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## COMMUNICATION IN NURSING SHIFT HANDOVER: PEDIATRIC PATIENT SAFETY<sup>1</sup>

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**ABSTRACT:** Qualitative, exploratory-descriptive study. The aim of this study was to discover how nursing professionals perceive the communication during shift handover and its repercussion in pediatric patient safety. This study was performed at a Pediatric Inpatient Unit of a University Hospital in the South of Brazil. Data was collected by a semi-structured interview, involving 32 nursing professionals. To analyze the data, thematic analysis was used. Data was grouped in categories: shift handover and its interface with communication. The results evidenced the importance of shift handover, in which effective communication is essential for safe care. However, greater objectivity is needed in the information transmission, the time used needs to be reduced and the shift handover records need to be systemized.

**DESCRIPTORS:** Communication. Shift work. Safety. Pediatric nursing. Child, hospitalized.

## COMUNICAÇÃO NA PASSAGEM DE PLANTÃO DE ENFERMAGEM: SEGURANÇA DO PACIENTE PEDIÁTRICO

**RESUMO:** Estudo qualitativo, exploratório-descritivo com o objetivo de conhecer a percepção dos profissionais de enfermagem sobre a comunicação durante a passagem de plantão e sua repercussão na segurança do paciente pediátrico. Realizado em Unidade de Internação Pediátrica de um Hospital Universitário do sul do Brasil. Os dados foram coletados por entrevista semiestruturada com 32 profissionais de enfermagem. Utilizou-se a análise temática para análise dos dados, agrupados na categoria: A passagem de plantão e sua interface com a comunicação. Os resultados evidenciaram a importância da passagem de plantão, sendo essencial a comunicação eficaz para o cuidado seguro. Porém, há necessidade de maior objetividade na transmissão das informações, redução do tempo utilizado e sistematização dos registros para a passagem de plantão.

**DESCRIPTORES:** Comunicação. Trabalho em turnos. Segurança. Enfermagem pediátrica. Criança hospitalizada.

## COMUNICACIÓN EN LA ENTREGA DEL TURNO EN ENFERMERÍA: LA SEGURIDAD DEL PACIENTE PEDIÁTRICO

**RESUMEN:** Estudio cualitativo, exploratorio-descriptivo que objetivó conocer la percepción de los profesionales de enfermería sobre la comunicación durante la entrega de turno y su repercusión en la seguridad del paciente pediátrico. Fue realizado en una Unidad de Internación Pediátrica en un Hospital Universitario del Sur del Brasil. Los datos fueron recolectados por medio de entrevista semiestructurada con 32 profesionales de enfermería. Se utilizó el análisis temático para el análisis de los datos. Estos fueron agrupados en la categoría: entrega de turno y su interconexión con la comunicación. Los resultados evidenciaron la importancia de la entrega de turno, siendo esencial la comunicación eficaz, para un cuidado seguro. Sin embargo, hay necesidad de una mayor objetividad en la transmisión de las informaciones, de la reducción de tiempo utilizado y de sistematizar los registros para la entrega de turno.

**DESCRIPTORES:** Comunicación. Trabajo por turnos. Seguridad. Enfermería pediátrica. Niño hospitalizado.

## INTRODUCTION

Patient safety is a source of discussion in recent times, in Brazil as well as internationally, mainly because of its importance for the health system and the repercussions for society in general.<sup>1</sup>

The initial concerns with patient safety emerged as from 1999 at the Institute of Medicine in the United States of America, through the publication of the book *To err is human: building a safer health care system*, which appointed the mortality data deriving from avoidable errors in health care and their costs. These evidenced the need for changes in patient safety.<sup>2</sup> That has been a priority of the World Health Organization (WHO) since the 55<sup>th</sup> World Health Assembly held in 2002.

In 2004, during the 57<sup>th</sup> World Health Assembly, the Global Patient Safety Alliance was created to facilitate the development of patient safety practices and policies in different countries, through programs that target the achievement of this objective.<sup>3</sup> This alliance elaborated some international targets, among which we highlight the improvement of effective communication among the health professionals.<sup>4</sup>

The effectiveness of communication among health professionals reduces the occurrence of errors and, consequently, favors patient safety.<sup>5</sup> The consequences of communication errors can cause significant patient damage, rupturing the continuity of the treatment and the quality of care.<sup>6-7</sup>

In view of these issues, the shift handover can be considered an essential activity for communication, supporting the continuity of care.<sup>8</sup> This practice, in turn, is intended to transmit information about the events that happened during a certain shift objective, clear and concisely, granting the professionals an overview of the sector and the patients' evolution, facilitating the planning and organization of their activities.

