contextual Analysis.*

Data is scrutinised to discover recurrent patterns of similar or different meanings, expressions, structural forms, interpretations, or explanations of data related to the domain of inquiry. The data area is also examined to show patterning with respect to meanings-in-context and along with further credibility and confirmation of findings.

### **Fourth Phase**

#### *Major Themes, Research Findings, Theoretical Formulations, and Recommendations*

This is the highest phase of data analysis, synthesis and interpretation. It requires synthesis of thinking, configuration analysis, interpreting findings, and creative formulation from data of the previous phases. The researcher's task is to abstract and present major themes, research findings, recommendations, and sometimes-theoretical formulations (Leininger, 1985).

This thesis will not attempt to formulate new theory. Chapters 4 and 5 apply phases 1-3 and chapters 6 and 7 apply phase 4. By using Leininger's 4 phases of ethnonursing I was able to analyse the data I had collected and abstract and present the major themes. Field notes from non-participant observations and transcripts of the audiotaped semi-structured interviews were the primary sources of data collection. Five nursing handovers between the morning and afternoon shifts in the medical ward were observed over a 1-week period. Field notes were taken during the observations and questions that developed from the observations were used to enhance the interview schedule, and were included in the data analysis.

## **Data Collection**

### **Non-participant observation**

Non-participant observation is the method used when the observer has no input into the activity or people being studied. This method was chosen for the study, as it was important to capture the non-verbal cues, attitudes, power struggles, body language and verbal reactions used in the nursing handover, as reflected in the aims and purpose of the study.

For me to be a participant observer I would have had to work in the ward for a period of time. This was not possible due to my work commitments and not required when using Leininger's ethnonursing approach. During the handovers I observed and took field notes and did not intend to participate in the handover process. I was aware that my participation as a senior staff member of the organisation could change the dynamics of the group, and the process.

Non-participant observation enabled me to observe and record the non-verbal cues, the setting, attitudes, rituals, language, and interruptions that took place during the handover. I also wanted to note any other factors that could significantly impacted on the handover process. On 3 occasions during my non-participant observation the nurses I was observing asked me direct questions. On 2 other occasions I could not refrain from giving advice, due to the nurse handing over incorrect clinical information to another nurse about a clinical procedure I was very familiar with. The safety of the patients was a real concern for me.

Being a non-participant observer in such a familiar setting was a new experience for me. Having decided I was a non-participant (not a passive one), the first time I inadvertently stepped out of this role I was unsure how to respond. I did reply in a short sentence, not knowing whether that was appropriate or not. As soon as possible I returned to my office and phoned my supervisor to ask for advice. She advised me that it was appropriate to answer a question when the safety of the patients was at risk, and that what I was experiencing was called the insider/outsider experience. I went back to Spradley and read:

You won't have this simultaneous insider/outsider experience all the time. On some occasions you may suddenly realise you have been acting as a full participant, without observing as an outsider. At other times you will probably be able to find an observation post and become a more detached observer (Spradley, 1980, p. 57).

He also explained that doing ethnographic fieldwork involved alternating between the insider and outsider experience, and at times having both simultaneously. So I followed up the clinical procedure I had advised on with the ward's Clinical Nurse Leader the next day ensuring that she was going to address this with the staff member. All of these events happened during the last 3 of my 5 observations. This may be due to the fact that the staff had become accustomed to having me present during the handover and no longer regarded me as a researcher but sought my professional advice as an insider.

Participant observation is a method whereby the researcher becomes totally immersed in the study of a group or a culture, participating while observing and recording what has been observed. Research studies using this technique expect the researcher to spend months or years living and working with the group under study in order to observe and record new, rich and valid data (Seaman, 1987). An ethnographer must work out a participant role that enhances data collection and blends in with the life of the participants being studied. This is influenced by the design of the study, the research purpose, the aspects of the culture being studied, and the ability of the ethnographer to assume tasks that are a natural part of the subculture under study (Germain, 1985).

### **Locating the social situation**

Participant observation and non-participant observation can be done in a variety of settings. A common feature of all setting is that all participant observation takes place in a social situation. This means that the first step in doing ethnography is to locate a social situation (Spradley, 1980).

Every social situation can be identified by three primary elements: a place, actors and activities. Any physical setting can become the basis for a social situation as long as it has people present who are engaged in activities. Each ethnographer begins with a single, identifiable place for participant observation (Spradley, 1980). This physical place is a primary element of any social situation as it gives meaning to the material and non-material aspects of culture being enacted. The ward of a large base hospital was the social situation for my study.

Every social situation includes people who are considered particular kinds of actors. In selecting a social situation it is not necessary to distinguish various types of actors, one only needs to know that people are present who are actors because they are engaging in some kind of activity (Spradley, 1980). The nurses and other ward staff were the actors in my study.

With repeated observations, acts become activities; sets of activities can then be linked together into larger patterns called events. The ethnographer begins by observing and recording activities in a social situation, as work proceeds, the structure of events will become clear (Spradley, 1980). The activity under investigation was the nursing handover.

### **Interviewing within ethnography**

A semi-structured interview format was used with the questions emerging from my non-participation observation sessions. Nurses were interviewed at a time and place convenient to them. The reason for the interviews was to develop a better understanding, gain more insight into the themes emerging from my observations, and to better understand what the nurses felt were the main reasons why the nursing handover either did, or did not adequately prepare them for the next shift.

The ethnographer encourages the participant to expand on their initial responses during the interview. It is important to develop a harmonious relationship to provide a basic sense of trust and a free flow of information between the two. The semi-structured approach to the interviews ensures flexibility so that issues could be discussed as they arose.

The interviews began with an open-ended question: Tell me what you need to know during the nursing handover that adequately prepares you for the next shift? An attempt was made to ensure the questions were open-ended and encouraged the nurses to explore the adequacy of the handover in depth yet focused enough to ensure that the aims of the research study were covered.

Nine of the ten interviews were performed on the ward at the request of the nurses. The tenth interview was carried out in a quiet room next to my office as the nurse chose to come in on her day off to be interviewed. On the ward I mainly used the 'bad news room'<sup>4</sup> as it was generally empty and quiet, and the nurses felt comfortable using it.

The majority of the interviews were between twenty and thirty minutes in length. One interview had many interruptions from staff as it was held in the equipment room, and consequently I failed to push the record button on my tape recorder, so I had to scribe what I remembered from this interview when I got home. Nine out of ten of the interviews were carried out after a morning shift had finished. All participants were offered a copy of their transcripts.

### **Accessing participants for the study**

Access was gained to the ward and the staff by my attendance at a ward meeting to explain the research. The nurse educator for the ward provided support by accompanying me to this meeting. He suggested that if anyone wanted to talk further about being part of the research study they could contact him.

I indicated to the nurses the time frame in which I hoped to complete the study and requested that they return the consent forms to me if they chose to participate in the interviews within 2 weeks. I explained that I would firstly be observing 5 handovers and these would be followed up by individual interviews with the nurses who volunteered.

I left an information sheet and consent form for all of the registered staff nurses on the roster, and wrote a short explanation in the communication book, so as staff not on duty would understand the reasons for me carrying out the research in their ward.

Return of consent forms for interviews was slow at first, however during my week of non-participant observations and the first week of interviews I received

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<sup>4</sup> The 'bad news room' is defined on page 40.

more completed consent forms. I believed that after asking the first nurse what the interview process was like, more nurses chose to consent. I had ten nurses to interview.

All of the nurses working in the ward at the time of my observations were participants in the study, as they were all actors in the handover process. They included both registered and enrolled nurses. All ten nurses interviewed were female registered nurses. Three of the participants had extensive experience in medical nursing. One had been nursing for thirty years in total, and 3 of the nurses had worked in the ward for more than 6 years. The remaining 6 participants had worked in the ward for less than 3 years. Six of the nurses had Bachelor of Nursing Degrees, 3 had Comprehensive Diplomas in Nursing, and 1 was a Registered Obstetric and General Nurse.

## **Ethical concerns**

Health Funding Authority approval to conduct the study had to be given before the study could proceed. An ethics proposal was submitted to the local Health Funding Authority Ethics Committee. After some points of clarification the application was approved. The General Manager of the hospital and the Director of Nursing also supported the application.

During my initial contact with the ward nurses, a question regarding anonymity for them and the patients was asked. I indicated to them that I would not disclose any information about them, or the patients in the ward at the time of my data collection as, like them, I had signed a confidentiality contract when I began working at the hospital. It was important for the collection of the data that the nurses felt secure and able to share their experiences with me. All field-notes, interview tapes and transcriptions were kept in a locked filing cabinet in my home. I transcribed the interview tapes.

Access to the tapes and the interview transcripts were only available to my supervisor and myself. At the completion of the study the audiotapes will be kept for the next ten years. If the participants wished to retain a copy of the taped interview or transcript, it was made available to them. In the final report

numbers were used instead of names so participants could not be identified, and details of the research location were not published.

Informed consent was an ongoing negotiated process. Each interview participant was given an Information sheet (see Appendix A) outlining the study and any questions they had about the research were answered. All participants were given the name and contact telephone numbers of both the researcher and the academic supervisor so that any concerns could be addressed.

The study was discussed and questions answered before the participants gave consent to participate in the study. Each participant was asked to complete a consent form (see appendix B). These were kept in a separate filing cabinet from the transcripts of the interviews. Participants were clearly told that their willingness to participate in the study or their withdrawal from the study at any time would not adversely affect their nursing career in any way

Consent for the researcher to observe and take field-notes during the nursing handovers was granted on a daily basis, by the researcher asking the co-ordinator of the shift to check with the nurses involved in each handover session, to consent to having the researcher present. As mentioned, patients' privacy was upheld by the researcher being a member of staff and having signed a confidentiality contract with the employer on employment, stating that no patient information would be disclosed to the public. Confidentiality was upheld as no information that would have identified the nurses or the ward was used in this study. Nursing jargon which may have identified the specific area of practice was removed from the verbatim comments before being used.

Lincoln and Guba (1985) discuss trustworthiness in qualitative research. They criticise the use of quantitative criteria such as reliability and validity, as inappropriate for qualitative studies and propose an alternative framework for examining studies in the naturalistic paradigm.

Credibility refers to the truth, accuracy, or believability of the findings that have been mutually established between the researcher and the participants as accurate, believable and credible (Leininger, 1985). Credibility was attained in this study when the participants saw the research findings as truly representing their nursing handover. The research participants were all given the opportunity to read the field notes and the findings from the data. The findings were also compared with other sources of information, such as literature.

## **Conclusion**

The literature reviewed on the nursing handover outlined the nursing handover as an avenue for sharing of information, socialisation, debriefing, and carrying out of rituals. It did not show whether handovers prepared nurses to adequately care for their patients. An ethnographic method seemed appropriate for a study that attempted to understand how the handover prepared nurses for the next shift. By using observations and interviews I was able to see what nurses were saying and doing during this process and compare this with the data from the interviews.

If nurses were able to articulate why they were not always adequately prepared during the nursing handover, and I was able to compare this with my observations, I may be able to make recommendations for change to practice. Patient care may be enhanced as a result of these findings and could lead to improved health outcomes. The analysis of the observations and interviews has the potential to increase nurses' awareness of the importance of being prepared, and may lead to them handing over more effectively.

Being a nurse ethnographer in a health care setting has advantages as it enables the capturing of data that may be missed or deemed insignificant by an ethnographer who is not a nurse (for example, understanding the procedures being discussed during the nursing handover). Nurse ethnographers also have the advantage of being trained in interviewing, knowing the language of health care, already being part of the culture, and understanding the norms and values of the environment as an insider.

This chapter has described qualitative research, ethnography, culture and the links between them. The ethnographic research cycle and Ethnonursing, as defined by Leininger, are described, and how I used the latter for my data analysis. Lastly ethical concerns, informed consent, and confidentiality are discussed.

The following chapter describes the ward setting in which I observe the nursing handovers.

## **Chapter 4**

### **The ward setting and the nursing handover**

#### **Introduction**

The purpose of this chapter is to describe the ward setting in which the research study took place, the nursing handover as I observed it, including the handover method used by the nurses in the ward. As previously mentioned, the social situation for the study was the ward setting, the nurses and other ward staff were the actors, and the nursing handover was the activity. The first step in doing ethnography is locating the social situation.

#### **The ward setting**

The medical ward chosen for this study was similar to any other ward in a large base hospital in New Zealand. The Hospital's Director of Nursing selected this ward as the setting for my research as it was typical of wards throughout the hospital.

The ward was on the fourth floor of an old hospital building that had recently been redecorated. The new colours chosen for the redecorating were the Board's corporate themes of cream and turquoise. There was a mixture of single and four bedded rooms with a central corridor and 24 bed spaces in total. The physical environment was generally tidy and bright.

The ward office was situated half way down the ward's main corridor. It consisted of an L-shaped bench for writing on, chairs, fridge, microwave, notice board, white board (on which patients' names, nurses' names, room numbers and tests and treatment details were written), computer, phones, book case, fax machine, and water cooler.

This room was situated next to the reception area and the doctors' office. It opened out onto the main ward corridor. Large windows on the corridor side

were covered with net curtains to give some privacy to those using the ward office but also permitted observation of the main corridor from the office.

Although the ward office was untidy there was a general sense of controlled untidiness. Large windows looked out onto the next building and the room was small, hot and stuffy. The main corridor of the ward was always busy with relatives and friends visiting patients and a constant flow of people delivering goods, meals, mail, transferring patients and carrying out the usual duties of a busy hospital ward.

On the other side of the reception area there was another small office that was used by the Clinical Nurse Leader and it too opened out on to the main corridor. A few meters away from the ward office on the internal side of the main corridor there was a room with a table, a white board and some chairs. This small room was an unusual shape, as though it had been a left over space in the plan when the ward was upgraded. This room had no windows but a clear glass panel in the door covered with a piece of paper so no one could see into the room from the main corridor.

The label on the door read 'interview room'. The nurses called it the 'bad news room' because it was the room where the doctors took patients and their families to tell them 'bad news'. It allowed for privacy and confidentiality in contrast to the public nature of 4-bedded rooms, and was big enough to accommodate 6-8 people. It was the only quiet space in the ward.

Just inside the main doors of the ward was the patients' lounge. Patients, relatives and their friends frequently used this space to meet, as it was more private than the bedrooms. This room was also very small. Although there was a sign on the front door of the ward stipulating specific visiting times, it seemed that visitors could enter the ward at any time.

The rest of the ward included a treatment room, a sluice room, a kitchenette, bathrooms, toilets, linen cupboards, small waiting areas, and a phone bay. The

floor was carpeted to diminish the noise level. The main lights were generally left on to give a sense of brightness to the otherwise dark main corridor.

The following is a summary of my observations of the nursing handover.

## **The nursing handover**

Like most other general wards there was a high turnover of staff nurses and a busy work environment. The ward had 24 beds and a mixture of registered and enrolled nursing staff. This meant that the enrolled nurses worked under the direction and supervision of registered nurses. Most of the registered nurses were in the first 3 years of practice after completing their undergraduate degrees leading to registration. The total number of nurses in the ward made up 23.2 full-time positions.

Staff sickness and/or predicted heavy workloads often meant nurses from the hospital's own nursing agency were deployed to the ward. Although these nurses were familiar with the hospital, they were not always used to working in this specific ward, so they too needed direction and supervision to care for their allocated patients. A combination of junior registered nurses, enrolled nurses and agency nurses meant that the senior registered nurses spent a large proportion of their day supervising other nurses' practice as well as carrying a patient workload, which generally included caring for the sickest patients.

The nursing handover took place in the ward office. The ward used a traditional verbal handover process. All nurses in the proceeding shift were expected to document the care they had delivered to their patients in the patient's clinical notes, and verbally hand over care that was required for the next shift to the incoming nurses. Any changes to the patients' conditions or tests ordered by the medical staff were communicated along with the patients well-being and tasks that needed to be performed, medications required to be administered, and a general overview of the current status of each patient.

The afternoon staff began to gather in the nursing office fifteen minutes before commencement of the afternoon shift time at 2 45 p.m. This pre-handover

phase was an opportunity to find out how busy the ward was, and discuss or debrief the events of the previous afternoon shift also. Questions were asked about specific patients around practice issues. The questions asked were often to clarify events from the previous shift with the Clinical Nurse Leader. This was generally done to ensure the nurse's actions were appropriate for that situation; a debriefing and reflecting session, where anyone could join in.

To assist with the repetitive nature of recording information about each patient on the ward, the nursing staff during the handover process used a computer generated shift report sheet. The nurses called this report 'the global'. On one side of the report sheet was each patient's name, age, diagnosis, (medical) history, and a column to write current information about the patient. This continued over the page and included a grid formation for the nurses to use to plan and prioritise the care they would deliver on the incoming shift.

One of the responsibilities of the nurses on the morning shift was to update the computer-generated shift report sheet for their shift, to ensure the information on the sheet was accurate and up to date, and copies were printed ready for the incoming staff to use as a reference during handover. Sometimes this shift report sheet was used by other members of the staff such as physiotherapists and occupational therapists as a reference when treating patients within the ward environment.

The arrival of the Clinical nurse leader at 2 45 p.m. signalled that it was time for handover to commence (generally the door was shut at this stage), and she would state something like: *Lets get this show on the road (field notes, observation 4)*. If there were any housekeeping items to be discussed these would be dealt with first, along with clarification of any care delivered over the past twenty-four hours that had come to the attention of the Clinical Nurse Leader because it was unsatisfactory or inappropriate.

The main handover would then begin with the nurses concentrating on their computer-generated shift report sheet as the Clinical Nurse Leader moved quickly and efficiently through the list of all the patients in the ward. As

mentioned above, the patients were all listed on the white board and the Clinical Nurse Leader used this as her reference point. Although the main objective was for the Clinical Nurse Leader to give an overview of the entire ward of patients, some of the information was quite detailed.

She accepted interruptions and used a mixture of formal and informal jargon and abbreviations specific to the work area and nursing to communicate to the nurses. These included: *Stable obs, IV ABs continue...needs all the bits and bobs, no dramas, a bit overloaded (field notes, observation 4)*. She also frequently made suggestions and recommendations for practice.

During this stage of the handover ward staff wanting to use the microwave, the fax machine, or the phone, or to retrieve something from the fridge frequently opened the door. Due to the busyness of the corridor the frequently opened door had implications for patient's privacy and confidentiality. Also the constant interruptions meant the nurses were often distracted and the Clinical Nurse Leader would frequently have to repeat the information she was giving. This part of the handover, including interruptions, took approximately fifteen minutes.

It officially ended with the Clinical Nurse Leader leaving the room after ensuring that everyone had a clear overview of what was happening for each patient in the ward, and that the person she had allocated as co-ordinator for the afternoon shift on the duty roster was sufficiently informed to allocate the patients for the nurses to care for during the next shift. This role was important as the Clinical Nurse Leader finished work at 4 00 p.m. and there needed to be someone appropriate to make decisions about the management of the ward in her absence. This position was allocated to the most senior registered nurse.

The door would then be shut again and the next phase of the patient-nurse allocation would commence. This was the responsibility of the co-ordinator for the afternoon shift. The shift co-ordinator would work out who had been working on the ward the afternoon before and would usually reallocate them the same patients. Patients were generally allocated by rooms and each nurse

would care for between 4-6 patients. If a nurse requested a change of patients because they found one of the patients difficult to care for, or felt that a patient was too complex for their level of skill and knowledge, that was generally acceptable. Patients were allocated according to the experience and status of the nurses on the incoming shift. The enrolled nurses were given the more stable patients, and the registered nurses were given the more complex patients.

This could take from 10-15 minutes depending on the number of staff. How vocal the staff were indicated how long the process would take to complete, and the skill of the nurse co-ordinating contributed to this. Time allocated for the staff to have a meal-break of thirty minutes was dependent on those who preferred first or second tea break and/or those who were non - smokers and smokers were generally grouped together.

There was generally a fair amount of negotiating as the co-ordinator tried to meet the individual needs of all the staff, keeping in mind the varying degrees of patient acuity and the need to keep a mix of registered nurses and enrolled nurses on the floor at any one time, in case of an emergency. This phase took the same amount of time as the handover of all the patients from the Clinical Nurse Leader.

The remaining fifteen minutes of double shift time was used for one-one individual handovers. The majority of the time this was performed in the nursing office with the door open, where there could be up to 4-5 individual handovers happening simultaneously, involving 8-10 nurses. This meant the noise level was high. The open door again had implications for the patient's privacy and confidentiality.

Some nurses left the ward office, and were seen handing over in the corridor or any other quiet space they could find. None handed over at the patient's bedside. The hand written notes that the morning shift nurses had added to their computer generated shift report form throughout the shift, guided the information that was being handed over. Very few nurses referred to the

patients' medication and observation charts, and no one handed over using the patient's clinical notes as a reference.