During the shift handover, communication is used as a basic tool and, in this process, different forms can be adopted, among which the spoken and face-to-face verbal form are the most used. On the other hand, these forms can be considered insufficient when they are used exclusively, compromising the patient safety. The use of other associated tools should be considered, as well as written records of the information that is relevant for the continuity of care.<sup>9</sup>

In pediatrics, patient safety represents a challenge. Estimates appoint that the probability of patient damage is thrice as high in hospitalized children when compared to adults.<sup>10</sup> In view of the hospitalization, many factors are involved in the safety of children and adolescents, due to their particularities in terms of frailty, vulnerability and peculiar growth and development conditions, demanding special attention from the professionals, mainly concerning effective communication in the care process. Pediatric patient care involves the prevention of errors and the analysis of what factors caused them, with a view to implementing measures and improvements to reduce them.<sup>11</sup>

Hence, in view of the importance of the theme, the question that guided this study was: how do the nursing team professionals perceive communication during the shift handover and its repercussion for pediatric patient safety? Based on this question, the goal was to get to know the nursing professionals' perception on communication during the shift handover and its repercussion for pediatric patient safety.

## METHOD

A descriptive and exploratory study with a qualitative approach<sup>12</sup> was undertaken at the Pediatric Inpatient Unit (PIU) of a University Hospital in the South of Brazil in the first semester of 2012. The selection of the study participants was intentional, including nursing professionals who worked at the PIU of the institution, were directly involved in care delivery to children, adolescents and families and participated in the shift handover. The inclusion criteria used were: having a job contract with the institution and working at the pediatric nursing ward at the time of the data collection.

In total, 32 nursing professionals complied with the inclusion criteria, all of whom accepted to participate in the study and signed the free and informed consent form. Then, the researcher scheduled a semistructured interview at a private location in the institution. A script was followed which consisted of two parts: the first served to characterize the participants, including questions related to age, sex, education, professional category, how long the professional had worked at the institution and the number of job contracts; and the second contained guiding questions on: communication as an important tool for the shift handover; description

of a shift handover; importance of the handoff for the continuity of nursing care and for the safety of hospitalized children and adolescents; and suggestions to improve communication during the shift handover.

All interviews were recorded and later fully transcribed. To analyze the data, thematic analysis was used, operated based on the pre-analysis, when the material was read in detail to group the statements; and the exploration of the material to elaborate the recording units; next, the data were coded and organized in an analytic category, when the most significant statements were selected to illustrate the analysis and discussion of the results.<sup>12</sup>

The ethical principles of research involving human beings were complied with, in compliance with Resolution N. 466/12. The project was forwarded to the Ethics Committee at the institution and received a favorable opinion under number 2232 (2011). To guarantee the secrecy and anonymity, the data were identified using the letter N for nurses, T for nursing technicians and A for auxiliary nurses, followed by an ordinal number.

## RESULTS AND DISCUSSION

The study participants were seven nurses, 14 nursing technicians and 11 auxiliary nurses who were working at the PIU. Among these professionals, 29 were female, between 23 and 61 years of age; and three were male, between 33 and 49 years of age. The length of experience at the PIU ranged between one and 20 years. Nine professionals had more than one professional affiliation. Five professionals held a specialization degree, seven a Master's degree and one was taking a Ph.D.

Based on the interviews and data analysis, the following category emerged: the shift handover and its interface with communication.

### **The shift handover and its interface with communication**

The nursing professionals' perception revealed that, during the shift handover, they share information, assess and decide on what care to deliver. At the same time, the nursing team shares the actions performed during a certain shift, reporting on the events and changes in the health conditions and other problems of pediatric patients.

These aspects were observed in some statements: [...] *during the shift handover, you find out about all inpatients, you get an overview of the entire unit, it's an information exchange among the employees (T1); [...] the shift handover is a means to guarantee that the team will continue the care and the safety of the child (T5); The shift handover is a means we have to avoid any rupture in the information flow, to obtain continuity. Without the handoff, the information would be deviated, not reaching the other team members correctly (N4).*

Therefore, the handoff is perceived as a moment of interaction among the nursing professionals who close off and those starting their shift, besides offering updates on the patients' health condition and helping the professionals to select priorities in the care that is due.<sup>10</sup>

Another issue the participants appointed refers to the organization and dynamics of the shift handover. The nursing team assesses the shift handover positively and strengthens that its dynamics is organized and systemized, contributing to the safety of pediatric patients.

*Among all places where I have worked, the shift handover is the most organized here and certainly helps with patient safety (T2).*

*The way the shift handover is organized, that is, when the entire nursing team participates, it gets easier to guarantee the continuity and safety of care (N5).*

In recent years, precise and operational forms have been constructed for the shift handover, without a consensus or standardization for this activity, which can significantly influence the continuity.<sup>9</sup>

In different health contexts, the shift handover varies strongly and sometimes in a hardly reliable manner. Therefore, around the world, it has been considered a high-risk area for patient safety. The shift handover is both subjective and abstract, with difficulties to be developed in a single and representative way.<sup>8</sup>

In this sense, no consensus exists in the literature on the most indicated model for the shift handover and few studies have focused on this matter. At most hospitals in Brazil, the shift handover is not standardized. Some motives can influence the development mode of this activity, including the constitution of the nursing team, the organization of the work and the meaning of the communication process for the professionals involved.<sup>14</sup>

Another relevant aspect for the shift handover is the nursing team members' effective participation, considering that each of them complements the information to guarantee the quality and continuity of the care. Some statements illustrate this aspect: [...] *during the shift handover in pediatrics, the nurse generally passes shift and the nursing team completes it (A3). [...] the team complements the information the nurse may not have mentioned, or which the technician finds relevant [...] questions are asked and problems are reported on (T11).*

As appointed earlier, the shift handover aims for the continuity of care. This aspect rests on the Ethics Code of Nursing Professionals, chapter I, article 16, which determines that Nursing has the responsibility and duty to guarantee the continuity of nursing care in conditions that offer safety.<sup>15</sup>

For the shift handover, (oral and written) verbal communication is used. Therefore, high-quality records need to be elaborated, that is, containing reliable and coherent information in accordance with the patient's actual conditions and reporting on the care that was actually delivered.<sup>16</sup>

The participants appointed that the registration of complementary observations is a tool that supports written communication, guiding the shift handover.

*The nurse uses the nursing notes made by the technical team as a baseline tool, she first informs on the problems (N5).*

*The records always need to be well written, clarified and detailed (N4).*

*The nurse hands off the shift and we register everything on a sheet (T2).*

As 50% of the information on the care the health team delivers comes from the nursing professionals, it is now expected that the records these professionals make permit effective communication, with a view to guaranteeing the transfer of the necessary and precise information, thus minimizing the risks associated with human errors.<sup>18</sup>

During the shift handover, spoken or written verbal language can be used. In written language, the records made serve to provide information on the care provided, to guarantee the communication among the health team members and to guarantee the continuity of the information 24 hours per day, being fundamental for patient safety.<sup>18</sup>

Written verbal communication emerged from the participants' testimonies as a type of complementary communication the nursing professionals use during the handoff, reducing the possible of omitting important issues and/or that could be forgotten if only spoken verbal communication were used.

This aspect goes against the literature findings, in which the shift handover is frequently informal and the available documentation is rarely used to support verbal communication of any kind.<sup>19</sup>

On the other hand, the spoken verbal transfer is incomplete when compared to the information available in the patient records or to a predefined handoff protocol.<sup>20</sup> Nevertheless, often, the fact that passing information on a small number of highly relevant items can be more effective than on a larger number of less relevant items is ignored.

The nursing professionals mention that the time dedicated to the handoff can influence the continuity of care positive or negatively.

*[...] there are preset times for the shift handover 7-13-19 hours. [...] taking 15 to 30 minutes on average (T3).*

*Sometimes, you lose your patience and focus because plenty of detail is passed, everything and the handoff becomes very long with repeated things and suddenly there are data that should be transmitted but are not (N3).*

The shift handover is an activity that consumes the professionals' time, willingness and commitment and happens at every shift change. The duration of the information transfer is not limited to the communication *in locu*, that is, preparation is needed, using background notes, and a final analysis of what will be transmitted to the other professionals, considering standardized information to contribute to effective communication.

A lengthy shift handover is often tiresome and causes demotivation for the professionals. Hence, agility and objectivity in the transmission of information reduces the time used for this activity, allowing the professionals to spend more time on pediatric patient care. Repetitive and irrelevant information can often overlap with important information.<sup>20</sup>

In addition, some handoff dynamics are lengthy and exhausting, making the nursing team

ignore fundamental aspects related to the patient and the unit, leading to superficial information, making it yet another task to be complied with.<sup>21</sup> Therefore, the shift handover is vulnerable to these limitations. Thus, it should be restructured, guaranteeing the safety of patient care and at the same time limiting the risk of errors.<sup>22</sup>

Communication is considered an essential component for patient safety, in accordance with the following statements: [...] *if communication during the shift handover is incomplete, it can lead to inappropriate care* (N3); *when communication is not effective, there is a risk of inappropriate information, incorrect information, information with noise and that negatively affects patient safety* (T4).