The individual handovers were not dissimilar to the Clinical Nurse Leader's and in some cases in less detail and in others more explicit detail was given. Nurses generally went through the events for that patient for that shift retrospectively. They would list all the things that had happened for that patient during the shift, including such things as personal cares, tests received and doctors' visits.

The incoming nurse often received handover from more than one morning nurse as the patients were moved from one bed space to another to accommodate admissions, transfers and patients who had deteriorated. Interruptions were common during the individual handover process as well. Nurses would be called away to take the phone, assist with patient care and talk to doctors or relatives.

Tasks that needed to be performed were explained in detail with time frames, for example, intravenous therapy regimes, wound dressings and catheter changes. Nurses waiting to go home, who had completed giving their handover would join in on other nurses' handover. On one occasion all handovers were stopped momentarily so the nurse on the phone in the office could clarify quantities when ordering asparagus for staff members. Although this was not typical, interruptions were common.

*A staff member enters the office to hand over the drug keys. Now 4 nurses are handing over at once... nurses waiting to handover join in, this takes about 5 minutes... only 2 staff are left in the office now, the rest line up outside the door as if waiting to catch a bus, I guess they are waiting to be told they can go home (field notes, observation 3).*

The morning shift ended at 3 30 p.m. Most verbal handovers were completed by this time. The nurses who had been working during the morning shift began to leave the ward to go home, or sat down to write the care they had delivered in the patients clinical notes, or they completed any tasks that had not been

finished before the handover began. Unfinished work was not generally handed on to the next nurse, even if this meant that the morning nurse stayed late. If there was still time before 3.30 p.m. the morning shift nurses generally sat and chatted. During this post handover phase the topics of conversation were not focused on patients, but family issues, holidays and life outside of work.

The only exception to the routine of the nursing handover was when there was a planned inservice education session, or a ward meeting indicated on the white board to commence at 3.15 p.m. The individual handovers were not given and had to wait until the inservice education session or ward meeting was completed. This meant that the morning staff did not finish work on time, and often rushed their individual handovers.

## **Conclusion**

This chapter has described in detail the ward setting used for this study, and the nursing handover process. The ward was chosen as it was similar to most wards in the hospital and the staff members were supportive of the research. The ward used the traditional verbal handover approach. The handover process mostly took place in the ward office and was delivered in 3 parts, firstly the Clinical Nurse Leader gave an overview of the patients, then patients were allocated to nurses, lastly each individual nurse handed over their patients to the incoming nurse who would be caring for their patients for the next shift. In chapter 5 the major themes that emerged from analysis of the observations and interviews are discussed.

## Chapter 5

### Needing to Know

#### Introduction

The analysis of the data revealed 4 major themes relating to the nurses' preparedness after the nursing handover. Needing to know about, Needing to have, Needing to know how to, and Needing to acknowledge. These themes describe how prepared nurses perceived they were for the next shift and what they identified as important to have handed over. The following analysis emerged from both the interviews and observations.

#### The major themes:

**Needing to know about** relates to the tasks, procedures, and patient history information nurses needed to know to adequately care for their patients during the next shift.

**Needing to have** relates to knowledge and skills nurses needed to have to adequately care for their patients.

**Needing to know how to** relates to knowing how to manage time and share information effectively to be adequately prepared for the nursing handover.

**Needing to acknowledge** relates to taking into consideration the changes to the noise level and constant interruptions that are part of the nursing handover, as well as being able to identify with being human.

#### Needing to know about

##### Tasks and procedures

Certain tasks and procedures needed to be carried out for patients in hospital on a regular basis, to ensure they were given the best opportunity to recover from their current illness. These were sometimes complex and took time to prepare and complete.

To be able to complete these tasks and procedures within the designated shift, the incoming nurse had to gain enough information about each procedure or task that they needed to perform, during the nursing handover. Some examples were things such as the giving of medication, monitoring or patients using technical equipment, carrying out of procedures such as testing the blood sugar levels, recording the input and output of food and fluids during a 24-hour period, and the taking of vital signs.

Nurses interviewed named a variety of tasks and procedures that they believed needed to be handed over to ensure that patient care was delivered effectively.

*You need to know all the things like IVs, antibiotics, blood glucose, all those set things that you use in your time clock, all that type of stuff you need to put in. Especially if I have just come on after a couple of days off and I don't know the patients well, then kind of like when they came in, what they are up to, and what the prognosis is (interview1, nurse 1).*

Individual patient's personal care needs were completed for each patient, in conjunction with a number of tasks and procedures. Nurses interviewed said that they did not want to know about the patients' individual personal care needs in any great detail during the nursing handover... *I don't want to know that they have been showered... and I don't want to know that they have been bed sponged, because that's general care, that's routine care, you know, I would expect to get or to do (interview 5, nurse 5).*

The times that certain tasks and procedures were due was important, because often they were dependent on being administered at regular intervals. If for some reason they were not given on time, this could mean that the patient's condition might deteriorate.

*What has been done, what hasn't, and then the current therapy that they have, you know things that they are having done, like if they are on telemetry etc. ... even things like if they are on an IDC (interview 3, nurse 3).*

During the night shift, tasks and procedures that needed to be completed at 2, 4, or 6 hourly intervals took longer to complete, as there were only 2 nurses on the ward to take care of the patients. During the morning and afternoon shifts there were generally between 5-7 nurses. The night nurse interviewed indicated that she needed to question the day staff more specifically to get enough information to carry out her work. With less nursing staff to cover the night shift, knowing when things were due to be given or completed was even more important.

*The most important things are things that relate to me on night shift, so those things that are relevant to know are when drugs are due, as in IV drugs, due immediately because I need to get onto that first. Things like [the] patient's condition, like how often things are due (interview 8, nurse 8).*

If the nurse had previously cared for the same patient, they only wished to know any changes to that patient's plan of care. Significant events were such things as a sudden deterioration in the patient's condition or a complex procedure that had been carried out during their shift.

*I am quite capable of reading, so they do not need to read everything out on the global, so all they have to do is just tell me what patient, what procedures have been done for today, and what procedures will need to be done for the shift... and if there have been any significant events during that day (interview 2, nurse 2).*

Less experienced nurses were more inclined to handover more significant events. Sometimes it was the first time they had encountered such a significant event and they wanted to share the experience with their colleagues. *Perhaps the tasks have been under control but they haven't put them into place, why they have been doing what they have been doing, why did this happen, and they can't put it all together (interview 9, nurse 9).* More experienced nurses only handed over what they deemed it was necessary for the incoming nurse to know, to care for the patient during the next shift.

If a patient had become unwell during the afternoon shift, the night staff then needed to know what had been done about it, and what was the ongoing plan of care for that patient. Being specific only came with experience, and unless the nurse handing over had worked at night, they were often not aware of the limitations that working the night shift placed on performing tasks and procedures on time.

Tasks and procedures were seen as a priority, to be handed over even though they were also written in the patient's clinical notes, drug chart, observation chart, on the white board in the ward office, and featured on their global sheet as well.

*Mrs P, blood glucose up, on Actrapid 24 tds, blood glucose up at lunch time, due at 5, tested urine, neg. ketones, asked her to mobilise more, Actrapid 24 at night, Immovane as well, not needed panadol, legs dry and scaly, hands tender, for dietician referral, been here, infected left heel site, doctor aware, marked and dressed (field notes, observation 1).*

Detailed accounts of tasks and procedures to be performed, along with a list of routine cares carried out for each patient, meant that each individual handover took a long time to complete. Less complex patients who were not having a large amount of intervention could be handed over more quickly. More complex patients, who had many tasks and procedures that required a level of knowledge and understanding to carry them out, could take longer to handover.

Before the nurses left the ward office to start their shift, they needed to have made a plan of how they were going to manage all the tasks and procedures due to be completed for their groups of allocated patients. If they did not understand each patient's needs individually, there was the potential for them to miss something, as they became busy completing routine cares.

Although the nurses' interviewed said they did not want to know about the routine personal care that the nurse handing over had completed for their allocated patients, like showering and dressing, this is exactly what nurses handed

over to each other in great detail. This showed what they had been doing for the last 8 hours, not what the patient required for the next 8 hours. It was as if they had to justify what work they had completed during the shift.

*Mrs T, unwell overnight, basically sepsis, multiple UTIs, puss draining from supra pubic catheter, now removed, IDC in, woken up, sat up and ate scrambled eggs, given some morphine, she was a bit dozey, no family in today, need family meeting for Resus status (field notes, observation 3).*

Multiple places for documentation of these tasks and procedures meant that there were several opportunities for the nurse to read what needed to be completed for their shift. The nurses handed over with the global sheet that was often not updated, and held information that was not always correct. No one took responsibility for ensuring that the global sheet information was correct, except for the night nurse who ensured it was up to date when she was on duty.

The patient's clinical notes were not used during the nursing handover because the nurses interviewed said they were not available. Making the patient's clinical notes available during the nursing handover would not have been very difficult, as they were located in the doctors' office next door. All the nurses needed to do was tell everyone that they had the notes for handover in the ward office, and that they would be available again at the end of handover. This may have the potential to cause more interruptions, however it would be a lot safer option than an inaccurate and out of date global sheet. The patients' clinical records were always available for doctors' rounds.

The difference between the information the night nurses sought and gained during the nursing handover and that of the afternoon staff was more explicit. The night nurses need for specific, detailed, and relevant information meant that they had to be able to ask relevant questions to gain appropriate knowledge about their patients. If you compare this to what the nurses who worked during the day said they needed to know, it shows the vigour of the night staff to get it right. They did not have the same resources available to them that the day nursing staff had, nor did they have as long a handover time as the day nursing

staff. Their overlap in time was generally only thirty minutes, not forty-five minutes.

Having to complete all tasks and procedures before handover placed pressure on the nurses who, because of no fault of their own, may have not physically been able to complete them. The incoming nurse did not usually offer to do this work for them, even if it would have benefited the patient. Lack of group cohesion meant that the morning nurse stayed and completed something that could have been handed over.

### **Patient's history**

Obtaining an accurate patient history was vital if the nurse was going to be able to care for them. This included such information as the patient's name, age, gender, current medical diagnosis, past medical history, previous admissions to hospital, nursing assessment, and a general run down of their condition for that day. *Whether there has been deterioration in the patient or an improvement in their general condition (interview 5, nurse 5).*

If the nursing handover was being delivered to someone who had not cared for the patient before, then the history given was generally more in-depth than the handover given to a nurse who had previously cared for the patient.