In a systematic literature review, it was identified that clear and structured language and the use of different communication techniques are fundamental for patient safety. In the same review, communication by responsibility transfer is presented as a structured method that permits the cohesive and reliable transfer of information between the shifts and service units.<sup>21</sup>

The study participants acknowledge that effective communication leads to the clarification, understanding and sharing of knowledge, being essential for the quality of care delivery to hospitalized children and adolescents. They also consider that, when the problems are not informed or when communication is ineffective, this leads to a mistaken understanding, with negative repercussions for pediatric patient safety.

[...] *Mistaken communication makes the patient totally lose structure and us too* [...] (N1).

[...] *If I transfer mistaken, insufficient information, that will compromise care and, consequently, patient safety* [...] (N2).

*Communication serves to pass doubts to a colleague, so that, before taking any conduct, that doubt is verified in order not to take the risk of doing something wrong* (A7).

Errors in the communication process at health institutions compromise the patient safety and adverse events can be reduced or avoided if information is transmitted more appropriately among professionals.<sup>23</sup>

Hence, the imprecision or omission of important data can cause problems for the hospitalized child and adolescent, as well as for the nursing team professionals.

*Getting partial, mistaken information due to a lack of attention, that information will be transmitted wrongly during the next shift, that causes damage and interferes with safety* (A9).

[...] *if communication is not effective, that compromise the safety of the child, the adolescent and the team* [...] (T3).

Communication errors mean the distortion or omission of data that can result in assessment errors in the conduction of care and treatment.<sup>24</sup> These can occur due to a lack of teamwork, a lack of professional training and the non-use of standardized communication tools, as well as to the vertical hierarchy and interpersonal conflicts.<sup>25</sup>

The nursing professionals identified some variation in the operation of the handoff at their unit, causing relevant concerns with regard to pediatric patient safety. They illustrate a gap with regard to the consensus on the information needed for the shift handover, as can be identified in the following statements: [...] *first, it is important to mention the name, age, presence of a companion, medical diagnosis, that is important to guarantee safety* (N5); *many children are using oxygen therapy, venous access, everything has to be repeated during the handoff* [...] (T5); *necessary and pending tests, as well as significant results that can interfere in the safety of the child or adolescent* (N4).

Thus, the information transmitted during the shift handover directly influence safe care. The nursing team considers that the pediatric inpatients should be identified correctly and that action is fundamental to guarantee safe care.

*Some children have similar names, therefore, correct identification is important, so as to avoid errors* (T2).

The identification problems of pediatric patients can lead to a series of negative consequences in care during hospitalization. According to WHO, effective identification involves three fundamental aspects: providing for the patient identification as early as during admission, having a visual and automated method to link the patient with his/her medical and therapeutic documentation and minimizing the possibility of transferring the identification data between patients. In addition, the importance of guaranteeing correct patient identification is emphasized, even if the professional is familiar with the patient, in order to guarantee the patient's right to receive correct care, as well as to

engage the patient and the family in the identification process.<sup>7</sup>

In that sense, the causes that can lead to errors at pediatric wards can be attributed to inappropriate patient identification, to the professionals' lack of experience, to the execution of technical procedures, to the calculation of medication doses, to communication problems between the emergency team and the professionals from the ward during shift handover between professionals and students and between professionals and relatives. Other sources of errors at these units include diagnostic and medication errors and environmental deficits, including malfunctioning equipment.<sup>7</sup>

In view of the above, it is clear that the shift handover should be systemized with standardized information. In that sense, according to the nursing professionals' reports, a tool was elaborated to contribute to nursing practice during the handoff, including the following items: identification of the child/adolescent (name and age); information on the presence of a companion; medical diagnosis; data about vital signs; clinical evolution; use of oxygen therapy; presence of venous access; food acceptance; bladder and intestinal elimination; past and pending tests; social issues for the child and family and administrative aspects of the sector.