*If I hadn't seen the patient before I'm probably asking history questions, whereas if I have had the patient the day before it may be I just need some follow up questions... like what's happened throughout the day, whether they have had a good day, a bad day, how things are going (interview1, nurse 1).*

*The age, the primary diagnosis of the patient, also their background and relevant needs, and I think a brief run down of what may have happened in the duty, but its more about what needs to be looked at for the next twelve hours, the key things to look at (interview 9, nurse 9).*

The patient's general condition could change rapidly therefore it was important to know what had happened for each patient on a shift by shift basis.

*Changes to their status, anything that has happened during the day, have they had a fall, if they have had mobility hassles, if something hasn't been reported but they noticed it during the day, if there is ongoing stuff, with some patients if they have passed urine, that sort of thing, an IDC has been removed, changes from IV's to orals, whether the IV antibiotics have been ordered (interview 6, nurse 6).*

Each patient's history was already documented on the global sheet, and in their clinical notes. During the handover, as previously mentioned, it was repeated again, even though the incoming nurse had a copy of the global in front of them. Some nurses gave an in-depth lengthy patient history that went back to their admission date and covered a range of topics from what circumstances brought the patient to be in hospital to their lifestyle at home.

Time was spent during the nursing handover discussing the patient's social issues and sharing concerns about their ability to cope on returning home. Aspects of adequate support, family situations, having to care for others, and coping with poor resources were common topics of discussion. Although important aspects of the patient's history, these discussions were often what slowed the handover down, as most staff felt the need to express their opinion. Other more important things were sometimes not handed over as the nurses ran out of time.

Keeping the patient's history brief and factual was difficult, especially if the history was interesting and unusual. Being able to give enough patient history information for the nurse to care adequately for the patient for the next shift, but not describe the entire patient's clinical notes was often hard.

Even when it had been established that the incoming nurse had previously cared for the patient, the handover contained information that they would already know, nurses still repeated history information. The incoming nurse however did not stop them and indicate they already knew this, but would let the nurse handing over repeat it all again, just in case I believe there was some new information that they did not know. Some nurses began to doodle and show with their body language that they were bored, but they never indicated

this to the nurses handing over. Large amounts of time were therefore wasted on delivering the same history information that the incoming nurse already knew.

The other extreme was the nurse who had previously cared for the patient but insisted on hearing it all again, even though they could have read it in the patient's clinical notes. This was frustrating for the nurse handing over, the incoming nurse interrupted often to ask questions that they should have already known. None of the nurses challenged these behaviours.

Changes to the patient's status were always handed over. Predicted changes for the next shift were not always made as clear by the nurse, depending on their level of knowledge. It was important for the incoming nurse to have a good understanding of the changes to the patient's status, as there was a possibility they would develop further changes during their shift.

In summary, the nurses interviewed identified needing to know about the tasks, procedures and history in detail for each patient that they were responsible for. How well this was communicated to the nurse during the nursing handover determined how prepared they were to then care for their patients. Repeating information already written down, or known, was a common factor noted by the nurses, and during my observations.

The time spent doing this may have been better spent in the planning of care for the next shift. With no planned approach to delivery of this information, adequately preparing the nurse to carry out tasks and procedures based on receiving an accurate up to date patient history was not always possible. Maintaining the nurses' interest in the patient handover process only happened when the information was relevant. These behaviours would continue however until the nurses themselves challenged each other's practice.

## Needing to have

### Knowledge and skills

Knowledge is gained through experience. Skills are learnt by practising something until you become familiar with it, and have the ability to repeat it. Gaining knowledge and skills of how to effectively hand over patient care adequately only comes with experience and practice.

*Yeah a lot of it depends on the experience of the nurse, if it's a younger nurse you might know to question them a bit more closely, not always the way, but if the nurse has been here a bit longer they probably know what you are going to be looking for so they are more inclined to know about ongoing monitoring... I guess it's about knowing what to ask (interview 6, nurse 6).*

The ward had recently employed a lot of new nurses. Comments were made about the lack of knowledge of the new staff members, and having to ask them more questions during the nursing handover.

*Currently I would say it is because a lot of the staff on the ward are new, and they have not got a lot of background speciality, or just general knowledge that is gained over time with practice, or intuition, or even general knowledge. They have not been here long enough to understand the finer details about the patients (interview 8, nurse 8).*

Nurses in the study describe how nurses used knowledge as power during the nursing handover.

*Sometimes it can be that there is a difference in what they think is required information, between what they think you know, and what you should look up for yourself. Like they will say that the drugs are 6 hourly, but they won't say when they last gave them, or they will say I can't remember or such (interview 1, nurse 1).*

Less experienced nurses' also talked about looking at the roster book where the shifts each nurse was working were written to see which nurses' were working

for the next shift, just in case they had to handover to someone who they felt threatened by.

*Handover still scares me, I know it is meant to be non-threatening. I just handed over to somebody this afternoon who I find not difficult to get on with, but is very direct in their approach and doesn't like being handed over things at the end of the day, like some days you just have days where you have to hand things over, and I have had to her, and I know before I start (interview 1, nurse 1).*

Knowing what questions to ask during the handover process only comes with experience also. Having more nursing experience enabled the nurse to more quickly assess what the nurse handing over was saying, and to know when to ask for more information. What was expected of them to discuss during the nursing handover surrounding patient care was not always clear. The nursing handover was a place where mistakes could be picked up so there was always an element of risk involved.

*Nurse A: Mrs D. day one post op, wound oozing through steri-strips, IDC draining well, query take out today.*

*Nurse B: Does it really need to be taken out today?*

*Nurse A: Well that's what the doc's said.*

*Nurse B: So the patient can go into retention in the middle of the night?*

*Nurse A: (shrugs her shoulders and moves onto the next patient)  
(field notes, observation 2).*

Having a lot of less experienced nurses meant that the nurses' delivered the best care they could for their patient for that shift. They used what knowledge and skill they had to make it to the end of the shift. Being able to match patient's needs with nurses who had an adequate level of knowledge and skill was not always possible. Often a complex patient was given to a nurse who required supervision to care for them appropriately.

Handing over was not easy on days when the knowledge and skills of the nurse did not match the needs of their patients. Repeating the information that was

already on the global I believe was the easiest way for them to handover care, and then they would wait for the questions that they knew they could not always answer correctly. The level of care the patient required therefore was not always reflected in the handover.

A lack of advanced nursing knowledge and skills is what nurses in the study discussed in their interviews, and this is what I observed during my non-participant observations. With few experienced nurses on the ward the less experienced nurses had to supervise each other. Nurses were not staying in the ward long enough to gain these advanced skills so they could be role models for new nurses.

In summary, needing to have knowledge and skills is as important as knowing about tasks, procedures and the patients' history. Without the knowledge to know why certain tasks and procedures were being performed, or how a certain aspect of a patient's history could be relevant to their care, made the whole concept of being adequately prepared for the next shift seem overwhelming. Having excellent role models with advanced practice skills, and nurses staying in the ward long enough to gain adequate knowledge and skills are key components to a well-prepared and implemented handover.

## **Needing to know how to**

### **Manage time**

The actual time of day that tasks and procedures were due to be completed was essential for the incoming nurse to know, to be able to complete a time clock. A time clock is a grid where each hour is represented on a horizontal axis and each patient's name is written on the vertical axis. Tasks and procedures due to be completed for a patient are documented in the corresponding square on the grid formation and used as a guide during the shift.

*I like to work with the charts and that gives me a lot of the time clock stuff, I would handover with my charts to show I have given things, what time things are due, it's also a double check because you can make sure that you have given something (interview 1, nurse 1).*

Admissions, transfers, complex treatments, sudden deterioration of a patient, or even a death of a patient meant that being able to manage ones time effectively often became more difficult.

*Even though you have divvied it up on the board 4 – 5 patients, like that nurse might have had 3 discharges and received another 3 patient's. So that means they have had 7 patients in one day and the thing is that you are still trying to get rid of the paper work for the ones you had in the morning and you are still trying to catch up on what's going on for the patient's that have turned up in your room (interview 2, nurse 2).*

Rushed handovers happened when the individual handover process was delayed by an inservice education session, which generally was delivered in the ward office. The inservice sessions would generally last between twenty and thirty minutes. Sometimes the ward was extremely busy and everyone was late handing over. *I think that sometimes it would be nice to allow a bit more time... especially when the pressure is on us about having inservice afterwards, I hate it, I absolutely hate it (interview 5, nurse 5).*

*Sometimes at the end of the day you have done so much, you couldn't actually put it all into perspective, and think what have I done for this patient, and you have done a million thing, but it all gets scrabbled, and trying to actually unravel it and make sense of it and give your colleagues a few things is hard (interview 9, nurse 9).*

The development of a time clock to be used as a guide for delivery of care was common among the nurses working in the ward. More experienced nurses relied on their memories and only referred to their written time clock at the end of the shift, to make sure they had not missed anything. Constant changes due to admissions and discharges to the number of patients that any one nurse could be caring for made it more difficult to complete everything on one's time clock.

On busy days handing over became more complex as the nurses who had been working in the ward for that shift struggled to work out which patients they

were still caring for, as mentioned earlier. This often meant that the nurse would rush through their individual handover as they were already late off work. During these rushed handovers nurses would give the bare minimum amount of information required to the incoming nurse. It was my observation that a more precise and accurate handover was often given when there were time restraints imposed due to meetings, extremely busy days, or inservice education sessions.

In summary, being able to complete all of the allocated work for the group of patients you were caring for, before individual handovers began meant that the nurses had time to plan what they were going to say during the handover. Without time to prepare, the nurse often struggled to handover accurately. Not using the patient's clinical notes or treatment charts as a guide, meant that unless the nurse had written it on their time clock then things could still be missed.

### **Share information**

By using the computer generated shift report sheet that they called the global the nurses' did not have to repeatedly write down the patient's name, medical diagnosis and ongoing treatment during each handover session.

*I wouldn't say that it [the global sheet] would equip you with everything you need because some people don't update it, or don't have time to update it, or some of the stuff may be old that's on it. So it is not something that you can always guarantee to be correct (interview 3, nurse 3).*

Interrogation by the night staff when receiving handover was talked about several times during the interviews. The night nurse when questioned about the supposed interrogation agreed that her questioning could be seen this way. *I will stop and challenge what they say because I want it clear in my mind because I have to rely on what they say for my shift (interview 8, nurse 8).*

When the night nurse was asked if she received adequate information after interrogation of the nurses handing over she said:

*Most of the time, but often only because we have prompted and questioned, or challenged what they have said, to get them to be more specific... because of lack of time at the beginning of the shift we have to rely on what they say... if we are not happy with what we have heard we will go straight to the notes, or the drug chart, whatever we are having a discrepancy about, to read it more accurately, to get a better picture of what we have to do (interview 8, nurse 8).*

The use of the global sheet did not speed up the process of handing over patient care, but was said to make it easier for the nurses' receiving the handover. It was often used as a guide during their shift and when handing over also. Patients were seen as a good source of information, especially when the nurse handover had missed some vital piece of information. A patient was often able to fill in the gaps. Patients sharing the same room were also another source of information and often could answer questions about their room mates care with accuracy.