This tool emphasizes the recommendation of the WHO program concerning the need to elaborate information communication protocols, as well as to use a standardized tool at the institution. An effective communication process is directly linked to the quality of the shift handover, as communication and information about the patients are essential for the health professionals to guarantee the continuity of care and patient safety.<sup>7</sup>

In pediatrics, the family should be included in care. The interaction among the team, the patient and the family is important to build bonds, respect and trust and to jointly program the best care form.

In their statements, the nursing professionals evidenced that the issues involving the family are also important and should be repeated during the handoff: [...] *it is also important to mention anything relevant that is happening to the family during the handoff, as that interferes in the care and safety of the child (T4); [...] I find it important to mention if the child has a companion, who that is [...] and how this family is doing, that greatly influences the continuity and the child's safety (N2).*

The nursing team acknowledges that taking care of pediatric patients also means taking care of the family, which is a fundamental part of care. Hence, understanding the family and social context the child and adolescent are inserted in contributes to the protection and safety of both. In view of these issues, knowledge is needed about their true needs during the handoff.

Anyway, it is highlighted that the nurse needs to establish effective communication, considering the difficulties of each relative to understand the information on the safety and health condition of the child and adolescent. The presence of the family member is extremely important as one of the main components to support coping with the disease.<sup>26</sup>

The results also appoint the need for an environment of teamwork and clear communication. These aspects are identified in the patient safety culture.

*[...] when the work targets safety, all professionals focus on that aspect, validating our professional commitment (N7).*

*[...] there needs to be a movement in which the entire team engages to achieve appropriate communication during the shift handover (N2).*

*[...] I think the first thing is to raise the team's awareness on the importance of the shift handover (T3).*

Overall, the nursing professionals' perception evidences that the quality of the handoff depends on an established safety culture, which involves the health professionals and the institution's commitment. It should be highlighted, however, that this culture is not simple and fast. On the opposite, the change will depend on the health professionals as well as the hospital managers, as they incorporate actions that permit the reconsideration of values to guarantee patient safety during the hospitalization.<sup>27</sup>

Hence, one of the pillars of pediatric patient safety is not just the nursing professionals' training or the quality of the institution's infrastructure, but the organizational culture.<sup>28</sup>

The nursing professionals highlight that the shift handover is a moment that favors technical, scientific and practical knowledge. That demonstrates the professionals' concern with proposing strategies and allocating resources to execute care based on technical-scientific knowledge, favoring pediatric patient safety: [...] *when there is something*

else or a disease we are not used to deal with, the nurse generally researches on that disease and information is transmitted during the handoff (T5).

The nursing team should aim for safe care, with as little risk or damage to the patient as possible and, to achieve this, they should rest on scientific knowledge, which is considered a fundamental element in this process. Scientific evidence can enhance the knowledge and the search for strategies to guarantee and promote pediatric patient safety. The professionals' doubts and uncertainties can promote adverse events, but these will be mitigated and solved by the search for knowledge.<sup>29</sup> Therefore, the shift handover is also a time of continuing education, with space for dialogue, inquiries and reflection of the nursing team to contribute to evidence based care.

Continuing education should be used as a management tool to improve the professional performance, contributing to an effective and safe practice, turning into a tool that can enhance communication and interpersonal relationships in nursing work.<sup>26</sup>

*I find it prudent for the nurse to hand off the shift, because she ends up having an overview of all children and of the unit too (N3).*

*When the nurse takes part in the handoff, we feel safer, because she can provide the orientations needed to guarantee the children's safety (T9).*

Nursing professionals are responsible for coordinating this activity, using the opportunity to clarify doubts and errors detected during the shift, aiming for orientations and technical qualification, reorganizing the care plan and listing the priorities and determining actions intended to guarantee the safety of pediatric patients.

## FINAL CONSIDERATIONS

The nursing professionals perceive the shift handover as an essential tool for the continuity of pediatric patient care, when they share information, assess and decide on further measures, in which the effective participation of all nursing team members is important.

The variation in the length of the shift handover pictured an aspect that can influence the quality of the information and the nursing team's participation in this activity. This appoints the importance of information records and of the

identification of the pediatric patients and their families as the focus of care.

In view of the magnitude and complexity involved in pediatric patient safety, nursing professionals should not only be concerned with the use of technological resources and/or with the improvement of techniques, but should also pay attention to the skills and competences to achieve effective communication during the shift handover.

Discovering how the nursing team perceives the shift handover permitted reflection on the communication and its interface with patient safety, as these professionals experience the nuances of this activity. Another important issue is related to the need to systemize the shift handover, making communication effective, thus considering the particularity of pediatric patients and their families.

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