One of the reasons given for information being missed out during the handover was that the nurses did not know that they were supposed to handover that information. This happened most frequently when nurses had come to the ward to help from another ward, or were agency nurses, who had a lack of knowledge in this specific area, so could only handover according to their limited knowledge of the speciality area. The Clinical Nurse Leader and the doctor caring for the patient were seen as alternative sources of information for the nurse to use, if they could not understand what was going on for their patients.

The nurses were very quick to point out when another nurse had not carried out their work appropriately. Very few nurses commended each other for delivering excellent nursing care during the handover. The nurses said that they learnt how to handover patient care by listening and watching others handover. They quickly learned to discern those who were skilled in the process. Inability to hand over patient care adequately was not challenged, even the next day

when things that were not completed or incorrect were picked up. The handover therefore was not being used as a teaching tool.

If the nurse could not find the answer to some aspect of care for their patient, with all other options exhausted, the nurse caring for a patient would phone the nurse previously caring for the patient at home to clarify the aspect of care for their patient. However more often the nurse from the previous shift phoned in from home to say they had forgotten to complete a task or procedure for one of their patients, or document something they had done. They had gone home and in a quieter environment thought about their day and remembered something they had forgotten to hand over, or complete.

Before the development of the global sheet a nurse would start handover with a blank piece of paper and would write down what they thought was significant to know for each patient. This process did not slow the handover down and meant that the nurse handing over kept to the facts because they knew that the nurse had to document them for themselves.

The traditional verbal handover used in this ward left no room for patient's to have input. Although the nurses claimed it was a good start they did not have any suggestions for how the current handover could be improved. Reliance on the global sheet meant that the nurses did not necessarily have the opportunity to write what they felt was important to know. If a patient had been included in the handover process they may have picked up on anything missed by the nurse handing over. The information shared by the nurses' at the bedside would have focused on what support was required with input from the patient.

In summary, knowing how to accurately share information during the nursing handover made it easier for the incoming nurses to prepare themselves for the next shift. The ability to share knowledge appropriately came with experience. This became easier if the workload of the nurses' matched their ability and skill level, then they were able to manage their time effectively and were ready to share information when it came to handover time. Never being challenged regarding poor practice, lack of time management skills, or an inability to share

information, meant that the nurses' handing over might never know that their handover was not good enough. There were no review processes in the ward of the content of the nursing handover.

## Needing to acknowledge

### Noise levels

During the individual handover sessions the noise level in the office increased. This session included up to twelve people in the same area, with 6 of them verbally handing over to each other at the same time. While this process was taking place other health professionals entered and exited the office adding to the noise level. *Yes it's really awful you can't hear yourself think (interview 3, nurse 3).*

The nurses' interviewed described how they learnt to cope with this level of noise.

*You do get used to it, when you first start you think oh! But after a while you actually get used to it, and you can see it happening, if you watch people you can see them tune out to just the two of them and everything else can be going on around them and these two people will just, you know (interview 1, nurse 1).*

When discussing the noise level in the individual nursing handover one nurse said: *Often it's not possible to listen which is a factor of sorts... if the phone rings things like that can be distracting, and you're not getting the full picture of the patient (interview 3, nurse 3).*

The noise level in the ward office was due to a number of factors. The number of nurses in the office at any one time, doctors' assessing patients, and relatives visiting patients and seeking information about their care from the nurses and doctors. This included the movement of equipment from one room to another as patients were moved to allow space for incoming patients. Phones ringing, staff communicating with each other down the main corridor, a constant flow of orderlies coming to drop off and pick up mail, collect specimens and patients who needed to leave the ward for tests and procedures. This usually meant checking with the nurse caring for the patient before they could leave the ward. All this took place while the handover was in progress.

During my first observation in the ward the social worker was using the office phone to talk to a patient's relative. Although the handover had commenced he was not asked to transfer this call to another room and continued to speak loudly during the entire handover. This could have had implications for the privacy and confidentiality of this patient.

Other health professionals who were not included in the nursing handover process continued to make noise during this time also. The social worker could have been asked to use the phone in the main ward office while the handover was taking place. Being able to cope with the noise level during the nursing handover was part of the being a nurse in this ward.

Occasionally one of the nurses handing over would take the incoming nurse to the bad news room or the treatment room to handover where it was quieter. More often than not they would just stay in this environment and try and handover as best they could. Making no effort to control the level of noise by shutting the ward office door, telling others to be quiet, leaving the environment to find a quieter place, or diverting the phone and holding all messages, meant that the nurses did not hold the handover process up as being important. The other health professionals were not going to do anything to help this process until the nurses communicated to them that it was not okay to make so much noise.

In summary, needing to acknowledge that the ward environment is a busy place and a noisy one does not excuse the nurses from being proactive when it came to how the nursing handover would be carried out. With very little effort they could have ensured the noise level was at a minimum. Being well prepared to handover their patients did not make a difference if they were unable to be heard by the nurse they were handing over to. This had the potential to lead to unsafe practice as things may be missed.

## Constant interruptions

The fridge, fax machine and computer were within the office where the handover took place. This meant that the other health professional constantly needed to access these facilities to effectively continue their work. *Doctor J. opens the door and uses the fax machine, while he's waiting for the fax to go through he asks one of the nurses if Mrs A's blood pressure has settled, she stops handing over to answer him (field notes, observation 3).*

It was accepted behaviour to interrupt, ask question, and call a nurse to the phone during the handover.

*If you have been involved with another nurse doing their patient [helping them to care for their patient] you tend to listen in and try and help them out, with handing over as well. But otherwise you try to focus on the person you are handing over to because it's really terrible in there, all the nurses are rrrr... and some if they have finished before the others they start talking and it's really frustrating (interview 5, nurse 5).*

*Nurse A: Mr O went down for CT, found infarct, speech deteriorating.*

*Nurse B: Not allowed to eat and drink then? Nurse A: Yes he can, fasting bloods in am... Receptionist enters and indicates to nurse B. to take the phone, she leaves the office to do so then returns minutes later. Nurse B. tells Nurse A. it was about Mr X. (another patient) and they have a brief discussion about Mr X. Nurse A: Back to Mr O. Another nurse enters the room and hands Nurse B. the drug keys. Now there are 4 nurses handing over at the same time, the nurse next to me has obviously finished her handover and gives directions to another nurse as to how to get to her house. Another nurse waiting to handover joins in (field notes, observation 3).*

Lack of a designated area for nurses to hand over in meant that the ward office was the only place available. The nurses interviewed spoke of not having the choice of a better environment in which to handover patient care, and could not think of any alternative area to the current office space. There were however a few other options within the ward like the bad news room, the equipment room, or even the doctors' office as mentioned earlier.

*Maybe a quiet area rather than all the time having other people around and yeah that room is not big enough. Our own separate room would be better and more private... handing over to someone and people are coming and going...often I come into the room and say lets move out. I find that I can't absorb what I need to and listen to other people instead. It's not good (interview 7, nurse 7).*

Other health professionals would enter the office space before they realised they were interfering with the nursing handover, even though the handover happened at the same time every day of the week. This however did not stop them from coming into the office or disrupting the handover to discuss patients. At no time did nurses indicate to the person interrupting that this was inappropriate as the nursing handover was in progress.

Due to the small size of the ward office and the large number of windows in it, in summer it was always hot and stuffy. If the door was closed it was difficult to maintain any airflow through the room. During winter with the heating on in the ward it also became hot and stuffy. Having the door open meant more staff came in and out of the office space providing more interruptions. The nurses claimed staying awake at any time in the ward office was difficult.

No sign was placed on the door of the office indicating that the nurses' were in a meeting and were not to be interrupted. The nurses did not see the handover as a significant nursing event in this ward, or they would have challenged anyone who came and interrupted them while they were delivering or receiving handover. Being constantly interrupted meant the incoming nurse could potentially miss vital information being handed over to them. Some interruptions were inevitable in such an environment, however decreasing the amount of them was a possibility that none of the nurses ever mentioned.

In summary, having a designated space for nurses to call their own, did not automatically mean that they would no longer be interrupted during the handover process. A plan needed to be put in place to minimise these interruptions. This needed to come from the nurses themselves. Being adequately prepared to receive information about the group of patients they

were allocated to care for was made more difficult for the nurses in a noisy environment with constant interruptions.

## **Being human**

All nurses interviewed in this study commented that not all nurses could get on with each other all of the time, and that there were situations in the ward where personalities clashed for some reason or another.

*So I think it could be different personality types, what one thinks is important compared to what the other one thinks... personalities can be a problem. Sometimes you might handover to this person, I know that I handover more detailed information to some people than to others, I know some girls are more casual with their approach and they are quite happy, they want the bare minimum from you (interview 1, nurse 1).*

*We have a few here where the personalities have just clashed and it's like I've got to handover to her! So you just, yeah that's it and leave and if you don't like it well go and read the notes (interview 2, nurse 2).*

Giving information that the nurse did not need to know was often spoken about during the interviews.

*Well sometimes it's just the nurse; a lot of it is just the nurse. Because a lot here give information you don't really need to know, well I don't think it's really important to know that, what they have handed over, like they will give you every single detail about the patient (interview 2, nurse 2).*

Being lazy or forgetful was also mentioned by 3 of the 10 nurses interviewed.

*Everybody's handover varies, from staff member to staff member. You have got some who may be a bit forgetful and some who may be bit lazy, or you know, personality, individuality with the nurses as well makes it a lot harder (interview 3, nurse 3).*

The nurses interviewed also commented on being tired and exhausted. They spoke of just wanting to handover and go home.

*We have all been through that where we just want to get out of here so you just handover what you know, and what you can remember that you have done, and then you go home (interview 2, nurse 2).*

*More busyness than tiredness, they are so busy that they haven't got time to sit and think things through, so they don't get everything done, that's when we tend to challenge everything they say (interview 8, nurse 8).*

Most of the participants acknowledged that there was a large workforce of nurses and that everyone could not get on all of the time. The nurses interviewed said they took this into consideration when handing over to someone whom they did not particularly like, and they would try really hard to at least get on with the person while they were at work. During my observations it was clear that some nurses' did not feel comfortable handing over to other nurses, however it did not effect the way they handed over it just meant that they did not stay after they had finished to chat.

In summary, maintaining a good working relationship with the nurses that you were working with was vital in ensuring that they handed over enough information for you to adequately manage your workload for that shift. Receiving information that wasn't necessary was common, however no one ever challenged their colleagues for doing this.

Without a peer appraisal system, or peer pressure to challenge the giving of information that was not required or inadequate, forgetfulness, and laziness, these practices were not likely to change. If the environment was too noisy, interruptions were frequent, and the nurse was handing over to someone they did not particularly like, then the likelihood of an adequate handover was decreased.

## **Conclusion**

Being able to communicate effectively during the handover was important for the new nurses to become part of the culture of the ward. Delivery of patient

care could not be carried out without the support of other nurses. Nurses required good role models to be able to understand what information should be shared in the nursing handover. With few experienced nurses on the ward this was difficult, especially if the less experienced nurses ended up working together on the same shift.

Nurses relied on the global sheet to hand on patient care. They rarely utilised the information available to them in the patients' clinical notes. The nurses did not communicate to other health professionals that the handover was important and significant to them, and that during this time they should not be interrupted.

The opportunity to test ones own knowledge and that of other nurses was not engaged in as clinical scenarios were not discussed, or followed up. Nurses were asked to manage complex workloads with little specific education about their condition. Making the best of the limited time meant that nurses had to make a choice whether formal or informal teaching could occur was necessary, appropriate and acceptable. The handover was an opportunity to teach a variety of topics both formally and informally as clinical aspects of patient's care were discussed and knowledge was shared.

A sense of belonging to the ward, nursing or organisational culture may not happen if nurses did not stay long enough to gain essential knowledge and skills to care for the specific types of patients in this ward. Matching workloads with nurses' ability was not always easy to accomplish. There needed to be a culture of support created for each other and teamwork, as was evident on night shift. Learning how to prioritise the workload so that the nurse could be adequately prepared for the nursing handover was important.

For the nurses learning how to get on with each other was part of learning to become part of the culture of nursing in this ward. Being able to communicate patients' needs effectively, use the nursing handover as an education tool, and socialise new nurses into the work environment was vital if the handover was going to adequately prepare the nurse for the next shift. In the following

chapter the concepts of communication, education and socialisation will be used to discuss the findings in light of the literature surrounding the nursing handover.

## Chapter 6

### Discussion

#### Introduction

The purpose of this study was to enable nurses to recognise the significance of their role in delivering the nursing handover, and the impact this has on direct patient care. The aims of the study were: To identify how prepared nurses perceived they were for the next shift at the end of the nursing handover; to describe what nurses identify as important to hand over to the nurse on the next shift; and to examine the processes by which nurses deliver the nursing handover. The research question was: Does the nursing handover adequately prepare the nurse for the next shift?

This project has identified that the nurses in the study perceived that they were not always adequately prepared for the next shift during the nursing handover. The data from this research suggests that the nurses frequently needed to access further information from a variety of other sources to ensure the provision of safe care to their patients. However, the findings indicated that the nursing handover is still important for nurses' preparation. Recommendations are made in the following chapter for suggested changes to make it more effective.

The nursing handover between morning and afternoon shifts has historically been used not only for communication of information related to the handover, but for both formal and informal education, and the socialisation of nurses for both working in the specific area and for developing their professional role. It has also provided an opportunity for nurses to debrief following significant events that impact on their practice.

This discussion will present and examine the findings under the headings of communication, education and socialisation. The findings will be discussed in relation to the research question and the literature pertaining to the nursing handover as reviewed in chapter 2.

## Communication

The fundamental purpose of the nursing handover is to communicate information to the incoming nurses that will adequately prepare them to work for the next shift. The actual process of handing over care has not changed dramatically in the last fifty years. In 1949 Barrett spoke of a well-organised handover as being one that emphasised 'important points', was unhurried, and uninterrupted unless an emergency occurred. While over fifty years later the same method is used an effective handover can not be guaranteed.

The nurses in this study perceived the fundamental requirements of what they needed to communicate during the nursing handover as knowing about tasks and procedures to be performed. Using a computer generated shift report they said made it easier to focus on what was being handed over. The nurses also identified that not repeating everything that was already written on the global sheet was important. The global sheet was only useful when it was accurate and updated on a regular basis.

Despite what nurses said they needed to know, my observations showed that during the handovers they frequently repeated everything written on the global sheet and shared information that was already known to the incoming nurses. There was no indication from the incoming nurses that they did not want to have the information read to them, or that they already knew the information being communicated to them. This supports McMahon's (1990) findings when he discussed the information shared during handovers. He suggested "that maybe the time has come to re-examine what nurses were saying" (McMahon, 1990, p. 39).

The global sheet was used as a substitute for the patients' clinical notes, and did not always provide an adequate overview of the patients' clinical needs. The nurses in the study did not however suggest that using the patients' clinical notes as a guide might enhance their ability to hand over care more effectively. Sherlock (1995) argued that using the patients' clinical notes as a basis for handover may improve the accuracy of the information communicated. Greater

use of the written documentation available may also give a better framework, and perhaps more consistency to the nursing handover.

This study supports Wolf's (1989) notion that new graduate nurses learn the language of nursing during the nursing handover. The observations of the nursing handovers in this study showed nurses use a variety of technical, descriptive, and abbreviated jargon when handing over care. The nurses also used slang or lay language to describe some aspects of nursing care. Jargon used for communication needs to be learnt by new nurses to the area so they feel part of the ward culture. As Wolf (1989) suggests communication is a vital element for transmitting cultural norms and mores, and as mentioned, jargon is an important element of this.

Other health professionals share much of the jargon used by nurses. In particular doctors and nurses share Latin terms and medical abbreviations (Payne, Hardey & Coleman, 2000). It is during the nursing handover that the language of nursing specific to the area of practice is learnt. Abbreviations were commonly used by the nurses during this study as seen in earlier chapters. Holloway and Wheeler (1996) proposed that communication systems include the common values and ideas acquired in learning from other members of the group.

Wolf (1989) refers to jargon as professional nursing language that serves to express complex meanings without lengthy discussion. Nursing jargon has been developed and used to ensure efficient use of time during the nursing handover. Wolf (1989) also claims the use of jargon consciously or unconsciously excludes non-nurses from nurses' discussions. This language form defines the nurses as a group, and is an important aspect of solidarity. It is where nurses demonstrate they are part of the professional group and at the same time seek group validation. Jargon such as IDC, obs, tds and ABs was used by the nurses in this study.

Research conducted by Parker, Gardner and Wiltshire (1992) stressed that the nursing handover constructs a collaborative narrative about the patients and

that nurses tend to package and stereotype patients using the accepted jargon of the specific area. The nursing handover enables the nurses to 'paint a verbal picture' for the incoming nurses. An example of this is describing a group of patients with similar conditions using one term, for example CHF patients (congestive heart failure) or CORD patients (chronic obstructive respiratory disease). The nurses in this study used specific terms for groups of patients with similar conditions also and sometimes called this the 'primary' diagnosis of the patient. Many patients had multiple conditions. The condition that was the reason for their current admission was always given first.

Nursing has traditionally been an oral discipline, as Parker (1996), and Parker and Wiltshire (1995) suggest the handover has traditionally provided a focus for the verbal exchange of information about patients. McMahon (1990) contended the handover also gives nurses the opportunity to discuss a range of general nursing issues, ward issues and sometimes social issues. Such things were discussed during this study as housekeeping matters, outcomes of patients' treatments, education, and hospital-wide events and social events such as ward outings, dinners, etc.

The literature also affirms that the nursing handover is a place where nurses can discuss aspects of their work that they would not generally talk about to their families due to the "disgust, distaste and strong mixed feelings they arouse" (Parker, 1996, p. 22). The findings in this study outline nurses describing in graphic detail such things as the removal of catheters, invasive procedures and the condition of wounds and infections. These things would generally not be discussed at home.

As for McMahon's 1990 study, the findings in this study showed that knowing how to share information was seen as important. When tasks and procedures were due was important to communicate as some medication and procedures were prescribed to be administered at regular intervals. Patients' social issues were also discussed during the nursing handover, sometimes in great detail and this took up large amounts of time.

This study supports McMahon's (1990) findings that when nurses communicated all the things that they had done during the day "this was enormously time consuming and unnecessary and left little time for debriefing and support" (McMahon, 1990, p. 39). However McMahon's findings were based on general observations, not part of a formal research process.

Although nurses during this study supported each other during the handover process this time was not used as an opportunity to debrief events that occurred during the shift. Less experienced nurses in this study who wanted to share significant events they had encountered for the first time during their shift did not always get the opportunity to do so. This was generally due to a lack of time.

During shortened handovers, as previously mentioned, nurses communicated more precise and accurate information due to imposed time restraints and the desire to go home, as they were already late finishing their shift. This also happened when the nurses were handing over to the night nurse who questioned them repeatedly for fuller information until she felt adequately prepared.

While sometimes the nurses in this study revealed that obtaining adequate information was difficult, they claimed retaining it became even more difficult due to constant interruptions and a noisy work environment caused mainly by other health professionals on the ward during the handover. Nurses in this study found these factors to have a significant impact on the quality of the handover process. The literature does not explore the effects that noise and interruptions have on the nursing handover, except for a brief mention from Barrett (1949) about reports being interrupted only in an emergency.

### **Methods of handover**

Parker (1996) who supported both the traditional verbal handover and the bedside handover suggested that the verbal handover communicated highly relevant information and was presented in a systematic and focused way.

Whilst the traditional verbal handover in a ward office was used by the nurses in this study to communicate patient information, the nurses recognised the significance of including patients in the handover process. When they did not receive adequate information during the handover they would often ask the patients where possible for further information about their own care requirements. The Clinical Nurse Leaders overview of the patients occurred in the ward office with no direct patient input. The individual handover process did not directly include the patients either.

Other methods of handing over patient care were addressed in the literature review in chapter 2 (Baldwin & McGinnis, 1994; Howell, 1994; McKenna, 1997; Mosher & Bontomasi, 1996; Parker, 1996; Prouse, 1995; Webster, 1999). Webster (1999) suggested that patients should be an important part of the communication between shifts and contended that if the handover takes place at the bedside the nurses were more focused on articulating the support the patient required for the next shift. However, as Parker (1996) explains there is a possibility that the nurses handing over may not include the patient.

As previously mentioned, maintaining patient confidentiality could also be a problem when handing over at the bedside, especially in a 4 bedded room. Parker (1996) also recognised that including the patients in the bedside handover is complex, and she suggested that nurses needed to learn how to communicate effectively using this method, while at the same time maintaining patient confidentiality.

Although the bedside handover as an alternative to the traditional verbal handover process was discussed most in the literature, the other 2 methods of tape-recorded and silent handovers also have their merits. With tape-recorded handovers interruptions and questions are eliminated, but debriefing and discussion do not occur. Silent handovers were seen as concise and consistent with less chaos and noise, although debriefing did not occur and clinical records needed to be up to date.

The findings indicate that the nurses in this study did not convey any other way of handing over patient care although they felt that the current method was not effective. However, Mosher and Bontomasi (1996) made a point when they said that it is what is communicated in the report, not the reporting method itself that determines the effectiveness of the handover process.

In summary, the nursing handover is expressed in language and actions. There is complex meaning in the words nurses use to describe the care they deliver. Communication is an important aspect of all nursing care, where nurses communicate with each other through verbal, non-verbal and written mediums. However, failure to communicate lies at the root of most complaints. This failure is often associated with the lack of liaison between nurses. Continuity of care relies on current patient information being passed on at handover, so that the incoming nurse can plan and implement care for their patients.

Many factors influence the degree of communication during the handover. These include the accuracy of the written communication, the ability of the nurses to hand on relevant information, and the capacity of the incoming nurse to understand what is required to care for their group of patients. If any one of these is inadequate then patient care may be compromised.

Lack of time for nurses to debrief about significant events was also a factor highlighted in this study. Making another time apart from the nursing handover for this to occur may improve the overall communication among the nurses. Nurses taking ownership of the nursing handover as being fundamentally important to their every day practice would ensure that the nursing handover continues as a key component for the communication of nursing practice.

## **Education**

Another function of the nursing handover is to educate nurses about specific clinical knowledge and skills required to deliver care for their patients for the next shift. Scales (1958) over forty years ago suggested the handover provided a focus for nurses' education. Senior nurses handing over needed to demonstrate an understanding of each patient's requirements. Scales was supported by Clair

and Trusell (1969) eleven years later who suggested that it was during the handover that nurses learnt how to be a nurse. They proposed that further interaction in the form of questioning should occur between the nurse handing over care and the nurses receiving this information.

Knowing how to answer any questions asked during the handover was identified by the nurses as important in this study. The risk of making a mistake made them cautious when handing over to more experienced nurses. They said that gaps in their knowledge and skills might be identified if their answers to the questions asked did not satisfy the incoming nurses.

Education on how to ask questions appropriately during handover needed to be delivered to all new nurses as they had generally had little opportunity to do this during their nursing training. As Parker (1996) claimed, the nurses did not often use opportunities to extend their own practice when mistakes were identified and learning could occur from these experiences. The nurses in the study did not recognise these as educational opportunities.

Formal education sessions in the form of inservice education did occur in the observed handovers as mentioned earlier, although some of the nurses interviewed did not recognise the importance of these sessions as advancing their own clinical knowledge and skills. The nurses in the study said that they saw the sessions as encroaching on their time, and that they were too tired to absorb any education delivered as part of the handover process. However, they did not specify another more appropriate time during the shift when education might occur.

Informal education sessions did not occur in this study on a regular basis. The findings indicate that complex patient care regimes were not discussed during handover so new nurses could learn from these discussions during the nursing handover. During my observations I also noted that new nurses had limited numbers of experienced nurses to listen to and learn from during the nursing handovers. This study supports research by Elkman and Segesten (1995) that showed that the handover was not always used to develop, improve, make

visible or upgrade the status of knowledge in nursing care for the nurses in the ward.

According to McKenna (1997), Rowe and Perry (1984), and Wolf (1989), providing education both formally and informally as part of the handover ensures that new nurses advance their knowledge and skills through listening to their peers. Without a planned approach to inservice education new nurses did not have the opportunity to improve their nursing care delivery for this group of speciality patients.

Parker (1996) highlighted that education needs to facilitate nurses learning about the complex dimensions of their practice. More opportunities for formal and informal education sessions would have enhanced the nurses' ability to hand over care adequately and maintain the nursing handover as a key element for the education of nurses.

## **Socialisation**

The distinctive language of the working nurse is used during the nursing handover as 'seasoned' nurses teach novice nurses what it means to be a nurse (Wolf, 1989). The handover historically took place in the ward office, away from the patients. It is the oral tradition of the ritual of the handover that is mostly discussed in the literature available (Barrett, 1949; Elkman & Segesten 1995; Lally 1999; Scales, 1958; & Strange, 1996).

Elkman and Segesten (1995) recognised the ritual of the handover as an important element of socialisation for new nurses. It socialises the new nurses into their professional roles. As mentioned above it is the ritual of the nursing handover that provides oral communication in a formal context that is ideally respected. It is here that the new nurse is initiated into the language, values and culture of the professional nurse. The nurses in this study did not recognise the nursing handover as a ritual, but they took an active part in its ritualistic processes and recognised the importance of having a nursing handover.

Strange (1996) recognised that the handover held a social function to promote group cohesion. The nurses in this study discussed group cohesion when they expressed a need to work together on a professional basis even though they did not always get on with each other. They saw group cohesion and taking responsibility for patient care to be important elements for the smooth running of the ward. It was noted during my observations that some nurses gathered before and after the nursing handover to chat socially. Support was also evident for the new graduate nurses coming into the area. Socialisation is about newcomers learning how to take on their expected roles.

Strange (1996) suggested that the handover was where power, control and responsibility for patients were transferred from one shift of nurses to the next. Having nursing experience was sometimes used as power during the nursing handover as previously mentioned. In this study less experienced nurses expressed fear when having to handover to someone more experienced than they were. More experienced nurses sometimes ask complex questions during the handover and expected all care to be completed despite the busyness of the shift. My observations showed that the incoming nurses did not often offer to complete work for their colleagues that had not been completed due to the busyness of the ward. As if this was some form of initiation into the culture of nursing in this ward.

Constant interruptions were also part of the ward culture as well. As long ago as 1969 Clair and Trusell stated that the handover was often 'taken for granted'. The findings of this study outline that until other health professionals are informed of the importance of handing over patient care in an environment with minimal noise and interruptions nothing would change. However, some of the interruptions came from the nurses themselves who had finished handing over their patients and felt a need to add verbally to the other nurses' handovers. This practice was then seen as normal to new nurses as they were socialised into their new roles.

As previously mentioned some of the nurses' personalities clashed. The nurses interviewed acknowledged this as being human and not being able to get on

with everyone all of the time. Some of the reasons given for the clashes were said to be nurses being lazy, handing over information already known, being forgetful, wanting to go home and the stress of working in such a busy environment. Efforts were made to maintain a sense of professionalism during working hours.

As mentioned above, the nurses in this study indicated that many nurses did not stay in the area long enough to gain advanced levels of knowledge and skills. As highlighted by du Toit (1995) this meant that overall there were fewer role models to provide support for new nurses as they became professionally socialised. With fewer role models, the nurses' socialisation into the culture and profession of nursing may take longer to achieve. The nursing handover has traditionally provided an avenue where more senior nurses assist new nurses to become part of the culture of the ward and nursing (Barrett, 1949; Strange, 1996). Therefore, the nursing handover remains a significant factor for the socialisation of nurses.

## **Conclusion**

The nurses interviewed outlined clearly what they identified as important to have handed over to them so that they would be adequately prepared for the next shift. My observations showed that the majority of nurses when handing over recited the list of tasks and procedures they had completed during their shift, rather than prospectively providing the information required by the incoming nurses. This suggested that while the nurses recognised they have a role to fulfil during the nursing handover, they did not always recognise its significance.

The change in skill mix following constant restructuring of the hospital, and difficulties with retention and recruitment of nurses, have led to insufficient experienced nurses being available to role model an ideal handover process. This has meant the ritual of handover has continued on the ward but it is not fully meeting the needs of preparing the incoming nurses. The nursing handover needs to be recognised by nurses, other health professionals and general hospital staff as a key component of nursing practice. Consideration

needs to be taken to establish where to deliver the nursing handover to minimise the effects of noise levels and interruptions.

The nurses in this study did not always feel prepared for the following shift. They needed to search out further information about their patient. While the Clinical Nurse Leader provided a structure for the handover, the nurses did not always have the expertise to effectively provide the necessary information. Nurses are under constant pressure to make the best use of their time. As the handover is often lengthy and sometimes involves up to 8 nurses, attempts are often made to reduce the amount of time spent handing over or to change the method.

The findings of this study identified the handover as having three key components: communication, education and socialisation. These components are of equal importance. If during further restructuring the traditional method of handover is replaced in the name of efficiency, other avenues will need to be created where information can be communicated, education can be delivered, and socialisation can take place. This study has revealed that the nursing handover is recognised as fundamental to nursing practice. The following chapter will identify the strengths and limitations of the research and make recommendations to improve the effectiveness of the nursing handover.

## Chapter 7

### Conclusion

The nurses in this study perceived that they were not always adequately prepared for the next shift at the end of the nursing handover. They frequently needed to access further information. Recruitment and retention problems have resulted in hospitals being short of nurses with adequate experience to provide the necessary role modeling to ensure nurses' handover appropriately.

The handover needs to be recognised as a significant part of nursing practice where nurses hand over responsibility for their group of patients to the nurse on the incoming shift. This promotes the safe care of patients and provides a focus for communication, education and socialisation of nurses. It is vital for nurses to recognise the importance of the handover, and to set aside a suitable place and adequate time where unnecessary interruptions and noise will not be a problem.

This chapter outlines strengths and limitations of the study, and makes recommendations for practice.

### Strengths

Using an ethnographic approach enabled me to recognise and make explicit my role as nurse, as well as researcher. It enabled me as a member of the same culture to interpret and analyse my findings as I speak the same language, understand the cultural norms and mores of the nurses, and the ward environment.

Ethnonursing is useful for understanding nursing practice and therefore generating nursing knowledge. It is a specific research method that focuses on describing and explaining nursing practice through observations and interviews. In doing so it yields insights that promote cultural change and improve practice.

The goal of ethnonursing is to advance in nursing practice, through understanding the culture of nursing and the context in which it takes place.

One of the strengths of using this method was it allowed me to capture the non-verbal cues, attitudes, power struggles, body language and verbal reactions of the participants within their own work environment, and these proved a basis for the questions used for the interviews. The data collected from the non-participant observations and the interviews gave me the opportunity to analyse the nurses' interview responses in light of the observations. For example, comparing what they said, with what I saw. This led to my further understanding of why the nursing handover was not being delivered effectively.

Because I was part of the culture the handovers were less effected by my presence than they would have been if I had been a researcher from outside nursing, and the hospital. My experiences as a staff nurse, nurse educator, and Charge Nurse in the same unit enabled me to develop a clear understanding of the setting, and the nurses' roles in the setting. My acceptance was demonstrated when the nurses asked me questions about the patients.

## **Limitations**

One of the limitations of this study was that I had to learn the method of ethnography while I was doing the study. While I was an insider, sometimes I was so close to the setting it was difficult to overcome the urge to participate in the handover and give advice on patient care.

Observing the nursing handovers between all of the shifts during a 24-hour period may have provided further opportunities to attend handover in the same ward, where a different process was used. Because the handover between afternoon and night nurses, and night and morning nurses were shorter in length they may have provided further data for analysis. The size and constraint of time prevented me from doing this.

## Recommendations

The following are recommendations for improving the handover process to ensure nurses are well prepared to provide safe and appropriate care for their patients for the next shift.

- Review the current handover practices, and ensure they are focused on adequately preparing the nurses for the next shift.
- Provide ongoing review of handover practices to ensure they continue to meet the desired outcomes.
- Develop guidelines for handover practices for each ward/unit.
- As part of orientation provide support for nurses new to the area, and student nurses to gain adequate knowledge and skills to be able to effectively handover care.
- Repeat the research in another ward/unit and include all handovers in a 24-hour period.
- Research the handover practices in other hospitals in New Zealand and compare the findings to promote more effective handover practices.

## References

- Baldwin, L., & McGinnis, C. (1994, September). A computer-generated shift report. Nursing Management, 61-64.
- Barrett, J. (1949). Ward Management and Teaching. New York: Appleton-Century-Crofts, Inc.
- Benner, P., & Wrubel, J. (1989). The primacy of caring. California: Addison-Wesley publishing company.
- Boyle, J. S. (1991). In Morse, J. M. (Eds.). Issues in Qualitative Research Methods. London: Sage publications.
- Burns, N., & Groves, S. K. (1995). Understanding Nursing Research. London: W. B. Saunders Company.
- Chenitz, W. C., & Swanson, J. M. (1986). From practice to grounded theory. California: Addison-Wesley publishing company.
- Clair, L., & Trussell, P. (1969). The change of shift report. Hospitals J.A.H.A., 43, 91-95.
- Denzin, N., & Lincoln, Y. (1994) (Eds.). Handbook of qualitative research. Thousand Oaks: Sage publications.
- Du Toit, D. (1995). A sociological analysis of the extent and influence of professional socialization on the development of a nursing identity among nursing students at two universities in Brisbane, Australia. Journal of Advanced Nursing, 21, 164-171.
- Elkman, I., & Segesten, K. (1995). Deputed power of medical control: the hidden message in the ritual of oral shift reports. Journal of Advanced Nursing, 22, 1006-1011.

Gehring, F. (1973). In Munhall, P., & Oiler, C. J. (Eds.). *Nursing research: A qualitative perspective*. Norwalk, CT: Appleton-Century-Croft.

Germain, C. P. (1985) In Munhall, P., & Oiler, C. J. (Eds.). *Nursing research: A qualitative perspective*. Norwalk, CT: Appleton-Century-Crofts.

Helman, C. G. (1990). *Culture, health and illness*. Oxford: Butterworth Heinemann.

Holloway, I., & Wheeler, S. (1996). *Qualitative Research for Nursing*. Oxford: Blackwell Science Ltd.

Howell, M. (1994). Confidentiality during staff reports at the bedside. *Nursing Times*, 90 (34), 44–45.

Lally, S. (1999). An investigation into the functions of nurses' communication at the inter-shift handover. *Journal of Nursing Management*, 7, 29-36.

Lamond, D. (2000). The information content of the nurse change of shift report: a comparative study. *Journal of Advanced Nursing*, 31 (4), 794–804.

Leininger, M. (1985). Ethnography and ethnonursing: models and modes of qualitative data analysis. In M. Leininger (Ed.), *Qualitative research methods in nursing*. Grune & Stratton: Orlando.

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Sage Publications: California.

McKenna, L. (1997). Improving the nursing handover report. *Professional Nurse*, 12 (9), 637–639.

McKenna, L., & Walsh, K. (1997). Changing handover practices: one private hospital's experiences. *International Journal of Nursing Practice*, 3, 128–132

- McMahon, R. (1990). What are we saying? Nursing Times, 86 (30), 38–40.
- Miller, C. (1998). Ensuring continuing care: styles and efficiency of the handover process. Australian Journal of Advanced Nursing, 16 (1), 23 – 27.
- Morse, J. M. (1989). Qualitative Nursing Research: A Contemporary Dialogue. London: Sage Publications.
- Morse, J. M., & Field, P. A. (1996) Nursing research. The application of qualitative approaches. (2<sup>nd</sup> ed.). London: Chapman & Hall.
- Mosher, C., & Bontomasi, R. (1996). How to improve your shift report. American Journal of Nursing, 96 (8), 32–34.
- Muecke, M. (1994). In Morse, J. M., & Field, P. A. (1996). Nursing research. The application of qualitative approaches. (2<sup>nd</sup> ed.). London: Chapman & Hall.
- Parker, J. (1996). Handovers in a changing health care climate. Australian Nursing Journal, 4 (5), 22–26.
- Parker, J., Gardner, G., & Wiltshire, J. (1992). Handover: the collective narrative of nursing practice. The Australian Journal of Advanced Nursing, 9 (3), 31–37.
- Parker, J., & Wiltshire, J. (1995). The handover: three modes of nursing practice knowledge. In Gray, G., & Pratt, R. (Eds.). Scholarship in the Discipline of Nursing. Melbourne: Churchill Livingstone.
- Payne, S., Hardey, M., & Coleman, P. (2000). Interactions between nurses during handovers in elderly care. Journal of Advanced Nursing, 32 (2), 277–285.
- Prouse, M. (1995). A study of the use of tape-recorded handovers. Nursing Times, 91, 40–41.

Rountree, K. (1993). Re-membering the witches and the goddess: feminist ritual-makers in New Zealand. PhD Thesis. University of Waikato.

Rowe, M. A., & Perry, A. (1984). Don't sit down nurse-it's time for report! Nursing Times, 80 (26), 42-43.

Scales, M. (1958). Handbook for Ward Sisters. London: Tindall and Cox.

Seaman, C. (1987). Research methods. Principles, practice, and theory for nursing. Sydney: Prentice-Hall.

Sherlock, C. (1995). The patient handover: a study of its form, function and efficiency. Nursing Standard, 9, 33-36.

Spradley, J. P. (1979). Participant Observation. Fort Worth: Harcourt Brace Jovanovich College Publishers.

Spradley, J. P. (1980). The Ethnographic Interview. Forth Worth: Harcourt Brace Jovanovich College Publishers.

Spradley, J. P., & McCurdy, D. W. (1979). Anthropology, the cultural perspective (2<sup>nd</sup> ed.). Illinois: Wavelean Press.

Strange, F. (1996). Handover: an ethnographic study of ritual in nursing practice. Intensive and Critical Care Nursing, 12 (2), 106-112.

Strauss, A., & Corbin, J. (1998). Basics of qualitative research. London: Sage publications Inc.

Webster, J. (1999). Practitioner-centred research: an evaluation of the implementation of the bedside hand-over. Journal of Advanced Nursing, 30 (6), 1375-1382.

Wolcott, H. F. (1990). Making a study "more ethnographic." Journal of Contemporary Ethnography, 19 (1), 44-72.

Wolf, Z. R. (1989). Learning the professional jargon of nursing during change of shift report. Holistic Nursing Practice, 4, 78-83.

## Appendices

Appendix A: Information Sheet

Appendix B: Consent Form

# **Appendix A**

## **Information Sheet**

### **The Nursing Handover**

You are invited to take part in this research looking at the nursing handover in one ward of our hospital. This information sheet will provide you with the information you will need to make a choice as to whether you wish to be involved or not. Your participation is entirely voluntary. If you do wish to participate please read the information and sign the consent form. At any stage if you decide to withdraw from the research no questions will be asked. The aim of this research is to answer the question “ Does the nursing handover adequately prepare the nurse for the next shift? ”

Participants are selected for this study if they are registered nurses who participate in the nursing handover on a daily basis. The theoretical framework used for this study will be Ethnography. The time span for completion of the study is one year. In a semi-structured interview of between thirty to sixty minutes (which will be audiotaped) you will be asked to answer a number of questions about the nursing handover. You do not have to answer all the questions. You may stop the interviews at any time. My supervisor and myself will study the information collected from you, analyse it to form the basis of my Masters Thesis. You will be given the opportunity to validate the transcription of the audiotape to ensure this is a true account of what you said. No one else will have access to this information and it will be stored in a locked filing cabinet in my home.

On completion of my analysis the audiotapes and written information will be offered to you, or destroyed. Your name will not be used anywhere in the report. No material that could personally identify you will be used in any reports on this study. When the audiotapes are transcribed I will give your information a number, not a name (i.e. nurse 1, tape one). The results of the research report will be available for you to read.

This study has received ethical approval from the Ethics Committee. The Director of Nursing and the General Manager of the Hospital have also given permission for this study to be carried out.

Please feel free to contact the researcher or her supervisor if you have any questions about this study.

**Student:**

Wendy Rowe

[REDACTED]

[REDACTED]

[REDACTED]

**Supervisor:**

Mary Finlayson

Massey University

Auckland

Ph: 09 443 9700 Ext. 9634.

## **Appendix B**

### **Consent Form**

#### **The Nursing Handover**

I have read and understood the information sheet for participants taking part in the study designed to explore the nursing handover. I have had an opportunity to discuss this study with the researcher. I am satisfied with the answers I have been given. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time. I understand that my participation in this study is confidential and that no material that could identify me will be used in any reports on this study. I have had time to consider whether to take part. I consent to my interview being audiotaped. I know whom to contact if I have any questions about the study.

I \_\_\_\_\_ (full name)  
hereby consent to take part in this study.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Full name of researcher: \_\_\_\_\_

Contact number of Researcher: \_\_\_\_\_

Project explained by: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_